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

13 Oct 2008

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - FINAL (C)/SSI - 0026-2008-CID789-53209 - 5H9A

DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 12 AUG 2008, 1829 - 12 AUG 2008, 1829; INTENSIVE CARE UNIT, 115TH COMBAT SUPPORT HOSPITAL, CAMP CROPPER, IRAQ, AE 09342

DATE/TIME REPORTED: 12 AUG 2008, 1832

INVESTIGATED BY:
SA (b)(2),(b)(6),(b)(7)(C)
SA
SA

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

VICTIM:
1. MUNAI AL-SAMARAI, ALLAH ALDIN (DECEASED); FRCIV; IRAQ; (DOB); (POB); MALE; OTHER; INTERNMENT SERIAL NUMBER (b)(6),(b)(7)(C) THEATER INTERNMENT FACILITY, CAMP CROPPER, IRAQ, ARMED FORCES AFRICA, CANADA, EUROPE & MIDDLE EAST 09342; XZ ; [DEATH BY NATURAL CAUSES]

INVESTIGATIVE SUMMARY:

THIS IS AN OPERATION IRAQI FREEDOM INVESTIGATION.

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

Investigation determined Mr. MUNAI died as a result of Acute Myelogenous Leukemia contributed by Atrial Fibrillation and the manner of death was natural.

EXHIBITS:

Attached:

1. Agent's Investigation Report (AIR) of SA (b)(6),(b)(7)(C) 12 Aug 08.
2. Rough Sketch Depicting Human Remains, 12 Aug 08.
3. AIR of SA (b)(6),(b)(7)(C) 20 Aug 08.
4. Memorandum For Record, 18 Jul 08.
5. Medical Records of Mr MUNAI AL-SAMARAI.
6. AIR of SA (b)(6),(b)(7)(C) 29 Sep 08.
7. Certificate of Death (Overseas), 12 Aug 08.
8. Convoy List Of Remains Of Deceased Personnel, 12 Aug 08.
9. Convoy List Of Remains Of Deceased Personnel, 26 Aug 08.
10. Release of remains to Next of Kin, 26 Aug 08.
11. Photographic Packet (Examination of Remains) (USACRC, USACIDC, and file copy only)

The originals of Exhibits 1-3, 6 and 11 are forwarded with the USACRC copy of this report. The originals of Exhibits 4 and 5 are retained in the files of TF115 Combat Support Hospital, Camp Cropper, Baghdad, Iraq APO AE 09342. The originals of Exhibits 7-10 are retained in the files of 111th Quartermaster Company (Mortuary Affairs), Baghdad International Airport,

Camp Sather, Iraq APO AE 09342.

Not Attached:

None.

STATUS: This is a Final (C) Report.

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

Report Prepared By:

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

Special Agent

Report Approved By:

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

Special Agent in Charge

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

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0026-08-CID789-53209

DETAILS

BASIS FOR INVESTIGATION: About 1832, 12 Aug 08, LTC [redacted] (b)(6), (b)(7)(C) PAD, 115th CSH, reported the death of Mr. MUNAI AL-SAMARAI, while in Bed 2, ICU, 115th CSH.

EXAMINATION OF REMAINS: About 1850, 12 Aug 08, SA [redacted] (b)(6), (b)(7)(C) conducted an examination of the remains of Mr. MUNAI AL-SAMARAI, while at Bed 2, ICU, 115th CSH.

Characteristics of Remains: The decedent was identified as Mr. MUNAI via retinal scan. The decedent appeared to be a Middle Eastern male, approximately 5'11", and weighed 134 pounds. The decedent had black hair and brown eyes. No tattoos were observed. There was minor bruising noted to the arms and chest of the decedent, which was explained as prior intravenous leads. Due to the decedent's prior medical history, his platelet count was low and bruised easily. Due to his combative nature during the last moments of his life from dementia, Mr. MUNAI could have possibly had additional bruising which had not yet developed. No petechiae was observed in any part of the eyes. No obvious signs of external trauma were noted.

Conditions of Remains: The remains were still warm to the touch and capillary refill of the nail beds was completed within 2 seconds. Rigor mortis was not present in either the small or large joints. No livor mortis was noted on the decedent. Signs of medical intervention was noted, to include a catheter, intravenous leads, and monitor pads. The decedent was not wearing any jewelry or clothing.

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.

Documentation of Remains: The remains were documented by SA [redacted] (b)(6), (b)(7)(C) utilizing a Nikon D80 Digital Camera with a built in flash. Additionally, a human remains sketch was prepared by SA [redacted] (b)(6), (b)(7)(C)

Collection of Evidence: No evidence was collected during the examination of the remains. ///Last Entry///

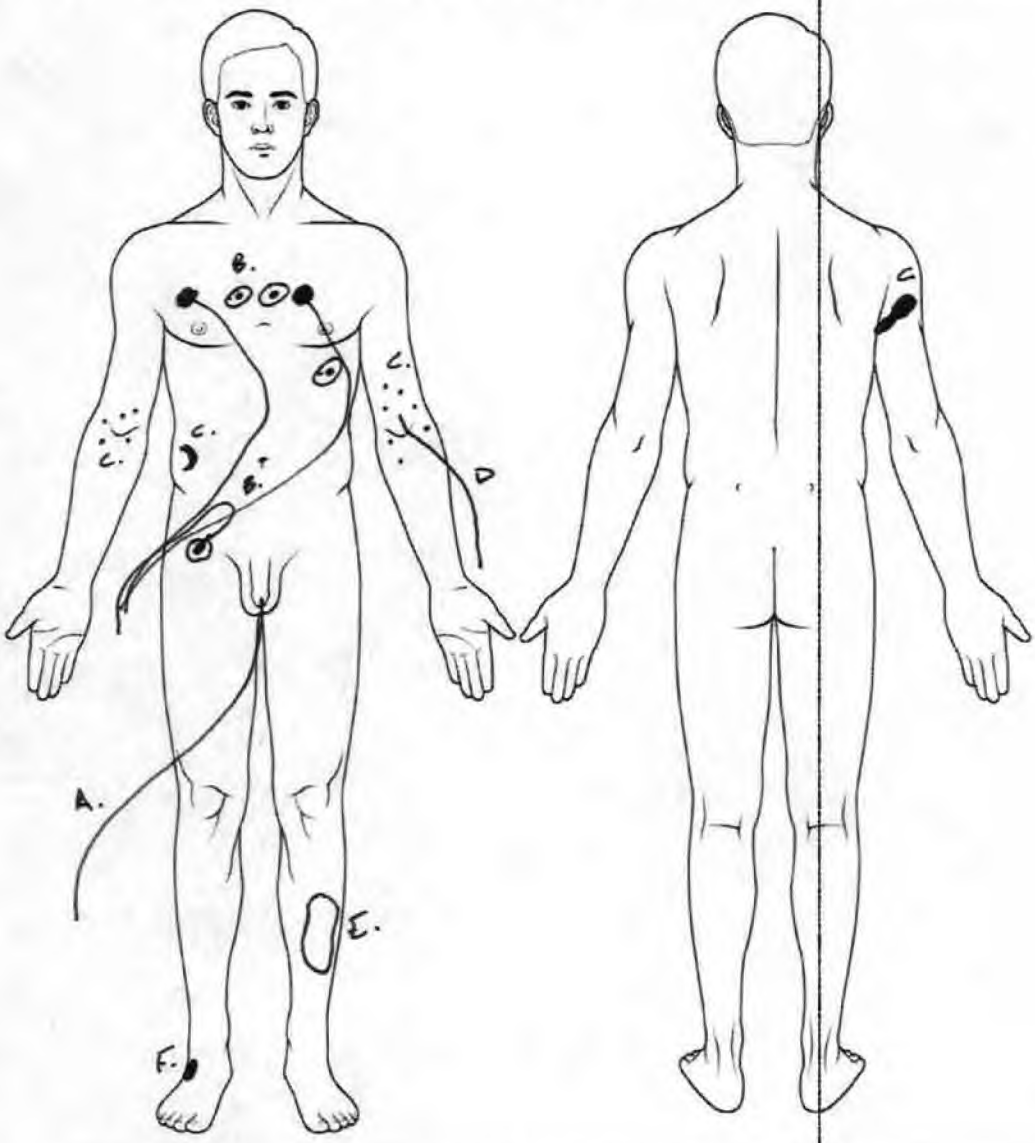
TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
for SA [redacted] (b)(6), (b)(7)(C), (b)(7)(F)	Camp Cropper CID Office, 1149th/20th MP DET (CID) Camp Cropper, Baghdad, Iraq APO AE 09342	
[redacted] (b)(6), (b)(7)(C)	DATE 12 Aug 08	EXHIBIT

ACLU DDII CID ROI 28079

CID FORM 94 (Automated)

[redacted]

Rough Sketch Depicting Human Remains



LEGEND	TITLE BLOCK:
A: Catheter	Case#: 0026-08-CID789
B: Lead wires	Offense: Undetermined Manner of Death
C: Bruising	Person Portrayed: ISN (b)(6), (b)(7)(C) [redacted]
D: IV Lead	Location: Bed 2, ICU, 115th CSH
E: Indention (Legs crossed)	Victim: ISN (b)(6), (b)(7)(C) [redacted]
F: Callous	Date/Time: 1910 / 12 AUG 08
G:	Sketched By: SA (b)(6), (b)(7)(C), (b)(7)(F) [redacted]
H:	Verified By: SA (b)(6), (b)(7)(C), (b)(7)(F) [redacted]
I:	

ACLU DDII CID ROI 28080

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EXHIBIT 2

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0026-08-CID789-53209

PAGE 1 OF 1 PAGE

DETAILS

About 1920, 12 Aug 08, SA (b)(6), (b)(7)(C) interviewed Dr. (MAJ) (b)(6), (b)(7)(C) Attending Physician, ICU, 115th CSH, who related Mr. MUNAI was admitted to the ICU on 29 Jul 08, for end stages of Acute Myelogenous Leukemia. Dr. (b)(6), (b)(7)(C) reported Mr. MUNAI was transported from Camp Bucca to the ICU, Camp Cropper, for treatment and to make Mr. MUNAI as comfortable as possible until death. Dr. (b)(6), (b)(7)(C) stated Mr. MUNAI experienced progressive respiratory failure at the time he was in the ICU, and was complicated by Atrial Fibrillation. Dr. (b)(6), (b)(7)(C) advised Mr. MUNAI's family was present four to five hours prior to his death and declined life saving measures and medical intervention should Mr. MUNAI die. Mr. MUNAI went into a state of cardiac arrest from which he did not recover and was pronounced deceased at 1829, 12 Aug 08. Dr. (b)(6), (b)(7)(C) opined the primary cause of death was Acute Myelogenous Leukemia, with secondaries of respiratory failure and empyema. Dr. (b)(6), (b)(7)(C) opined the manner of death was natural.

About 1700, 20 Aug 08, SA (b)(6), (b)(7)(C) coordinated with PFC (b)(6), (b)(7)(C) PAD, 115th CSH, who provided all medical documentation concerning Mr. MUNAI to include a Memorandum For Record (MFR), which documented the Transfer Medical Summary of Mr. MUNAI. A review of the records indicated Mr. MUNAI was admitted to the ICU on 29 Jul 08, as a transfer from Camp Bucca. The preliminary opine as to the cause of death was Acute Myelogenous Leukemia. Mr. MUNAI's condition worsened on 11 Aug 08, and his mental status deteriorated as he developed Atrial Fibrillation with Rapid Ventricular response. Mr. MUNAI's records indicated he was pronounced deceased at 1829, 12 Aug 08.

About 0800, 16 Sep 08, SA (b)(6), (b)(7)(C) this office, coordinated with PFC (b)(6), (b)(7)(C) 111QM CO (Mortuary Affairs), Camp Sather, Iraq, who stated the remains of Mr. MUNAI were received and shipped to Balad on 12 Aug 08. PFC (b)(6), (b)(7)(C) stated the remains of Mr. MUNAI were received from Balad on 26 Aug 08, at which time they were released to the next of kin. ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
For SA (b)(6), (b)(7)(C), (b)(7)(F)	20th/1149th Military Police Detachment (CID)(FWD) Camp Cropper, Baghdad, Iraq APO AE 09342	
SIGNATURE (b)(6), (b)(7)(C)	DATE 20 Aug 08	EXHIBIT

ACLU DDII CID ROI 28081

CID FORM 94

(Automated)

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Exhibit(s) 4 and 5

Page(s) 000008 thru 000083 referred to:

CDR U.S. Army Medical Command
Freedom of Information/Privacy Act Office
ATTN: MCFP Bldg 126 Stop 76
1216 Stanley Road 2nd Floor
Fort Sam Houston, TX 78234-5049

DEPARTMENT OF THE A
TASK FORCE 115 MEDICAL
CAMP BUCCA, IRAQ
APO AE 09375

REPLY TO
ATTENTION OF:

0026-08-CID789-53209

FICI-MB-CHA

18 July 2008

MEMORANDUM FOR RECORD

SUBJECT: Transfer Medical Summary

ISN: 171567

Accepting Physician (b)(6) Camp Cropper

Diagnosis: Acute Myeloid Leukemia (AML)

Hospital Summary:
NARRATIVE: The patient is a 42 yr old who is admitted with an anemia, weakness, malaise, and early satiety. Initial laboratory studies showed a Hct of 16 with over 40 % blasts on the peripheral smear. CT scan of the abdomen and pelvis showed splenomegaly. Bone marrow aspirate and biopsy was consistent with a myelodysplastic process, likely AML. Consultation with the oncologist in theatre was done via email. (b)(6) (b)(6) Hematology/Oncology, stated that there was no in-theater therapy for AML and suggested palliative care with transfusion support, pain medication, and antiemetics. In addition, the patient has been persistently febrile on broad spectrum antibiotics. He did have a peripheral IV site that became infected and this was incised and drained and treated with IV antibiotics. He also has significant periodonatal disease, but dentistry feels that tooth extraction is the only effective treatment- and the patient has refused this. The patient remains weak and has difficulty with ambulation, and requires significant assistance. He has also complained of left sided chest pain, and a chest x-ray showed a moderate left pleural effusion. Bedside ultrasound was performed on 26 July and was consistent with a multiloculated pleural effusion, most likely malignant, with no pockets of fluid large enough to drain. On 28 July, due to increased pain in his left chest, a repeat chest x-ray was done which shows a multiloculated fluid collection as well as a large pericardial effusion. Due to the finding of an enlarging pericardial effusion, the patient was counseled that he may not have long to live. He understands this and that we are doing our best to facilitate his medevac to Camp Cropper.
DISCHARGE ACTIVITY: Falls risk-ambulate with assistance only.
Diet: Soft mechanical.

DISCHARGE MEDICATIONS:

1) Clotrimazole troche 10 mg orally once per day.
2) Percocet 1-2 tablets by mouth as needed every 4-6 hours for pain or fever.
3) Orajel 10cc orally tid.
4) Cepacol 30 cc mouth rinse TID
5) Omeprazole 20 mg orally every night at bed
6) Clindamycin 450 mg TID
7) Fentanyl 50 mcg/hour patch.
8) MS Contin 30 mg by mouth twice per day.
9) Tegretol 200 mg by mouth twice per day.
10) Clindamicin 450 mg by mouth three times per day

Recommendations:

1. Transfer to Camp Cropper for palliative care, transfusion support and to allow family visits. Compassionate release has been applied for.

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EXHIBIT 4

SUBJECT: Task Force 116 Medical Operations

Thank you for your assistance with this patient. Please call our PAD at (b)(6) if there are questions.

