DEPARTMENT OF THE ARMY
U.S. ARMY CRIMINAL INVESTIGATION COMMAND
Camp Cropper CID Office
20th/1149th Military Police Detachment (CID), 11th Military Police Battalion
(CID), Camp Cropper, Baghdad, Iraq APO AE 09342

22 May 2008

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - FINAL (C)/SSI - 0010-2008-CID789-53199 - 5H9A

DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 29 MAR 2008, 1348 - 29 MAR 2008, 1348; BED 4, INTENSIVE CARE UNIT, 31ST COMBAT SUPPORT HOSPITAL, CAMP CROPPER, BAGHDAD, IRAQ

DATE/TIME REPORTED: 29 MAR 2008, 1555

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

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

VICTIM:
1. MUHAMMED AL-ITHAWI, TAHA DAHER (DECEASED); FRCIV; IRAQ; (DOB); (POB); MALE; OTHER; CAMP REMEMBRANCE II, THEATER INTERNMENT FACILITY, CAMP CROPPER, BAGHDAD, IZ; XZ ; [DEATH BY NATURAL CAUSES]

INVESTIGATIVE SUMMARY:

This is an Operation Iraqi Freedom Investigation.

This office was notified by SGT (b)(6), (b)(7)(C) Patient Administration Division, 31st

Combat Support Hospital (CSH), Camp Cropper, IZ APO AE 09342 (CCIZ), of the death of Mr MUHAMMED Al-Ithawi while treated in the Intensive Care Unit (ICU), 31st CSH, CCIZ.

Investigation determined Mr. MUHAMMED was admitted to the 31st CSH on 16 Mar 08 for numerous physical ailments to include an acute myocardial infarction, untreated diabetes and acute renal failure. Mr. MUHAMMED's physical condition deteriorated until his death on 29 Mar 08. An autopsy conducted by the Office of the Armed Forces Medical Examiner (OAFME) revealed Mr. MUHAMMED's cause of death was hypertensive atherosclerotic cardiovascular disease and the manner of death was reported as natural. The results of this investigation were consistent with their findings.

STATUTES:

N/A

EXHIBITS:

Attached:

1. Agent's Investigation Report (AIR) of SA (b)(6), (b)(7)(C) 12 Apr 08.
2. Medical Records of Mr. MUHAMMED.
3. AIR of SA (b)(6), (b)(7)(C) 29 Mar 08.
4. Human Remains Sketch prepared by SA (b)(6), (b)(7)(C) 29 Mar 08.
5. Photographic Packet (Remains Examination).
6. CD containing original images associated with Exhibit 5 (USACRC and file copies only).
7. AIR of SA (b)(6), (b)(7)(C) 9 Apr 08.
8. Photographic Packet (Autopsy).
9. CD containing original images associated with Exhibit 8 (USACRC and file copies only).

10. AIR of SA [(b)(6), (b)(7)(C) redacted] May 08.

11. Autopsy Report of OAFME pertaining to Mr. MUHAMMED, number ME08-0244.

12. DD Form 2064, Certificate of Death (Overseas), 1 Apr 08.

The originals of Exhibits 1, and 3 - 10 are forwarded with the USACRC copy of this report. The original of Exhibit 2 is retained in the files of TF31, Camp Cropper, Baghdad, Iraq APO AE 09342. The originals of Exhibits 11 and 12 are retained in the files of the Office of the Armed Forces Medical Examiner, 1413 Research Boulevard, Building 102, Rockville, MD 20850.

Not Attached:

None.

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

CID reports of investigation may be subject to a Quality Assurance Review by CID higher headquarters.

Report Prepared By:
(b)(6), (b)(7)(C)
[redacted]
Special Agent

Report Approved By:
(b)(6), (b)(7)(C)
[redacted]
Special Agent in Charge

DISTRIBUTION:
Dir, USACRC, Ft Belvoir, VA (Original)
Commander, 20th/1149th MP DET (CID), Camp Slayer, Baghdad, Iraq APO AE 09342
Commander, 11th MP BN (CID) (FWD), Camp Victory, Baghdad, Iraq, APO AE 09342
Commander, 3D MP GRP (CID), USACIDC, Fort Gillem, GA 30297
Chief, DSCOPS, USACIDC, 6010 6th Street, Fort Belvoir, VA 22060
Director, Armed Forces of the Institute of Pathology, Office of the Armed Forces Medical Examiner, 1413 Research Boulevard, Building 102, Rockville, MD 20850
Commander, 31st Combat Support Hospital, Camp Cropper, Baghdad, Iraq APO AE 09342 (Email only)
FOB Commander, 1-161 Field Artillery, ATTN: LTC (b)(6), (b)(7)(C) [redacted] Camp Cropper, Baghdad, Iraq APO AE 09342 (Email only)
Commander, 744th MP BN, Camp Cropper, Baghdad, Iraq APO AE 09342 (Email only)
FILE

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER: 0010-10-CID789-53199

DETAILS

BASIS FOR INVESTIGATION: About 1555, 29 Mar 08, SA [redacted] was notified by SGT [redacted] Patient Administrative Department (PAD), 31st Combat Support Hospital (CSH), Camp Cropper, Baghdad, Iraq APO AE 09342 (CCIZ), of the death of Mr Taha Daher MUHAMMED Al-Ithawi, Internment Serial Number (ISN): US9IZ-324305-CI, Camp Remembrance II (CRII), Theater Internment Facility (TIF), CCIZ, while in the Intensive Care Unit (ICU), 31st CSH, CCIZ.

About 1612, 29 Mar 08, SA [redacted] interviewed MAJ (Doctor) [redacted] Attending Physician, ICU, 31st CSH, CCIZ, who related Mr MUHAMMED was admitted to the ICU on 16 Mar 08 for numerous ailments, to include an acute myocardial infarction, untreated diabetes, and acute renal failure. Further, MAJ [redacted] stated Mr MUHAMMED was given an emergency surgery for a gastro intestinal bleed, which was remedied by the procedure, however; Mr MUHAMMED went into a state of cardiac arrest subsequent to the procedure. MAJ [redacted] reported lifesaving measures initiated by the medical personnel brought Mr MUHAMMED out of cardiac arrest and into a stable condition. Additionally, MAJ [redacted] advised Mr MUHAMMED was administered 20 units of blood, numerous intravenous solutions, pain medication and diuretics. MAJ [redacted] related Mr MUHAMMED was placed on a "do not resuscitate order" due to his deteriorating condition and no dialysis machine to treat Mr MUHAMMED's kidney failure. Subsequently, MAJ [redacted] stated on 29 Mar 08, Mr MUHAMMED went into a state of cardiac arrest, from which he did not recover. MAJ [redacted] pronounced Mr MUHAMMED dead at 1348, 29 Mar 08. Further, MAJ [redacted] preliminarily opined the cause of death was cardiac arrest and manner of death as natural.

About 0845, 12 Apr 08, SA [redacted] coordinated with SSG [redacted] PAD, 31st CSH, CCIZ, who provided all medical documentation concerning Mr MUHAMMED. A review of the records indicated Mr MUHAMMED was admitted to the ICU, 31st CSH on 16 Mar 08 for physical ailments to include myocardial infarction, untreated diabetes, and acute renal failure. Mr MUHAMMED's physical state deteriorated over the course of his treatment until his death on 29 Mar 08. ///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
SA [redacted]	Camp Cropper CID Office, 1149th/20th MP DET (CID) Camp Cropper, Baghdad, Iraq APO AE 09342
SIGNATURE [redacted]	DATE: 12 Apr 08 / EXHIBIT: 1

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

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)*

600-00-4439

32 4305

Muhammed, Aha

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)*

1548-29-03-08

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

4. RELIGION

5. CHAPLAIN NOTIFIED ☐ YES ☐ NO

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

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* Cardiac Arrest	
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) Coronary Artery Disease	
	(2) Acute Renal Failure	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a. Diabetes Mellitus	
	b.	

9. DATE: 29 MARCH 08

10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE: (b)(6)

11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE: (b)(6)

SECTION B - ADMINISTRATIVE ACTION

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

SECTION C - RECORD OF AUTOPSY

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

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

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

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. USAPA V2.01

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	DISPOSITION OF BODY

RECEIPT OF BODY AT MORGUE

The body of _____ was received
(Name)

at _____ A.M. / P.M. on _____
(Date)

_____
(Signature)

CERTIFICATE OF REMOVAL

The body of _____ was removed
(Name)

by _____
(Name and address of undertaker

at _____ A.M. / P.M. on _____.
(Date)

_____ _____
(Signature of person releasing body to undertaker) *(Signature of representative of undertaker)*

The following statement shall be completed only when specifically ordered.

PHYSICIAN'S STATEMENT REGARDING CONDITION OF REMAINS AS RELEASED *(Describe post-mortem, surface discolorations, abrasions, lesions, incisions, whether remains were embalmed, etc.)*

THIS BODY CONTAINS A MEDICAL IMPLANT WHICH MAY INCLUDE A BATTERY OR POWER CELL. ☐ YES ☐ NO

_____
(Signature of physician)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name–last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.
000-00-4439 324305 Muhammed, Aha		

*U.S. GPO: 2000-461-707/20310

DISPOSITION OF BODY

Medical Record

STANDARD FORM 523-A (REV. 12-83)
Prescribed by GSA/ICMR, FPMR (41 CFR) 201-8.202-1

EXHIBIT 07

TAB

CERTIFICATE OF DEATH

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

INTERNMENT SERIAL NUMBER

FROM:

TO:

NAME (Last, first, MI)	GRADE	SERVICE NUMBER
Muhammed, Abu	DBT	600-32-4305

NATIONALITY	POWER SERVED	PLACE OF CAPTURE/INTERNMENT AND DATE

PLACE OF BIRTH	DATE OF BIRTH

NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN	FIRST NAME OF FATHER

PLACE OF DEATH	DATE OF DEATH	CAUSE OF DEATH
ICW, 31st CSH	29 MARCH 08	Cardiac Arrest

PLACE OF BURIAL	DATE OF BURIAL

IDENTIFICATION OF GRAVE

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

___ RETAINED BY DETAINING POWER

___ FORWARDED WITH DEATH CERTIFICATE TO *(Specify)*

___ FORWARDED SEPARATELY TO *(Specify)*

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

This man had suffered from a massive heart attack in the setting of diabetic ketoacidosis, followed by fulminent renal failure. Subsequent acidosis and volume overload led to cardiac arrest. He was pronounced dead at 1548 on 29 March 08. His death was peaceful.

DO NOT WRITE IN THIS SPACE
CERTIFIED A TRUE COPY

DATE
29 MARCH 08

SIGNATURE OF MEDICAL OFFICER
(b)(6)

SIGNATURE OF COMMANDING OF
(b)(6)

WITNESSES

SIGNATURE	ADDRESS
SIGNATURE	ADDRESS

DA FORM 2669-R, MAY 82 EDITION OF 1 JUL 63 IS OBSOLETE. APD V1.00

Exhibit 008 2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 MARCH 08	Death Summary
1550	Pt had been suffering from progressive renal failure leading to acidosis and volume overload. He had also suffered from a recent acute myocardial infarction at his admission during a severe diabetic ketoacidosis state. After initial stabilization, he developed an upper GI bleed requiring 20 units of blood products + emergent X-lap. Pt had mallory-weiss injury repaired in OR. However, pt continued to have problems c progressive renal failure, coagulopathy, another acute myocardial infarction. He suffered from cardiac arrest in less 48 hrs responding to shock, later developing tachyarrhythmia's (PSVT) responding to Ca channel blockade. However, his renal function continued to deteriorate, he did not regain renal function + did not respond to diuresis after multiple attempts. Disease process had been discussed with pt yesterday, and he agreed to no resuscitative efforts. Today, he continued to have increased volume overload, min urine output w/o response to diuresis, pulmonary edema, and acidosis. Pt later suffered from cardiac arrest + was pronounced dead. Mrs Muhammed was present at bedside was managed with IV morphine, and his death appeared very peaceful.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SP	

(b)(6)

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

600-00-4439
324305
Muhammed, Aha

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

Exhibit 00002

CAMP CROPPER 2008 0110 Page 1

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

* * * ADMISSION COVER WORKSHEET * * *

VOL II

Reg No: 0004497 Name: CROP,C600324305 FMP/SSN: 20/600-32 4305

ADMISSION

Date/Time: 16 Mar 2008@0410 Source: ERA MEPRS: ABAA
Sex: MALE Age: 55 DOB: 01 Jan 1953 Ward: ICU1

Patient Category: FRGN NAT POW/INTERNEE Pay Grade: Fly Status:
Marital Status: UNKNOWN Race: WHITE
Duty Zip: Ethnic: OTHER
Sponsor Name: CROP,C600324305 Religion: MUSLIM

MTF Trans from:
MTF of Initial Adm: Init Adm Date:
Disposition Date: 29 Mar 2008@1907 Type of Disposition: HOME

Sponsor Name: CROP,C600324305
Adm Physician: (b)(6)
Adm Diagnosis: SHORTNESS OF BREATH (786.05)
Adm Proc1:
Adm Proc2:

Administrative Remarks:

Cause of Injury:

Principle Dx:

Other Dx:

Principle Procedure:

Other Procedure:

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

Signature Attending Medical Officer

*** End of Report ***

Exhibit 010 2

PERSONAL DATA - PRIVACY ACT OF 1974

RECORD OF INPATIENT TREATMENT

REGISTER: 0004497 NAME: CROP,C600324305 FMP/SSN: 20/600-32-4305

A D M I S S I O N

DATE/TIME: 16 Mar 2008@0410 SOURCE: ERA CLIN SVC: GEN SUR/ABAA
SEX: M DOB: 01 Jan 1953

D I S P O S I T I O N

DATE/TIME: 29 Mar 2008@1907 TYPE: HOME CLIN SVC: INT MED/AAAA
AGE : 55

D I A G N O S E S

DX 1. Principal DX: 78605
SHORTNESS OF BREATH

P R O C E D U R E S

PR 1. Principal PR: NO PROCEDURES ON FILE

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

ATTENDING PROVIDER (b)(6)

Provider Taxonomy: 2083P0901X
PHYSICIANS/ALLOPATHIC/OSTEOPATHIC/PREVENTIVE & OCCUPATIONAL MEDICINE/PUBLIC HEA

DRG: RECORD NOT GROUPED

MDC:

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

ADMISSION:

PATIENT CATEGORY: FRGN NAT POW/INTERNEE
MARITAL STATUS: UNKNOWN
DUTY ZIP:
MTF TRANS FROM:
MTF OF INITIAL ADM:

PAY GRADE:
RACE: WHITE
ETHNIC: OTHER
RELIGION: MUSLIM
INIT ADM DATE:

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

DISPOSITION:

MTF TRANS TO:
ICU CLINICAL SVC:
BED DAYS OTHER FEDERAL FACILITIES:

AUTOPSY:
ICU DAYS SPENT: 12
MEDICAL HOLD DAYS:

REGISTER: 0004497 NAME: CROP,C600324305 FMP/SSN: 20/600-32-4305

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

*** CONTINUED ON PAGE 2 ***

PERSONAL DATA - PRIVACY ACT OF 1974

RECORD OF INPATIENT TREATMENT

REGISTER: 0004497 NAME: CROP,C600324305 FMP/SSN: 20/600-32-4305

BED DAYS CIVILIAN HOSPITALS:
BED DAYS THIS MTF: 13
TOTAL SICK DAYS THIS MTF: 13
CONVALESCENT LEAVE TAKEN: 0

COOPERATIVE CARE DAYS: 0
SUPPLEMENTAL CARE DAYS: 0

RECOMMENDED: 0

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

OTHER:

SPONSOR NAME: CROP,C600324305
DUTY ADDRESS:

MATERNAL/NEWBORN REGISTER:

EMERGENCY ADDRESSEE:
RELATIONSHIP:
NAME:
ADDRESS:

PHONE:

PATIENT ADDRESS:

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

PREV ADMISSION THIS MTF: Y
UNITS:

INJURY REMARKS:

CLINICAL RECORDS APPROVAL SIGNATURE BLOCK:

_____ _____

Medical Record Approved by Date

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

*** End of Report ***

DATE	NOTES
7 MAY 08	0700 - PT RECEIVED A+OX3, NAD, NO SOB, NO CAW/N/V/D/HA/CP. VSS. MAE. SAO2 100% ON RA. FOLLOWS ALL COMMANDS. RESTING COMFORTABLY IN BED. (b)(6)
	0815 - DRESSING TO (L) FOOT A'D BY MD @ BEDSIDE. NO C/O PAIN. WOUND PACKING. REPLACED W/ IODOFORM W/ IODINE. (BETADINE). DENIES SOB/CP. (b)(6)
	1235 - EKG RECORDED ON PT ~~W~~ W/ COMPLICATION. (b)(6)

IONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
RT./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
T'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
AFD PE v1.00

600-32-4305
ICU#3

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17Mar08	(0115) BS 309. Discussed c (b)(6) Recieved new orders. Gave 8units Reg insulin sc now. Pt. denies CP/dizziness/nausea. VSS. NAD. IVF d'd to 1/2NS@150cc/hr. Will check BS q4hours and follow insulin sliding scale written previously by (b)(6) (b)(6)
	(0200) Lungs remain CTA c diminished bases. 0SOB. BS 303. Notified (b)(6) + received new orders.
	(0220) Gave 500cc NS bolus. (b)(6)
	(0245) Pt. amb c assist x2 to BR. Had med soft tan BM. (+) flatus. Amb back to bed. No problems. (b)(6)
	(0400) Pt. reassessed. Lungs CTA c diminished bases bilat. VSS. No other As noted. BS 363. Gave 10 units Regular insulin per sliding scale. Pt. has not had anything to eat or drink all night. UO decreasing and is now cloudy + tan colored. Will notify MD. (b)(6)
	(0515) Discussed BS↑ c (b)(6). Received order for bolus. Gave 500cc NS bolus now. Will notify (b)(6) in a.m. about ↑BS + poor results c sliding scale. (b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*		REGISTER NO.	WARD NO.	