0026-08-CID309-53209

(b)(6)

(b)(6)

Camp Bucca, Iraq

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EXHIBIT 4

500-00-2107

AEROMEDICAL EVACUATION PATIENT RECORD

PATIENT IDENTIFICATION

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
SAMARAI, ALLAH AL	171567			U P R	

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A-5/7)	11. ACCEPTING PHYSICIAN	12. CITE/AUTHORITY NO.
42	X Male / Female			AMBULATORY / X LITTER	(b)(6)	

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. NUMBER OF ATTENDANTS: 16a. MEDICAL	16b. NON MED
	Balad	Cramer	1	
	14b. ORIGINATING FACILITY PHONE NUMBER	15b. DESTINATION FACILITY PHONE NUMBER		

17. DIAGNOSIS

Acute myeloid Leukemia
anemia

18. [ ] BATTLE CASUALTY [X] DISEASE [ ] NON-BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.		X	HYPERTENSION	f.		X	MOTION SICKNESS	k.		X	AMBULATORY
b.		X	CARDIAC HX	g.		X	VISION IMPAIRED	l.		X	AMBULATORY AID
c.		X	DIABETES	h.		X	VOIDING PROBLEMS	m.	X		SELF-MEDS
d.		X	RESPIRATORY	i.		X	BOWEL PROBLEMS	n.	X		ADEQUATE SUPPLY OF MEDS
e.		X	EARS/SINUS	j.		X	SELF-CARE	o.			OTHER

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
18 Jul 06	1310	NKDA

20d. DIET [ ] [✓] REG [ ] 2GM NA [ ] CARDIAC [ ] DIABETIC ____ CALS

[ ] RENAL ____ Gm prot ____ Gm Na ____ Meq K ____ mg PO4

[ ] TUBE ____ TYPE ____ cc/hr, 1/2, 3/4, FULL STRENGTH

[ ] PEDIATRIC: AGE ____ [ ] OTHER (Specify) ____

[ ] TPN: Change to D10 at ____ cc/hr for max of ____ days

[ ] TUBE FEEDING ____ at ____ strength at ____ cc/hr

20e. IV/BLOOD [ ]

20f. SPECIAL EQUIPMENT

[ ] SUCTION	[ ] TRACTION	[ ] ORTHOPEDIC BRACES
[ ] NG TUBE	[ ] IV PUMP	[ ] CHEST TUBE/HEIMLICH
[ ] STRYKER FRAME	[ ] TRACH	[ ] RESTRAINTS
[ ] INCUBATOR	[ ] MONITOR	[ ] OTHER (Explain in 23)
	[ ] FOLEY	

O2: [X] 2 LITERS: ROUTE: NC PRN

[ ] VENTILATOR SETTINGS

20g. ALTITUDE RESTRICTION: NONE

20h. RECORDS TO ACCOMPANY PATIENT

[ ] OUTPATIENT RECORDS	[ ] X-RAYS	[ ] FINANCIAL
[ ] INPATIENT RECORDS	[ ] OB RECORDS	[ ] OTHER (Specify)
[✓] NARRATIVE SUMMARY	[ ] DENTAL RECORDS	

20i. MEDICATIONS/TREATMENTS

Decadron 2mg qAM
Tylenol PRN for fever
fentanyl patch 50 mg/hr
ativan 30 cc TID
cepacol 40 cc BID
Omeprazole 20 mg PO qD
Clindamycin 450 mg TID
fentanyl patch 50 mcg/hr

21. PRE-FLIGHT VITALS

21a. DATE/TIME	21b. TEMP	21c. PULSE	21d. RESP	21e. BP

22. BRIEF NARRATIVE

42 year man with acute leukemia who desires to travel to Cramer & be closer to his family

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES
MA: nurse	(b)(6)
Guards:	(b)(6)
	(b)(6)

Ready Date:
Birthdate:
Point of Contact:

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

(b)(6)

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM 3835, MAR 95

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EXHIBIT 5

0026-08-CID789-53209

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

RESTRAINTS:

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

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
~~(R) wrist~~					
(L) Arm #18 ga	8/11		CDE ✓		
(L) Bicep #18 ga	8/11		CDE ✓		
(R) wrist/FM #18 ga	8/10		CDE ✓		

PREPARED BY: (signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
	ICU	12 Aug 0X
PATIENT'S IDENTIFICATION		
SEE CC-2107	☐ HISTORY/PHYSICAL ☐ OTHER EXAMINATION & EVALUATION ☐ DIAGNOSTIC STUDIES ☐ TREATMENT	☐ FLOWCHART ☐ OTHER

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EXHIBIT 5

NEUROLOGICAL	TIME
Level of consciousness, Glasgow	
Coma Scale (GCS), pupil size &	
response, motor & sensory function,	
Muscle strength, pain, other	
findings, verbal expressions	
CARDIOVASCULAR	
Rhythm, Rate, Ectopy, PMI, Lead selected,	
Normal Heart Sounds (S1, S2),	
Abnormal Heart Sounds – (S3, S4	
murmur, gallop, click, rub), color,	
skin temp, JVD, Capillary refill,	
Pulses (strength, bilaterally), turgor,	
moisture, edema, carotid bruits/thrills,	
CVP, abnormal findings, Central lines	
(Location, appearance, dressing, etc.)	
RESPIRATORY	
Respiratory rate, rhythm, SaO2, oxygen	
delivery method, Ventilator settings,	
chest expansion, Accessory muscle use,	
lung sounds, cough, secretions/sputum	
(Color, amount, consistency) , ETT/Trach	
(size, placement, appearance), Chest	
Tubes (location, Suction/H20 seal, air	
leaks, drainage amount & color, dressing)	
Arterial line (appearance, location, etc.)	
GASTROINTESTINAL	
Oral cavity appearance, dentition,	
Mucosal appearance, odor, Abdomen	
(contour, distention, tenderness, soft,	
Firm, guarding, bowel sounds), NG/OG/	
G-Tube (placement, verified, residuals),	
Tube feeds (type, rate), suction, stool/	
Emesis (color/consistency/amount),	
Colostomy (stoma location & appearance)	
GENITOURINARY	
Mode of elimination (void, foley, urostomy),	
Foley size, bladder distention,	
Urine (color, amount, sediment)	
INTEGUMENTARY	
General skin condition, dressings	
(locations, condition), wounds, lacerations,	
Incisions (staples or sutures, approximation	
of wound edges, drainage, signs of	
infection), drains (#, locations, etc.),	
Dressings (color, amount), protective aids,	
Decubitus ulcers, IV sites (location, fluid,	
rate, appearance, dressing), any additional	
Skin findings	
SIGNATURE	

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EXHIBIT 5

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0026-08-CID789-53209

INPUT	3250
OUTPUT	1148
DIFFERENCE	+2102

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

Resp. Rate										
Temperature										
%CO2										
%O2										
O2 Delivery Mode										
Rate										
Tidal Vol.										
Peep										
PS										
Pain Scale										
Pain Med										
Pt Position										
CVP										

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

OUTPUT

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

Legend:
Int. Jugular Venous Determination
C. Lat
NIBP-Noninvasive Blood Pressure
N=No
Y= Yes
+2= strong +1=weak

Legend:
P=Prone
R=Right
Sat O2=Saturation of Arterial Oxygen
S= Supine
ABP= Arterial Blood Pressure
PS=Pharmacologically Sedated

Time	Signature

ACLU DDII CID ROI 28088

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EXHIBIT 5

CLINICAL RECORD | THERAPEUTIC DOCUMENTATION CARE PL | 0026-08-CID789-53209 | Aug 08

ORDER DATE	CLERK'S NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	DATE DISPENSED 6 7 8 9 10 11 12 13 14 15 16 17 18 19	
6 Aug	(b)(6)	Vancomycin [illegible] 11 g 12°	16	(b)(6) (b)(6)
6 Aug	(b)(6)	Cipro 400 mg IV g12°	22	(b)(6) (b)(6)
28 July	(b)(6)	Prilosec 20 mg PO q AM	10	(b)(6)
28 July	(b)(6)	Clotrimazole Troche 5x a day	07 12 18 22	(b)(6) (b)(6)
28 July	(b)(6)	Benzocaine 10% gel orally TID	07 12 18	(b)(6)
28 July	(b)(6)	MS Contin 15 mg PO BID	00 12	(b)(6) (b)(6)
6 Aug	(b)(6)	Zosyn 4.5 gm IV q8°	06 14 22	(b)(6) (b)(6) (b)(6)
7 Aug 08	(b)(6)	D5 ½ [illegible] 40 mEq KCL @ 85 mL/hr (b)(6)	07 19 19 27	(b)(6) Wrong fluid - Rewritten (b)(6)

ALLERGIES: ☐ YES ☑ NO | PRIMARY DIAGNOSIS: AML | SJ | ADDITIONAL PAGES IN USE: ~~YES~~ ☒ NO | PAGE NO. 2 of 2

PATIENT IDENTIFICATION: 500-00-2107 171567

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

ACLU DDII CID ROI 28089

DA FORM 4678, 1 FEB 79 | EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED | PAGE 1 OF 2

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EXHIBIT 5

CLINICAL RECORD | THERAPEUTIC DOCUMENTATION CARE BY MEDICAL STAFF | 0026-08-CID789-53209 | Aug. 08

ORDER DATE	CLERK NURSE	ACCURENC MEDICATIONS DOSE, FREQUENCY	HR	DATE DISPENSED 7 8 9 10 11 12 13	
1 Aug 08	(b)(6)	NPO Vital Sig	17	(b)(6)	
			19	(b)(6)	
			21		
			X		
11 Aug 08	(b)(6)	1 NS to 125 cc/hr.	07	/ / / / /	(b)(6)
			15	/ / / / /	(b)(6)
			23	/ / / / /	
			X		
12 Aug 08	(b)(6)	Vancomycin one gram	12	X X X X X	(b)(6)
↓	↓	IV Q 12° first now	00	X X X X X	
12 Aug 08	(b)(6)	Ciprofloxacin 400mg		Rewritten - Redit	
↓	↓	IV Q12° first now			
			X		
12 Aug 08	(b)(6)	Ciprofloxacin 400mg	10	X X X X X	(b)(6)
		IV Q12° 1st dose now	22	X X X X X	
			X		
12 Aug 08	(b)(6)	ΔIVF to D5 1/2 NS @ 75ml/hr	07	X X X X X	
			15	X X X X X	(b)(6)
			23	X X X X X	
			X		

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: AML

SC

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO PAGE NO. 3

PATIENT IDENTIFICATION: 500-00-2107 171567 ICU # 2

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 | FOR OFFICIAL USE ONLY UNTIL EXHAUSTED | LAW ENFORCEMENT SENSITIVE

ACLU DDII CID ROI 28090

EXHIBIT 5

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN

The proponent agency is the Office of The Surgeon General

0 0 2 6 8 7 8 9 - 5 3 2 0 9

MILITARY

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
	(b)(6)			(b)(6)
				(b)(6)
			23	(b)(6)
			X	
25 May 08		Left Leg	07	/ (b)(6)
			11	/ (b)(6)
			17	/
			X	
4 May 08		RUE, RL, LOE & LL	02	/ (b)(6)
			X	
6 May 08		Left	7	/ (b)(6)
			15	/ (b)(6)
			23	(b)(6)
			X	
6 May 08		SCD Bilt	07	/ (b)(6)
			15	/ (b)(6)
			23	(b)(6)
			X	
10 May 08	(b)(6)	Chest PT (RT) Q Shift	11	/ (b)(6)
			X	
12 May 08	(b)(6)	DNR/DNE	07	/
			15	/ (b)(6)
			23	/

ALLERGIES ☐ YES ☐ NO: NKDA

PRIMARY DIAGNOSIS: AML

SI

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION

500-00-2107

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

ACLU DDII CID ROI 28091

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LAW ENFORCEMENT SENSITIVE

DA FORM 4677, 1 OCT 1978 EDITION OF 1 DEC 72 MAY BE USED.

EXHIBIT 5

ACLU-RDI 5591 p.17

000016

CLINICAL RECORD | THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) | Aug 08

0026-08-CID789-53209

DATE	CLERK NURSE	RECURRING MEDICATIONS DOSE FREQUENCY		6 7 8 9 10 11 12 13 14 15 16 17 18 19
28 July	(b)(6)	Cepacol mouth wash 30cc TID	08 13 18	(b)(6) (b)(6) (b)(6)
29 July	(b)(6)	Colace 100mg PO BID	10 22	(b)(6) (b)(6)
29 July	(b)(6)	Dulcolax 10mg PO q HS	22	(b)(6)
29 July	(b)(6)	Chlorhexidine (Peridex) oral solution - TID	08 13 18	(b)(6) (b)(6)
30 July	(b)(6)	Tegretol 400mg PO BID	10 22	(b)(6) (b)(6)
30 July	(b)(6)	Fentanyl patch 75mcg every 3 days	do	(b)(6) (b)(6)
31 July	(b)(6)	DS½C 40mel KCl @ 100 ml/hr NS A'd 25 ml/hr NS A'd	07 15 23	(b)(6) (b)(6) Rewritten 7 August @ 15:22 (b)(6)

ALLERGIES: ☐ YES ☑ NO | PRIMARY DIAGNOSIS: AML | SI | ADDITIONAL PAGES IN USE: [X] YES ☐ NO | PAGE NO. 1 of 2

PATIENT CERTIFICATION: 500-00-2107 171567

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 | EDITION OF 1 FEB 79 IS OBSOLETE | PAGE 1 OF 2

ACLU DDII CID ROI 28092

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 6

0026-08-CID789-53209

UPDATE ON ISN 171567 12 AUG 2008

This is a 42yo male detainee with AML in blast crisis transferred from Camp Bucca on 25 JULY 2008. Presumably this transfer was done so that the detainee would have an opportunity to see his family before he expired. Since his transfer his clinical condition has worsened steadily. Please refer to (b)(6) (b)(6) previous Ethics Committee briefing/note for events that transpired prior to 10 AUG 2008.

This detainee's course has taken a precipitous downward turn in the last 48hours. During this period of time, his mental status has worsened significantly, to the point that I would no longer consider him capable of making any health care decisions. During a lucid interval yesterday, 11 AUG 2008, I discussed with him the fact that I believed his current medical situation to be medically futile. I explained that it would be unlikely that he would survive beyond another 1-2 weeks. I specifically stated that chest compressions and mechanical ventilation would not cure his disease but rather prolong his current condition. He expressed understanding and stated that he wanted to talk with me more after praying. Unfortunately, when I returned later in the morning, his mental status had already begun to decline and I no longer felt it reasonable to discuss such a weighty matter with him.

Overnight his condition has worsened as he has developed atrial fibrillation with rapid ventricular response. His mental status has deteriorated further such that now he is minimally responsive to verbal stimuli, although still quite responsive to painful stimuli. I have given him IV lopressor and IV lasix with temporary improvement in his CV parameters but this improvement is tenuous at best. I have also restarted his Vancomycin and Ciprofloxacin given his clinical deterioration overnight (he was already on Zosyn). At this time he is on full face mask oxygen at 10L with oxygen saturations in the high 90's and a heart rate in the low 100's. As mentioned previously, his mental status is poor and consistent with medical delirium.

(b)(6)

ACLU DDII CID ROI 28093

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE NOTES 0026-08-CID789-53209

0700 12 Aug 08. Pt moved up to Med Ward from the PRU. Exercises to (b)(6) (b)(6) (b)(6) (0700) Pt ambulated to the Restroom IV ordered and 40 mg lasix IV - Alert & oriented pt cont periods of agitation pulling at lines and on desk. O.T. Rotrax given IV. (b)(6) (1100) Chris pt completed pt services full code awaiting family visit today. See flowsheet note for additional O.T. & IV activity given. (1230) Pt assessed. Cont calm & no unusually pt somnolent but arousable on HC & 110-120 & 98° warm & dry lungs NS @ 120ml/hr 18G @ AC @ upper arm dep (1) IV Cont NS 18G @ AC dep (1) IV 6I hypoactive BS ⊖ BM today ⊖ PO intake (b)(6) Urine 6U response to lasix UOP > 300cc yellow Tube D.A. Clear ① cont full code ② Fair nutrition & comfort ③ labs ordered! (b)(6) (1400) IVE & PO 75ml/hr D5 1/2 NS Pt tolerated IV given pt per (b)(6) order. pt cooperative pulling at NPB 0.5mg Ativan IV given (b)(6) (1415) Pt to PACU room monitored for pain & nausea (b)(6) (1415) Family present (b)(6) (b)(6) present during exam & pt status update by (b)(6) + (b)(6) (b)(6) (1545) family mtg concluded. Cer (b)(6) pt now DNR/DNI status. Pt expired 8 mg total morphine for discomfort since 1445 (b)(6)

STANDARD FORM 509 (REV. 5/1993) BACK

USAPA V1.00

ACLU DDII CID ROI 28094

500-00-3107

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LAW ENFORCEMENT SENSITIVE

EXHIBITS

B7 #2 171567

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES 0026-08-CID789-53209

[illegible] (b)(6) [illegible]
[illegible] (b)(6) [illegible] DNI/DNR [illegible]
[illegible] (b)(6) [illegible]
comfort care (b)(6)
1829 Pt asystolic, (b)(6) pronounced TOD 1829 -- (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

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

500-00-2107
ISN# 171567

ACLU DDII CID ROI 28095

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBITS

MEDICAL RECORD | PROGRESS NOTES

AUTHORIZED FOR LOCAL REPRODUCTION

0026-08-CID789-53209

DATE	NOTES
1600	[illegible] to have [illegible] discharge [illegible] US & somnolent
	[illegible] (b)(6) [illegible]
	(b)(6) [illegible] paged + notified. [illegible] (b)(6)
	flow sheet +
1650	(b)(6) present @ bedside, pt cont sleep
	RR 10-12 [illegible] Cont to monitor (b)(6)
1745	Pt awakened, awoke followed commands cont
	somnolence. (b)(6)
11 AUG 08	Pt awake, alert, oriented to self only. Assumed care ō report
@ 0700	received. Assessment completed. 2 person at BS at all times
	to protect pt from pulling lines and to keep mask on. Pt
	on C-R monitor (b)(6)
11 AUG 08	Pt's am cares completed c̄ some assistance from the pt for face
@ 1000	and peri care (b)(6) at Bedside to discuss POC and tx's
	desired by pt. Pt occasionally oriented and cooperative alternate
	with confusion and aggitation. After bath, pt calm and
	relaxed and resting. c/o cold, 2 blankets applied. New
	Fentanyl patches on. Pt completed oral care after taking
	Some Ensure (≈60mL). Tolerated water c̄ meds. Currently
	sitting up dozing in tripod position. (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 FIRMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

FOU-OC-2107

ICU #2

ACLU DDII CID ROI 28096

EXHIBIT 5

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LAW ENFORCEMENT SENSITIVE

LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE | NOTES 0026-08-CID789-53209

11 AUG 08 @0700 [illegible] (b)(6)

11 AUG 08 @1300 Attempted to give MS Coth PO. Pt decided. Interpreter BS PZ instructed on what and why we were medicating him. Pt cooperative and took pills w/ difficulty. Pt continues to attempt to take off mask and needs frequent instructions to stop. (b)(6)

11 AUG 08 @1400 Pt continues to fight restraints and attempt to pull off mask. ↑RR @ 32 and ↓s ↑ccors & supraclavicular and sternocleidomastoid muscle use. Pt ↓'d to NC on 4L. Sats remain 96-97% and pt calm. Attempts to restart IV as IV in RT wrist with restraint is ineffective. Pt calm and cooperative with IV starts. Mouth breathing continues but suprasternal/SCM muscles decreased during sleep without ↑ since initial shift assessment. New PIV to distal bicep LT. Pt drowsy and lethargic with only occasional outbursts. VSS. Afebrile. (b)(6)

11 AUG 08 @1700 Ativan 0.5 mg given. VS remain stable. Pt calm and resting with sats 96% on 4L per NC. Continues to decline H.O. Report to oncoming shift nurse. (b)(6)

STANDARD FORM 509 (REV. 5 1990) BACK

USAPA V1.00

ACLU DDII CID ROI 28097

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

VERY SERIOUSLY / SERIOUSLY ILL/SPECIAL CATEGORY PA / REPORT

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

TO: X PATIENT ADMINISTRATOR
[ ] ADMINISTRATIVE OFFICER OF THE DAY

PERSON TO BE NOTIFIED

5. RELATIONSHIP

1. DATE: 08 August 2008

2. HOUR: 1000

3. DATE OF ADMISSION

4. WARD: [illegible]

6. NAME AND ADDRESS: 0026-08-CID789-53209

ACTION TAKEN BY PATIENT ADMINISTRATOR

7. PRIMARY DIAGNOSIS (Use lay terminology)

Cancer of the bone marrow (leukemia) with resultant low blood count, low platelets, and high white blood cell count. Also has fluid around heart and fluid in pleural space (space between chest wall and lungs) causing increased heart rate and low blood oxygen, requiring patient to be on oxygen

8. STATUS OF PATIENT

PLACED ON ROSTER

a. [X] VERY SERIOUSLY ILL
b. [ ] SERIOUSLY ILL
c. [ ] NON SERIOUSLY ILL
d. [ ] SPECIAL CATEGORY (Specify)

PROGNOSIS: RECOVERY IS -

[X] NOT EXPECTED
[ ] QUESTIONABLE
[ ] EXPECTED

EXPECTED LENGTH OF HOSPITALIZATION ____ DAYS

CHANGE OF STATUS

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

9. REMARKS

10. TYPED OR PRINTED NAME OF MEDICAL OFFICER: (b)(6)

11. SIGNATURE: (b)(6)

ACTION TAKEN BY PATIENT ADMINISTRATOR OR ADMINISTRATIVE OFFICER OF THE DAY

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

19. REMARKS

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

PISN #: 500-00-2107
ISN #: 171567

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

21. SIGNATURE

APD PE v1.00ES

DA FORM 2984, AUG 2007 PREVIOUS EDITION IS OBSOLETE

ACLU DDII CID ROI 28098

EXHIBIT 5

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

BRADEN SCALE FOR PREDICTING PRESSURE ULCER RISK

				Date of Assessment: 2/7			
Sensory perception Ability to respond meaningfully to pressure-related discomfort	**1. Completely limited:** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation, OR limited ability to feel pain over most of body surface.	**2. Very limited:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**3. Slightly limited:** Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	3		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Moist:** Skin is often but not always moist. Linen must be changed at least once a shift.	**3. Occasionally moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely moist:** Skin is usually dry; linen requires changing only at routine intervals	4		
Activity Degree of physical activity	**1. Bedfast:** Confined to bed.	**2. Chairfast:** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheel chair.	**3. Walks occasionally:** Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	2		
Mobility Ability to change and control body position	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly limited:** Makes frequent though slight changes in body or extremity position independently	**4. No limitations:** Makes major and frequent changes in position without assistance.	3		
Nutrition Usual food intake pattern	**1. Very poor:** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, OR is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	**2. Probably inadequate:** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate:** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN[3] regimen, which probably meets most of nutritional needs.	**4. Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	3		
Friction and shear	**1. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. Potential problem:** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No apparent problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		3		
				Total Score	16		

Patient Name: [illegible]
ISN: XX-00-2107
Hospital Number: _____
Capture Number: _____

Circle: ICU ICW DMC

Perform Braden Scale on admission, after major changes, discharge
When Braden Scale Score 16 or less, implement Pressure Ulcer Prevention Protocols
Egg Crate Mattress: Yes_____ No ✓
Nutrition Consult Ordered: Date:_____ Initials:_____

**15-16 = Low Risk 13- 14 = Moderate Risk 12 or Less = High Risk

4 April 2008

ACLU DDII CID ROI 28099
EXHIBIT
000024
IMAGE ONLY
PRECAUTIONARY
0026-08-CID789-532209

0026-08-CID789-53209

SIGNATURE CARD

(b)(6)

(b)(6)

The Resourceful 67Ts

(b)(6)

8-shift...0700-1900	Let me know who is working a 1st, 2nd, or 3rd shift. "O" indicates day off. Too easy for this to happen.
9-shift...1900-0700	List all the names of people in your section.
5-shift...0900-2100	Please send me a list of monthly roster/schedule.
2-shift...1500-2300	
1-shift...0700-1500	
3-shift...2300-0700	
TD...Temporary Duty	*Please send me a list of monthly roster/schedule.*
RD...Recovery Day	
PX...PX Guard	
TG...Translator Guard	(b)(6)

ACLU DDII CID ROI 28100

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LAW ENFORCEMENT SENSITIVE

SIGNATURE CARD 0026-08-CID789-53209

(b)(6)

(b)(6)

8-shift...0700-1900	Let me know who is working a 1st, 2nd, or 3rd shift. "O" indicates day off. Too Easy for this to happen.
9-shift...1600-0700	List all the names of people in your section.
5-shift...0900-2100	Please send me a list of monthly roster/schedule..
2-shift...1500-2300	
1-shift...0700-1500	
3-shift...2300-0700	
TD...Temporary Duty	*Please send me a list of monthly roster/schedule..*
RD...Recovery Day	
PX...PX Guard	
TG...Translator Guard	(b)(6)

ACLU DDII CID ROI 28101

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

0026-08-CID-89-53209

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: 500-00-2107

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	11 Aug 08	1520 HOURS	
1	NS TKO 125cc/hr		
2	NS boluS 500 cc x 1 now		
	(b)(6)		(b)(6)
	24. hr. Chart Check	(b)(6)	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: 500-00-2107

	DATE OF ORDER	TIME OF ORDER	
	12 Aug 08	0955 HOURS	(b)(6)
1	Lopressor 5mg IV x one now -		1244CE 0945
2	Nexium	12hrs first now	
3	Ciprofloxacin	12hrs first dose now	
4	Lasix 40mg IV	now - Chem 12	(b)(6)

(b)(6) Notified 12 Aug 08

NURSING UNIT | ROOM | BED NO.

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF ORDER
	12 Aug 08	1350 HOURS
1	D IV to D5 1/2 NS @ 75cc/hr	
2	Lopressor 5mg IV x one now	
	(b)(6)	

(b)(6) Notified 12 Aug 08 1400

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

	DATE OF ORDER	TIME OF ORDER
	12 Aug 08	1637 HOURS
1	DNR/DNI	
2	Lasix 40mg IV x one now	
3	Lopressor 5mg IV x one	
	(b)(6)	

(b)(6) Notified 12 Aug 08 1700

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

0026-08-CID789-53209

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT

(b)(6)

(b)(6)

PRIOR MEDICATIONS

ALLERGIES

TAGS

CATEGORY OF TREATMENT

TIME

MEDICINE

URGENT

NON URGENT

RN

IMMEDIATE INTERVENTIONS ☐ NONE

☐ O2 ☐ CARDIAC MONITOR ☐ EKG ☐ FSBG

☐ IV

☐ C-SPINE PRECAUTION

☐ BACK BOARD REMOVED @

☐ PRESSURE DRESSING ☐ TOURNIQUET

☐ C-SPINE IMMOB

EMERGENCY ROOM VISIT

DATE 1ST VISIT

24 HOUR RETURN ☐ YES

MEDICATION	DOSE	ROUTE	TIME	INT	RESPONSE
Morphine	5mg	IV	2115	PM	
Zofran	8mg	IV	2216	PM	

IV SITE	SIZE	TIME	INT	DCD	INT
				☐	
				☐	

ORDERS

(b)(6)

CBC, CMP
Tox, U/S
EKG
CXR

(b)(6)

Morphine 5mg IV
Zofran 8mg IV

VITAL SIGNS

TIME	2021	2115	HT	WT
BP	103/60	97/63		
PULSE	119	117		
RESP	28	18		
TEMP	98.2			
SPO2	91 (2L)	96 (2L)		
PAIN	3/10	2/10		

MEDIC NOTE

MED HX

SURG HX

SOCIAL HX

see back page

CONTACT MEDICAL INFORMATION

IN FLUID INTAKE

.9 NS 1L (IV)

OUTPUT

PATIENT SIGNIFICATION

I SN 171867

500 00 2107

ACLU DDII CID ROI 28103

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

0026-08-CID789-53209

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

500-00-2107

NURSING UNIT	ROOM NO.	BED NO.
ICU		

DATE OF ORDER: 10 Aug 08 TIME OF ORDER: 0857 HOURS

LIST THE ORDER NOTED ABOVE SIGN

(b)(6)

NS 1000 ml IV bolus over 4 liters x 1

D/C Vancomycin & Cipro Flexi

Pt Lite CXR x 1

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

500-00-2107

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

DATE OF ORDER: 10 Aug 08 TIME OF ORDER: 1445 HOURS

(b)(6)

Chest PT (respiratory therapy) q shift

(b)(6)

PATIENT IDENTIFICATION

500-00-2107

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

DATE OF ORDER: 11 Aug 08 TIME OF ORDER: 1800 HOURS

(b)(6)

IV NS bolus 250 ml x 2

evaluate resp. status between boluses Read back confirmed

(b)(6)

PATIENT IDENTIFICATION

500-00-2107

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

DATE OF ORDER: 11 Aug 08 TIME OF ORDER: 1800 HOURS

Ativan 0.5 mg q 1 prn IV

(b)(6)

(b)(6)

ACLU DDII CID ROI 28104

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

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ACLU-RDI 5591 1250

000029

0026-08-CID789-53209

CLINICAL RECORD - DOCTOR'S ORDERS

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

A. DOCTOR SHALL 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 | ORDER NOTED AND SIGN

(b)(6)

500-00-2107

Transcribed 8/15 OPIC STRE 3ER

07 Aug 2008 — 3pm HOURS

NPO p MN

Sign A without consent

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

(b)(6)

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER | ORDER NOTED AND SIGN

500-00-2107

8 Aug 08 — 0837 HOURS

(b)(6)

(1) Transfuse 2U PRBC, each unit over 3 hours

(2) Tylenol 650 mg PO x 1 30 min

(3) Benadryl 25 mg PO x 1 30 before transfusion

(4) DC NPO; change to regular Diet

NURSING UNIT	ROOM NO.	BED NO.
ICU		

(b)(6)

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER | HOURS

(b)(6)

500-00-2107

8 Aug 08 — 0940 hours

(1) post transfusion CBC

(2) Coag panel (PT/PTT/INR) 2hrs after transfusion

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER

(b)(6)

9 Aug 08 — 1145 hours

(b)(6)

500-00-2107

(b)(6)

(1) Vitamin K 10 mg SC x 1

(2) PT/PTT/INR 9am

Noted 9 Aug 08 1230

(b)(6)

(b)(6)

(b)(6)

ACLU DDII (

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

FOR OFFICIAL USE ONLY

PRIVACY SENSITIVE

DA FORM 4996 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

0026-08-CID789-53209

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-68; the proponent agency is OTSG.

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

ATTENDING PHYSICIAN

500-00-2107 Verified 7 Aug 08 1415

DATE OF ORDER	TIME OF ORDER	HOURS	DATE ORDERS NOTED AND SIGN
6 Aug 08	0900		
① Lasix 45 mg IV q 8 hours — continue this previous order			(b)(6)
② SCD's bilaterally			

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

(b)(6)

PATIENT IDENTIFICATION

Transcribed (b)(6)

500-00-2107

DATE OF ORDER	TIME OF ORDER	HOURS	DATE ORDERS NOTED AND SIGN
7 Aug 08	0830		Verified 7 Aug 08 @ 1500
① Blood CX, urine CX			
② Urinalysis			
③ Tylenol 650 mg PO x1 now			
④ Decrease IVF to 85 ml/hour			

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

(b)(6)

PATIENT IDENTIFICATION

Transcribed (b)(6)

500-00-2107

DATE OF ORDER	TIME OF ORDER	HOURS	DATE ORDERS NOTED AND SIGN
7 Aug 08	0900 #8		Verified 7 Aug 08 @ 1500
① D/C Clotrimazole Troche			

(b)(6)

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

PATIENT IDENTIFICATION

500-00-2107

DATE OF ORDER	TIME OF ORDER	HOURS	DATE ORDERS NOTED AND SIGN
7 Aug 08	1420		Noted 7 Aug 08 @ 1420
① NS 1000 ml bolus over 2 hours x 1			

(b)(6)

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

ACL 06

Who Dir Check

(b)(6)

DA FORM 3888, 1 APR 73 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED. FOR OFFICIAL USE ONLY AWE ENVIRONMENT SENSITIVE

ACLU-RDI 5591 p.256

0026-08-CID789-53209

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 TRANSFER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	DATE NOTED AND SIGN
500-00-2107	6 Aug 08	1010 HOURS	
	① Magnesium Citrate 296ml Take/drink one bottle x1		
	(b)(6)		

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	DATE NOTED AND SIGN
500-00-2107	6 Aug 08	1437 HOURS	
	① Activity: OOB to chair TID (wheelchair) PRN — Also has bathroom privileges (to prevent worsening deconditioning)		
	(b)(6)		

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	DATE NOTED AND SIGN
500-00-2107	6 Aug 08	2040	
	① CXR x1 in am		
	(b)(6)		

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	DATE NOTED AND SIGN
500-00-2107	21 Mr. Chest Clear		
	(b)(6)		

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	DATE NOTED AND SIGN
500-00-2107			

ACLU DDII CID ROI 28107

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

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

EXHIBIT 5

0026-08-CID789-53209

CLINICAL RECORD - DOCTOR'S ORDERS

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

PHYSICIAN SHALL RECORD DATE, TIME AND SIGN EACH ENTRY OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, ENTER PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	ORDERS NOTED AND SIGN
500-00-2107 (b)(6)	4 Aug 08	0755 HOURS	
	① Post CXR		
	② Percocet 2 tabs PO q6hrs PRN		(b)(6)
	(b)(6)		(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

24 hr. Chart Check (b)(6)

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	6 Aug 08	0930 HOURS	
	Stat ABG, Blood Total Lactate		✓ done

NURSING UNIT	ROOM NO.	BED NO.