PROGRESS NOTES
Medical Record

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

600-39-4305
ICU #3

Exhibit 2
000014

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16Mar08	(2210) Interpreter at bedside. Explained to pt. he is receiving Kayexalate to ↓K+ level in blood. Pt. made aware it may cause diarrhea & to ask to go to bathroom prn. Pt. agreed & verbalized understanding. Lungs re-assessed & remain CTA all lobes. ϴ SOB/CP. RR 15-22. sats 98% on RA (b)(6)
	(2228) BS now 195. Insulin gtt off since 2100.
	(2240) Notified (b)(6) of ↑ BS. Received new order. Gave 4units Regular insulin SC. Will re-check (b)(6)
	(2300) Post-transfusion CBC drawn & sent to lab. Drsng Δ done to (L) foot. Great toe + 2nd toe have been amputated previously. Wound covers toes + top of foot. Dry, necrotic, flaky tissue noted c 2 deep holes on top of foot. Moderate amount whitish-yellow thick mucousy drainage noted. Multiples moist yellowish wounds noted between remaining toes. Packed deep wounds c Dakins soaked fluffs and covered c Ace wrap. Pt. tolerated well. No c/o pain. Able to wiggle toes on command. Unable to find DP pulse c Doppler. Found PT pulse c Doppler (b)(6)
17Mar08	(0005) Pt. re-assesed. Lungs CTA c diminished bases. sats 98-100% on RA. ϴ dyspnea|CP|pain|v|n|d. No other As noted. BS now 188. Discussed c (b)(6) Said to re-check in 1° and discuss c MD again. D5½NS @ 150cc/hr. UO 20-30cc/hr. (b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*		REGISTER NO.		WARD NO.

600-32-4305

ICU #3

PROGRESS NOTES
Medical Record

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

Exhibit 2
000015

AUTHORIZED FOR LOCAL REPRODUC

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 Mar 08 0845	Report received from (b)(6) assumed care of pt at 0830. Will continue to monitor. (b)(6)
0935	Nurses Note: Pt given 10 units Reg Ins per MD order 0840. Will continue to monitor (b)(6)
1035	Nurses Note: Pt "BG" upon assessment 572. Insulin drip at 5cc/hr gtt will continue (b)(6)
14 Mar 08	(1900) Received report & assumed care of pt. VSS. Assessment done. See flowsheet. PRBCs infusing at 125 cc/hr. Pt. in NAD & denies pain. Denies appetite. No food eaten today. Insulin gtt @ 4 units/hr. See BS flowsheet. Will monitor (b)(6) (1930) Lab results from 1830. K+ 6.1, CO2 11, BUN 62, Cr 3.6. (b)(6) at bedside & aware. (b)(6)
	(2100) Insulin gtt discontinued per order. BS = 111 at this time. D5 1/2 NS ↑ to 125 cc/hr. PRBCs were completed at 2010. Bag turned into lab. No reaction to transfusion noted. See SF 518.
	(2125) 8 units NPH insulin given SC. Order was clarified by (b)(6) Will start 10 units NPH BID in a.m (b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

600-32-4306.
ICU #3.

HORIZED FOR LOCAL REPRODUCTION

DICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7MAR08	NURSE NOTE - ASSUMED CARE OF PT, ASSESSMENT —
330	COMPLETE, AOX3, GCS 15, 4mm PUPILS & PERRLA, PMS
	X4, MOVES ALL EXTREMITIES AGAINST GRAVITY & RESISTANCE,
	MUSCLE STRENGTH GOOD X4 EXTREMITIES, HR TO'S, NO
	ECTOPY NOTED LD II, GOOD S,S, NO ABNORMAL HS NOTED,
	SKIN WARM/DRY, COLOR GOOD FOR RACE, SKIN TURGOR
	↓ LUE, CAP REFILL <3 SEC ALL EXTREMITIES, RESP RATE
	LOW 20'S & REG RYTHM, ADEQUATE CHEST EXPANSION
	LUNG SOUNDS CTA ALL FIELDS, NO COUGH NOTED @
	THIS TIME, PT ON ROOM AIR & O2SAT 97-99, —
	ORAL MUCOSA PINK/MOIST, 75% OF DENTITION
	GONE - REMAINING IN POOR CONDITION, ABD DISTENDED
	NON-TENDER, NO GUARDING NOTED, F/C IN PLACE
	DRAINING YELLOW URINE & SEDIMENT, SKIN CONDITION
	FAIR, DSG TO ⓑ FOOT C/D/I, PIV TO BILAT AC - SITES
	C/D/I. — Agree w/ assessment (b)(6)
8MAR08	NURSE NOTE - BLOOD DRAWN FOR LAB & DIFFICULTY
0020	VSS, WILL MONITOR — (b)(6)
8MAR08	NURSE NOTE - NOTICED PT LUE STARTING TO GET
145	EDEMATOUS - ELEVATED ON FOLDED BLANKETS, VSS
-A	WILL CONTINUE TO MONITOR — (b)(6)

IONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
T./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
'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.	

600-32-4305

ICU #3

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
APD PE v1.00

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EDICAL RECORD | PROGRESS NOTES

DATE	NOTES
19 March 08	PT seen @ bedside Resting comfortably in NAD.
	PT states he has no noted pain (L) Foot. PT
(S)	was admitted to Hospital secondary to DKA PT also has
	Diabetic ulceration s/p amputation (L) Foot surgery s/p approx
	14 days.
(O)	VASC DP/PT 2/4 CFT <3 secs 1-5 B/L skin temp W→W
	P→D below knee to digits B/L
	PERM noted amputation site (L) Foot 1st/2nd digit with
	noted opening (L) 2nd metatarsal area dorsally with
	necrotic tissue (L) dorsal foot at amputation site 1st digit
	muscle strength 5/5 all groups tested B/L. Incision site
	LEFT dorsal Foot over 2nd met with noted Dehiscence.
	currently there are no clinical signs infection (L) Foot.
(A)	1) Diabetic amputation site with dehiscence dorsally at
	2nd met
(P)	1) Exam/Eval
	2) DSD change using Iodoform gauze with Betadine
	3) F/U QD For dressing changes POR Podiatry

(b)(6)

19 March 08

TIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
RT./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

T'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.

600-32-4305

ICU 4

PROGRESS NOTES
Medical Record

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Exhibit 2
000018

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29 marus 1543	Called to bedside to pronounce pt in Bed 4 pulseless and apenic ~5 min. Arrived to find pt s pulse or respirations. Pronanced pt death @ 1543.

(b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER *(SSN or Other)*
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*		REGISTER NO.	WARD NO.	

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 Mar 08	0705 Pt's HR 150's, narrow QRS on monitor. ? SVT v A-fib c RVR. Pt did not respond to carotid massage. (b)(6) called to bedside. 6mg Adenosine given IVP. Pt's HR ↓ 80's-90's, rhythm switching between A-fib and sinus. (b)(6)
	0719 HR 160's. Responded to carotid massage immediately. HR 90's (b)(6)
	0725 IV fluids on hold.
	0740 HR 160's. (b)(6) @ bedside. 6mg Adenosine IVP given. HR 90's
	0749 20mg Diltiazem given IVP. HR 80's. IVF ↓ to 75 ml/hr (b)(6)
	0840 Pt appears to have stabilized - HR 80's-90's since diltiazem given. Continues to have PAC's and PVC's. (L) radial arterial line zeroed, good waveform noted on monitor. Pt lying quietly @ this time. Lifepak + crash cart remain @ bedside for time being. See ICU flowsheet for assessment findings and hourly VS, I+O documentation. (b)(6) continue to monitor closely
	0853 HR 150's, narrow QRS. Carotid massage done, HR 90's. (b)(6) bedside. 25mg diltiazem given IVP. (b)(6)
	1100 Pt made DNR/DNI @ 1040 (b)(6)
	1215 Pt reassessed. Lungs remain clear. IVF @ 100/hr. Pt currently on bedpan. VSS, afebrile. Monitoring (b)(6)
	1400 Pt passed very small, formed stool earlier on bedpan. Approx 50mL serous fluid drained from scrotum into bedpan (cont'd)

LATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
PART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO.	WARD NO.

600-32-4305
ICU #4

PROGRESS NOTES
Medical Record

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USAPA V1.00

Exhibit 0020202

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29MAR08	0700- PT RECEIVED A+OX1, FOLLOWS SOME SIMPLE COMMANDS. APPEARS SOMEWHAT CONFUSED. NAD. NO NOTED SOB. MAE. +3 EDEMA TO ABDOMEN + SCROTUM. (SCROTUM IS 10X LARGER/DISTENDED THAN USUAL). WOUND TO LLE (FOOT) IS OOZING GREENISH YELLOW DRAINAGE AND HAS VERY FOUL ODOR. (b)(6)
	1300- PT HAS OCCASSIONALLY- APNEIC PERIODS IN BETWEEN RESPIRATIONS. APPEARS TO BE GASPING. ROUSES TO CONFUSED STATE. MAE. SAO2 91%. (b)(6)
	1435- MD PAGED FOR PT'S SAO2 OF 75%, HR 61. OCCASIONAL PERIODS OF APNEA. PT ON 4L NC. (b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER *(SSN or Other)*
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*		REGISTER NO.	WARD NO.	

600-32-4305

ICU 4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CA.
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each)
5/16/08	2330 after labs Returned Pt seen to have ↑ kt @ 6.9. EKG showed borderline LBBB. foley placed, IV $CaCl_2$ given, Insulin/glucose, kayexalate, Lasix given. will treat pt as possible Acute (L)heart CHF due to lack of (R) side heart failure and ↑BNP. No signs Acute ischemia on EKG and absence of chest pain subjectively. Acute Renal failure likely Pre-renal but unsure @ this time. Cannot procede w/ CTangiogram
to RAPE	@ this time due to ↑Creatine. Also cannot give ut heparin dosing of Lovenox due to Renal failure. Started on Bi-pap in ER which significantly decreased pts work of breathing and Resp rate. Also started on Nitro paste/ASA in ER. will treat w/ Lovenox 30mg SQ BID due to Renal failure and monitor for signs of Bleeding. Most likely Dx Acute CHF or asthma/COPD with Acute Renal failure.

(b)(6)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*		REGISTER NO.	WARD NO.

600 324 305

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

Exhibit 2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 Mar 08 @ 0430	Admitted to ICU via stretcher from E.R. Awake, cooperative. Denies pain, dsabic-speaking. MAE x4 spontan. to command BIPAP 10/5, FiO_2 = 0.50 where SaO_2 @ 100%. Breathing is even, mildly labored, R=26. Tolerating facemask w difficulty. (R) AC PIV (20ga) w redness or swelling, dsng dry & intact. (L) foot c first and second metatarsals amputated, tissue appears black and necrotic.
16 Mar 08 @ 0600	Blood drawn for BMP, sent to lab earlier. ↓ FiO_2 to 0.40 via BIPAP 10/5. Pt is asleep. K = 6.5 meq/l, glucose = 336 mg/dl. Pt receiving Solumedrol, IV and Regular insulin, IV in E.R. (b)(6) has reviewed lab results, no new orders.
16 Mar 08 @ 0700	EKG @ bedside to compare to previous studies. (b)(6)
16 Mar 08 @ 0715	Report given to nurse assuming care of pt. (b)(6)
16 Mar 08 @ 1900	Pt is an iraqi ♂ male admitted for difficulty breathing sub ♂ ↑ wob ♂ asthma. Pt complains of ↑ wob ♂ sob. Pt is currently on Bipap of H-peep 10 low peep 5 ♂ 35%. Pt RR between 20-25. Pt is tolerating Bipap well. Pt is on ♂ off sleeping. Pt is on RL A/b/Attending Notes. Pt shows no signs of any difficulty breathing. Bs are dim t/o. Vitals HR 102, BP 142/79, RR 22, SpO_2 100%. Will continue to monitor ♂ wean pt. (b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY: Cropper	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) 600-32-4805		REGISTER NO.	WARD NO.: ICU	

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.0C

ICU #3

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Memorial

0830

ICU Admit Note

Pt is 55yo M detainee admitted for COPD exacerbation c/b fever to have Ibuprofen this am s/w NSTEMI. Pt presented to ED from DMC c 9503 x 3d and CP x 1d. Pt reports chest tightness yesterday progressing throughout the day (pressure c/b chest) and 9503. ER described extremely & accessory muscle use — responded very well to nebs per pt. Placed on BiPAP, TnI meh. ECG showed ST depressions laterally 1mm, resolved p Ibuprofen (? NTG paste). Given ASA, sublingual, nebs, zosyn for foot wound.

DMHx

CRF (c 3 16th)

DM (on insulin)

COPD (by hx)

?CHF in chart

Meds

Pt admission

Pt is breathing comfortable — b/l BBP noted c/w RR 17, K 6.9, pH 7.2, urine output for last hour, BG > 400, 1st dose @ 5.

NKDA

V5 - afebrile, 140's systolic, HR 80's, RR 20's
NAD — says much much better
HOOWT - @ JVD, Pulm
C - CTA bl anteriorly → post. rales @ 1/3 way up BL
C - RRR
abd - obese, NT, NBS
ext - edema, dressing on @ foot.

ABG on BiPAP - 7.23/33/149

133 | 98 | 63
6.9 | 18 | 3.2

(b)(6)

@ foot → necrotic tissue overlying wound, purulence expressed @ suture line. Open wound probed, but not to bone

12 / 27 / 405

(con't).

Alk phos - 101/20/134/0.5

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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GOO-32-4305

JCU #3

Exhibit 2

000024

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Ortho
16 Mar 08	Asked by ICU to eval Lt foot.
	Briefly, 55yo ♂ c MMP included CAF, DM, COPD, CHF,
	also in mild DKA upon admission. Had 1st/2nd toe amputation
	approx 10-14 days ago.
	AF upon admission, VSS & clinically stable
	Left foot - dorsal incision on 1st c sutures, mild purulence
	dorsal draining on 2nd open c minimal purulence
WBC 12	DP+PT dopplerable (biphasic), sens to, ↓ pain c
	palpation. Probed both wounds (after releasing 1st sutures)
	no new significant purulence, no blind tracts, no exposed
	pus
	XR - pending
	A/P - would not recommend further surgery / amputation at
	this stage, BID dressing Δ/pack c Dakins
	- cont Abx per ICU/ID recs

(b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*		REGISTER NO.	WARD NO.	

Gov-32-4305 ICU-3

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
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Exhibit 2

000025

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MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

ICU Note

17 Mar 08 1230

S: Pt is HD #2 for CHF, CAD, NSTEMI, ~~DKA~~, ARF. He states he feels much better since admission. He denies any CP, SOB, N/V. Pt no longer in DKA. Pt off of insulin gtt and on SC insulin. His serum ketones are negative.

Meds

O: 136-143/69-81, 71-80P, 19-23RR, T~98.4, 100% RA

>NPH BID/SSI

Gen: NAD

~~Avix~~ Plavix 75mg qd

Neck: ~~JVP~~ JVD, carotid bruits

~~enox~~ 95mg SQ BID

Heart: RRR, +m

6/Atrovent nebs q4hrs or prn

Lungs: +Bibasilar rales

~~nipine~~ 30mg PO q6° prn

Abd: Obese, ~~soft~~, NT, ND, +BS

Ext: 0c/c/E

~~ranitidine~~ 150mg IV q8° prn

Labs: 9.1 / 26.9 / 28.9 / 391 ; ~~129~~ / ~~100~~ error 9 / 4.5 / ~~26~~ / 10.9 ; 128 / 103 / 82 / 29 ; 6.9 / 14 / 9.3 ; AG 11

EKG: No Δ from 3/16

APO 88 ALT 26 AST 42

~~ASA~~ 325mg po qam prn ~~bowel~~ pain

Serum ketones: Neg Acetone

ABG: 7.29 / 28 / 84 / 14 / 95%

CXR: No interval Δ in mild Pulm edema ~~on~~ eff.

A/P ① DKA - ~~Pt~~ Resolved. Serum ketones negative. He is still acidotic but likely 2° to his chronic renal failure. Cont SC NPH and Reg SSI. Pt's Metformin was d/c'd 2° to his CRI. Currently on glyburide 5mg as outpatient. AIC 6.3 on 06 Mar 08.

② NSTEMI - No current CP. Cont Plavix 75mg qd, ~~ASA~~ 325mg qd, and Lovenox 95mg SC BID.