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
500-00-2107	6 Aug 08	0930 HOURS	
	Xrays: Lumbar spine x Lower thoracic x		✓ done
	B.A.S. x		
	Blood culture x 2 x		
	Sputum culture x		
	Urine culture x		

NURSING UNIT	ROOM NO.	BED NO.
24 hr.		Chart Check

(b)(6)

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
(b)(6)	6 Aug 08	0845 HOURS	
500-00-2107	① Place on SI		done
	② Disregard previous DIC Antib order & Continue Zosyn		(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

③ DIC D5 1/2 NS + KCl IVF
Start NS IVF @ 100 ml/hr

(b)(6)

ACLU DDII CID ROI 08

ACLU-RDI 5591 6234

DD FORM 1 APR 72 1256 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED

EXHIBITS

0026-08-CID789-53209

CLINICAL RECORD - DOCTOR'S ORDERS

DOCTOR SIGNS RECORD DATE, TIME AND SIGN ACCURACY OF ORDERS. IF PROBLEM OCCURRED ACCORDING TO AR 40-66, the proponent agency is OTSG. VOID IS USED, LEAVE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION (b)(6) 500-00-2107

DATE OF ORDER	TIME OF ORDER	HOURS	ORDERS NOTED AND SIGN
1 Aug 08	0811		
(1) T&C for 2 units PRBC			
(3) Transfuse 2 units PRBC - Infuse each unit over 3 hours			
(4) Premedicate with Tylenol 650 mg PO x1 & Benadryl 25 mg PO x1 30 min before transfusion begins			

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

Transfused @1000 1AUG2008

PATIENT IDENTIFICATION (b)(6) 500-00-2107

DATE OF ORDER	TIME OF ORDER	HOURS	ORDERS NOTED AND SIGN
(b)(6)			
(1) Phenergan 25 mg PO/IV q 6 hours PRN Nausea/emesis			

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

24 hr. Chart Check (b)(6)

PATIENT IDENTIFICATION (b)(6) 500-00-2107

DATE OF ORDER	TIME OF ORDER	HOURS	ORDERS NOTED AND SIGN
3 Aug 08	0930		(b)(6)
(1) portable CXR now			

Transferred @0940 3AUG2008

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

(b)(6)

PATIENT IDENTIFICATION (b)(6) 500-00-2107

DATE OF ORDER	TIME OF ORDER	HOURS	ORDERS NOTED AND SIGN
4 Aug 08	0900		
(1) D/C Antibiotics (Zosyn) on 6 Aug 08			
(2) D/C Coag panel			
(3) D/C CMP 8am			
(4) BMP and CBC 8am			

Transferred @1000 4AUG2008

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

(b)(6)

ACLU DDII CID ROI 2810

ACLU-RDI 5591 1235

DA FORM 5591, 1 APR 79 REPLACES ED FORM 1256 EXHIBIT

0026-08-CID789-53209

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-68, 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	HOURS	DATE AND TIME ORDER NOTED AND SIGN
500-00-2107 ICU #2	30 July 08	1022		
	① Zosyn 4.5 grams IV q8 hours			
	② Tegretol 400 mg PO BID			
	- D/C 200 mg PO BID			

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	HOURS
500-00-2107 ICU #2	30 July 08	1040	
	△ order on Fentanyl patch 75 mg 1 patch to every 3 days.		

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU	24 hrs	

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	HOURS
500-00-2107	31 July 08	0900	
	① CBC, CMP, coag panel q 9am		
	- First one this am		
	② D/C Benylin		

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	HOURS
500-00-2107	31 July 08	1406	
	① Type & Screen in am		
	② KCl 40 mEq PO x 2		
	- give now & then repeat a second dose in 30 minutes		
	③ D/C D5 1/2 NS		
	④ Start D5 1/2 NS with 40 mEq KCl @ 100 ml/hr		

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

(b)(6)

ACLU DDII CID ROI 28110

DA FORM 4256, 1 APR 79 REPLACES

ACLU-RDI 5591 p36

000035

0026-08-CID789-53209

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 IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: 500-00-2107

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

DATE OF ORDER: 29 July 08 TIME OF ORDER: 0815 HOURS

1. Tegretol 200 mg PO BID

(b)(6)

ORDER NOTED AND SIGN

PATIENT IDENTIFICATION: 500-00-2107

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

DATE OF ORDER: 29 July 08 TIME OF ORDER: 0835 HOURS

1. Colace 100 mg PO BID
2. Dulcolax 10 mg PO qhs
3. Reglan 30 mg PO AC & qhs

(b)(6)

(b)(6)

(b)(6)

PATIENT IDENTIFICATION: 500-00-2107

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

DATE OF ORDER: 29 July 08 TIME OF ORDER: 0945 HOURS

1. Chlorhexidine (Peridex) oral solution - rinse mouth out with one capful TID
2. D/C Flagyl
3. D/C Levaquin
4. D/C Cleocin

(b)(6)

PATIENT IDENTIFICATION: 500-00-2107

NURSING UNIT	ROOM NO.	BED NO.
ICU		2

DATE OF ORDER: 29 July 08 TIME OF ORDER: 1000 HOURS

1. Zosyn 4.5 mg IV q8 hours

(b)(6)

(b)(6)

(b)(6)

ACLU

DA FORM 4256, 1 APR 75 REPLACES EDITION OF 1 JUL

EXHIBIT

0026-08-010789-53209

CLINICAL RECORD - DOCTOR'S ORDERS

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

PHYSICIAN 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

500 | 00 | 2107

NURSING UNIT	ROOM NO.	BED NO.

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

7/28/07

(1) Prilosec 30mg po qdaily ✓
(2) Flagyl 500mg po tid ✓
(3) Clotrimazole - Trace 5x/day ✓
(4) Benzocaine 10% gel orally tid ✓
(5) Tegretol 200mg PO bid ✓
(6) Cepacol Mouthwash 30cc tid ✓
(7) MS Contin 15mg PO qm bid ✓

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

500-00-2107

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

(8) Cleocin 150mg po q8h ✓
(9) Fentanyl Patch 25µg PO q3d ✓
(10) Levaquin 500mg PO q qm ✓
(11) Percocet PO qm tid ✓
(12) Nasal Crusts 2-4 Intranasal ✓
(13) Zofran 8mg IV q8h prn nausea ✓
(14) Morphine 2-4mg IV q15m prn pain ✓

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

500-00-2107

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT	ROOM NO.	BED NO.

ACLU DDII CID ROI 28112

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LAW ENFORCEMENT SENSITIVE

DA 1 APR 79 1286 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

EXHIBIT

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 06-08-01 | OTSG APPROVED (Date) 789 5209

DATE: 28 Jul 08 TIME: _____ SERVICE: (X) MED ( ) SURG ( ) ORTHO ( ) POD

DIAGNOSIS: PAIN CONDITION: ( ) STABLE ( ) CRITICAL (X) GUARDED

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

Activity: Up ad lib Weight Bearing Status: _____

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

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

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

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

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

X-Rays: _____

MEDICATIONS

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

PRN MEDICATIONS

( ) Percocet 1-2 tablets PO q 6 hours PRN pain
( ) Morphine 2-8 mg IV q 1 hour PRN severe pain or while NPO
( ) 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
( )
( )
( ) 2Lt Swartchuck 28 Jul 08 2300
( )

PREPARED BY (Signature & Title)	DEPARTMENT/ SERVICE/ CLINIC	DATE (yyyymmdd)
(b)(6) 115th Combat Support Ho	DCCS	20080701

PATIENT'S IDENTIFICATION (For typed or [redacted] Name (Last, First, Middle); Grade; Date; Hospital or Medical Facility)

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

PSUEDO ISN: _____ ISN: _____

LOCATION: ( ) ICU ( ) ICW BED # _____ AGE _____

MEDCOM FORM 4700 FEB 2003

ACLU DDII CID ROI 28113

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

0026-08-C10789-53209

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: 171567

DATE OF ORDER / TIME OF ORDER: 1502 HOURS

PROBLEM NUMBER | ORDERS UNDER NOTED AND SIGN

MEDSEUAC Order Set

(1) Diagnosis: Myelodysplastic Syndrome

(2) Sending Provider: (b)(6)

(3) Vital Signs Every 15 minutes enroute

(4) IV Fluids: Normal Saline @ 125 ml / hour

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER _____ HOURS

(5) Prilosec 20 mg Capsule QHS x 14 days (ending 1 Aug 08)

(6) Flagyl 500 mg tabs one po TID x 14 days (ending 2 Aug 08)

(7) Clotrimazole-TROC 10 mg tab po 5 times a day x 14 days (ending 2 Aug 08).

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER _____ HOURS

(8) Benzocaine 10% mouth gel TID x 14 days. Starting 25 Jul 08

(9) Tegretol 200 mg 2 tabs (400 mg) po BID

(10) Copacol Mouthwash po 30 ml TID for 14 days (Starting 26 Jul 08)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER _____ HOURS

(11) MS Contin 15 mg 2 tabs po BID x 14 days - Starting 27 Jul.

(12) Fentanyl 25 mcg/hr Patch x3

(13) Percocet 5/325, ½ po q 8 hrs

(14) Percocet 5/325, ½ po q 8 hrs prn

(15) Oxygen via nasal cannula 2-4 L/min to keep O2 sat >92%

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

(Continued)

ACLU DDII CID ROI 2011 14

LAW ENFORCEMENT SENSITIVE

DA FORM 5560, 1 APR 79 1256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

ACLU-RDI 5591 p.260

0026-08-010789-53209

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 NUMBERS IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

500-00-2107
171567

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER	HOURS	DR'S TIME ORDER NOTED AND SIGN
	25 JUL 03	1523		
	Continued			
15	Clindamycin 150 mg Cap give 2 tid po Q 8 hrs for 14 days			
16	Levaquin 500 mg IVPB q AM			
17	Regular diet			
18	Bed rest.			

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

ACLU DDII CID ROI 28115

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 6

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES 0026-08-CID789-53209

12 Aug 08 11:45 Ethics Com - brief summary - full report pending

1. Previous minutes reviewed

2. Change in status

Progressive deterioration

now has cardiopulmonary compromise

CR is still pending

3. Recommendations

a. Keep alive, CPR, intubation if needed until his status can be discussed by (b)(6) with family & their attorney

b. Do not transfer

4. (b)(6) will see if body can be released to family rather than personal procedure if he expires in Iraq

5. (b)(6) will try to expedite CR.

(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.

Cop, ISN 171567

20/500 00 2107

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 DDII CID ROI 28116

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

0026-08-CID789-53209

CAMP CROPPER

Personal Data - Privacy Act of 1974 (PL 93-579)
Progress Notes
For: 11 Aug 2008@0700 - 11 Aug 08

Report requested by: (b)(6)

11 Aug 2008@1511 INPT Register # (b)(6) CLINICAL NURSE
PROG NOTES
End of Shift Note:

Pt finally resting quietly in bed with HOB elevated at 60 degrees. WOB returned to baseline. Lungs crackles to BUL,diminished to BLL anteriorly and crackles ULL and diminished throughout all other lobes posteriorly. Goals for today were to maintain oxygenation status and fluid and comfort status. Assessed oxygenation via pulse ox continuously with sats 84% on RA, keeping O2 mask on, noted mask causing further aggitation despite Ativan. Changed to NC 4Lpm, sats maintained at 96%. Pain status assessed. Pt indicated all over his chest with breathing. Fentanyl patches changed to new ones today. MS Contin noted as refused for MN dose. Encouraged patient with interpretor to explain treatment to take noon dose. VSS continue stable. UOP decreasing. (b)(6) notified and NS 500 ml bolus ordered and maintenance IV fluid up to 125 ml/hr. Pt comforted with pillows and padding with BUE and LLE in security restraints. Guard and one nurse at bedside throughout the day. Pt continues to rest. Report to oncoming shift RN.

Signed (b)(6)

11 Aug 2008@1202 INPT Register # (b)(6) PHYSICIAN
PROG NOTES
Attending Physician: (b)(6)
HN: 500-00-2107 ISN #171567
Admission Date: 29 July 2008
Date: 11 August 2008

Allergies: NKDA Antibiotics: Zosyn 4.5 g IV q8 D#14; Vancomycin 1gram iv q12h d#6, Ciprofloxacin 400mg iv q12hrs d#6

Meds: Dulcolax, cepacol, colace, peridex, zofran prn, MSO4 prn, phenergan prn, Percocet prn
Prilosec 20mg qd, tegretol 400mg bid, fentanyl patch 75mcg

O/N events: Nursing reports detainee became combative last night requiring physical re-direction. Also desatted requiring full face mask at 10L to maintain sats.

PE: BP 115-136/75-79 HR 114-124 RR 28-35 afebrile O2sat % 97-100 on 10L facemask
I/O: 2210/1315 (+895)
Exam
Sitting up in bed in tripod position pulling at facemask, conversant in short sentences
Tachy, regular, no m/r
Decreased bs throughout r>l (lung sounds end at just below the level of the scapula posteriorly)
Abdomen soft, nt
Ext: moving all extremities purposefully, pulses 2+ and equal

==========

20/500-00-2107 CROP,ISN171567
01 Jan 1981 / Male
Reg # (b)(6) Loc: ICU 1
Spon: CROP,ISN171567
Unit:
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ACLU DDII CID ROI 28117

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

CASE: CROP,ISN

Personal Data - Privacy Act of 1974 (PL 93-579)
Progress Notes
For: 11 Aug 2008@2300 11 Aug 08

(b)(6)

[illegible]
Fe 145 6.4 [illegible] Lymp 25 M/G 25/1.5 Gln 125
PT/INR 12.1/1.2
blood and urine cx (7 Aug) - NGTD

P: 1) AML - blast crisis w/ anemia, worsening thrombocytopenia, coagulopathy

2) loculated pleural effusion/pulmonary infiltrates
3) ARF
4) Pericardial effusion

WBC continuing to rise rapidly c/w his blast crisis and now with significant pulmonary decompensation overnight. I have expressed my opinion to him that his current medical situation is terminal and that his life will most likely end within the next 1-2 weeks. I also explained that, in my opinion, mechanical ventilation would only prolong his current suffering. He seemed to express understanding initially. However, on repeat visits to the ICU this morning he is clearly delirious and not capable of making health care decisions. Have briefed DCCS regarding patient's current situation and requested another Ethics committee meeting to determine the utility (futility?) for continued aggressive care in this detainee, particularly with regard to escalation of care (intubation, CPR, etc). Ethics committee meeting will meet tomorrow at 1100hrs.

Additionally, I have spoken with our surgical service this am regarding potential chest tube placement. Given his current situation and extremely grim prognosis, they have elected to not proceed with chest tube placement in the OR.

On a positive note, GI's and coags improved today with IVF and Vitamin K yesterday. Currently remains afebrile, but given his significant respiratory compromise overnight will not d/c Cipro and Vanc today as previously planned.

Signed (b)(6)

11 Aug 2008@0911 INPT Register # (b)(6) PHYSICIAN
PROG NOTES
Surgery
Have reviewed pt's hospital clinical course extensively with IM team (b)(6
(b)(6) ; in short patient has end-stage AML and has entered a likely fatal blast crisis from which he will not recover. We have considered surgical options to address his poor pulmonary function (thoracentesis, chest tube thoracostomy, open thoracotomy with pleurodesis), and given his declining clinical condition feel that none of these are likely to result in significant improvement in his overall prognosis and/or survival, and may even hasten his demise. Feel that end-of life care measures are appropriate at this time.

Signed (b)(6)

*** END OF REPORT ***

20/500 08-[illegible] CROP,ISN171567
01 Jan 1981 / Male
Reg # (b)(6) Loc: ICU 1
Spon: CROP,ISN171567
Unit:
Automated version of [illegible]

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EXHIBIT 5

[illegible] CAC[illegible]

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

0026-08-CID789-53209

Report requested by: (b)(6)

[illegible] ADMISSION INIT Register #(b)(6) PHYSICIAN
[illegible]

[illegible] by physician (b)(6)
[illegible]
[illegible] ONLY [illegible]

Allergies: NKDA

S: This is a 42 yr detainee who was transferred from Bucca yesterday for palliative care due to diagnosis of AML. Patient initially presented with fatigue, malaise, weakness and was found to have a HCT of 16 with 40% blasts on peripheral smear. He then had a bone marrow biopsy done which supported diagnosis of likely AML. CT scan also showed splenomegaly. In addition he had a CXR which showed large left sided pleural effusion with infiltrate, appearing to be loculated with no good pockets for thoracentesis, along with pericardial effusion. Case was discussed with theater hem/onc consultant who advised palliative care with transfusions as needed, analgesia, and comfort care. No possibility of chemotherapeutic intervention in theater. Patient also with some dental caries, gingivitis in addition to apparent gingival involvement based on mouth exam on admit. Per notes from Bucca, patient refused any dental intervention (i.e. tooth removal). Main issue for patient is pain in back and mouth, throat pain. Of note he also had an infiltrated IV which was i&D, and he was started on Cleocin. Upon arrival to the ER, patient was also started on Levaquin and Flagyl for apparent pneumonia and possible complicated effusion.

PMHx: AML

PSHx: None

SOCHx: No tobacco/ETOH

MEDS: Percocet 2 tab po q6 prn, Orajel topical, Lepacol oral solution, Prevacid 30 mg QD, Clindamycin 450 mg TID, Fentanyl 50 mcg/hr patch, MS Contin 30 mg BID, Tegretol 200 mg PO BID

VS: BP 122/75 HR 101 RR 18 Temp 98.9 O2sat 96% on 4L NC
HEENT: oral > poor dentition with some gingival hyperplasia/infiltration roof of mouth near 2 front teeth, and dental caries
CV: RRR S1/S2, no S3/S4/M
Pulm: decreased BS on left, no wheeze, rhonchi
Abd: Benign
Ext: no c/c/e

Pertinent LABS: WBC 19.4 HCT 24.8 PLTS 51
Na 141 K 4.1 HCO3 27 B/Cr 8/0.7 Glu 114
Mg 2.5 PO4 4.7 PT/INR 15.1/1.5

CXR: L pleural effusion with enlarged cardiac silhouette, with possible infiltrate LLL

A/P: Acute Myelogenous Leukemia (AML) with blasts

[illegible]

23/520 DD-2107 (ROI,ISN17156?
01 Jan 1981 / Male
Run # (b)(6 Lang: ENG 1
Sysm: CB/P,ISN17156?
Unit:

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Exhibit 5

CHOP CSC/DER

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

Progress Note

Report requested by: (b)(6)

0026-08-CID789-53209

[illegible] may be postponed due to availability of treatment [illegible] provided. Vital [illegible] to be monitored. Will die [illegible] hospital. Flagyl and start Keppra therapy regimen for empiric Rx of [illegible] seizure either as physical and environmental injury [illegible] impact [illegible], pain medications, and oral hygiene, and bowel regimen to prevent constipation given narcotic usage. Add Periodex oral solution also along with Bonyline.

BID transfusion if HCT<20. Plan if PLTS count<20K and febrile or if [illegible] bleeding.

Will also plan on neutropenic precautions if ANC drops below 1000.

Will center with DCWS on status of compassionate release/disposition of care/level of care.

(b)(6)

ATTENDING PHYSICIAN ICD/ICW

Signed: (b)(6)

20/500-00-2107 CHOP,ISN:71567

01 Jan 1981 / Male

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

Spec: CHOP,ISN:71567

Unit:

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EXHIBIT 5

CAPT CROPPER

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

0026-08-CID789-53209

Entered by (b)(6)

[illegible] (MD) [illegible] (b)(6)

[illegible]

Night has been restless but tired this morning. Got up to bedside commode within the last hour with no results returned. Respirations shallow but regular. Now on O2 per NC @ 6 L/min. Very cloudy yellow urine per foley catheter. Getting NS IVF bolus of one liter over four hours. Just received routine HS central. Nurse now attempting to place PICC line per sterile technique. Patient resting quietly.

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

20/500-00 2107 CROP,ISN171567
01 Jan 1981 / Male
Reg # (b)(6) Loc: ICU 1
Spon: CROP,ISN171567
Unit:
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ACLU DDII CID ROI 28121

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EXHIBIT C

NAME: CROPPER

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

0026-08-CID789-53209

Transcribed by (b)(6)

[illegible] (NP) Reg# (b)(6) CLINICAL NOTES

[illegible]

End of shift summary: Received pt this am with [illegible], and B/P of [illegible]. Tx for 2 U PRBC which were given t/o day. Pt tachy @ 0700 130, t/o blood [illegible] decreased to 102. At 1600 assessment pt with [illegible] pleural rub, otherwise no change in BBS. C/o pain in throat, but declined use of Cepacol, Orajel. Also c/o HA, percocet offered though pt affect diminished and "I don't know" response, and wanted to pray. Pt uncomfortable, and multiple attempts made to offer bath, linens adjustment but patient has declined.Appetite has diminished pt had only approx 120ml Ensure at lunch. C/o nausea which he was medicated for with 8mg Zofran.

Repeat CBC and Coag pending. Plan : Cont to monitor labs 2 Pain control 3-Encourage nutrition.

Signed (b)(6)

[illegible]

Reg #: (b)(6)

[illegible] CROP, ISNI 1567
01 Jan 1981 / Male
Loc: 100 1
Spon: CROP, ISNI 1567
Pain:

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ACLU DDII CID ROI 28122

EXHIBIT 5

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0026-08-CID789-53209

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11/4/	Pt received R stump, cov. to thoracoplasty for x 2 u complete post transfusion labs stat. Cont to appetite encouraged Enema diet approx 1/2 of cal & Inspiratory sub on (R) fair range crackles (L) & aeration BL CX HR 100-105; T 97.8. No other Sx (a) Hist Fac — (b)(6)
1950	Assumed care of pt See ICU Flow Sheet for complete Cxtns. Pt VS stable H/H to 2u PRBC 8/26.5. W.I. cont to monitor VS & urine output. (b)(6)
2009	Pt epsode of N/V gen pro anti emetics (b)(6)

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STANDARD FORM 509 (REV. 5-10) 2A CH

EXHIBIT

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE | 0026-08-CID789-53209

1200 05AUG08 pt received 30mg MS contin scheduled at 1200, pt lying in bed sleeping with HOB elevated at 30°. (b)(6)

1900 05AUG08 pt received scheduled Zosyn and was ambulated to the restroom to have a bowel movement and to urinate (b)(6)

5 Aug 08 ADD pt received in bed awake alert and oriented X 3 note no acute resp distress at this time denies any pain or discomfort @ this time (b)(6)

5 Aug 08 2200 pt voiced C/O 5/10 level pain to left shoulder, pt said that the pain move from his right shoulder to his left VS T 98.6 P 131 R 20 Bp. 104/70 pt medicated @ Morphine 2mg ore IVP by Charge Nurse will evaluate later (b)(6)

5 Aug 08 2230 pt resting quietly in bed eyes close resp even and unlabored note no acute distress at this time will continue to monitor (b)(6)

6 Aug 08 0000 pt C/O Nausea with 2 Dark mucoid emesis scheduled MS contin held pt medicate with Zofran 8mg IV nausea will evaluate later for extended note no acute distress at this time (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.

500-00-2107

171567

ICU #2

PROGRESS NOTES
Medical Record

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

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EXHIBIT 5

0026-08-CID789-53209

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

[illegible] (b)(6)

[illegible] (b)(6) [illegible]

[illegible]

[illegible] spiked temperature to 102.1 this morning. Given [illegible] Tylenol and blood [illegible] urine cultures drawn. [illegible] scheduled to go to surgery tomorrow for [illegible]tomy. All fluid in [illegible] lungs was shown to be loculated so thoracic [illegible] antibiotic would be ineffective. Vital signs have been stable throughout [illegible]. [illegible] has not eaten anything all day but is NPO after midnight tonight [illegible] surgery. [illegible] urine output has dropped to approximately 30cc/hr, received 1000cc bolus over 2 hrs but still no changes in pts urine output.

Signed: (b)(6)

[illegible]

[illegible] CNCP.1SN71567
01 Jan 1981 / Male
Reg. # [illegible] Loc: [illegible]
Spec: CNCP.1SN71567
Test:

AUTOMATED DATABAND OF [illegible]

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ACLU DDII CID ROI 28125

EXHIBIT 5

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

Report requested by: (b)(6)

0026-08-CID789-53209

Tue 20Aug17 INFO Register # (b)(6) CLINICAL NURSE
NOTES

Resting most of day. OOB for bathroom and up to wheelchair for approx 5 mins. Few episodes of emesis meds given. vitals wnl. pt didnt eat today due to vomiting. tried to encourage small amounts but none eaten. pt takes meds well tought.

Signed: (b)(6)

20/500-00-2107 CROP,ISN171567 FOREIGN NATIONAL - POW/INTERNE
01 Jan 1981 / Male H: not on file
Reg #: (b)(6) Loc: ICU 1 W: not on file
Spon: CROP,ISN171567 Rank:
Unit: RR:

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ACLU DDII CID ROI 28126

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EXHIBIT 5

CAMP CROPPER

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

0026-08-CID789-53209

Last Name/Identity (b)(6)

Log Number: [illegible] Reporter (b)(6) ORIGINAL DRAFT
Log Notes:
Maintained BP from 2100 to 0400 as above patient was getting DX 946. Patient only c/o pain when moving around, but did not want pain meds. Fentanyl patches replaced. Fluids DS 1/2 NS with 40meq at 100ml/hr. Heart rate tachy overnight even at rest from 104-114.
Signed (b)(6)

20/520-00-2127 CROP,ISN171567
01 Jan 1981 / Male
Reg #: (b)(6) Loc: 1CT 1
Span: CROP,ISN171567
Unit:
Automated version of 5F765

ACLU DDII CID ROI 28127

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EXHIBIT 5

MEDICAL RECORD | PROGRESS NOTES

DATE | HOUR

0026-08-CID789-53209

PD Attending

6 Aug 2003

0630 Originally asked to see pt @ 3:45 AM ie Resp rate, Tachycardia, T 102 recurrent. pt also febrile to 101.3. pt on 2 mm Aug BID, repeat CXR ordered, T(B) pleural effusion, strike (L) pleural effusion. recent notes reviewed, note from (b)(6) on LAS states pt remains "full code". pt also on NPA, PCIVA, cultures obtained. ABG, AM labs ordered, consider volume overload due to (+) 2L's IVF yesterday - TTE later AM. Add IV vancomycin to cover nosocomial pneumonia. closely follow resp status for need for ET intubation

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

6 Aug 2003

0730 PD Attending

pt was seen, on NC, HR 110's, ABG ordered, will consider CVP (b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: 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. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

ACLU DDII CID ROI 28128

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EXHIBIT 5

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Program Notes

0026-08-CID789-53209

[illegible] (b)(6)

[illegible] AT THE [illegible] OF THE [illegible] 112 120 AND WPT PROGRESSIVELY [illegible] 15 [illegible] SHIFT T [illegible] 120 [illegible] IT CONTAINS OF BLOOD CULD WITH SHAKES [illegible] AND [illegible] 2 [illegible] 2 OR 19 [illegible] WAS NOTIFIED AND WAS AT THE BED SIDE. [illegible] WEATHER [illegible] PLACE TO MAINTAINED O2SAT ABOVE 92%.SENT FOR CHEST X-RAY [illegible] WITH BLOOD CULTURES,CMP, CBC,UA/CULTURES AND ABG ANTIBIOTIC THERAPY [illegible] TYLENOL GRAM PO FOR TEMP WITH MOTRIN EFFECT. 40MG LASIX ADMINISTERED VIA IV AND 10MG K-DUR TO GRAVITY PLACED. AT 0630 VITALS BEGINS TO STABILIZE TEMP AT 99.5 AND PULSE AT 127 BEAT PER MIN.O2SAT 100% VIA NR WITH 10L [illegible] ON SNS WITH 40MCL MAINTAINED THROUGH LEFT AC 18G IV VIA PUMP. PT RESTING QUIETLY DENIES ANY PAIN OR DISCOMFORT AT THIS TIME.

Signed (b)(6)

[illegible] CHG:LAN171367
01 Jan 1981 / Male
Reg # (b)(6) LOC: ICU 1
Spec: CHG:LAN171367
Test:
Authorized Version of SF509

ACLU DDII CID ROI 28129

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EXHIBIT 5

CUMC CROSSER

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Progress Notes
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0026-08-CID789-53209

[illegible] (b)(6)

[illegible] Not [illegible] (b)(6) [illegible]

[illegible]

24 hours CXR repeat d new pleural effusion on the R in addition to known effusion on the left. Pain at site, patient reports feel being tired/fatigued [illegible]

S: [illegible] (range 97's to 112's) [illegible] (range 100's to 120's)
[illegible] on 4LNC; I/O +1550
[illegible] decreased BS bilateral at bases, L>R
CV: tachy distant S1/S2, no S3/S4/M
Abd: benign

Labs: WBC 10.8 HCT 29.1 PLTS 68
Na 140 K 4.2 Cl 98 HCO3 32 B/Cr 9/1.2 Glu 114
Mg 1.8 PO4 5.5 LDH 461

A/P: 1) AML
2) Pleural effusion and pericardial effusion

-patient CBC stable at present, afebrile. Patient with obvious dyspnea/fatigue when getting up to go to restroom and hypoxia on RA, O2 increased from 2L to 4L, likely from increasing effusions.
I have advised patient on effusions and likely progression and overall prognosis given disease and patient understands. Will stop antibx after 1 week of therapy (on Zosyn D#6).
Also discussed family visit (b)(6) in process of coordinating with his wife for a date. Once known, will again discuss with patient thoracentesis day prior to visit in order to attempt to wean off O2 so he may leave ICU to see them.
Will also add SCD's for DVT prophy; Lovenox held on admit due to question of coagulopathy (AML type M3 and due to headache and unable to clear brain as CT scan was functional, and given thoracentesis and possible thoracentesis. But patient has refused).

(b)(6)

Signed: (b)(6)

05 Aug 2006@0733 INPT Registrar # (b)(6) CLINICAL NURSE
PROG NOTES
Increased NC from 2LPM to 4LPM because patient was setting 92-94%. Patient only c/o pain when moving around, but did not want pain meds. Fentanyl patches replaced. Fluids DS 1/2 NS with 40meq at 100ml/hr. Heart rate sinus tach overnight even at rest from 104-114.
Signed: (b)(6)

*** END OF REPORT ***

[illegible] TEST,ISN172567
21 Jan 1981 / Male
Test # (b)(6) Loc: ITU 1
Spon: CROP,ISN171167
Unit:
Aut Dated Version: 1 [illegible]

ACLU DDII CID ROI 28130

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EXHIBIT 5

0026-08-CID789-53207

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
[illegible]	[illegible]
[illegible]	COMPLAINTS VS. AFFIDAVIT. SEE KU FLOWSHEET FOR ASSESSMENT. FINDINGS. (b)(6)
[illegible]	PT REFUSED TO TAKE ACTIVE CITRATE. THE GUARDS HELD HIM PRIVACY. "DID NOT CLOSE DOOR" WHEN HE USES BATHROOM. PT DID TAKE DULCOLAX AS ORDERED. (b)(6)
0700 4 AUG 2008	Received Report, VSS, pt. lying in bed c̄ HOB @ 30°, pt. currently stating "Hungry", breakfast is in the process of being delivered to pt. (b)(6) (b)(6)
0930 4 AUG 2008	pt. in 8/10 pain in (R) chest area, given 325mg Percocet P.O. (b)(6) (b)(6)
1400 4 AUG 2008	pt. given scheduled percocet ii̇ tabs, pt. sleeping soon afterwards. (b)(6) (b)(6)
5 Aug 2008 0100	Assumed pt. care @ HS time. Pt. sleeping comfortably. Sats 93-94% on RA 2L. HR Sinus tach @ 110. (b)(6)
5 Aug 2008 0249	Pt. offered pain meds because he was moaning when turning in bed. Pt. refused pain meds. (b)(6)
5 Aug 2008 0638	Lab draw X4 attempts. Unable to obtain labs because of frequent lab draws & veins collapsing. Will notify day shift. Will sched labs every other day. (b)(6)
0700 5 Aug 08	Recieved Report, VSS, HOB elevated @ 30°, pt. had a 6/10 pain to Right Chest, gave to percocet @ 0800, med was effective [illegible] See ICU flowsheet for rest of assessment. (b)(6)