(b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | ~~ISSN or Other~~ Tricare

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

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

PROGRESS NOTES
Medical Record

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4/305

Bed #5

Exhibit 2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
16 MAR 05	ICU PM Pt 55yo M HD 3 for MVP admission no: NS76MZ4DKA.
0430	Pt now improved, s/p pericardiocentesis, on SQ insulin c BG ~ 200-300 range. 3 U reg in last 24hrs, s/p 10 PRBC VSS 150/78, HR 87 R 18 94% pulse ox OE - 152/61, HR 87
Pt's parents plan to go to Disney 06 ASA	Labs - 183/5 | 99/19 | 102/4.5 ~~188~~ 82 | 17 | 23 | 0.5 21 ~~40~~ (30) EKG - NS T wave (flip T's in lateral leads) - QTc MB today 9.6 (peak >30) trop 2.79 (peak >50.0) Imp/Plan - ① DKA - much improved. keytones ⊖, but AG remains 14 ↑ 5 K 5 ↓ BG >200-250. will TNPH to 16U today, and cont volume repletion 5 ½NS D5. ① NS76MI - pain free since admission, myo peaked yest. @ >50.0. start on antiangiotensin (after today). Awaiting Cypress bed to MOD → will reduce nebs. → Q4h tc today. Add ACE today. Cont ASA, plavix. ↓ to pattie (NSC) (cont)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

600-32-4305
ICU #3

PROGRESS NOTES
Medical Record

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EDICAL RECORD | PROGRESS NOTES

DATE	NOTES
3MAR08	ICU PN
	- No sig. events o/n. VSS 130-150's, HR 70's, BG 200-325,
	PE → VSS ei chore, pt in comm
	INF ⇒ D5 ½NS @ 150/hr 14.5 / 27 X 349 133/4.6 | 98/17 | 136/4.6
	ECG = NSR's
	Exp/Rec
	1)- NSTEMI - completed 48hr of anticoagulation, consult product control, TRACE to 2011
	2) DKA - gap remains may be related to Propranol and ARF/CRF BG improved, to will INCREASE to 20.
	3) COPD - resp. stable, O2 to prn per yesterday
	4) CHF - euvolemic
	5) Wound - dressing D's per podiatry daily
	6) ARF/CRF - Cr trending as pt increasing BUN/Cr ratio Cont renal dose in setting of DKA ⇒ volume resuscitation. Send UA + urine lytes.
	A INF to NS since pt eating diet.

(b)(6)

IONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
T./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
'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.	

600-32-4305

ICU # 34

PROGRESS NOTES
Medical Record

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Exhibit 028

ACLU-RDI 5586 p.28

MEDICAL RECORD

DATE

20Mar08 1410 Nurses Note: Assumed care of Pt (35? Report received from (b)(6) Pt has no c/o CP or SOB at this time. It is no nauseas. Will continue to mon.

20Mar08 @ 1530 Report received from (b)(6) Pt. awake, alert and oriented x3. Appears tired, pale color c pale mucous membranes. Pupils 3mm and brisk reaction to light equally. Speech is clear, Arabic speaking. SR@ 77 c ectopy/head III. Pulses @ +1 in both feet. Generalized edema, pitting @ 2+. Room air c SaO2 @ 99%. Breathing is even, mildly labored, R=18-20. lungs clear in anterior lobes, diminished in bases, scattered rales in RML, RLL, LLL. BS + x4 quadrants. Inserted foley catheter (18 fr) on admission to ICU. Lavaged pt's stomach c H2O p inserting 16 fr NG tube via (R) nare. Obtained pink-tinged/green aspirate that was slightly cloudy c dark-red flecks of blood. (R) AC PIV (20 ga) c NS bolus, IV ≈ 1000mL. (b)(6)

20Mar08 @ 1710 first of PRBCs started p verifying pt. information. Informed pt via interpreter re: transfer to ICU. Pt. verbalized understanding of care-provided. (b)(6)

20 Mar 08 @ 1730 VSS, no signs or symptoms of transfusion rxn. (b)(6)

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

PART./SERVICE | HOSPITAL OR MEDICAL FACILITY: Cropper | 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)

600-32-4305.

REGISTER NO. | WARD NO.: ICU

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1988)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.206(b)(2)
[illegible] 00

ICU #3

MEDICAL RECORD

DATE

20 MAR. 08. Nursing: Pt. Soley - d/c'd, ATV - 16.00 hrs. Dr. recommended a 1000 hrs strictly count of urine output every 4 hrs. — (b)(6)

20 MAR 08 @ 1400 PT C/O CP 7/10 X 13 IS MD PRESENT EKG DONE. Ø ST SEG. ELEVATION. BP 90/60 & PAIN 7/10 - 10 7-8/10 @ 1320 SUBLINGUAL NITRO GIVEN. PT 4-5/10 & BP 93/54 MS 4 2mg GIVEN. PT IS PAIN FREE & VOMITING. AMT NOT ABLE TO RECORD. COFFEE GROUND IN COLOR & TEXTURE C CLOTS OF BLOOD PRESENT. Pt TRANSFERED TO ICU. — (b)(6)

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

GOC - 32 - 4305
ICW #8

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1988)
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[illegible] v1.00

000030

Exhibit 2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	TICU PN
4 mmHg OS	Pt did well o/n w/o further worsening BRBPR melena
1000	but elevated from 15 → 26 w/ 4U PRBC. Pt tol
	transfusions w/o complication. Today had one episode
meds	of N/V/retching w/o blood. NGT still in place. Pt c/o
ktrolyte IV	complaints & transmit monitor. ECP/SOB (s/p protamine)
ntonix IV	PE - BP stable @ >100 systolics, CR 80-90's, pulse ox 100% RA
2H 2nd V BID	L-basilar rales @ bases w/ crackles
SSI	abd soft
wo 250 QOD	Impression/Plan —
nida 300 QID	① GIB stable - s/p protamine
	for ?decidual bronchitis as
Links	well as pantoprazole/octreotide.
NOT	Suspect erosions oozing/bleeding — d/c anticoagulation (thrombosis) for AFib,
today	profound anemia/ARF, steroids for COPD. Stopped all anticoag
IVF implan	meds but appears stable s/p transfusions & no evidence
	of additional bleeding via NGT. Will cont. QD CBC today,
	Q12 tomorrow if stable. Cont. on monitor in TICU.
	② NSTEMI AMI - stable, pantoprazole, asa ~ ECG: Attempt to keep Hct over
	25-30 as able.
	③ ARF/CRF - ?? BUN d/t by bleeding but likely ? ARF as well. Pre-renal
	on urinalytics & unclear renal dz (diabetic nephropathy likely)
	will avoid nephrotoxins and continue IVF.
	④ ID - Low grade — will dc asa to avoid polypharmacy.
	⑤ COPD - stable since admission, stopped
	a few days of pulse steroids, likely OK
	long term. However, will follow for adrenal sx.
	⑥ DKA/DM on NPH/SSI at home
	will INPH to 25 BID + SSI. Diet.

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)*

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21MAR08 0343	Nurses note: Assumed care of pt @ 0300. Report received from (b)(6) (b)(6) will continue to monitor.
0456	Nurses note: Pt had bout of emesis. Coffee ground appearance. will continue to monitor. (b)(6)
1200	Nurses note: Pt reports no more bouts of emesis since last notation. Will cont to monitor. (b)(6)
1500	Nurses note: Pt HH Crit value 47.20 (b)(6) paged. Pt then vomited 400 ml of coffee grounds + bright red blood. Md dr coffee grounds scant bright red blood. Report given to (b)(6) (b)(6) Will continue to monitor.
21MAR08/ 1400	Pt. vomited ~ 450 cc's dk red partially clotted blood, NG tube lavaged until clear (approx 500cc's), (b)(6) @ bedside, TLC for 4u PRBC's ordered, (b)(6) TLC inserted under sterile conditions by (b)(6) pt. VSS & tolerated procedure well. PRBC's pending (b)(6)

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	Dropper		ICU

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

600-32-4305

PROGRESS NOTES
Medical Record

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ICU #4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22Mar08	ICU PN
0630	Yesterday pm pt vomited ~400-500cc clots. BP stable, HR 60's. Repeat hct was 20 (down from 30 earlier in am). Pt got DDAVP, platelets, + 4U PRBC's this a.m. Repeat hct after 2nd unit was 22.4 — 3rd unit hct still pending. Pt was
meds	discussed yesterday afternoon & BMAD, but unable to transfer for scope
protonix	they would not accept. Plan was to manage medically as above,
octreotide	Gastro consulted to case pt continued to bleed. 4U pt who
DDAVP x1 (peak)	further vomit, no melena. BP stable @ 120's systolic 60's, HR 80-90's.
pramoxine 2.5/d	Pt is awake, alert, breathing comfortable.
KVO NS	RR - L-sided @ baseline (baseline)
	chest - diffuse coarse unchanged
	PIV 18, PIV 20, TL (R Lum) 20
	Some labs pending (CBC, CMP)
	MIC. Acute GI bleed - continue to follow CBC Q4 for now +
	monitor for signs of bleeding. Continue meds.
	AMI - post-MI, now stable w/o pain
	ARF - worse yesterday Cr 5.3 (baseline 3), BUN observed by GI bleed
	need + watch K s/p 4U PRBC
	DM - doing well on TNPH, on D5 as KVO — BS 80-150

(b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME	
	LAST	FIRST

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

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
	Operative Note
22 MAR 08	Pre-Operative Diagnosis UGIB — Surgeon
4pm	Anesthesia: GETA LMA MAC
	Fluid
	Post-Operative Diagnosis Mallory-Weiss tear — EBL 300
	Specimen
	Blood 4u pRBC
	Complication None
	Procedure EGD. Laparotomy
	Laparotomy + oversewing of Mallory-Weiss tear at GE jxn.
	Findings

(b)(6)

Large fundal clot in cardia / proximal
stomach through longitudinal gastrotomy. No evid of erosive
gastritis, GU or DU. After extensive mobilization, GE junction
able to be visualized → there laceration @ GEJ c/w Mallory-
Weiss tear that was oversewn. Remainder of stomach & large
bowel normal to inspection / palpation - both devoid of enteral
(likely blood) contents.

(b)(6)

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

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DATE

22 JUNE 08 GS

9pm Pt was had substantial progressive clinical deterioration since his return from the OR.

Briefly - taken to OR today for continued UGI bleeding evidenced by bloody NGT aspirates w/ flushing Hct despite pRBC transfusion, plt transfusion, dDAVP, estrogen & no blood per rectum. No reasonable endoscopic options in theater. Findings in OR: clw Mallory Weiss tear; no gastric or duodenal ulcerations or evidence of ongoing bleeding. M-W tear overcam to the extent we could visualize the injury.

Postop - progressive decline in BP, Hct 27→20, no significant bloody return from NGT. INR now 1.7, plt 7.2 on heparin drip. Renal insufficiency worsening w/ Cr >5, K+ 6.9. Without endoscopy or angiography assist, further surgical exploration is not a feasible options & in my opinion constitutes futile care. After extensive clinical discussion w/ ICU staff (b)(6) & DCS (b)(6) we will continue resuscitative efforts to include: transfusion to a →

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	LAST	FIRST	MI	
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STANDARD FORM 600 (REV. 5/1988)
Prescribed by GSA/OMR FPMR (41 CFR) 101-11.206(b)(1)

DATE

55 y/o ♂ admitted ~1wk ago c mild DKA & Large INF MI
S/P Lytic c reperfusion — Now C/O T CP's & UGI Bleed
Pt treated conservatively c PPI, Octreotide, H_2 Blockade
and Plavix/ASA/Lovenox DC'd. Tx c RBC/Platelets &
given DDAVP & Premarin 2° uremia. Pt continued to
bleed. Called Board for GI consultation 20 & 21 MAY BUT
No GI available in Theater. Today due to continued
bleeding => OR - Duodenum NVI by palpation & blood, Stomach
normal but @ Malloy Weiss - oversew. Pt c
minimal blood loss intraop but post op PH 7.0,
INR 2.0, Cr ~ 5.0 and Hct 27 => 20. Pt with
Multiple Problems - Poor prognosis for recovery - Discussed
c Nursing, EMT Staff, Surgeon & Intensivist - Prognosis
very guarded. D/w - 2u PRBC, 2u FFP, DDAVP,
Cryo then observation - No further blood products after
next 12°. Reevaluate in AM. Given current course
feel DNR appropriate if he experiences Cardiac Arrest
+/- use of pressors. WRT Factor VII - feel that
it will be of limited benefit and risk high.

(b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR | NUMBER

LAST | FIRST

PART./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)*

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PROGRESS NOTES
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STANDARD FORM 600 (REV. 5/1949)
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Hosp #

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23MAR08	SICU addendum
1945	Came in to see pt + SD docs @ bedside
	resuscitation pt from 1900-2030. Pt's BP dipped
	to 60 systolic → 70-80 systolic 2L NS b.lus. Upon
	assumption of care, CBC/CMP/ABG sent which revealed
	Hct 20 (down from 27), s/p 4 SCDs from NOF + Sahara
	Concern for acute bleed, 4 units ordered, dDAVP, cryo,
	and RFP. Gen Surgery here to eval — note labs above.
	D/w DCCS as well, expressed my opinion that prolonged
	efforts in setting of post-MI, ?? ARF & pH 7-7.2, 10U PRBC
	bleed + post-op today. With continue to volume resuscitate as
	able, + provide 2U more of PRBC (brings total to 20U). No
	more platelets are available @ this time. Transfer to BMED
	was previously not possible, now pt has unstable Wil
	ensure sedation adequate for ? minimum + cont. tricare days
	for uterine evisceration. If cardiac arrest, no plan for chest
	compressions due to futility of efforts in setting of pt co-morbidities,
	but will add epinephrine if BP continues to be low. With attempt to
	exhaust other medical efforts as able still + degree utilized thus
	far with meds, fix no more blood products + platelets not
	available, Emergent intervention is OR not an option — see Gen Surg. note

RELATIONSHIP TO SPONSOR: Pt will not be kept comfortable

SPONSOR'S NAME — LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

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

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(b)(6)

600-32-4305

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22 March 08	(0910) Assumed care of pt @ 0700hrs. Pt awake, alert - c/o lower back pain, but ϕ bruising noted over back/flank + there is ϕ tenderness c palpation. Pt denies need for pain medication. FS @ 0830 = 79, ϕ units insulin given and notified that blood sugar has been low. D5 1/2 NS infusing @ 150cc/hr. Octreotide gtt @ 50mcg/hr - gtt rate and concentration verified c night shift. Cardiac monitor on, alarms on and verified. See ICU flowsheet for complete assessment, V.S + I + O documentation. Plan to give 2units PRBCs this a.m. Pt in NAD, VSS, afebrile. Will continue to monitor closely + report changes as they occur —— (b)(6) ——
	(1245) Pt given 1unit PRBCs @ 1030, infusion completed @ 1230. ϕ S/Sx of transfusion reaction. 2nd unit to be given in OR. Pt reassessed ϕ blood complete. Drsgs remain clear. Pt taken to OR by OR staff @ 1240. VSS, afebrile. Interpreter @ bedside to explain procedure (ex-lap) to patient, + pt's understanding was verbalized. Consent signed + witnessed. 1200 dose of Kayexalate held because pt ~~was taken~~ going to OR. FS @ 1200 = 64. (b)(6) and OR staff notified.
	1700hrs Pt back from OR, ETT 24cm 8.0 at teeth c event, foley @ yellow urine c white sediment. + 3 grey drsgs, semi firm abdomen c dressings.

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

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.
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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
23 MAR 08 1100	GI Minimal improvement overnight - not stimulated @ 29 + Coagulopathy corrected, improving acid/base status + improved renal fxn. Cont present mngmnt - vaso- da (@ 10mcg/kg/min), + sedation, supportive care.
25 MAR 08 1200	ICU Note Pt stable o/n required small amt's of dopamine to keep BP > 90, slight tachy - remains blind from above/below & Cr 20 → 30 & 4u. Pt c/o. signs of acute GI bleeding, but will follow CBC's closely. Pt continues & REF/uremic acidosis, but improved & forced resp alkalosis + bicarb drip will start feeds today, take up & treat as' d/c, + drip already to below previous support levels. Cont to dose NPH & SSI tube feeds, will need to increase if tol. feeds. No other acute issues

(b)(6)

(b)(6)

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

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PROGRESS NOTES
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DATE

23 Mar 08 (0515) Critical labs: K+ 6.4, BUN >180. Ca 6.6. Will notify MD upon arrival. (b)(6)

(0615) PRBC #2 of 2 Unit # (b)(6) completed at this time. Total 337cc. Will draw CBC in one hour. Lungs slightly coarse on inspiration. (b)(6)

23 Mar 08 (0930) Assumed care of pt @ 0700 hrs. Pt sedated c Versed, & purposeful movement @ that time. Pt assessed - see ICU flowsheet for documentation. Gtts @ change of shift were Versed @ 10mg/hr, fentanyl @ 100 mcg/hr, dopamine @ 20mcg/kg/min, and Bicarb (3amps in 1L D5W) @ 150mL/hr. At 0800, dopamine ↓ to 15 mcg/kg/min. ~~Hbo~~ (b)(6) Pt on Pressative TF via (R) NGT started @ 30mL/hr. (L) ~~radial~~ Peep ↓ to +5. (L) radial arterial line zeroed - good waveform noted on Monitor, + ABP ~~cause~~ correlating within 10mmHg of NIBP. VSS. Will continue to monitor + report changes. (b)(6)

(1000) Dopamine ↓ to ~~15~~ 10 mcg/kg/min. ABP 90's/40's (60's). Versed gtt turned off for ventilator weaning (b)(6)

(1215) Pt reassessed. Lungs ↑ coarse c diffuse rhonchi noted in BUL. Moderate amt thin, yellow secretions c suction. Dsg to abdomen changed - staples are well approximated, & drainage noted. Skin on abdomen blistered, some blisters draining serosanguinous fluid. Large amt scrotal edema noted. Dopamine @ 5mcg/kg/min, ABP 90's/40's (cont'd)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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PART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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PROGRESS NOTES
Medical Record

STANDARD FORM 600 (REV. 5/1988)
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600-32-4305
ICU #4

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
23Mar08 @ 1940	(cont.) Midline abdominal incision c staples intact. Wound edges approximated, telfa dsng in place c paper tape. Pt. has small blisters from Medipore tape. (R) femoral TLC (7fr) c redness c swelling, dsng CIDI. drainage, firm abdomen is tender and distended. NG tube via (R) nare. (b)(6)
23Mar08 @ 2015	Repositioned onto (R) side. Oral care and mouth suctioned. Obtained an large amt. of tan / white secretions (b)(6)
23Mar08 @ 2030	Blood glucose = 251 mg/dL per fingerstick. Given Regular insulin 6u, SQ per sliding scale. (b)(6)
23Mar08 @ 2210	Repositioned pt. onto back. Suctioned mouth c Yankeur tube. Obtained moderate amt. of tan secretions. NPH 10u, SQ per scheduled dose. (b)(6)
24Mar08 @ 0020	Blood glucose = 235 mg/dL per fingerstick. Given Regular insulin 4u, SQ per sliding scale. No acute change noted in reassessment. RRT titrating RR to 2/min where pt. breaths spontaneously to maintain RR ≠ 14-16/min c V_T = 700-800 mL, PIP = 27-31 cm H_2O. (b)(6)
24Mar08 @ 0035	Given Kayexalate 40 gm, via NGT. Tube feed residual 85mL. Will hold TF x 2 hrs. and recheck. Total volume of 160mL of Kayexalate given (15g/60mL). (b)(6)

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

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MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

24 Mar 07

0700

ICU PN

R no sig. event o/n. Persist drop SpO2 ? 12hrs, on fentanyl only & breathing over vent. pH improved to 7.3. N-GCS 7T yesterday pm + this am on fentanyl drip @ 100 → will d/c fentanyl drip today

CV- today ~100, BP's ? low sys tolerated — off dopamine ~24hrs ago; ECG today NSR, NS2w ds Normal in the upright on admission

P- SIMV rate 2 (pt breathing @ 10), PS10, PEEP 5 F_iO_2 set @ 60%, pt making good exp volumes.

7.27/43/97 this am

L-CTA c/l CXR - cont. pulmonary congestion (ETT high, but has been replaced since)

GI - on pantoprazole @ 30/d, residuals @ 60cc. Will increase today & get dietician consult for more round-the-clock diet (? supplem)

Persistent bleeding: ⇒ s/w to supplem.

Renal - 144/104/180
5.7/21/5.1

ARF continues, will maximize volume status as could Na rise very low due pre-renal component underlying dz. Need UOP — previously pt euvolemic & GN/ATN on u/a; but ATN very likely.

Hemat 15.5/97 — stable hct, plus decreased today + pt remains unstable on pressors s/p dobutrex x 2, coags WNL

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

nutr (cont)
This TF will also provide 37.4 meg K & 44 meg Na & 908 mg PO4.
P- Continue to follow.

(b)(6)

(b)(6)

25MAR08
(200 lbs

ICU PN

Pt sig events Sh ↓ Sedation + ↓ CR ⇒ ABG showed pCO_2 50 but pt doing well otherwise. ↓ Sedation this am but not resolve pCO_2 - plan to increase resp rate & RT + maintain ventilation ~7 to 8. No other issues today.

N- GCS - 10T on versed/fentanyl drips.
→ dc versed + switch to propofol for faster waking, pt on

CV- tachy & 100-110's, BP 160-180 hypertensive, card on ⊕
→ pt's spouse took after hypertension/GI bleed (2UU) few days ago.
→ will start Lopressor for sinus tach + tachy, low dose (LLG RSD)
pt tolerated lopressor well previously, + lopressor later metabolized in the liver

P- Resp acidosis suspect sedation related, ↓ resp rate
7.3/52/130. will attempt to wean + get parameters in am
C- CTA 2L, CXR -
Continue Duplera @ 55/hr - attempt free water replace (200 cc)
→ EVD needed (PBM) (Cont)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

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MEDICAL RECORD — PROGRESS NOTES

DATE	NOTES
24Mar08 @ 0900	Assumed care of pt Pt resting comfortably receiving 100mcg/kg/min of fentanyl drip. Pt has no acute s/s of distress. Pt vs remain stable. Will continue to monitor. (b)(6)
24Mar08 @0800	pt receiving large amounts of fentanyl fentanyl + to 50mcg/kg/min per (b)(6) will monitor pt to maintain adequate pain control. (b)(6)
24Mar08 @1300	no changes in pt assessment from earlier. Decreased pt fentanyl @1230 to 40mcg/kg/min. Pt tolerating well. Pt turned q2h. Will monitor. (b)(6)
24Mar08/1600	Pt. unchanged, VSS, O2 sats 99-100% on current vent. settings, Fentanyl drip T to 75mcg/hr d/t nodding head "yes" when asked if in pain. Continues on 1:1 vop to NaHCO3 drip replacement. (b)(6)
24Mar08/1700	Urine S'd + portal bath given. (b)(6)
24Mar 08 1900	Received report + assumed care of pt. Fentanyl gtt @ 100mcg/hr. NaHCO3 titrated hourly according to output. TF infusing @ 55cc/hr. Pt is sleeping but easily awakens on his own + appears to be wide awake. Able to shake his head yes or no to simple questions. Vent settings: see vent flowsheet. Reaches for ETT when awake + appears uncomfortable. No sedation on at this time (b)(6)

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

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

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ICU #4

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MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

25 Mar 08 (1210) Pt reassessed. Pt unable to wean from ventilator - RR ↑ to 12 bpm @ 1100hrs, pt not overbreathing. (b)(6) + interpreter @ bedside, pt able to follow some commands, but falls asleep easily. Versed gtt re-started @ 2.5mg/hr. Fentanyl gtt @ 80 mcg/hr. Plan to d/c $NaHCO_3$ disp + start D5 1/2 NS @ KVO + begin running free water through NGT. ϕ other changes to report. Will continue to T+P pt q 2° for good pulmonary toilet. Monitoring (b)(6)

(1215) Sedation changed to propofol @ 25 mcg/kg/min + fentanyl ↑ to 100 mcg/hr (b)(6)

(1355) DHT placed in (L) nare, per MD @1315hrs. KUB obtained @ 1330. Pt turned to (L) side. Propofol ↑ to 30 mcg/kg/min. (b)(6) Monitoring

(1530) Addendum: At 0930 hrs, noted occas. aberrant beats on monitor. (b)(6) notified + 12-ld EKG obtained. ϕ new orders @ that time. Pt continues to have occas. early/aberrant beats. (b)(6)

(1615) Pt reassessed. Lungs remain CTA. Fentanyl gtt @ ~~80~~ 100 mcg/hr + propofol gtt @ 30 mcg/kg/min. Residual TF's = 200mL's. TF held for 1hr. Will recheck residual @ 1700. No additional (cont'd)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUM (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.	

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ICU #4

Exhibit 5 2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26 Mar 08 @ 0515	Pt. began having frequent PVCs, and small periods of irregular atrial activity c morphology of P wave changing, BP=84/55. 12-lead ECG performed @ bedside. Weaned propofol to 10 mcg/kg/min. ↓ fentanyl gtt to 25 mcg/hr. Consulted c (b)(6) PA in E.R. No intervention necessary except to continue to hold Suplena until pt. seen by (b)(6) this A.M. Currently in SR c freq. PACs @ 89, BP ↑ to 105/57 p Propofol and fentanyl gtts were decreased. (b)(6)
26 Mar 08 @ 0610	Propofol gtt turned off, port on T.C flushed c 10mL NS. Fentanyl gtt ↑ to 50 mcg/hr p dressing pt.'s teeth and providing oral care. RRT @ bedside to change ventilator circuit and oral ET tube holder p pt. vomited onto airway equipment earlier. Abdomen feels dense tense, firm than earlier. NG to LIS when R.N. noted fluid backing up bn to bed, obtained 300 mL of green, bile-colored fluid, and mod. amt. of air. Pt. passing flatus from rectum earlier. (b)(6)
26 Mar 08 @ 0700	Report given to nurse assuming care of pt. (b)(6)
26 Mar 08 (1015)	Assumed care of pt @ 0700 hrs. Pt lying quietly, occassionally shakes head side to side, fighting ETT. Withdrawals BUE to pain. Non-purposeful movement to BLE. Propofol gtt off @ 0600 (cont'd)

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

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

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

600-32-4305

REGISTER NO.

WARD NO. ICU

PROGRESS NOTES
Medical Record

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

ACLU DDI CID ROI 29674

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

Exhibit 2
000046

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26 MAR 04 1200	Pt vomited x/o, not bloody, and has had NG output 150-300/8 since. Tube feeds held. Noted tays last from 4a 103, no entries. Abdomen thought this am. Am ABG much improved. N-IOT holding sedation to wake. P-(W) CVP 9/6, CXR-stable (per mid-level), ABG- 7.4/40 → RC cont to be febrile, may re-do- VAP CV- tachy afib on & off mostly 90's, BP stable 90-100 systolic RR- tube feeds held, NG to suction Neuro- Lids & pupils, some getting hyperextension of BUE PCP's today eyes- EOMI, brisk bilat, not tracking / cooperative Lines- 139/95/180 5.4/28/5.4 peaks on DOPES @ 100 also tube feeds held AM/ATN - working on peak, pt minimum & blood drips PRN available renal dose meds Renal- 17 ~~/28~~ 126 on CPAP 7/24/Sat 40K U Lines- (R) from 3C 14, may need to OR have recurs, need blood's through line + one peripheral to have a line, NG, dobhoff (pending placement).

(b)(6)

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY: Cropper | 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. ICU

600-32-4305

PROGRESS NOTES
Medical Record

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

ACLU DDI CID ROI 29675

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LAW ENFORCEMENT SENSITIVE

Exhibit 2

000047

ACLU-RDI 5586 p.47

ICU #4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
26MAR08	PT was received from (b)(6) in stable cond. VSS
1945	VSS, temp. elevated constantly around 99.5, 95 sessions
	complete will cont to monitor and provide excellent
	and effective care following Icu guidelines and
	protocols
1800	PT still elevated temp. 99's to 100 T pt son:
	with draws to painful stimuli and to verbal (b)(6) (b)(6)
2100	PT washed, linen changed, bacitracin (b)(6) applied to
	stomach/abdomen blisters to weeping edema to scrotal
	area (b)(6)
2240	PT self extubated himself, immobile cotton (b)(6)
	taken. pt put on 10L NRB sats at 95%
	and @ 2300 ~~cbt~~ 100% S/P, ETT removed by pt
	and help by Icu staff ambu bag by bedside (b)(6)
	(b)(6) notified ABG will be taken and pt
	will be restrainted better and watched (b)(6)
	and monitored closely
26MAR08 2340	NURSE NOTE-ASSUMED CARE OF PT, O2 SAT 94
	RESPIRATIONS ADEQUATE S/P SELF-EXTUBATION, VSS (b)(6)
	WILL CONTINUE TO MONITOR

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			
	LAST	FIRST	MI	(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.

600-32-4305
ICU#4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1700	PT had 2 more episodes. 12 Lead done K-Mon STRIP printed
27Mar08	out (b)(6) notified and came to bedside. PT returned back
	to NSR on mon. Dr said to inform him of continuing episodes
	and print a strip, will continue to monitor (b)(6)
1720	PT in & out of Sinus tachy NSR with STRIPS printed
27Mar08	C/O pain in stomach @ this time Fentanyl given as ordered
	for pain PT is lying on side @ this time will continue to
	monitor (b)(6)
1835	PT stated has not. But he is very anxious & he
27Mar08	wants to get up and move around Explained that it
	is not possible @ this time also requested some water
	diet is clears advanced as tolerated so 1 glass of water
	given (b)(6)
1920	PT agitated pulling off pulse Ox shutting around Mon
27Mar08	Cycle is still continued but more vocal will continue to monitor (b)(6)
2040	PT had another episode of Sinus tach. 12L STRIP printed carotid
	massage done down to baseline PT was also rolled and had
	linen & chucks D/O were saturated in sweat and sacral
	Leakage-pt resting in bed @ this time will continue to monitor (b)(6)
2100	PT had another episode last <1 minute show no signs of
27Mar08	discomfort during has returned to baseline @ this Time (b)(6)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

600-32-4630

ICU 4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER *(SSN or Other)*
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*		REGISTER NO.	WARD NO.	

600-32-4305
ICU 4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

Exhibit 2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 MAR 07	ICU NOTE
	Pt had periods of PSVT yesterday with stable responses. To avoid confusion for a potentially reversible problem (tachy), DNR order was cancelled 1412 pm. Pt had PSVT 1612 pm, resulting in HBP → responded to vagal maneuvers + adenosine. 1615, pt developed sustained VT + VFib requiring DC shock x 1. This am, upon my exam, pt ~~barely~~ stable on pressors, but having episodes of PSVT (rates 150-160's) & sinus CP/tachy/HBP. Pt given dilt x 2 w/ min response duration → started on PO dilt @ small dose & 60mg Pt's BP's now 80's/40's after previous episodes of PSVT this am. Rates slow in 100-120's. Pt given 2UF boluses/drops & min response. Discussed w pt and interpreter that underlying heart dz, current arrhythmia/BP episode & VFib 1615 pm in setting of progressive renal failure (Cr >6, BUN 70's) w/o access to dialysis is a grave prognosis. I Doubt that resuscitative efforts in setting of CV compromise would anything other than prolonging his discomfort. Pt agreed to DNR/DNI status. Will do everything possible to keep pt comfortable + supportive care provided
	(b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			'S ID NUMBER
	LAST	FIRST	MI	ther)
PART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO.

WARD NO.

600-32-4305

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD - PROVIDER ORDERS

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

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

DATE/ TIME	ORDERS (SIGNATURE REQUIRED FOR EACH ORDER/SET OF ORDERS. SIGNATURE MUST BE LEGIBLE; PROVIDER WILL USE SIGNATURE STAMP OR PRINT NAME
	Sliding Scale Insulin:
	( ) Target Glucose Range 70-120 mg/dL
	<70 mg/dL = give 1 Amp D50 IVP & call MD
	70-120 mg/dL = no action
	121-150 mg/dL = 2 units Regular Insulin SC
	151-200 mg/dL = 4 units Regular Insulin SC
	201-250 mg/dl = 6 units Regular Insulin SC
	251-300 mg/dL = 8 units Regular Insulin SC
	301-350 mg/dL = 10 units regular Insulin SC
	>350 mg/dL = call MD
	(X) Target Glucose Range 70-180 mg/dL
	≤70 mg/dL = give 1 Amp D50 & call MD
	70-180 mg/dL = no action
	181-200 mg/dL = 2 units Regular Insulin SC
	201-250 mg/dL = 4 units Regular Insulin SC
	251-300 mg/dL = 6 units Regular Insulin SC
	301-350 mg/dL = 8 units regular Insulin SC
	351-400 mg/dL = 10 units Regular Insulin SC
	>400 mg/dL = call MD
	(X) Fingersticks ~~AC & HS~~ Q4hours
	( ) Draw HbA1c
	( )
	( )
	( )

16 Mar08 @ 0535

(b)(6)

(b)(6)

(b)(6)

Verified 16 Mar 08 @ 1532

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

Complete the following information on page 1 of provided orders or Note any changes on subsequent pages.