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STANDARD FORM 5

0026-08-CID789-53209

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29 Jul 08 @ 1400	PT [illegible] [illegible] [illegible] [illegible] [illegible] physician. PT tolerated well & occasional grimace. [illegible] self repositioning. Tylenol for pain and as per sch. [illegible] Lasix 45gm IV administered per DVM. PT returned to bed LT side lying position for comfort. Hemodialysis added to [illegible] PT returns to nothing quietly. Social area assessed and (b)(6) notified and assessed to see stage I approximately 2cm in diameter. Nodule to RHC palpable with palpable area to more proximal area that was just within the tissue approximately 3cm diameter. VS remain stable. Continue to monitor. (b)(6)
29 Jul 08 @ 1600	PT nothing quietly changing position per self. VSS. Afebrile 97.7 Skin moist & desquamation. Fan turned on for comfort. PC early morning dressing. DVT continue to inflate. PT has not vomited and denies nausea. Continues on CR monitor. Continue ENS @ 88. Sats 94-96% on 4L per NC. (b)(6)
2000	PT asleep. See flowsheet for VS. PT remains @ [illegible] line. (b)(6)
0000	PT asleep, awaken for scheduled MS [illegible] measured, no [illegible] line 2100. (b)(6)
7/30	Measured as [illegible] PT [illegible] comfortably [illegible]
0545	NPO @ worst and PT placed old [illegible] off in [illegible] bilateral restraints to [illegible] side. Offered [illegible] PT declined [illegible] line. "I want to rest". (b)(6)
30 Jul 08 @ 0700	Received report. Assumed care [illegible] VSS. Afebrile. Fan CR monitor. Will continue to monitor. (b)(6)

ACLU DDII CID ROI 28132

STANDARD FORM 5 EXP USAPA V1.00

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ACLU-RDI 5591 p.58

000057

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

Progress Notes

For: 31 Jul 08 - 04 Aug 08

Report requested by: (b)(6)

0026-08-CID789-53209

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01 Aug 2008@0629 INPT Register # (b)(6) CLINICAL NURSE
PROG NOTES
End of Shift:
Pt resting quietly. Pt offered chance to use restroom to conduct ADL's but refused stating he is not given privacy. Pt also refused ordered Colace stating he is not given enough privacy. VSS, afebrile, no c/o break through pain overnight. See icu flowsheet for full assessment. Report given to oncoming shift.
Signed: (b)(6)

02 Aug 2008@0643 INPT Register # (b)(6) CLINICAL NURSE
PROG NOTES
VSS, pt resting quietly. No changes in pt status. A&Ox3,SR and no s/s of ectopy. S1/S2. BBS CTA. Abdomin soft and non-tender. Skin W/D/I.
Signed: (b)(6)

02 Aug 2008@1746 INPT Register # (b)(6) CLINICAL NURSE
PROG NOTES
Patient resting quietly at present in bed with siderails elevated. Moving all extremities. Sitting up eating evening meal. Awake and alert. Oriented X 3. Lungs clear with BBS except LLQ diminished. Heart tones audible. S1S2. SR. Palpable pulses in extremieis. Good skin turgor. Skin warm,dry, and intact.Abdomen soft and non-tender to palpation with bowel sounds decreased in all quadrants. Patient understands a great deal of english. Got two units of PRBC's yesterday. Was scheduled for thoracentesis today but was postponed. Patient said he didn't want to do it today. Voiding well. Amber urine. Has pain with movement (as in sitting upright from lying down). No distress noted currently. NC O2 at 2 L/min. VSS.
Signed: (b)(6)

02 Aug 2008@0349 INPT Register # (b)(6) CLINICAL NURSE
PROG NOTES
Patient slept throughout the night except to recieve meds. Recieved blood during the day for possible thorocentesis in the morning. Labs to be drawn in the morning consist of cbc, cmp, mg, phos, coag. VS stable throughout the night.
Signed: (b)(6)

01 Aug 2008@1833 INPT Register # (b)(6) CLINICAL NURSE
PROG NOTES
Pt. recieved 2 units PRBC throughout the shift, VSS, currently on 2L N.C. with SaO2 96%, lung sounds CTA Throughout, No changes throughout the shift.
Signed: (b)(6)

01 Aug 2008@1333 INPT Register # (b)(6) PHYSICIAN

==========

20/500-00-2107	CROP,ISN171567	FOREIGN NATIONAL - POW/INTERNE
	01 Jan 1981 / Male	H: not on file
Reg #: (b)(6)	Loc: ICU 1	W: not on file
	Spon: CROP,ISN171567	Rank:
	Unit:	RR:

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ACLU DDII CID ROI 28133

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

Personal Data - Privacy Act of 1974 (PL 93-579)
Progress Notes
For: 31 Jul 08 - 04 Aug 08

Report requested by: (b)(6)

0026-08-CID789-53209

S) NOTES
[illegible] 2nd [illegible] patient with decreased PCT and consented to thoracentesis. Also has had a couple episodes of N/V, treated with [illegible] and phenergan.

O) BP 1[illegible]/51 HR 87 RR 12 SaO2 3L NC

Exam unchanged with decreased BS on left lung field

Labs -> WBC 13.8 H/H 6.7/20.2 PLTS 57
Na 134 K 4.5 Cl 97 HCO2 36 B/Cr 6/1.0 Glu 116
TP 6.3 alb 2.3 LFT's 353/32/46/0.7

A/P) 1) Acute leukemia 2) Pleural effusion/pericardial effusion

-Patient with anemia, oxygen requiring, and pleural effusions. Plan for 2U PRBC transfusion and thoracentesis tomorrow to improve lung function and oxygenation. PLTS count stable and coags normal. Will continue supportive care and antibx. Will also attempt to coordinate with DOC and (b)(6) for family visit once patient hopefully off O2 (after transfusion and thoracentesis).

(b)(6)

Signed: (b)(6)

01 Aug 2008@0643 INPT Register # (b)(6) CLINICAL NURSE
PROG NOTES
End of Shift: Pt resting quielty without complaints. Pt OOB to bathroom to conduct ADLs, no BM, 300ml clear yellow urine noted. Type & screen this AM for Thoracentesis today. No further changes since last assessment noted. VSS, afebrile. Report given to oncoming shift.
Signed: (b)(6)

31 Jul 2008@1908 INPT Register # (b)(6) CLINICAL NURSE
PROG NOTES
Pt remained stable t/o day. Nausea X 2 relieved with zofran. Occ HA, denied additional pain medicine. All systems unchanged from am assessment @ 1200/1600. Long discussion held with MD, interpreter and pt regarding endo of life and thoracentesis. Pt has agreed to thoracentesis, and consented. Pt to have T+C in am. PLan - Thoracentesis in am 2-Cont to monitor labs 3-Pain management.

Signed: (b)(6)

20/500-00-2107 CROP,ISN171567 FOREIGN NATIONAL - POW/INTERNE
01 Jan 1981 / Male H: not on file
Reg #: (b)(6) Loc: ICU 1 W: not on file
Spon: CROP,ISN171567 Rank:
Unit: RR:
Automated version of SF509

ACLU DDII CID ROI 28134

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

Personal Data - Privacy Act of 1974 (PL 93-579)
Progress Notes
For: 31 Jul 08 - 04 Aug 08

Report requested by: (b)(6) 0026-08-CID789-53209

04 Aug 2008@1326 INPT Register # (b)(6) PHYSICIAN
PROG NOTES
DX2 NKDA Antibx D#7

No significant changes overnight. Main issues this am was question of thoracentesis and overall code status/end of life issues. Pt still declines thoracentesis for now. Wants to think about this and end of life issues. Main concern is seeing family.

VS 119/69 HR 98 RR22 SaO2 97% on 4L NC (goes to 89% on RA at rest)
Exam notable for decreased BS on left lung field about 2/3 up
CV - distant tach S1/S2, no S3/S4/M

Labs: WBC 19.6 HCT 22.9 PLTS 59
Na 143 K 3.0 CL 95 CO2 95 B/Cr 6/0.6 Glu 152
AP 306 A/A 25/30 T.bili 0.9

A/P) 1) Acute Myelogoneous Leukemia 2) L pleural effusion/pericardial effusion 3) Hypokalemia
-Anemia, thrombocytopenia due to leumkemia; also has splenomegaly
-Will T&S for possible PRBC Tx
-Replace K with oral and change IV to include KCL
-Cont pain regimen/bowel regimen/oral care and anitbx (for possible CAP)
-Discuss with patient tomorrow option of thoracentesis again; explained to patient that best option is get off O2 so he can go to TIF and have family visit, as they can not come to hospital
-CR submitted and currently awaiting decision
-Will also re-visit issue of code state/end of life issue; currently full code

(b)(6)

Signed: (b)(6)

31 Jul 2008@0637 INPT Register # (b)(6) CLINICAL NURSE
PROG NOTES
End of shift: Patient has had headaches intermittently throughout the night, but for the most part slept after he got 4mg of morphine around 22:00, except for medication times. Continuing to recieve IV abx. zosyn. Fluids are still at D5 1/2 NS at 100ml/hr.
Signed: (b)(6)

*** END OF REPORT ***

20/500-00-2107	CROP,ISN171567	FOREIGN NATIONAL - POW/INTERNE
	01 Jan 1981 / Male	H: not on file
Reg #: (b)(6)	Loc: ICU 1	W: not on file
	Spon: CROP,ISN171567	Rank:
	Unit:	RR:

Automated version of SF509

ACLU DDII CID ROI 28135

EXHIBIT 5

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LAW ENFORCEMENT SENSITIVE

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

Progress Notes

Report requested by: (b)(6)

0026-08-CID789-53209

0 Aug 2008@0629 INPT Register # (b)(6) CLINICAL NURSE

P SUBJ:

Start of Shift:

Resting quietly. Pt offered chance to use restroom to conduct ADL's but refused stating he is not given privacy. Pt also refused offered toilet stating he is not given enough privacy. VSS, afebrile, no c/o break through pain overnight. See icu flowsheet for full assessment. Report given to incoming shift.

Signed: (b)(6)

==========

20/500-00-2107 CROP,ISN171567 FOREIGN NATIONAL - POW/INTERNE

01 Jan 1981 / Male H: not on file

Reg #: (b)(6) Loc: ICU 1 W: not on file

Spon: CROP,ISN171567 Rank:

Unit: RR:

Automated version of SF509

ACLU DDII CID ROI 28136

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 6

CAPT CROPPER

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

0026-08-CID789-53209

[illegible] (b)(6)

Ann [illegible] that Keyanos (b)(6) CLINICAL NURSE
[illegible]

I had [illegible] to [illegible] Prosthetic legs and [illegible] this am. Pt
sat to chair, walked w/ walker approx 10 ft. Pt now eating mech soft diet
tolerating well, swallowing w/o difficulty. (b)(6) & Interpreter w/
interpreter discussed plan of care, pt states he understands. Fentanyl patch
being started today for longer acting pain management, c/t increased amnt of
morphine overnac. Plan: Eval pain mgmt cont. X-ray as col 3 labs as
ordered

Signed: (b)(6)

20/002-08 1970 CRUP,ISN:10193
01 Jan 196: / Male
Reg # (b)(6) Loc: ICU 1
Spon: CRUP,ISN:10193
Unit:
Automated version of SF509

ACLU DDII CID ROI 28137

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

[illegible] CROPER

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

0026-08-CID789-53209

[illegible] regarding [illegible] (b)(6)

[illegible] (b)(6) [illegible] CRIMINAL INVES-
TIGATOR

[illegible] the subject [illegible] the right [illegible] the way for possible [illegible] in the morning. Late to be drawn [illegible] the morning consist of chc, cmp, mj, phos, cbas. VS stable throughout the [illegible]

c (b)(6)

20/500-00-2107 CR01,ISN171567
01 Jan 1981 / Male
Req # (b)(6)
Loc: ICU 1
Stan: CR02,ISN171567
Unit:
Automated version of SF508

ACLU DDII CID ROI 28138

EXHIBIT 5

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LAW ENFORCEMENT SENSITIVE

CASE CHECKER

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

0026-08-CID789-53209

(b)(6)

(b)(6)

(b)(6)

/500 00-2107 CROP,ISNI?1567
01 Jan 1981 / Main
Q #: (b)(6)
Loc: 1CU 1
Spon: CROP,ISNI?1567
Unit:
tomated version of SF509

1 Cu Bed 2

ACLU DDII CID ROI 28139

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LAW ENFORCEMENT SENSITIVE

EX-115 5

[illegible] CROPPER

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

0026-08-CID789-53209

[illegible] (b)(6)

[illegible] (b)(6) [illegible]

[illegible] RN-C

[illegible] with diaphoresis elevated. Monitor [illegible] transmitted. Sitting up eating evening meal. Awake and alert, oriented X 3. [illegible] clear with bag except LLQ diminished. Heart tones audible. S1S2. SR [illegible] palpable pulses in extremities. Good skin turgor. Skin warm, dry, and [illegible] tact.Abdomen soft and non tender to palpation with bowel sounds decreased [illegible] all quadrants. Patient understands a great deal of english. Got two units [illegible] PRBC's yesterday. Was scheduled for thoracentesis today but was postponed. Patient said he didn't want to do it today. Voiding well. Amber urine. Has pain with movement (as in sitting upright from lying down). No distress noted currently. NC O2 at 2 L/min. VSS

Signed: (b)(6)

29/500-03-2127 CROP,ISN171567
01 Jan 1981 / Male
Reg # (b)(6) LOC: ICU 1
Spec: CROP,ISN171567
Unit:
Automated version of SF509

ACLU DDII CID ROI 28140

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

CAPT CROPPER

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

0026-08-CID789-53209

1. Suspected by (b)(6)

2. Suspected after Report of (b)(6) CLINICAL NURSE

3. [illegible]

4. [illegible] 2002 903, lung sounds CTA throughout, No changes throughout the shift.

Signed (b)(6)

10/5/02-08:23:07 CROP,IGN171567
01 Jan 1981 / Male
Reg # (b)(6) Loc: ICU 1
Spon: CROP,IGN171567
Unit:
Automated version of SF509

ACLU DDII CID ROI 28141

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LAW ENFORCEMENT SENSITIVE

EXHIBITS

CONFIDENTIAL

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

0026-08-CID789-53209

Patient: (b)(6)

Encounter ID: Provider: (b)(6) STATION NURSE

SUBJ:

Ambulatory Encounter 1/2 day. Patient [illegible] with [illegible] for [illegible] chronic pain medicine. All systems unchanged from an assessment @ [illegible]/1600. Long discussion held with MD, interpreter and pt regarding endo of [illegible] and thoracentesis. Pt has agreed to thoracentesis, and consented. Pt to [illegible] PAC in am. Plan - Thoracentesis in am 2 Cont to monitor lead 3-Pain management.