Diagnosis: [illegible] Congestive Heart Failure

Height:: _____ Weight (lbs): 211 lb Diet: NPO

Allergies: NKDA

000052

Exhibit 2

294 365

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **PROVIDER ORDERS** | OTSG APPROVED (Date)

DATE: March 16/08 TIME: 0328 SERVICE: (X) MED ( ) SURG ( ) ORTHO ( ) POD

DIAGNOSIS: COPD vs CHF ± Acute Renal failure CONDITION: ( ) STABLE ( ) CRITICAL (X) GUARDED

Vital Signs: ( ) ICW Protocol (X) ICU Protocol Allergies: _____ (X) NKDA

Activity: None Weight Bearing Status: Bed

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

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

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

(b)(6)

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

Labs: (X) CBC ( ) CRP ( ) ESR ( ) Coags ( ) ABG (X) CMP ( ) BMP (X) Other Lytes q 6hrs x 2 then 0700 x U/A Now

( ) NOW (X) in AM ( ) q AM ( ) q AM x 3 days

X-Rays: _____

MEDICATIONS

( ) Saline Lock w/flush q 8 hrs (X) NS ( ) LR @ 90 ml/hr (X) D5 1/2 NS + 20mEq KCL @ _____ ml/hr

( ) Other IV Fluid: _____

(X) Lovenox 30 mg SQ BID ( ) Lovenox - Weight Based ____ mg SQ BID ( ) Hold PM dose the night before surgery

(X) Zosyn 3.375 grams IV q 6 hours

( ) Unasyn 3 grams IV q 6 hours

( ) Ancef 1 gram IV q 8 hours

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

( ) Vancomycin 1 gm IV q 12 hours

( ) Levofloxacin 500 mg q day ( ) PO ( ) IV

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

( ) MS Contin _____ mg PO q 12 hours

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

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

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

PRN MEDICATIONS

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

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

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

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

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

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

( ) Zofran 4 mg IV q 6 hours PRN nausea

ADDITIONAL ORDERS

( ) Sign and Witness Consent

(X) ASA 325mg PO QAM

(X) Kayexalate 50 grams PO BID (1st given in ER)

(X) BMP in 1 hour (0430)

(X) Lasix 40mg IV BID

(X) ~~Nitropaste 1 inch BID~~ Nitropatch 3mg/hour BID

(X) solumedrol 125mg IV Q6 hours

(X) ISS

(X) Albuterol/Atrovent Neb x 1 hour

(X) Bipap 10/5 50% FiO2 → Begin Weaning @ Resp Rate of 20

PREPARED BY (Signature & Title) (b)(6) DATE (yyyymmdd) 20080315

Orders Witnessed by Cmb Sgt at 0330 1530

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

PSUEDO ISN: (000) 324305 ISN: _____

( ) HISTORY / PHYSICAL ( ) FLOW CHART

( ) OTHER EXAMINATION (X) OTHER (specify) Provider Orders

( ) DIAGNOSTIC STUDIES

( ) TREATMENT

LOCATION: (X) ICU ( ) ICW BED # 3 AGE

MEDCOM FORM 4700 FEB 2003 31 OSTG OR 08-01 15 Jan 08

MED[redacted]L [redacted]CORD - SUPPLEMENTAL MEDICAL DATA

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

(b)(6)

REPORT TITLE	PROVIDER ORDERS	OTSG APPROVED (Date)

✓ DATE: 22 MAR 08 TIME: 4pm SERVICE: ( ) MED (✓) SURG ( ) ORTHO ( ) POD

✓ DIAGNOSIS: UGI Bleed (Mallory Weiss) CONDITION: ( ) STABLE (✓) CRITICAL ( ) GUARDED

✓ Vital Signs: ( ) ICW Protocol (✓) ICU Protocol Allergies: NKA ( ) NKDA

✓ Activity: BR Weight Bearing Status: _____

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

✓ Dressing Change: (✓) POD # 1 ( ) Daily ( ) BID ( ) PRN ( ) Dakins ( ) Wet-Dry ( ) Xeroform-Dry

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

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

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

✓ X-Rays: PCXR on arrival to ICU

MEDICATIONS

( ) Saline Lock w/flush q 8 hrs ( ) NS ( ) LR @ _____ ml/hr ( ) D5 1/2 NS + 20mEq KCL @ _____ ml/hr

✓ (✓) Other IV Fluid: D5½NS @ 150 cc/hr

( ) Lovenox 30 mg SQ BID ( ) Lovenox - Weight Based _____ mg SQ BID ( ) Hold PM dose the night before surgery

( ) Zosyn 3.375 grams IV q 6 hours

( ) Unasyn 3 grams IV q 6 hours

( ) Ancef 1 gram IV q 8 hours

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

( ) Vancomycin 1 gm IV q 12 hours

( ) Levofloxacin 500 mg q day ( ) PO ( ) IV

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

( ) MS Contin _____ mg PO q 12 hours

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

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

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

✓ SEDATION: Propofol IV gtt, titrate

✓ PRN: Fentanyl IV gtt, titrate

PRN MEDICATIONS

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

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

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

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

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

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

( ) Zofran 4 mg IV q 6 hours PRN nausea

ADDITIONAL ORDERS

( ) Sign and Witness Consent

( ) VENT: SIMV 14 / 600 / PS 10 / PEEP 5 FiO_2 to keep sats > 92%.

( ) Protonix 40mg IV BID

( ) Pramarin 2.5mg PO/NGT QD

( )

PREPARED BY (Signature & Title)	DEPARTMENT/ SERVICE/ CLINIC	DATE (yyyymmdd)
31st Combat Support H[redacted] (b)(6)	DCCS	20080115

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

PSUEDO ISN: 600 32 4305 ISN: _____

LOCATION: (✓) ICU ( ) ICW BED # 4

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

FOR OFFICIAL USE ONLY

MEDCOM FORM [redacted] FEB 2000 (b)(6)

24 Chart V 3/23/08 0245

000054

Exhibit 2

18 Oct 11 — 12 MAC 08

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

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	3/22/08	0950 HOURS	
6	Change NPH to 10 U BID with NPO on D5 ½NS.		3/22/08C 1020

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

	DATE OF ORDER	TIME OF ORDER	
	03/22/08	12N HOURS	
	T&C for PRBC		
	Sign & witness consent		3/22/08C 1245

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

	DATE OF ORDER	TIME OF ORDER	
	22MAR08	1700 HOURS	
6	TRF to CB SIMV, FiO2 40%, PSV, PEEP 5		VOID 22MAR 08 1800

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

	DATE OF ORDER	TIME OF ORDER	
	22MARCH	1700 HOURS	
6	3amps bicarb in 1L D5W over 4 hours repeat ABG and call MD with result. Restart monitoring IVF as previously ordered when complete.		

(b)(6)

(b)(6)

ACLU DDI 29683

DA FORM 4256 APR 79 REPLACES EDITION OF 1 JUL 73, WHICH MAY BE USED.

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

Exhibit 2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU	4	

DATE OF ORDER 21 MARCH 07 **TIME OF ORDER** 2145 **HOURS** — LIST TIME ORDER NOTED AND SIGN

✓ ① Premarin 25mg PO QD when available

✓ ② Call if Hct after 2nd unit

✓ ③ Get CBC q 4h x 1

✓ ④ Call MD for HR persistently 7100, BP < 90 systolic, or signs of active bleeding.

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU	C	4

DATE OF ORDER 22 MARCH 07 **TIME OF ORDER** 0650 **HOURS** — noted 3/21 0345

✓ ③ Continue q4 CBC x 1 more

Blood products complete.

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

DATE OF ORDER 22 MARCH 07 **TIME OF ORDER** 0650 **HOURS**

① Change premarin order to 4 tabs (2.5mg total) PO QD

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

DATE OF ORDER 22 MARCH 07 **TIME OF ORDER** 0720 **HOURS**

① T+C for 2 units, give when available each one 2 hrs.

② Give Kayexalate 60g PO Q6

(b)(6)

noted 3/22 @ 0735

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: 600-32-4305

NURSING UNIT: ICU | ROOM NO. | BED NO. 4

↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	21 MAR 07 / 0900 HOURS	
6	Increase NPH to 28U BID	
6	Give 4U NPH to bring am dose to 28U total	
6	IVF maintenance at 150/hr D5 ½NS	
6	Hold maintenance for 1hr, and give 1L NS 6hrs.	

PATIENT IDENTIFICATION: 600-32-4305

NURSING UNIT: ICU | ROOM NO. | BED NO. 14

	DATE OF ORDER / TIME OF ORDER	
6	Increase SSI dose:	
	FSBG 150-200: 6U regular	
	201-250: 8U regular	
	251-300: 10U regular	
	301-350: 12U regular	
	>350: 14U regular	

(b)(6)

PATIENT IDENTIFICATION: 600-32-4305

NURSING UNIT: ICU | ROOM NO. | BED NO. 13

	DATE OF ORDER / TIME OF ORDER	
	21 MAR 1100	
6	Change CBC order to Q8hrs x 3.	

(b)(6)

PATIENT IDENTIFICATION: 600-32-4305

NURSING UNIT: ICU | ROOM NO. | BED NO. 4

	DATE OF ORDER / TIME OF ORDER	
	Chart check completed 21 Mar 08/1130	
	21 MAR / 1200 HOURS	
6	Give DDAVP 30 mcg IV over 30min	
6	T+C for 4U PRBC's, start 1st unit when available	
2	6 pack platelets when available	

(b)(6)

PATIENT IDENTIFICATION: 600-32-4305

NURSING UNIT: ICU | ROOM NO. | BED NO. 14

	DATE OF ORDER / TIME OF ORDER	
	21 Mar 1200	
6	Change CBC order to Q8hrs x 3.	

(b)(6)

DA FORM 4256 REPLACES EDITION OF [illegible]

FOR OFFICIAL USE

LAW ENFORCEMENT SENSITIVE

000057 2

Exhibit

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

600-00-4439

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER 20 March 08 TIME OF ORDER 1600 hrs HOURS

LIST TIME ORDER NOTED AND SIGN

✓ (1) Diet — NPO overnight, ✓ NG in place

✓ (2) Meds - ~~to reboot following~~ ~~[illegible]~~

✓ Levaquin 250mg PO QOD — next dose 22 Mar

✓ Clindamycin 300mg PO QID

✓ protonix 40mg IV Q12 (repeat order)

PATIENT IDENTIFICATION

600-00-4439

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER TIME OF ORDER HOURS

✓ Octreotide 50mcg/L infusion

✓ ✓ 24U NPH in am + pm, ✓ sensitive D-tens running when not getting blood and 20cc/hr with PRBC running

✓ Regular insulin on sliding scale with FSBG q 4hr intervals

BG 150-200 give 4U

201-250 give 6U

251-300 give 8U

301-350 give 10U

> 350 give 12U

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER TIME OF ORDER HOURS

✓ (3) Labs — CBC q 4hrs x after blood products

✓ CMP in am

✓ Cardiac enzymes x 3 to r/o MI

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER TIME OF ORDER HOURS

✓ (4) ECG in am, ~~and~~ after any CP

✓ (5) NTG SL 0.4mg if needed for CP up to 3 doses in 15 min

✓ morphine 2mg IV q4-6hrs for pain, or for CP not responding to SL NTG x 1

✓ (6) CMP in am

✓ (7) Give for Hct < 28 PRBC now, repeat over 4hr, all total not to exceed 4 units, and no over 2hrs

20 March 08 @ 1740 Orders verified

DA FORM APR 08 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

(b)(6)

(b)(6)

(b)(6)

3/18/08 @ 1634 hrs

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

600-00-4439

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
IW		6

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	20 MARCH 07	1120 HOURS	
(1)	Change sliding scale to		
	FSBG 150-200 give 4U		
	201-250 give 6U		
	251-300 give 8U		
	301-350 give 10U		
	7350 give 12U		

3/20/05 1120

(b)(6)

PATIENT IDENTIFICATION

600 00-4439

#324305

NURSING UNIT	ROOM NO.	BED NO.
ICU		8

	DATE OF ORDER	TIME OF ORDER	
	3/20/2008	1330	
	VIMOVOLYCENTIVE SUBLINGUAL 0.4mg NOW		
	MORPHINE 2mg IV NOW		
	Send gastric contents for occult blood		
	Transfer ICU		

(b)(6)

3/20/08 1400

(b)(6)

PATIENT IDENTIFICATION

600-00-4439

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

	DATE OF ORDER	TIME OF ORDER	
	3/20/08 @ 1415 HRS		
✓	Transfer ICU		
✓	Give octreotide 100mcg IV x1, then 50 mcg		
✓	Protonix IV 80mg now, then Q12		
✓	Protamine 50mg IV over 10 min.		
✓	T+C x 4U PRBC + give when available		

(b)(6)

PATIENT IDENTIFICATION

600-00-4439

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

	DATE OF ORDER	TIME OF ORDER	
✓	Dx: AMI, GI bleed, DKA		
✓	Cont-guarded, NKDA		
✓	IVF - ~~PRN write policy~~ blood, ~~otherwise~~ 100cc/hr ~~D5 1/2 NS~~ IVF for maintenance D5 1/2 NS		
✓	Insert foley		
✓	~~Vital signs~~		

(b)(6)

3/20/08 @ 1400 (b)(6)

(b)(6)

(b)(6)

(b)(6)

Orders Verified (b)(6)

EXHIBIT

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

600 324305

324305

NOTED 19 MAR 08 @ 2136

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICW		8

PATIENT IDENTIFICATION

600 324305

NURSING UNIT	ROOM NO.	BED NO.
ICW		4

PATIENT IDENTIFICATION

324305
600004439

NURSING UNIT	ROOM NO.	BED NO.
ICW		6

PATIENT IDENTIFICATION

CCW-00-4439

NURSING UNIT	ROOM NO.	BED NO.
ICW		8

DATE OF ORDER 19MAR2008 **TIME OF ORDER** 2000 **HOURS**

LIST TIME ORDER NOTED AND SIGN

21 12 19 MAR 08 Transcribed

FS Q4°

(b)(6)

(b)(6)

DATE OF ORDER 20 MARCH 08 **TIME OF ORDER** 0600 **HOURS**

① Send urinalysis and urine lytes

(b)(6)

Noted 1300, 20 March 08

(b)(6)

Transcribed 3/20/08 0935

(b)(6)

(b)(6)

DATE OF ORDER 20 MARCH 08 **TIME OF ORDER** 0900 **HOURS**

① Ne Foley

② Start I/O's — very strict (q4)

Noted 1300, 20 March 08

(b)(6)

(b)(6)

Transcribed 3/20/08 2035

(b)(6)

DATE OF ORDER 20 MARCH 08 **TIME OF ORDER** 1130 **HOURS**

① NS IV give one Liter over an hour, then at 150/hr after.

② Change FS stick to before meals (0700, 1200, 1700) and 2200 hrs.

Increase NPH to 24 U QD

Noted 1300, 20 March 08

(b)(6)

(b)(6)

Transcribed 3/20/08 2140

(b)(6)

(b)(6)

DA FORM 4256 APR 70 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

Exhibit 2

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER
0010-08-CID789-53199

DETAILS

EXAMINATION OF REMAINS: About 1630, 29 Mar 08, (b)(6) conducted an examination of the remains of Mr Taha Daher MUHAMMED Al-Ithawi, Internment Serial Number (ISN): US9IZ-324305-CI, Camp Remembrance II (CRII), Theater Internment Facility (TIF), Camp Cropper, Baghdad, Iraq APO AE 09342 (CCIZ), located at Bed 4, Intensive Care Unit (ICU), 31st Combat Support Hospital (CSH), CCIZ.

Characteristics of Remains: The decedent was identified via retinal scan as Mr MUHAMMED. The decedent appeared to be Middle Eastern male, approximately 5'11", and weighed 222 pounds. The decedent had black/gray "peppered" hair and brown eyes. No tattoos were viewed, but a healing cut, sutured with staples was noted on the midsection of the decedent. The decedent was not clothed, but covered with a bed sheet upon arrival. Evidence of medical intervention included an intravenous lead in the left foot, a catheter inserted into the penis, numerous leads around the midsection, healing wounds in both arms of intravenous leads, and a scar measuring approximately 16" in the midsection, which was described as a wound from emergency surgery for a gastrointestinal bleed.

Conditions of Remains: The remains were still warm to the touch and rigor mortis was not present. Minor amounts of livor mortis was noted on the back of the decedent. No signs of external trauma, except for signs of medical intervention, were observed. The decedent was not wearing any jewelry.

Environmental Conditions: At the time of the examination, the temperature inside the ICU was 68 degrees. There were no odors out of the ordinary near the remains during the time of the examination.

Factors Pertinent to Entrance/Exit (E/E): The main entrance and exit point to the ICU could be gained from the southern most wall in the ICU. There was a set of double doors which could be accessed by pushing in either direction.

Documentation of Remains Documentation: The remains were documented by (b)(6) utilizing a NIKON D80 Digital SLR Camera with a built in flash. Additionally, a human remains sketch was prepared by (b)(6)

Search for Latent Impressions: There was no search for latent impressions due to all who worked in the ICU had unfettered access to Mr MUHAMMED.

Collection of Evidence: A collection of evidence was not performed due to the fact that the remains were located at the ICU for an hour prior to his demise and all clothing had been disposed of by hospital staff.

Search Beyond the Remains: A search beyond the scene was not conducted. ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
(b)(6)	Camp Cropper CID Office, 1149th/20th MP DET (CID) Camp Cropper, Baghdad, Iraq APO AE 09342
SIGNATURE	DATE: 24 Mar 08 / EXHIBIT: 3

CID (Automated) ONLY-LAW ENFORCEMENT SENSITIVE

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

660-32-4305
ECW #8

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	19 MAR 08	2030 HOURS	
(1)	Transfer to ECW		
(2)	Dx - acute MI, DKA, renal failure		
(3)	Condition - stable, NKDA		
(4)	Vitals q shift		
(5)	Activity - bedrest, bathroom privileges		
(6)	Diet - regular		
(7)	IVF - 1/2 NS overnight, then TKO		

PATIENT IDENTIFICATION

Transcribed 19 MAR 08 @ 2120
(b)(6)

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
(8)	Dressing change ~~per protocol~~ daily (b)(6) to change)	~~HOURS~~ HOURS	
(9)	Labs - CMP in am, then daily; BG q4h		
(10)	Meds - ASA 325 mg PO QD		
	Plavix 75 mg PO QD		
	nitro patch 0.3 mg/hr QD to be removed q4.5,		
	Prednisone 60 mg PO QD x 2d,		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	then 40 mg PO q ~~8~~ HOURS		
	Nebs (albuterol/atrovent) q4-6h		
	Levaquin 250 mg PO QD		
	• Clindamycin 300 mg PO QID		
	NPH 20U BID SQ and sliding scale		
	cs fasting → 150-200 → 2U reg		
	201-250 → 4U reg		
	251-300 → 6U reg		
	301-350 → 8U reg		
	350 → 10U reg		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
(11)	Tylenol 650 mg PO q4-6hrs prn [illegible] pain	HOURS	
(12)	Encourage pt to eat each meal		
	TID		

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
600-32-4305	ICU		3	18 March 08	0845 HOURS	
				@	10mg Lisinopril PO QD	
						NOK
				@	Give 1LO$_2$ NS over 1 hr x1	13am
				@	Hc paste, add NTG patch QD	
					0.3 mg/hr to be removed	9a1
					at night (8hrs)	

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER
600-32-4305	ICU		3	(H)	Increase NPH to 16U BID HOURS + continue sliding scale.
				@	nebs (alb/ctrovent) q shift & prn for symptoms.
				@	d/c Solumedrol, start prednisone PO 60mg QD x 3d, then 40mg x 3d

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER
600-32-4305	ICU		3	18Mar08@2039	
				24 Chart ok, completed	

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER
600-32-4305	ICU		4 3	19 March 08	1600 HOURS
				Transfer to ICU	
				ICU protocol	
				Continue Meds + Tx per	
				ICU orders	

(b)(6)

(b)(6)

(b)(6)

(b)(6)

ACQUIRED ROI 29691

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: 600-32-4305

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 43

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	19 MAR 08	0930 HOURS	
①	NPH increased to		noted
	20 U BID		(b)(6)
			19 MAR 08
			1000

PATIENT IDENTIFICATION: 600-32-4305

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 43

	DATE OF ORDER	TIME OF ORDER
	19 MAR 08	1420 HOURS
①	Dressing d's BID	
	wet to dry with NS, pack	
	open wound & tape form.	
	(b)(6)	
	CANCEL NEOBL	

PATIENT IDENTIFICATION: 600-32-4305

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 43

	DATE OF ORDER	TIME OF ORDER
	19 MAR 08	1430 HOURS
①	Dressing changes will	
	be done by podiatry AD	
	(b)(6)	
	(b)(6)	19 MAR 08 1530

PATIENT IDENTIFICATION: 600-32-4305

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 43

	DATE OF ORDER	TIME OF ORDER
	19 MAR 08	1445 HOURS
①	dc Levaquin	
	(b)(6)	
	19 MAR 08 1740	
①	transfer to [illegible]	
	(b)(6)	

DA FORM 4256 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED.

Exhibit 2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	17Mar08	1613 HOURS	
	NS 500 cc bolus		

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER
	17Mar08	1700 HOURS
	Kayexalate 60g po x1 dose	

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

	DATE OF ORDER	TIME OF ORDER
	17Mar08	1730 HOURS
1	CMP, CBC daily in am	
2	Neuro another cardiac enzyme	

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

	DATE OF ORDER	TIME OF ORDER
	17Mar08	0815 HOURS
1	d/c Impression.	
2	Cont Levaquin 500 QD PO	
	Avida 300 QID PO	
	18Mar08 @ 2030	
	24 chart ck AC	

(b)(6)

(b)(6)

(b)(6)

(b)(6)

(b)(6)

PM 0809

DA FORM 4256 REPLACES EDITION OF 1 JUL

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

Exhibit 2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Mar 17/08	0220 HOURS	

(1) 500cc NS Bolus IV x1

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER	TIME OF ORDER
3/17/08	0505 HOURS

Bolus 500cc NS IV now

(b)(6)

V.O.

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER	TIME OF ORDER
17 Mar 08	0956 HOURS

(1) ABG

(2) Serum ketone

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER	TIME OF ORDER
17 Mar 08	1258 HOURS

EKG q am

(b)(6)

(b)(6)

18 Mar 08 @ 2025

2nd Chart CK Completed

(b)(6)

694-705

DA FORM 4256, APR 98 REPLACES EDITION OF 1 JUL 79, WHICH MAY BE USED.

Exhibit 2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

	DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
	16 March 08	2100	
1	Please give Plavix 150mg PO x 1 then 75mg PO QD		
2	Wg Kayexalate x 1		
3	DC drip. Give 10 U NPH BID and 8U Insulin SQ now & D5 ½ NS maintenance as prev. ordered		
	(b)(6)		
	2200 16 March		3/16 2205
	Clarification: 8U NPH insulin SQ now		
	V.O. (b)(6)		

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

	DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
	16 March 08	2225	
	Lasix (R) 40 IV SQ		(b)(6) 3/16 2245

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

	DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
	17 March	0100	
1	Continue Sliding Scale Insulin		(b)(6)
2.	D+ fluids ½ NS @ 100cc/hour		(b)(6) 3/17 0230
3	Dstick q4 hours		
	18 Mar 08 0025		
	24 Chart Completed		969

(b)(6)

DA FORM 4256 REPLACES EDITION MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

20/600-32-4305

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	16 MAY 08	1520 HOURS	
	(b)(6)		
✓ (1)	~~Hold~~ give benadryl 25mg IV x 1 prior to PRBC's and tylenol 1 gram PO prior to PRBC's.		MW 1420
✓ (2)	~~Hold~~ give another 25mg of benadryl IV if itching or reaction develops		(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
IW		3.

	DATE OF ORDER	TIME OF ORDER	
✓ (1)	Tylenol 650 mg ~~po q 4-6 hrs~~ HOURS for fever ↑ PRBC's		MW 1420
	(b)(6)		(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

	DATE OF ORDER	TIME OF ORDER	
	16 MAY 08	1525 HOURS	
✓ (1)	Recheck BMP @ 1800		DMW 1430
✓ (2)	CBC, CMP in am		(b)(6)
(3)	CXR in am		
	(b)(6)		

24° chart ✓ 3/14 2140C

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

	DATE OF ORDER	TIME OF ORDER	
	16 MAY 08	HOURS	
(1)	Titrate insulin drip to get BG < 200. Increments of 2 u/hr.		(b)(6)
	(b)(6)		

Ordered 5/16/08 2140

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

(b)(6)

18 MAY 08 A01 LLDLCID ROI 29[illegible]6

DA FORM 4256 REPLACES EDITION OF [illegible]

LAW ENFORCEMENT SENSITIVE

000068

Exhibit 2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.
600-32-4305	ICU		3

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	16 MAY 08	0930 HOURS	
1	d/c BIPAP, d/c Lasix		
2	250cc NS bolus again + 500/hr x 1		
3	Alb/atrovent nebs q4hrs or prn		
4	CXR now -		
5	Keyder line		

(b)(6)

(b)(6)

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.
600-32-4305	ICU		3

	DATE OF ORDER	TIME	
	16 MAY 08	1045 HOURS	
6	dc keyevalate		
7	dc octopetch -		
8	dc reglan		
9	dc zosyn,		
10	Imipenem 250 mg IV q6 hrs		
11	type + cross for 2U PRBC's - + give one unit over two hours, evaluate, and if lung exam stable → give 2nd unit over 2hrs. Call me if SOB. + get CXR.		
12	Give 10u IV Morphine now for K < 2.5.		

(b)(6)

(b)(6)

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.
600-32-4305	ICU		3

	DATE OF ORDER	TIME OF ORDER	
	16 MAY 08		HOURS
13	BID Dakins packing Left foot wounds		
14	Normal Diet		
15	Give 500cc NS over 30 min		
16	done for K 2.5		

(b)(6)

(b)(6)

(b)(6)

(b)(6)

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

20/600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
DCU		3

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
DCU		3

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	16 Mar 08	1500 HOURS	
✓①	d/c NS, give D5½NS		MD
	IV maintenance at 150/hr		1600
	for 2L, then reassess		1630
✓②	Insulin drip @ 4U/hr on protocol		before
	- BG q 1 hr, q2hr when BG < 200		
	- If BG > 350, give 10U reg insulin IV		
	during insulin therapy		
	DATE OF ORDER	TIME OF ORDER	
	- if BG < 200 x 3 ⇒ HOURS		d/c drip
	and give 10U reg insulin SQ and		
	10U NPH & then 10U NPH BID		
	and use sliding scale below:		
	BG 150-200 ⇒ 2U reg insulin		
	201-250 ⇒ 4U		
	251-300 ⇒ 6U		
	300-350 ⇒ 8U		
	DATE OF ORDER	TIME OF ORDER	
		>350 ⇒ 10U HOURS	
✓③	While on D5½NS @ 150/hr —		
	assess lung exam q 2hrs,		
	if symptoms of failure (SOB)		
	or worsening exam, slow		
	IVF rate to KVO and call MD		
✓④	May turn IVF rate down to 50/hr		
	DATE OF ORDER	TIME OF ORDER	
	while getting PRBC — give units HOURS		over
	4hrs with assessment of lungs		
	between units. If symptoms		
	of SOB or worse exam —		

(b)(6)

(b)(6)

(b)(6)

24 Oct v 3 No 28

ACLU

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

DA FORM 4256 APR 79 REPLACES EDITION OF [illegible] WHICH MAY BE USED.

000070

Exhibit 2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

600 32 4305

ER orders

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	3/16/08	0257 HOURS	
Hel	D→1 Amp D50 (1) 10 units Regular		(b)(6) Dr Hall
0310	500grams Kayexalate PO		(b)(6) (b)(6)
0325	40mg Lasix IV		(b)(6)
0300	1 Amp CaCl2 @0300		(b)(6)
0250	250cc NS IV Bolus		(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	16 Mar 08	0501 HOURS	16Mar08 0530
	V Vobs to Q 2 hours		
	(b)(6)		Noted (b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	3/16/08	0830 HOURS	
~~A~~	~~65mg~~ (b)(6)		(b)(6)
①	65mg lovenox SQ ~~BID~~ at 1 then		(b)(6) 09
	95mg lovenox SQ BID		(b)(6)
②	RBG ✓		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF OR
	(CONTINUED)	0845 HOURS
①	Give 10u Nisulin now (regular) IV	
②	Start Nisulin drip @ 5U/hr ✓	
	100u in 100cc NS (Regular Nisulin).	
③	Check BG in one hr	
④	Change maintenance to	
	D5-½NS at KVO for now	
⑤	250cc NS Bolus	

(b)(6)

(b)(6)

2nd done 3/16/08 @ 1525

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	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
600-32-4305	ICU		4	28 Mar 08	1040 HOURS	
				⊘ DNR/DNI		
					(b)(6)	(b)(6)
						28 Mar08 1045

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
600-32-4305	ICU		4	28 Mar 08	1530 HOURS	
				⊘ Start 60mg cardizem PO q6hrs, hold for HR<60 or SBP<90		
				⊘ IVF to KVO, unless BP/HR + UOP drops, then 100 cc/hr.	(b)(6)	(b)(6)
				28 Mar08 @ 2300		(b)(6)
				24° Chart ck. completed	(b)(6)	

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
600-32-4305	ICU		4	29 Mar 08	0600 HOURS	
				6 Review DNR/DNI status		
				⊘ Do not replace a-line.		
					(b)(6)	

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
600-32-4305	ICU		4		HOURS	
				Check done 27 Mar08 @1815		

(b)(6)

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	27Mar08	1850 HOURS	
(1)	dlc DNR order		
			Noted 3/27/2130
			(b)(6)
			(b)(6)
			(b)(6)
	√done 3/28/08@ 1400		

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

DATE OF ORDER	TIME OF ORDER	
28Mar08	0640	HOURS
- 500 cc NS Bolus IV		
- ABG IV		
- CXR IV		
- Adenosine 6mg IV NOW		Done
		(b)(6)
		(b)(6)
		Noted 28Mar08 0810 HRS

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

DATE OF ORDER	TIME OF ORDER	
28March	0730	HOURS
Diltiazem 20mg Bolus IV over 2 min may repeat 15 min PRN x 1		
		(b)(6)
		(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

DATE OF ORDER	TIME OF ORDER	
28March08	0800	HOURS
(1) 2nd dose diltiazem at 25mg IV bolus over 2min		
(2) Core Coding cardiac PD x 1		
		(b)(6)
		(b)(6)
		Noted Blake PS 0810
28March08 2250		
24 Chart completed		

(b)(6)

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

Exhibit

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.

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 27 March 08 TIME OF ORDER: 1100 HOURS

LIST T ORDE NOTED SIGN

✓ ① Give Ca gluconate 3 grams in 100cc D5W over 30 minutes

✓ ② Give Mg sulfate 2g over 2hrs

(b)(6)

Noted 1124

PATIENT IDENTIFICATION

600-32-4305 ✓

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 27 March 08 TIME OF ORDER: 1400 HOURS

① ~~If BS <60 or >~~

Lasix 40mg IV x1

(b)(6)

Noted 27 Mar 08 1420

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 4 84 chart ✓ 3/27 0137

DATE OF ORDER: 27 Mar 08 TIME OF ORDER: 1449 HOURS

(b)(6)

① ~~If BS <60 or >~~

② may 1 PRN IV BP < 88 systolic

③ Continue D5 ½ NS @ 100/hr for now.

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 27 March 08 TIME OF ORDER: 1500 HOURS

① d/c nebs / d/c vent

② d/c bag exalate

③ clear diet, advance as tolerated

④ d/c free water/tube feeds, d/c DNT

⑤ d/c premarin

(b)(6)

(b)(6)

Noted 3/27

Chart ACCUDOC GIL (b)(6) 29702

DA FORM 4256 REPLACES EDITION OF [illegible] MAY BE USED.

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LAW ENFORCEMENT SENSITIVE

Exhibit 0000742

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

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
PCU		4

DATE OF ORDER 26 MAR 08 **TIME OF ORDER** 1845 **HOURS**

X ① Reglan IV 5mg TID

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 26 MAR 08 **TIME OF ORDER** 1900 **HOURS**

① Pt Vss < 7, increase rate 6 as needed on SIMV. Current rate is 4

(b)(6)

(b)(6)

EMART ✓ 720 26 MAR 08

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 26 MAR 08 **TIME OF ORDER** 2355 **HOURS**

IVFAN Fluids as tolerated

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 27 MAR 08 **TIME OF ORDER** 9am **HOURS**

✓ Lasix 20mg IV x1 now 0920

✓ d/c Fentanyl gtt 0900

✓ Fentanyl 25-50 mcg q1hr PRN pain Notified 27 Mar 08 0958

✓ ↓ D5½NS to TKO.

X Change Protonix 40mg via NGT BID (if on formulary)

→ Donethan (b)(6)

24 chart AGIBE (b)(6)

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

DA FORM 4256 REPLACES EDITION OF [illegible] MAY BE USED.

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000075

Exhibit 2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
600-32-4305		26Mar08	0435 HOURS	26Mar08 @ 0445 noted (b)(6)
		Hold Tube Feed until (b)(6) in AM. (b)(6)		
NURSING UNIT: ICU / ROOM NO.: / BED NO.: 4		Orders verified 26 Mar 08 @ 0745 (b)(6)		
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER	
600-32-4305		26 Mar 08	0730 HOURS	3/26/08 @ 0800 (b)(6)
	①	↑ D5 ½NS to 100mL/hr while tube feeds on hold		
	②	KUB to ✓ DHT placement		
		V.O. (b)(6)		
		(b)(6)		
NURSING UNIT: ICU / ROOM NO.: / BED NO.: 4				
PATIENT IDENTIFICATION		DATE OF ORDER		
600-32-4305		26Mar08 1248 HOURS		(b)(6) 3/26/08@1315
	①	Please get blood cultures x 2 sets if temp ≥ 101 - one set via line, one peripheral (b)(6)		
NURSING UNIT: ICU / ROOM NO.: / BED NO.: 4				
PATIENT IDENTIFICATION		DATE OF ORDER	TIME OF ORDER	
600-32-4305		26Mar08	1250 HOURS	(b)(6) 3/26/08@1300
	①	Give Ca gluconate 3 grams in 100cc D5W over 30 minutes		
	②	Hold WPH off tube feeds (b)(6)		
	③	wean rate down to 4 on SIMV		
NURSING UNIT: ICU / ROOM NO.: / BED NO.: 4				

ACLU DDI CID RØI 29704

DA FORM 4256, APR 78 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE U(b)(6)

CHART ✓ 2201 26 Mar08

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LAW ENFORCEMENT SENSITIVE

EXHIBIT

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
600-32-4305		25MAR08 1500 HOURS	
		Apply bacitracin to Steri-strips on abdomen TID	Noted 3/25/08 @ 1500 (b)(6)
		(b)(6)	
NURSING UNIT: ICU / ROOM NO.: / BED NO.: 4		24° chart check completed 3/25/08 @ 1520 hrs. (b)(6)	
600-32-4305		26Mar08 0022 HOURS	
		Hold Tube feeds for 4 hours. ✓ Residual < 50 then resume @ 30 cc/° + progress based on residuals. (b)(6)	26Mar08 @ 0025 noted (b)(6)
NURSING UNIT: ICU / ROOM NO.: / BED NO.: 4			
600-32-4305		26Mar08 0100 HOURS	
		Tylenol ~~650mg~~ 4 Suppositories PR	26Mar08 @ 0110 noted (b)(6)
		(b)(6)	
NURSING UNIT: ICU / ROOM NO.: / BED NO.: 4			
600-32-4305		26 Mar08 0100 HOURS	
		Order clarification: Tylenol 325mg supp x4 or Tylenol 650mg supp x2 = 1300mg total dose, P.R. x 1. C.Y.O. (b)(6)	26Mar08 @ 0110 noted (b)(6)
NURSING UNIT: ICU / ROOM NO.: / BED NO.: 4		✓ done 3/26/08 @ ~~0745~~ (b)(6)	