Patient: (b)(6)

AR/SOC 06-2:07 CROP,ISN171567
01 Jan 1981 / Male
Reg #: (b)(6) LOC: 100 1
Spon: CROP,ISN171567
Unit:
Automated version of SF509

ACLU DDII CID ROI 28142

EXHIBITS

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LAW ENFORCEMENT SENSITIVE

NAME CHOPHER

Personal Data - Privacy Act of 1974 (PL 93-579)
Progress Notes
From: 10 Jul 08 - 31 Jul 08

0020-00-0709-53209

Generated by (b)(6)

20080710 INPT Register # (b)(6) CLIN CL NURSE
PROC NOTES
Subject: Patient not to be used for emergency Circumcision the night. For the most part slept after he got 4mg of morphine around 22:00, except medication times. Continuing to receive IV abx, zofran. Fluids are still D5 1/2 NS at 100ml/hr.
Signed: (b)(6)

10 Jul 20080836 INPT Register # (b)(6) CLINICAL NURSE
PROC NOTES
END OF SHIFT

Pt denies headache at this time. Has rested off and on throughout the day. VSS and afebrile. Fentanyl patches order changed to q3rd day instead of qd. Continues with MS Contin BID, Percocet TID, Morphine for BTP, and D5 1/2 NS at 100 ml/hr. Zofran one dose today of 8mg IV for nausea and small amt biliary emesis. Zofran # 5 qm IV qShr. PIV to RT wrist #20g patent without s/s infiltration or infection. Voided this am qs dark amber urine. Tolerates small amounts of warm and room temperature fluids without further emesis. Small epistaxis with emesis episode. Resolved. Declines meals, has tolerated one can of ensure this am. BMx1 today. Resting quietly with monitors in place. Report to oncoming shift.
Signed: (b)(6)

10 Jul 20080811 INPT Register # (b)(6) OPERATING ROOM
PROC NOTES
Nursing: Please disregard progress note dated 23July08 at 1611. Note charted under wrong patient.
Signed: (b)(6)

10 Jul 20080807 INPT Register # (b)(6) CLINICAL NURSE
PROC NOTES
End of shift summary:Pt over noc slept w/o distress O2 SpO2 decreased to 90% on RL increased o2 to 4L now SpO2 94%. C/o no additional pain f/o noc. Pt affect improving from admission last noc. Pt urinated X 1 400ml dk yellow. Offered bath this am, pt declined stating "I would like to rest". No other changes in assessment. Plan: 1-Cont to monitor cardiopulm status 2-Labs as ordered 3-Pain management.
Signed: (b)(6)

*** END OF REPORT ***

22/300-08-2197 CROP,ISN17156?
01 Jan 1981 / Male
Rec: # (b)(6)
Loc: ICU 1
Spec: CROP,ISN17156?
Unit:
Automated version of SF509

ACLU DDII CID ROI 28143

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

Personal Da (R 3-579)
Progress Notes

Report requested by: (b)(6)

0026-08-0789-53209

11 Aug 2008@0643 INPT Register # (b)(6) CLINICAL NURSE
PROG NOTES
End of Shift: Pt resting quietly without complaints. Pt OOB to bathroom to conduct ADLs, no BM, 300ml clear yellow urine noted. Type & screen this AM for Thoracentesis today. No further changes since last assessment noted. VSS, afebrile. Report given to oncoming shift.
Signed: (b)(6)

0/500-00 2107 CROP,ISN171567 FOREIGN NATIONAL - POW/INTERNE
01 Jan 1981 / Male H: not on file
Reg #: (b)(6) Loc: ICU 1 W: not on file
Spon: CROP,ISN171567 Rank:
Unit: RR:
Automated version of SF509

0026-08-0789-53209
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LAW ENFORCEMENT SENSITIVE
EXHIBIT
ACLU DDII CID ROI 28144

MEDICAL RECORD | PROGRESS NOTES

0026-08-CID789-53209

DATE	
30 Jul 08 @ 0700	Pt awake and sleeping on Exam table. Pt [illegible] dizziness. Attempts to ambulate, but unable to [illegible] that does not relieve. Will continue to monitor. (b)(6)
30 Jul 08 @ 1000	Pt up to void, go dark amber. Ambulatory. Morphine sulfate 4mg IV given per HS PRN orders. Pt slept back to sleep. Will continue to monitor. (b)(6)
30 Jul 08 @ 1100	Pt's HR continues, but able to doze intermittently. Denies nausea. Sips on water. Frequent reassessments. (b)(6)
30 Jul 08 1230	Pt continues to c/o HA 8/10. MS Contin given per standing order. Pt requested to speak to HS (b)(6) BS to answer questions. Continue to monitor pt. (b)(6)
30 Jul 08 @ 1330	Pt up to BR for BM. Got weak therefore transported via w/c. Pt washed up while in the BR. Denies c/o. Returned to bed. Sat at side of bed for 10" and then "need to lie down" again. Repositioned for comfort. VSS. Afebrile. Continue to monitor. (b)(6)
30 Jul 08 @ 1430	Pt sat up in bed and started to vomit small amt dark green liquid. Zofran 2mg IV given. Oral care completed. Cool washcloth to neck. Pt given per standing order. Pt comforted. Zofran effective. Zosyn infusing. Pt c/o. Continue to monitor. (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.
500-00-2107		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

ICU #2

ACLU DDII CID ROI 28145

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

CROP CROPPER

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

0026-08-CID789-53209

[illegible] Reported by: (b)(6)

[illegible] Pt. or R (b) [illegible]

[illegible]

[illegible] SHIFT

[illegible] denies headache at this time. Has rested off and on throughout the day [illegible] and afebrile. Fentanyl patches order changed to q3d day instead of qd. Continues with MS Contin BID, Percocet TID, Morphine for BTT, and D5 1/2 NS @ 150 ml/hr. Zofran one dose today at 8mg IV for nausea and small amt biliary emesis. Zosyn 4.5 gm IV q8hr. TIV to RT wrist #20g patent without s/s infiltration or infection. Voided this am qs dark amber urine. Tolerates small amounts of warm and room temperature fluids without further emesis. Small epistaxis with emesis episode. Resolved. Declines meals, has tolerated one can of ensure this am. BMx1 today. Resting quietly with monitors in place. Report to oncoming shift.

Signed: (b)(6)

20/100-00 2107 CROP,ISN171767
01 Jan 1981 / Male
Reg #: (b)(6) Loc: ICU 1
Spon: CROP,ISN171567
Unit:
Automated version of SF509

ACLU DDII CID ROI 28146

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ACCOMPLISHMENT SENSITIVE

EXHIBIT 5

CAMP CROPPER

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

0026-08-CID789-53209

1. Sequential: (b)(6)

2. Appointment INT: Begins # (b)(6) CLINICAL NOTES

S: 1900

1. 1st Shift summary:Pt over net slept w/o distress O2 SpO2 decreased to 90% 3L increased O2 to 4L now SpO2 94%. C/o no additional pain t/o noc. 2. after improving from admission last noc. Pt urinated X 1 400ml dc yellow. offered bath this am, pt declined stating "I would like to rest". No other changes in assessment. Plan: 1 Cont to monitor cardiopulm status 2-labs as ordered 3-Pain management.

Signed: (b)(6)

20/500 00-2101 CROP,TSN171567
01 Jan 1981 / Male
Reg #: (b)(6) Loc: ICU 1
Spon: CROP,TSN171567
Unit:
Automated version of SF500

ACLU DDII CID ROI 28147

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

CAMP CROPPER

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

0026-08-CID789-53209

[illegible] reported by (b)(6)

[illegible] Patient # (b)(6) (Bed No.)
[illegible]
END OF SHIFT:

Pt has rested throughout most of the shift. IV of D5 1/2 NS infusing at 100 ml/hr. VSS. Afebrile. Declines any food. Sips of water rarely. U/S today demonstrates nonloculated fluid. Pt declines aspiration of the fluid at this time with interpreter at bedside. Voided x1. Continues to require O2, baseline on room air continues to be 84% when patient removes oxygen. Pt reminded to keep O2 on and pulse ox on. Pt assisted to position of comfort. Report to oncoming RN.

Signed: (b)(6)

20/506-00-2107 CROP,ISN171567
01 Jan 1981 / Male
Reg # (b)(6) Loc: ICU 1
Span: CROP,ISN171567
Unit:
Automated version of SF509

ACLU DDII CID ROI 28148

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ENFORCEMENT SENSITIVE

EXHIBIT 5

[illegible] CRAFTER

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

0026-08-CID789-53209

[illegible] by: (b)(6)

[illegible] Encounter #: (b)(6) Clinical Note

[illegible]

[illegible] admit for possible cva or acute toxic [illegible] ations but AMS, pleural and pericardial effusion. O2 sats were 94% on 4lpm [illegible]. Left lung has scattered rhonchi and is more diminished in the left than [illegible] right. Heart rate is tachycardic most of the time and when he moves [illegible] round in the low 100's to 1 teens. No ectopy, CVD, or extra heart sounds [illegible]. 20 guage IV in Left Forearm infusing D5 1/2 NS at 100ml/hr. Voids [illegible] dark yellow urine spontaneously. Bowel sounds active in all 4 quadrants, [illegible] sound, soft, with no tenderness. C/o pain in the center of his chest. Speaks good English.

Signed: (b)(6)

26/5[illegible] 00 210[illegible] CROP,1SN171567
01 Jan 1981 / Male
Reg #: (b)(6) Loc: ICU 1
Spon: CROP,1SN171567
Unit:
Automated version of SF509

ACLU DDII CID ROI 28149

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

0026-08-CID789-53209

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

RESTRAINTS:

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

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
~~(1) PACC~~					
(2) EA 20 IV	08 AUG 2008	~~DTF~~ NC	CDF		

PREPARED BY: (b)(6)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 10 AUG 2008

PATIENT'S INDENTIFICATION

500 - 00 - 2107

ICU #2

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

ACLU DDII CID ROI 28150

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

SYSTEM	FINDINGS
NEUROLOGICAL	
Level of consciousness, Glasgow	Pt ↑ [illegible] UCSA Pt and
Coma Scale (GCS), verbal, motor	[illegible] pupils, very weak Pt c/o S/Sx
response, motor strength, bowel	Hx gum PRN pain med
bladder function, [illegible]	0026-08-CID789-53209
Sensation, [illegible]	
CARDIOVASCULAR	
Rhythm, Rate, Ectopy, PMI, Lead selected,	ST on EKG, [illegible]
Normal Heart Sounds (S1, S2),	[illegible]
Abnormal heart sounds – (S3, S4,	Pt [illegible]
murmur, gallop, click, rub), color,	
skin temp, JVD, Capillary refill,	
Pulses (strength, bilaterally), turgor,	
moisture, edema, carotid bruits/thrills,	
CVP, abnormal findings, Central lines	
(Location, appearance, dressing, etc.)	
RESPIRATORY	
Respiratory rate, rhythm, SaO2, oxygen	Pulmonary 90-92% on 6L NC. Pt
delivery method, Ventilator settings,	c̄ increased WOB c̄ RR 8-12. ⊕ ⊕
chest expansion, Accessory muscle use,	on BS albuterol bilat [illegible]
lung sounds, cough, secretions/sputum	
(Color, amount, consistency) , ETT/Trach	
(size, placement, appearance), Chest	
Tubes (location, Suction/H20 seal, air	
leaks, drainage amount & color, dressing)	
Arterial line (appearance, location, etc.)	
GASTROINTESTINAL	
Oral cavity appearance, dentition,	Patient BS pt poor oral intake
Mucosal appearance, odor, Abdomen	
(contour, distention, tenderness, soft,	
Firm, guarding, bowel sounds), NG/OG/	
G-Tube (placement, verified, residuals),	
Tube feeds (type, rate), suction, stool/	
Emesis (color/consistency/amount),	
Colostomy (stoma location & appearance)	
GENITOURINARY	
Mode of elimination (void, foley, urostomy),	Dark cloudy [illegible] post
Foley size, bladder distention,	Foley
Urine (color, amount, sediment)	
INTEGUMENTARY	
General skin condition, dressings	#15, #20 on [illegible] UCSS
(locations, condition), wounds, lacerations,	
Incisions (staples or sutures, approximation	
of wound edges, drainage, signs of	
infection), drains (JP, hemovacs, etc.),	
Drainage (color, amount), protective aids,	
Decubitus ulcers, IV sites (location, fluid,	
rate, appearance, dressing), any additional	
Skin findings	
SIGNATURE	

ACLU DDII CID ROI 28151

FOR OFFICIAL USE ONLY
SIGNATURE MENT SENSITIVE

EXHIBIT 5

0026-08-CID789-53209

BP	115	119	121		115	127	120	126
	78	41	85	80	23	72	4	52
Pulse	109	115	117	110	115	118	115	121
Respirations	10	10	10	10	12	11	11	20
Temperature						97.8		
SaO2	94	97	94	98	98	97	97	96
FiO2	60	100	100	100	60	100	100	100
O2 Delivery	VM	SM	SM	SM	RA	SM	SM	SM
Vent Mode								
Rate								
Tidal Vol								
Peep								
PS								
Pain Scale	asleep	asleep	asleep	asleep	asleep	sleep	sleep	sleep
Pain Med								
Pt Position								
CVP								

	1210	1540
OUTPUT	1875	660
DIFFERENCE	+375	+880

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

(INTAKE) TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
IV	85	85	85	85	85	85	85	85	680	1560
IVPB								100		
PO/ TF										
Other										
TOTAL										

OUTPUT

TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
Urine output /Total	60	25	30	60	50	50	50	50	375	660
NG output										
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

Legend

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

Name	Signature	In
(b)(6)		

ACLU DDII CID ROI 28152

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

0026-08-CID789-53209

ICU FLOW SHEET

Eyes Assessment Scale

(4) Spontaneously
3 – To speech
2 – To Pain
1 – None

Verbal Response:
5 – Oriented
(4) – Confused speaking only Arabic now
3 – Inappropriate Words
2 – Incomprehensible Sounds
1 – None (Note – "T" = tube)

Motor Response:
6 – Obey Commands
(5) – Localizes to pain
4 – Withdraws to Pain
3 – Flexion to pain
2 – Extension to pain
1 - None

Grade Strength
(5) – Normal strength
4 – Moves against resistance
3 – Moves against gravity
2 – Moves not against gravity
1 – No movement

Pupil Scale

2mm	3mm	4mm	5mm	6mm	7mm	8mm	9mm
●	●	(●)	●	●	●	●	●

RESTRAINTS: to RT ankle for security purposes only

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

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
RT wrist	10 Aug 03		CDI, patent, &		—
(L) Arm	11 Aug 03		S/S infection		C,D,I Patent
(L) Brea	11 Aug 03		or infiltration		C,D,I Patent

PREPARED BY (Signature & Title) (b)(6)

DEPARTMENT/SERVICE/CLINIC ICU

DATE 11 Aug

PATIENT'S IDENTIFICATION

500-00-2107

ICU Pt 2

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

ACLU DDII CID ROI 28153

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LAW ENFORCEMENT SENSITIVE

EX-PART 5

ICU #2 26 OC-2IC 4 IS 17156 K 11 Aug 03

SYSTEM	NIGHT	
NEUROLOGICAL	TIME:	
Level of consciousness, Glasgow	Mental status awake	
Coma Scale (GCS), pupil size &	[illegible] GCS 13 [illegible]	
response, [illegible]	[illegible]	
Muscle strength, [illegible] abnormal	0026-08-AID-89-53209	
findings, spinal [illegible]		
CARDIOVASCULAR		
Rhythm, Rate, Ectopy, PMI, Lead selected,	ST [illegible] II heart sounds	
Normal Heart Sounds (S1, S2),	auscultated S1 S2 [illegible]	
Abnormal Heart Sounds – (S3, S4,	JVD <3 [illegible]	
murmur, gallop, click, rub), color,	Pulses 2+ bilat [illegible]	
skin temp, JVD, Capillary refill,	[illegible]	
Pulses (strength, bilaterally), turgor,		
moisture, edema, carotid bruits/thrills,		
CVP, abnormal findings, Central lines		
(Location, appearance, dressing, etc.)		
RESPIRATORY		
Respiratory rate, rhythm, SaO2, oxygen	BS diminished [illegible]	
delivery method, Ventilator settings,	[illegible]	
chest expansion, Accessory muscle use,	[illegible]	
lung sounds, cough, secretions/sputum	[illegible]	
(Color, amount, consistency) , ETT/Trach	O2 Sats 97 - 100%	
(size, placement, appearance), Chest		
Tubes (location, Suction/H20 seal, air		
leaks, drainage amount & color, dressing)		
Arterial line (appearance, location, etc.)		
GASTROINTESTINAL		
Oral cavity appearance, dentition,	Oral cavity pink Bowel	
Mucosal appearance, odor, Abdomen	Sounds noted x 4 quad soft	
(contour, distention, tenderness, soft,	[illegible]	
Firm, guarding, bowel sounds), NG/OG/		
G-Tube (placement, verified, residuals),		
Tube feeds (type, rate), suction, stool/		
Emesis (color/consistency/amount),		
Colostomy (stoma location & appearance)		
GENITOURINARY		
Mode of elimination (void, foley, urostomy),	Foley to BSD cloudy urine	
Foley size, bladder distention,	[illegible]	
Urine (color, amount, sediment)		
INTEGUMENTARY		
General skin condition, dressings	Skin warm dry and intact	
(locations, condition), wounds, lacerations,	at [illegible] appears dusky,	
Incisions (staples or sutures, approximation	IV to R [illegible] and R	
of wound edges, drainage, signs of	arm	
infection), drains (JP, hemovacs, etc.),		
Drainage (color, amount), protective aids,		
Decubitus ulcers, IV sites (location, fluid,		
rate, appearance, dressing), any additional		
Skin findings		
SIGNATURE	(b)(6)	

ACLU DDII CID ROI 28154

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SENSITIVE

EXHIBIT 5

ICU #2 PATI 500-00-3167 DAT. 4.16.08

0026-08-CID789-53209

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP (MAP)	117/ 72	127/ 78	132/ 82	136/ 90	120/ 83	134/ 87	120/ 77	124/ 81
Pulse	141	142	144	145	139	142	143	144
Ventilations	14	21	27	[illegible]	28	17	24	22
Temperature		98				97.8		
SaO2%	94	92	93	96	97	96	95	97
FiO2%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
O_2 Delivery	Ex	Ex	Ex	Ex	Ex	Ex	Ex	Ex
Mode								
Rate								
Tidal Vol.								
Peep								
PS								
Pain Scale								
Pain Med								
Pt Position								
CVP								