DA FORM 4256, 1 APR 78 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: 600-32-4305

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 4

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	25 Mar 08	1200 HOURS	
6	Dc bicarb drip		
2	restart versed drip + titrate to effect as needed		(b)(6)
3	Need waking period mam, turn off versed at ~0600.		
4	Plain film of abdomen (KUB) now		

PATIENT IDENTIFICATION: 600-32-4305

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 4

	DATE OF ORDER	TIME OF ORDER	
	Start D5 ½NS to KVO.	HOURS	
	Add free water to DNT 200cc Q6hrs		
	Simv rate @ 12	(b)(6)	

PATIENT IDENTIFICATION: 600-32-4305

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 4

	DATE OF ORDER	TIME OF ORDER	
	25 Mar 08	1200 HOURS	
	Start propofol drip @ 25 mcg/kg/min + titrate for sedation & max of 8 mcg/kg/min		
	Dc versed drip	(b)(6)	9am
	dc propofol @ 0600	(b)(6)	

PATIENT IDENTIFICATION: 600-32-4305

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 4

	DATE OF ORDER	TIME OF ORDER	
	25 Mar 08	1246 HOURS	
	Place DHT before KUB obtained		
	Scannon		
	25 Mar 08 1230	NAS, MC, USA	
	Give Epo 10K units SQ TIW		
	Start today (Tues/Thurs/Sat)		

Noted @ 1245

Noted @ 1845

(b)(6)

ACLU DD[illegible]9706

DA FORM 4256 APR 79 REPLACES EDITION OF [illegible] WHICH MAY B[illegible]

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000078

Exhibit 2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
600-32-4305 24mar08 Transferred 0930 (b)(6)	ICU		4	①	24 MAR 08	0900 HOURS	
					Decrease IVF feeds to 55cc/hr goal. Change parenteral to cyclenex. (b)(6)		
600-32-4305	ICU		4	②	24 MAR 08	1430 HOURS	
					2nd IV Vessel now d/c'd SC. (b)(6) (b)(6)		
600-32-4305	ICU		4	③	24 MAR 08	1940 HOURS	
					Rosine Vessel drip Stop @ 0600 for worsening Trend (b)(6)		noted 3/25 0120
600-32-4305	ICU		4	④	25 MAR 08	1160 HOURS	
					3grams Caglucomate in 50cc D5W over 30min to 4hr x 1 (b)(6)		(b)(6) Noted 3/25/08 1254

DA FORM 4256 PREVIOUS EDITIONS OF 1 JUL 72 ARE OBSOLETE. REPLACES EDITION OF 1 JUL 72, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	23Mar08	1950 HOURS	
✓ (2)	d/c 9400 CBC, check i-am		23Mar08
✓ (2)	urean cath on 5-min, as able		@2000
	but keep min (minimum) urination 6-8		noted
	or more		

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

↓	DATE OF ORDER	TIME OF ORDER	
	23Mar08	2120 HOURS	23Mar08 @ 2120 noted
✓ (2)	Decrease brk drip to		
	100 cc/hr (3 amps brk in		
	NS).		

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

↓	DATE OF ORDER	TIME OF ORDER	
	23Mar08	2130 HOURS	23Mar08 @2130
✓ (1)	D/C D5½NS		
	(Y.O.		

(b)(6)

(b)(6)

noted

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

↓	DATE OF ORDER	TIME OF ORDER	
	24Mar08	0600 HOURS	
(1)	ECG OK, send cardiac enzymes		
(2)	+ Lasix/ today as able		
(3)	Match output with IVF (brk		
	trip as previously ordered) ratio.		
(4)	Need V/R OK		

(b)(6)

24 Mar 08 @ 1000 Transferred to

(b)(6)

ACLU DDI 9708

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LAW ENFORCEMENT SENSITIVE

DA FORM 4256

REPLACES EDITION OF 1 JUL 77, WHICH 24° chart ✓ 3/25 0035

(b)(6)

2

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

000-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	23 MAR 08	0500 HOURS	
1	Continue Nicardipine @ 150/hr (3 amps in D5W)		
2	Give regular insulin SQ according to sliding scale of FSBG Q4		
	150-200 ⇒ 2U		
	201-250 ⇒ 4U		
	251-300 ⇒ 6U		
	301-350 ⇒ 8U		
	> 351 ⇒ 10U		
3	Give Pentamidine @ 300cc/hr over 60 min + check residuals at 4 hrs — hold if > 200cc.		
4	Titrate dopamine to off as able, maintain systolic BP > 90.		
5	Send U/A and urine lytes		
	DATE OF ORDER	TIME OF ORDER	
6	CBC q 4 hrs HOURS		
7	Premarin 2.5mg PO via NGT		
8	Protonix 40mg IV BID		
9	Wean versed to off for waking period		
10	CXR this am		
11	PEEP to 5, wean [redacted] rate down as wakes up		
	DATE OF ORDER	TIME OF ORDER	
	23 MAR 08	1200 HOURS	
1	Kayexalate 40g PO Q6		
2	If tolerates tube feeds, start SQ NPH 10U this pm, then BID		
	23 MAR 08 @ 1855		
	order [redacted]		

(b)(6)

(b)(6)

(b)(6)

(b)(6)

(b)(6)

Noted 3/23/08 @ 0840

Noted 3/23/08 1239

DA FORM 4256 APR 79 REPLACES EDITION OF [illegible] MAY BE USED.

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LAW ENFORCEMENT SENSITIVE

DDI CID ROI 29709

0000812

Exhibit

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

G00-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	22MAR08	2130 HOURS	
✓ 6	Give 30mcg dDAVP over 30min		
	(b)(6)		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	22MAR08	2139 HOURS	
✓	(1) Give bicarb drip @ 150/hr		
✓	(2) Albuterol neb Q4 or as needed.		
✓	(3) 2mg versed bolus, titrate drip to effect		
✓	~~(4) Give~~ (4) Simv rate 20, Vt 600, PSCO		
✓	(5) No chest compressions		
	(b)(6)		

PATIENT IDENTIFICATION

G00-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

	DATE OF ORDER	TIME	
	22MAR08	2200 HOURS	
✓	(1) Start dopamine drip @ 10mcg/kg/min and titrate for BP (systolic) > 90		
✓	(2) May start 2U PRBC when available		
	(b)(6)		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
	24° chart rev	

	DATE OF ORDER	TIME OF ORDER	
	22MAR08	2139 HOURS	
	V.O. (b)(6)		
✓	(1) NO DEFIB		
	(b)(6)		
	(b)(6)		

29710

DA FORM 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED. FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

0000822

Exhibit 2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	22 Mar 08	~~0150~~ 2030 HOURS	
✓ 1	T+C for 4 units PRBC/FFP/CSC now		
✓ 2	Grid 2L NS BV, start 2U PRBC when ready		
✓ 3	2mg IV Morphine now		
✓ 4	Repeat 1mg IV Morphine q 1hr PRN chest pain		
✓ ~~5~~	25mg IV Lasix now		
✓ 5	↑ 5mg/hr rate q 20 min		

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	03/22/08	9pm HOURS	
✓	Transfuse: 2U FFP,		FFP 2300 22Mar08
	- 4U cryoprecipitate		

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	22 Mar 08	2100 HOURS	
✓ 6	Give 250/hr of bicarb drip		
	(3 amps of bicarb in 1L D5W)		

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	22 Mar 08	2120 HOURS	
✓	Calcium Chloride 1gm, IV-now x1.		
✓	↑ Sodium Bicarb gtt to 500ml/hr.		
	(V.O.	(b)(6)	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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LAW ENFORCEMENT SENSITIVE

 24° chart ✓ 3/23/08 0255 (b)(6) it

CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	29 MAR 08	0900 HOURS	
①	morphine 2mg IV x1		
②	Lasix 40mg IV x1		
	(b)(6)		NOTED (b)(6) 0909 29 MAR 08

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	29 MAR 08	1050 HOURS	
①	meropenem 500mg IV q 24°		
②	vancomycin 1gram IV Qweek		
	(b)(6)		NOTED 1044 29 MAR 08

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	29 MAR 08	1050 HOURS	
①	Resume 40mg Lasix IV x1		
	(b)(6)		NOTED 1050 29 MAR 08

Order verified 3/29/08 1247 (b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	29 MAR 08	1200 HOURS	
①	Start Lasix 80mg IV BID, 1st dose this evening @ 2000hrs		
②	Morphine 2mg IV prn for increased work of breathing Q 1-2hrs.		
	(b)(6)		1247 29 MAR 08 (b)(6)

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE
ACLU DDI

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

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

DATE OF ORDER 29March04 **TIME OF ORDER** 1400 **HOURS**

LIST TIME ORDER NOTED AND SIGN

① Change previous order
to lasix 120mg IV BID
starting @ 2000hrs

(b)(6)

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

DATE OF ORDER **TIME OF ORDER** ________ **HOURS**

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

DATE OF ORDER **TIME OF ORDER** ________ **HOURS**

PATIENT IDENTIFICATION

600-32-4305

NURSING UNIT	ROOM NO.	BED NO.
ICU		4

DATE OF ORDER **TIME OF ORDER** ________ **HOURS**

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

DA FORM 4256

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

Exhibit 2

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0010-08-CID789-53199

PAGE 1 OF 1 PAGE

DETAILS

EXAMINATION OF REMAINS: About 1630, 29 Mar 08, SA [redacted] conducted an examination of the remains of Mr Taha Daher MUHAMMED Al-Ithawi, Internment Serial Number (ISN): US9IZ-324305-CI, Camp Remembrance II (CRII), Theater Internment Facility (TIF), Camp Cropper, Baghdad, Iraq APO AE 09342 (CCIZ), located at Bed 4, Intensive Care Unit (ICU), 31st Combat Support Hospital (CSH), CCIZ.

Characteristics of Remains: The decedent was identified via retinal scan as Mr MUHAMMED. The decedent appeared to be Middle Eastern male, approximately 5'11", and weighed 222 pounds. The decedent had black/gray "peppered" hair and brown eyes. No tattoos were viewed, but a healing cut, sutured with staples was noted on the midsection of the decedent. The decedent was not clothed, but covered with a bed sheet upon arrival. Evidence of medical intervention included an intravenous lead in the left foot, a catheter inserted into the penis, numerous leads around the midsection, healing wounds in both arms of intravenous leads, and a scar measuring approximately 16" in the midsection, which was described as a wound from emergency surgery for a gastrointestinal bleed.

Conditions of Remains: The remains were still warm to the touch and rigor mortis was not present. Minor amounts of livor mortis was noted on the back of the decedent. No signs of external trauma, except for signs of medical intervention, were observed. The decedent was not wearing any jewelry.

Environmental Conditions: At the time of the examination, the temperature inside the ICU was 68 degrees. There were no odors out of the ordinary near the remains during the time of the examination.

Factors Pertinent to Entrance/Exit (E/E): The main entrance and exit point to the ICU could be gained from the southern most wall in the ICU. There was a set of double doors which could be accessed by pushing in either direction.

Documentation of Remains: The remains were documented by SA [redacted] utilizing a NIKON D80 Digital SLR Camera with a built in flash. Additionally, a human remains sketch was prepared by SA [redacted]

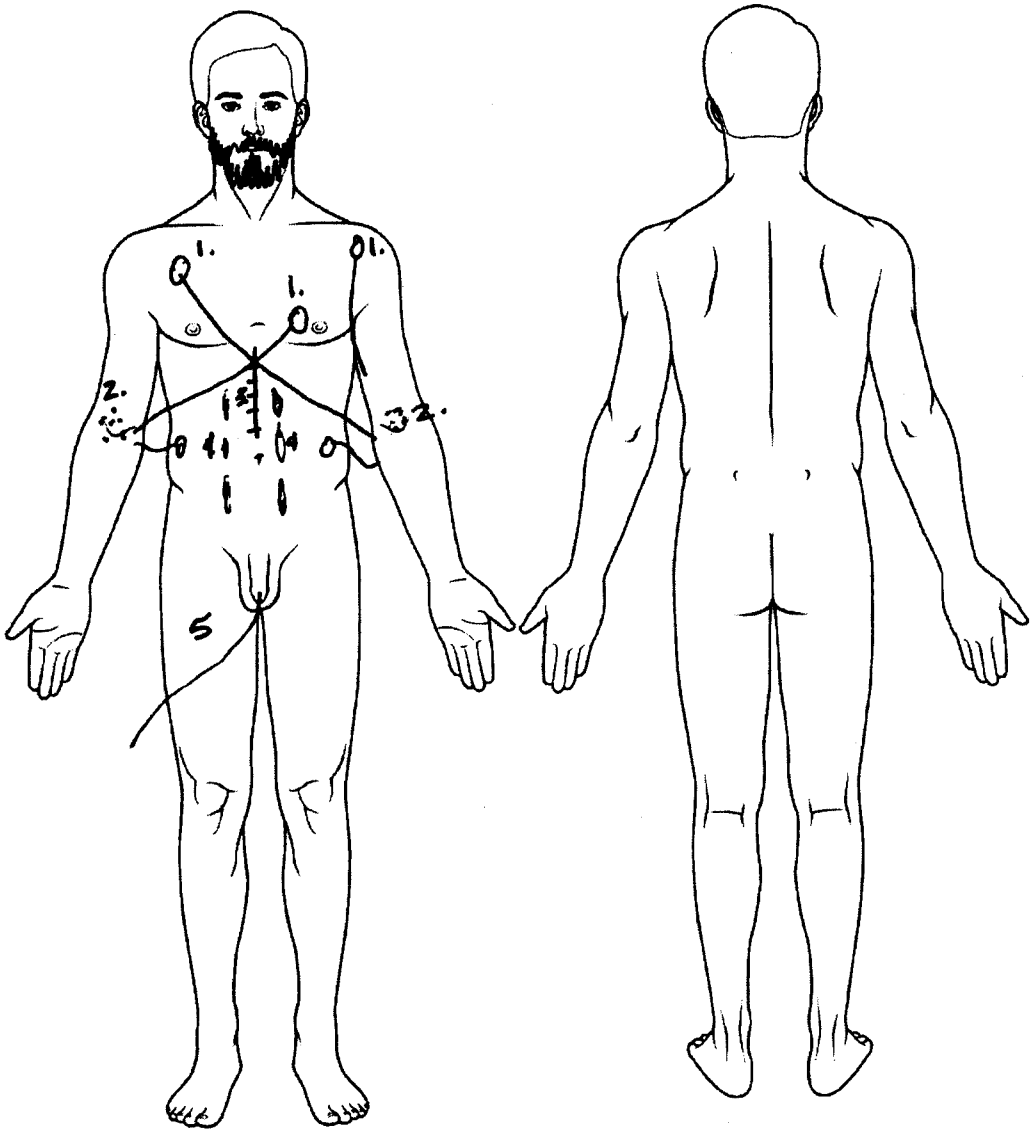
Search for Latent Impressions: There was no search for latent impressions due to all who worked in the ICU had unfettered access to Mr MUHAMMED.

Collection of Evidence: A collection of evidence was not performed due to the fact that the remains were located at the ICU for an hour prior to his demise and all clothing had been disposed of by hospital staff.

Search Beyond the Remains: A search beyond the scene was not conducted. ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
SA [redacted]	Camp Cropper CID Office, 1149th/20th MP DET (CID) Camp Cropper, Baghdad, Iraq APO AE 09342
SIGNATURE [redacted]	DATE 29 Mar 08 / EXHIBIT 3

Rough Sketch Depicting Human Remains



LEGEND	TITLE BLOCK:
A: Labs measuring vitals	Case#: 0010-08-CID789-53199
B: Healing IV sticks	Offense: Undetermined Manner of Death
C: Healing GI Bleed incision	Person Portrayed: Bed 4, ICU, 31st CSH
D: Healing tape abracions	Location: Camp Cropper, Baghdad, IZ 09342
E: Catheter	Victim: Mr Taha Daher Muhammed (ISN 324305)
F:	Date/Time: 1639/29 Mar 08
G:	Sketched By: SA (b)(6), (b)(7)(C) [redacted]
H:	Verified By: SA (b)(6), (b)(7)(C) [redacted]
I:	

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0080-08-CID112

PAGE 1 OF 1 PAGE

DETAILS

BASIS FOR INVESTIGATION: On 7 Apr 08, this office received a Request for Assistance (RFA) from SA (b)(6), (b)(7)(C) Special Agent-in-Charge, Camp Cropper, 20th/1149th MP DET (CID), 11MP BN (CID), Iraq APO AE 09342. The request required this office to attend the autopsy of Mr. Taha Daher MUHAMMED, US91Z-324305, Camp Remembrance II, Theater Internment Facility, Camp Cropper, Iraq APO AE 09342.

About 0925, 1 Apr 08, Dr. (LCDR) (b)(6), (b)(7)(C) Office of Armed Forces Medical Examiner (OFAME), Armed Forces Institute of Pathology (AFIP), 1413 Research Blvd, Bldg 102, Rockville, MD 20850, conducted the autopsy of Mr. MUHAMMED. The preliminary cause of death and the manner are pending further medical review. Photographs from AFIP exposed digital photographs of the autopsy and prepared a compact disc (CD) containing all images exposed.