24 Hour Totals	Yesterday	Today
INPUT	1960	3650
OUTPUT	600	1148
DIFFERENCE	+340	+2502

6 1985

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

+4287

(INTAKE) TIME	23	24	01	02	03	04	05	06	**Total 8 HRS**	**24 HOUR TOTAL**
IV	125	125	125	125	125	125	125	125	1000	
IVPB								100	100	
PO/ TF										
Other										
TOTAL										3650

OUTPUT

TIME	23	24	01	02	03	04	05	06	**Total 8 HRS**	**24 HOUR TOTAL**
Urine output /Total	15	25	10	5	3	13	300	85	456	1,148
NG output							60			
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

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

Name	Signature	Init.
(b)(6)		

ACLU DDII CID ROI 28155

EXHIBIT 5

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

0026-08-CID789-53209

ICU FLOW SHEET

Pupil Scale

Spontaneously
3 – To speech
2 – To Pain
1 – None

Verbal Response:
5 – Oriented
4 – Confused, speaking only Arabic now
3 – Inappropriate Words
2 – Incomprehensible Sounds
1 – None (Note – "T" = tube)

Motor Response:
6 – Obey Commands
5 – Localizes to pain
4 – Withdraws to Pain
3 – Flexion to pain
2 – Extension to pain
1 – None

Grade Strength
5 – Normal strength
4 – Moves against resistance
3 – Moves against gravity
2 – Moves not against gravity
1 – No movement

Pupil Scale

2mm	3mm	4mm	5mm	6mm	7mm	8mm	9mm

RESTRAINTS: to RT ankle for security purposes only

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

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
RT wrist	10 Aug 08		CDI, patent &		—
(L) Arm	11 Aug 08		s/s infection		C,D,I Patent
(L) Brach	11 Aug 08		or infiltration		C,D,I Patent

PREPARED BY (b)(6)

DEPARTMENT/SERVICE/CLINIC ICU

DATE 11 Aug 08

PATIENT'S INDENTIFICATION

500-00-2107

ICU Pt 2

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

☐ FLOWCHART
☐ OTHER

ACLU DDII CID ROI 28156

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

ICU #: 20-CC-2107 ID: 17567 [illegible]

SYSTEM	NIGHTS	
NEUROLOGICAL	TIME:	
Level of consciousness, Glasgow	Pt awake at times [illegible]	
Coma Scale (GCS), pupil size &	No self care GCS 13 Pt [illegible]	
reaction, motor & sensory function	[illegible]	
Muscle strength, [illegible]		
findings, spinal precautions	0026-08-CID789-53209	
CARDIOVASCULAR		
Rhythm, Rate, Ectopy, PMI, Lead selected,	ST Lead II [illegible]	
Normal Heart Sounds (S1, S2),	[illegible] S1 S2	Pacer
Abnormal Heart Sounds – (S3, S4,	[illegible]	
murmur, gallop, click, rub), color,	Pulses 2+ bilat	No [illegible]
skin temp, JVD, Capillary refill,	[illegible]	
Pulses (strength, bilaterally), turgor,		
moisture, edema, carotid bruits/thrills,		
CVP, abnormal findings, Central lines		
(Location, appearance, dressing, etc.)		
RESPIRATORY		
Respiratory rate, rhythm, SaO2, oxygen	BS diminished on [illegible]	
delivery method, Ventilator settings,	[illegible]	
chest expansion, Accessory muscle use,	Fine rales Pt [illegible]	
lung sounds, cough, secretions/sputum	muscles to help breathe	
(Color, amount, consistency) , ETT/Trach	O2 Sats 97-100%	
(size, placement, appearance), Chest		
Tubes (location, Suction/H20 seal, air		
leaks, drainage amount & color, dressing)		
Arterial line (appearance, location, etc.)		
GASTROINTESTINAL		
Oral cavity appearance, dentition,	Early pink Bent	
Mucosal appearance, odor, Abdomen	Sub-[illegible] soft	
(contour, distention, tenderness, soft,	[illegible]	
Firm, guarding, bowel sounds), NG/OG/		
G-Tube (placement, verified, residuals),		
Tube feeds (type, rate), suction, stool/		
Emesis (color/consistency/amount),		
Colostomy (stoma location & appearance)		
GENITOURINARY		
Mode of elimination (void, foley, urostomy),	Foley to BSD cloudy urine	
Foley size, bladder distention,	[illegible]	
Urine (color, amount, sediment)		
INTEGUMENTARY		
General skin condition, dressings	Skin [illegible] dry and intact	
(locations, condition), wounds, lacerations,	at times [illegible]	
Incisions (staples or sutures, approximation	IV to R [illegible] 12 and R	
of wound edges, drainage, signs of	[illegible]	
infection), drains (JP, hemovacs, etc.),		
Drainage (color, amount), protective aids,		
Decubitus ulcers, IV sites (location, fluid,		
rate, appearance, dressing), any additional		
Skin findings		

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

(b)(6)

Bed # 2 PATI 500-06-9167 DAT 11-2-03

0026-08-^!D789-53209

TIME	23	24	01	02	03	04	05	06
NIBP	111	127	132	130	120	134	120	124
ABP (MAP)	87	78	82	90	83	87	87	81
Pulse	142	142	134	145	150	142	143	144
Respirations	[illegible]	21	[illegible]	21	28	27	27	26
Temperature		98						
SaO2	94	90	90	[illegible]	90	96	95	97
FiO2	[illegible]	100	[illegible]	[illegible]	[illegible]	[illegible]	100	[illegible]
O_2 Delivery	Fm	Fm	Fm	Fm	Fm	F	Fm	Fm
Mode								
Rate								
Tidal Vol.								
Peep								
PS								
Pain Scale								
Pain Med								
Pt Position								
CVP								

24 Hour Totals	Intake	Output	Balance
	[illegible]	[illegible]	[illegible]
Output #	660	1,148	
DIFFERENCE	+2,10	+2,502	

+1785

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

+4287

(INTAKE) TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
IV	125	125	125	125	125	125	125	125	1000	
IVPB								100	100	
PO/ TF										
Other										
TOTAL										3650

OUTPUT

TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
Urine output /Total	15	25	10	5	3	13	300	85	450	1,148
NG output										
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

Removed 7/14/

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

Name	Signature	Init.
(b)(6)		
	EXHIBIT 5	
	000083	

ACLU D[illegible]
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LAW ENF[illegible]MENT SENSITIVE

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0026-08-CID789-53209

DETAILS

About 1720, 16 Sep 08, SA (b)(6), (b)(7)(C) and SA (b)(6), (b)(7)(C) coordinated with SSG (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) 111th QM CO, Mortuary Affairs, Camp Sather, Iraq, who stated the remains of Mr. MUNAI were received on 12 Aug 08, and prepped for transport to Balad, where the remains would then be put on a direct flight to Dover for Autopsy. SSG (b)(6), (b)(7)(C) stated he received instruction from CPT (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) Theater Mortuary Affairs Officer (TMAO), Kuwait, to release the remains to the Next Of Kin and an autopsy was not required as the Detainee had a documented terminal illness. SSG (b)(6), (b)(7)(C) stated it was common practice to release Detainee remains without an autopsy if the individual died under certain circumstances. SSG (b)(6), (b)(7)(C) provided all documentation pertaining to Mr. MUNAI, to include the Certificate of Death (Overseas), Convoy List Of Remains Of Deceased Personnel, and receipt of remains by the Next Of Kin.

About 1920, 16 Sep 08, SA (b)(6), (b)(7)(C) coordinated with MAJ (b)(6), (b)(7)(C) Mortuary Affairs Officer (MAO), International Zone, Iraq, who stated he was not aware the remains of Mr. MUNAI were released without an autopsy, as he was out of the net for an unrelated mission, but stated he would have never authorized the release of detainee remains without either an autopsy, or written approval by the concerned investigative agency or the Armed Forces Medical Examiner (AFME).

About 0930, 29 Sep 08, SA (b)(6), (b)(7)(C) coordinated with COL (b)(6), (b)(7)(C) 115th CSH, Camp Bucca, Iraq, who stated Mr. MUNAI would not have lived longer do to Acute Myelogenous Leukemia. ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA (b)(6), (b)(7)(C), (b)(7)(F)	24th/348th Military Police Detachment (CID)(FWD) Camp Cropper, Baghdad, Iraq APO AE 09342	
SIGNATURE (b)(6), (b)(7)(C)	DATE 29 Sep 08	EXHIBIT

ACLU DDII CID ROI 28159

CID FORM 94 (Automated)

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~~LAW ENFORCEMENT SENSITIVE~~

0026-08-CID789-53209

ICU FLOW SHEET

Spontaneously
3 – To speech
2 – To Pain
1 – None

Verbal Response:
5 – Oriented
4 – Confused, speaking only Arabic now
3 – Inappropriate Words
2 – Incomprehensible Sounds
1 – None (Note – "T" = tube)

Grade Strength
5 – Normal strength
4 – Moves against resistance
3 – Moves against gravity
2 – Moves not against gravity
1 – No movement

Motor Response:
6 – Obey Commands
5 – Localizes to pain
4 – Withdraws to Pain
3 – Flexion to pain
2 – Extension to pain
1 - None

Pupil Scale

2mm	3mm	4mm	5mm	6mm	7mm	8mm	9mm

RESTRAINTS: to RT ankle for security purposes only

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

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
RT wrist	10 Aug 08		CDT, patent, ⊕		—
(L) Arm	11 Aug 08		s/s infection		C,D,I Patent
(L) Brach	11 Aug 08		or infiltration		C,D,I Patent

PREPARED BY (b)(6)

DEPARTMENT/SERVICE/CLINIC ICU

DATE 11 Aug 08

PATIENT'S INDENTIFICATION

500-00-2407

ICU Pt 2

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

☐ FLOWCHART
☐ OTHER

ACLU DDII CID ROI 28156

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

ICU #: 20-CC-2167 ID: 17567 [illegible]

SYSTEM	NIGHTS	
NEUROLOGICAL	TIME:	
Level of consciousness, Glasgow	Pt awake at times [illegible]	
Coma Scale (GCS), pupil size &	No self [illegible] GCS 13 Pt [illegible]	
reaction, motor & sensory function	[illegible]	
Muscle strength, [illegible]		
findings, spinal precautions	0026-08-CID789-53209	
CARDIOVASCULAR		
Rhythm, Rate, Ectopy, PMI, Lead selected,	ST Lead II [illegible]	
Normal Heart Sounds (S1, S2),	[illegible] S1 S2	Regular
Abnormal Heart Sounds – (S3, S4,	[illegible]	[illegible]
murmur, gallop, click, rub), color,	Pulses 2+ bilat	No [illegible]
skin temp, JVD, Capillary refill,	[illegible]	
Pulses (strength, bilaterally), turgor,		
moisture, edema, carotid bruits/thrills,		
CVP, abnormal findings, Central lines		
(Location, appearance, dressing, etc.)		
RESPIRATORY		
Respiratory rate, rhythm, SaO2, oxygen	BS diminished on [illegible]	
delivery method, Ventilator settings,	[illegible]	
chest expansion, Accessory muscle use,	Fine rales Pt [illegible]	
lung sounds, cough, secretions/sputum	muscles to help breathe	
(Color, amount, consistency), ETT/Trach	[illegible] Sats 97-100%	
(size, placement, appearance), Chest		
Tubes (location, Suction/H20 seal, air		
leaks, drainage amount & color, dressing)		
Arterial line (appearance, location, etc.)		
GASTROINTESTINAL		
Oral cavity appearance, dentition,	[illegible] pink Bowel	
Mucosal appearance, odor, Abdomen	Sounds noted x 4 [illegible] soft	
(contour, distention, tenderness, soft,	[illegible]	
Firm, guarding, bowel sounds), NG/OG/		
G-Tube (placement, verified, residuals),		
Tube feeds (type, rate), suction, stool/		
Emesis (color/consistency/amount),		
Colostomy (stoma location & appearance)		
GENITOURINARY		
Mode of elimination (void, foley, urostomy),	Foley to BSD cloudy urine	
Foley size, bladder distention,	[illegible]	
Urine (color, amount, sediment)		
INTEGUMENTARY		
General skin condition, dressings	Skin [illegible] dry and intact	
(locations, condition), wounds, lacerations,	at times [illegible]	
Incisions (staples or sutures, approximation	IV to R [illegible] 12 and R	
of wound edges, drainage, signs of	[illegible]	
infection), drains (JP, hemovacs, etc.),		
Drainage (color, amount), protective aids,		
Decubitus ulcers, IV sites (location, fluid,		
rate, appearance, dressing), any additional		
Skin findings		

ACLU DDII CID ROI 28157
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LAW ENFORCEMENT SENSITIVE

EXHIBIT 5

(b)(6)

Bed # 2 PATI 500-06-9167 DAT 11-2-03

0026-08-^!D789-53209

TIME	23	24	01	02	03	04	05	06
NIBP	111	127	132	130	120	134	120	124
ABP (MAP)	87	78	82	90	83	87	87	81
Pulse	142	142	134	145	150	142	143	144
Respirations	[illegible]	21	[illegible]	21	28	27	27	26
Temperature		98						
SaO2	94	90	90	[illegible]	90	96	95	97
FiO2	[illegible]	100	[illegible]	[illegible]	[illegible]	[illegible]	100	[illegible]
O_2 Delivery	Fm	Fm	Fm	Fm	Fm	F	Fm	Fm
Mode								
Rate								
Tidal Vol.								
Peep								
PS								
Pain Scale								
Pain Med								
Pt Position								
CVP								

24 Hour Totals	Output	Input
Totals	[illegible]	3650
Output	660	1148
DIFFERENCE	+2910	+2502

4785

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

+4287

(INTAKE) TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
IV	125	125	125	125	125	125	125	125	1000	
IVPB								100	100	
PO/ TF										
Other										
TOTAL										3650

OUTPUT

TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
Urine output /Total	15	25	10	5	3	13	300	85	450	1,148
NG output										
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

Removed 4/14

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

Name	Signature	Init.
(b)(6)		
	EXHIBIT 5	
	000083	

ACLU D

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LAW ENFORCEMENT SENSITIVE

ULTI-NATIONAL FORCES - IR

0026 08 C10789 53209

The Multinational Force-Iraq deeply regrets the loss of your loved one and wishes the return of the human remains of Samarai, Allah Al to his/her primary next of kin. The remains have been treated with the same respect and courtesies required by Muslim or Christian tradition and have been treated with the same respect and courtesy as those of the Coalition forces. The person receiving the remains acknowledges that Coalition forces have provided the remains in a respectful manner. Any perceived violation of local customs is wholly unintentional on the part of Coalition forces. All personal effects that were found with the remains are being turned over and an inventory is attached.

القوات المتعددة الجنسية - العراق تتقدم بكل الأسف العميق والأعتدار لفقدان احبايكم و تتمنى ان تقدم و ترجع اليكم البقايا الادمية الخاصة بالمرحوم\ Samarai, Allah Al
الى نسب اهلة القريب الاولى الية. مع العلم بأن البقايا الادمية تم معاملتها بكل الاحترام واللطف التى تتطلبها تقاليد وعادات الديانة الاسلامية او الديانة المسيحية و تمت معاملتها بنفس المعاملة التى تلقاها الموتى من قوات التحالف. الشخص المتسلم للبقايا الادمية يدرك جيدا بان قوات التحالف قامت بالعمل اللازم و بكل اساليب الاحترام التامة.
و فى حالة وجود او ادراك آية انتهاك للعادات و التقاليدالمحلية فبكل الاسف انة ليس عمدا و غير مقصود كليا من جانب قوات التحالف.
مع العلم جميع المتاع الشخصية التى وجدت مع البقايا سوف ترجع اليكم بالقائمة المرفقة.

(b) (6), (b) (7c) [redacted]

اسم الشخص للتاكد و اثبات االبقايا الدمية \
Person verifying identity

(b) (6), (b) (7c) [redacted]

اسم الشخص المستلم \
Person receiving remains

العلاقة بالمرحوم \ مرسا اكي / عديلكي
Relationship to deceased

التاريخ \ 26 August 08
Date

ACLU DDII CID ROI 28164

EXHIBIT 10

ACLU DDII CID ROI 28165