About 1400, 9 Mar 08, SA (b)(6), (b)(7)(C) obtained the fingerprints of Mr. MUHAMMED and a copy of the CD containing all images. (See Fingerprints and CD of Mr. MUHAMMED for details.)

Agent's Comment: The official results of the autopsy will be documented in the Final Autopsy Report, which will be provided upon completion. //////////////////////LAST ENTRY//////////////////////

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
(b)(6), (b)(7)(C), (b)(7)(F)	Aberdeen CID Office Aberdeen Proving Ground, MD 21005
SIGNATURE (b)(6), (b)(7)(C)	DATE: 9 Apr 08 / EXHIBIT: 7

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0010-08-CID789-53199

PAGE 1 OF 1 PAGE

DETAILS

About 2230, 7 May 08, SA (b)(6), (b)(7)(C) received the Autopsy Examination Report, number ME08-0244, Armed Forces Institute of Pathology, Office of the Armed Forces Medical Examiner, 1413 Research Boulevard, Building 102, Rockville, MD 20850. The report listed the cause of death concerning Mr. MUHAMMED was Hypertensive Atherosclerotic Cardiovascular Disease and the manner of death was reported as Natural.//// LAST ENTRY ///

TYPED AGENT'S NAME AND SEQUENCE NUMBER

SA (b)(6), (b)(7)(C), (b)(7)(F)

ORGANIZATION

CAMP CROPPER CID OFFICE
BAGHDAD, IRAQ APO AE 09342

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

DATE 8 MAY 08

EXHIBIT 10

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
(b)(6)

AUTOPSY EXAMINATION REPORT

Name: BTB Muhammed Al-Ithawi, Taha Daher
ISN: 324305
Date of Birth: Unknown
Date of Death: 29 Mar 2008
Date/Time of Autopsy: 1 Apr 2008@1130
Date of Report: 10 Apr 2008

Autopsy No.: (b)(6)
AFIP No. (b)(6)
Rank: Iraqi Civilian
Place of Death: Iraq
Place of Autopsy: Port Mortuary
Dover AFB, Dover, DE

Circumstances of Death: Per investigation, this Iraqi male was admitted to the 31st Combat Surgical Hospital on 16 March 2008 for multiple medical problems, including acute renal failure, untreated diabetes mellitus, and an acute myocardial infarction. While in the hospital he underwent surgery for gastrointestinal bleeding, and was also treated for continued renal failure and another myocardial infarction. Despite aggressive medical intervention, he eventually succumbed to his multiple ailments.

Authorization for Autopsy: Armed Forces Medical Examiner, per 10 U.S. Code 1471

Identification: Presumptive identification is established by examination of paperwork in the case file. Post-mortem fingerprints and a specimen suitable for DNA analysis are obtained. .

CAUSE OF DEATH: **Hypertensive atherosclerotic cardiovascular disease**

MANNER OF DEATH: **Natural**

AUTOPSY REPORT (b)(6)
Muhammed Al-Ithawi, Taha Daher

EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished unclad male. The body weighs 273 pounds and is 73 inches in length. The body is cold. Rigor is passing. Lividity is present and fixed on the posterior surface of the body, except in areas exposed to pressure. The head is normocephalic, and the scalp hair is black and gray. Facial hair consists of a beard and mustache. The irides are brown. The corneae are cloudy. The conjunctivae are congested. The sclerae are white/red. The eyelids are edematous. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The earlobes have creases bilaterally. The nasal skeleton and maxilla are palpably intact. The lips are without evident injury. The upper teeth are absent and the lower teeth are in poor condition. Examination of the neck reveals no evidence of injury. No evidence of injury of the ribs or the sternum is evident externally. The abdomen is soft and distended. There is a 10 ½ inch vertical stapled incision on the midline of the abdomen. The external genitalia are those of an adult circumcised male, and the scrotum and penis are edematous. There are numerous pinpoint pustules on the posterior torso. The anus is unremarkable. The extremities are diffusely edematous. The fingernails are short and intact. Underneath the wrap and gauze on the left foot is a necrotic ulcer, 2 x 2 inches, and the 1st and 2nd toes on the left foot are absent. Scars and tattoos are not noted.

CLOTHING AND PERSONAL EFFECTS

No items of clothing or personal effects accompany the body.

MEDICAL INTERVENTION

- EKG leads (5) on the torso
- Stapled incision, mid abdomen
- Foley catheter
- Triple-lumen catheter, right femoral area
- Wrap and gauze on left foot, labeled with "29 Mar 08 0930"

RADIOGRAPHS

A complete set of postmortem radiographs is obtained and demonstrates the medical intervention and natural disease as noted.

EVIDENCE OF INJURY

No significant injuries are identified.

INTERNAL EXAMINATION

BODY CAVITIES:

The body is opened by the usual thoraco-abdominal incision and the chest plate is removed. The ribs, sternum, and vertebral bodies are visibly and palpably intact. All body organs are present in normal anatomical position. There are dense left–sided pleural adhesions. There is 100 ml of serosanguinous fluid in the left pleural cavity. There is 1500 ml of serosanguinous fluid in the peritoneal cavity. The subcutaneous fat layer of the abdominal wall is 1 ½ inch thick.

HEAD AND CENTRAL NERVOUS SYSTEM:

The scalp is reflected. The galeal and subgaleal soft tissues of the scalp are free of injury. There are no skull fractures. 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 cerebral hemispheres are symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels, are intact. Clear cerebrospinal fluid surrounds the 1410 gram brain, which has unremarkable gyri and sulci. Coronal sections through the cerebral hemispheres reveal no lesions. Transverse sections through the brain stem and cerebellum are unremarkable. The atlanto-occipital joint is stable.

NECK:

The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact white mucosa. The tongue is free of bite marks, hemorrhage, or other injuries.

CARDIOVASCULAR SYSTEM:

The 660 gram heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution. They demonstrate the following amounts of atherosclerotic stenosis: approximately 95% of the proximal left anterior descending coronary artery, approximately 50% of the mid right coronary artery, and approximately 95% of the proximal and mid left circumflex coronary artery. The myocardium is homogenous, pale tan, and moderately firm. The valve leaflets are thin and mobile. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels, and demonstrates severe calcific change distally, which extends into the iliac arteries. The renal arteries demonstrate approximately 75% atherosclerotic stenosis bilaterally. The mesenteric vessels are unremarkable.

RESPIRATORY SYSTEM:

The upper airway is clear of debris and foreign material; the mucosal surfaces are smooth, yellow-tan and unremarkable. The right pleural surface is smooth and glistening; the left pleural surface is tan-white and fibrotic. The pulmonary parenchyma is diffusely congested and edematous, exuding large amounts of blood and frothy fluid; no focal lesions are noted. The pulmonary arteries are

normally developed, patent, and without thrombus or embolus. The right lung weighs 1090 grams; the left 1070 grams.

HEPATOBILIARY SYSTEM:

The 2330 gram liver has an intact smooth capsule covering tan-red moderately congested parenchyma with no focal lesions noted. The gallbladder is markedly distended and contains 50 ml of green-brown, mucoid bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of calculi.

GASTROINTESTINAL SYSTEM:

The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is arranged in the usual rugal folds and the lumen contains approximately 500 ml of thick, yellow material. There is a 4 inch sutured incision on the mucosal surface of the distal stomach. The small bowel is unremarkable. The serosal surface of the large bowel is diffusely dark purple-gray. The pancreas has a pale tan lobulated appearance and the ducts are clear. The appendix is present.

GENITOURINARY SYSTEM:

The right kidney weighs 200 grams; the left 200 grams. The renal capsules are smooth and thin, semi-transparent and stripped with ease from the underlying granular, red-brown cortical surfaces. The cortex is sharply delineated from the medullary pyramids, which are red-purple to tan and unremarkable. The calyces, pelves and ureters are unremarkable. White bladder mucosa overlies an intact bladder wall. The bladder contains a catheter and is empty. The testes, prostate gland and seminal vesicles are without note.

LYMPHORETICULAR SYSTEM:

The 460 gram spleen has a smooth, intact capsule covering red-pale tan, moderately firm parenchyma; the lymphoid follicles are unremarkable. Lymph nodes in the hilar, periaortic and iliac regions are not enlarged.

ENDOCRINE SYSTEM:

The thyroid gland is symmetrically enlarged and red-brown, without cystic or nodular change. The right and left adrenal glands are symmetric, with bright yellow cortices and red-brown medullae. No masses or areas of hemorrhage are identified.

MUSCULOSKELETAL SYSTEM:

There are degenerative changes of the 6^{th} and 7^{th} cervical, and 9^{th}-12^{th} thoracic vertebral bodies (seen radiologically). No abnormalities of muscle are identified.

AUTOPSY REPORT (b)(6)
Muhammed Al-Ithawi, Taha Daher

ADDITIONAL PROCEDURES

1. Documentary photographs are taken by an OAFME staff photographer.
2. Specimens retained for toxicology testing and/or DNA identification are: vitreous fluid, blood, spleen, liver, lung, kidney, brain, myocardium, bile, gastric contents, adipose tissue and psoas muscle.
3. The dissected organs are forwarded with body.

MICROSCOPIC EXAMINATION

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

AUTOPSY REPORT (b)(6)

Muhammed Al-Ithawi, Taha Daher

FINAL AUTOPSY DIAGNOSES:

I. Hypertensive atherosclerotic cardiovascular disease:
A. Near-occlusive atherosclerotic stenosis of the left anterior descending and left circumflex coronary arteries, and approximately 50% atherosclerotic stenosis of the right coronary artery
B. Atherosclerotic stenosis of the renal arteries, approximately 75% bilaterally
C. Diffuse calcific change of the distal aorta and iliac arteries
D. Cardiomegaly, 660 grams
E. Gross hypertensive changes of the kidneys

II. Additional findings:
A. Bilateral pulmonary congestion, right 1090 grams, left 1070 grams
B. Dense left-sided pleural adhesions
C. Left pleural cavity, 100 ml serosanguinous fluid
D. Peritoneal cavity, 1500 ml serosanguinous fluid
E. History of untreated diabetes mellitus, with a necrotic ulcer and missing digits on the left foot
F. History of upper gastrointestinal bleeding, with a stapled abdominal incision and a sutured gastric incision
G. Grossly necrotic large bowel
H. Diffusely enlarged thyroid with no focal lesions identified

III. No evidence of significant injury

IV. Evidence of Medical Intervention: As noted above

V. Identifying marks and tattoos: None noted.

VI. Postmortem Changes: As noted above

VII. Toxicology (AFIP):
A. Ethanol: No ethanol is detected in the blood and vitreous fluid.
B. Drugs: No screened drugs of abuse are detected in the blood. Diltiazem is detected in the blood at a level of 0.78 mg/L. No other medications are detected in the blood.
C. Carbon Monoxide: The carboxyhemoglobin saturation in the blood is less than 1%.
D. Cyanide: No cyanide is detected in the blood.

Exhibit 11

AUTOPSY REPORT (b)(6)

Muhammed Al-Ithawi, Taha Daher

OPINION

This Iraqi male, Taha Muhammed Al-Ithawi, died of hypertensive atherosclerotic cardiovascular disease. There was almost complete blockage of two of the three main coronary arteries, and moderate blockage of the third. There was also atherosclerotic disease of the aorta and arteries supplying blood to the legs and kidneys. The heart and kidneys demonstrated changes consistent with hypertension (high blood pressure). The decedent also had a non-healing ulcer on his left foot, consistent with the given history of untreated diabetes. Additionally, the decedent's stay in the hospital was complicated by progressive kidney failure, a myocardial infarction (heart attack), and bleeding in the gastrointestinal tract. Toxicological testing was positive for a medication used to treat hypertension, but otherwise negative. The manner of death is natural.

(b)(6)

(b)(6) MEDICAL EXAMINER

Exhibit 11

(REMOVE, REVERSE AND RE-INSERT CARBONS BEFORE COMPLETING THIS SIDE)

DISPOSITON OF REMAINS

NAME OF MORTICIAN PREPARING REMAINS	GRADE	LICENSE NUMBER AND STATE	OTHER

NAME AND ADDRESS	DATE	SIGNATURE
436 SVC/SVD 116 26th Street, Dover AFB DE 19902		

NAME OF CEMETERY OR CREMATORY	LOCATION OF CEMETERY OR CREMATORY

TYPE OF DISPOSITION	DATE OF DISPOSITION

REGISTRATION OF VITAL STATISTICS

REGISTRY (NAME AND ADDRESS)	DATE REGISTERED	FILE NUMBER	
		STATE	OTHER

NAME OF FUNERAL DIRECTOR	ADDRESS

SIGNATURE OF AUTHORIZED INDIVIDUAL

DD FORM 2064, APR 1977 (EACH) *USAPA V1.00*

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

REPLY TO
ATTENTION OF

AFIP-CME-T

TO:

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

PATIENT IDENTIFICATION

AFIP Accessions Number (b)(6) **Sequence** (b)(6)

Name
BTB MUHAMMED, AL-ITHAWI

SSAN: **Autopsy:** (b)(6)
Toxicology Accession #: (b)(6)
Date Report Generated: April 9, 2008

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: 3/29/2008 **Date Received:** 4/3/2008

CARBON MONOXIDE: The carboxyhemoglobin saturation in the blood was less than 1% as determined by spectrophotometry with a limit of quantitation of 1%. Carboxyhemoglobin saturations of 0-3% are expected for non-smokers and 3-10% for smokers. Saturations above 10% are considered elevated and are confirmed by gas chromatography.

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

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

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

Positive Diltiazem: Diltiazem was detected in the blood by gas chromatography and confirmed by gas chromatography/mass spectrometry. The blood contained 0.78 mg/L of diltiazem as quantitated by gas chromatography/mass spectrometry.

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

REPLY TO
ATTENTION OF

REPORT OF TOXICOLOGICAL EXAMINATION (CONT (b)(6) MUHAMMED, AL-ITHAWI):

(b)(6)

Office of the Armed Forces Medical Examiner

0010-08-CID789-53199

[redacted] FORENSIC TOXICOLOGY: TOXICOLOGY [redacted]

TO:

ARMED FORCES INSTITUTE OF PATHOLOGY
ATTN: DIVISION OF FORENSIC TOXICOLOGY
BUILDING 54
3825 16TH STREET, N.W.
WASHINGTON, DC 20306-6000

FORWARD FIT

Dover AFB Port Mortuary
(b)(6)
Incident : OIF
Remains/Case #: (b)(6)
Recovery/TC #:
Process Date: 01 Apr 08 ME # (b)(6)

NAME OF PATIENT (Last, First, MI)	SOCIAL SECU...			
BTB Muhammed, Ahq	ISN 324305			

DATE OF INCIDENT/ ACCIDENT	TIME AND DATE OF DEATH	AUTOPSY [redacted]
29 mar 08 →	→	

[redacted] HISTORY (Prescribed or administered, to include [redacted])
unk

[redacted]	[redacted]	[redacted]
1. Blood	5. Lung	9. Gastric
2. Vitreous	6. Liver	10. Urine
3. Heart	7. Kidney	11. Adipose
4. Brain	8. Spleen	12. Bile

DFT# 08-2300

[redacted] ACCIDENT DETAILS (Include pertinent information regarding [redacted])
h/o MI, ARF, DM; was in ICU x 2 weeks prior to death

PRINTED NAME OF [redacted]/TITLE	SIGNATURE	[redacted]
(b)(6)		01 Apr 08

CHAIN OF CUSTODY			
RELEASED BY:	RECEIVED BY:		
(b)(6)			
(b)(6)	(b)(6)		
	(b)(6)	APR 03 2008 0810	Received From Courier TOXICOLOGY TESTING SECURED STORAGE
(b)(6)			
(b)(6)		APR 03 2008 0810	

Exhibit
000160

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

NAME OF DECEASED (Last, First, Middle) Nom du défunt (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Armée	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
BTB Muhammed, Al-Ithawi, Taha Daher		Civilian	C1D786631995H9B
CITIZENSHIP Organization	NATION (e.g. United States) Pays	DATE OF BIRTH Date de naissance	SEX Sexe ☐ MALE ☐ FEMALE

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

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du défunt avec le sus
STREET ADDRESS Domicile à (Rue)	CITY OR TOWN OR STATE Province ZIP CODE Ville (Code postal compris)

MEDICAL STATEMENT Déclaration 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.	Hypertensive Atherosclerotic Cardiovascular Disease	
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		
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives		

MODE OF DEATH Condition du décès		AUTOPSY PERFORMED Autopsie effectuée ☒ YES Oui ☐ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort résultant par des causes extérieures
X	NATURAL Mort naturelle		
	ACCIDENT Mort accidentelle		
	SUICIDE Suicide	(b)(6)	
	HOMICIDE Homicide	(b)(6)	DATE Date 1 April 2008 — AVIATION ACCIDENT Accident d'Aviation ☐ YES Oui ☒ NO Non

DATE OF DEATH Date, month, year Date du décès (jj/mm/aa) 29 March 2008 — PLACE OF DEATH Location Lieu: Iraq

I HAVE VIEWED THE REMAINS OF THE DECEASED AND SEEN OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.

NAME OF MEDICAL OFFICER Nom du médecin traitant ou du médecin examinateur: Mark Sholly — TITLE OF OFFICER Titre du signataire: Deputy Medical Examiner

(b)(6) — INSTALLATION OR ADDRESS Installation ou adresse: Dover AFB, Dover DE

DATE Date: 4/1/2008 — (b)(6)

DD FORM 2064