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

28 Feb 2009

MEMORANDUM FOR: SEE DISTRIBUTION
SUBJECT: CID REPORT OF INVESTIGATION - FINAL/SSI - 0035-2008-CID789-53215 - 5H9B

DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 07 DEC 2008, 0800 - 07 DEC 2008, 2245; AIR FORCE THEATER HOSPITAL, JOINT BASE BALAD, IRAQ, APO, AE 09391

DATE/TIME REPORTED: 08 DEC 2008, 1112

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

SUBJECT:
1. NONE, ; [UNDETERMINED MANNER OF DEATH] (NFI)

VICTIM:
1. MARUSH, MUHAMMAD FAHDIL KHAMAT (DECEASED); FRCIV; IRAQ; (DOB); (POB); MALE; WHITE; INTERNMENT SERIAL NUMBER (b)(6), (b)(7)(C) [redacted] THEATER INTERNMENT FACILITY, CAMP CROPPER, IRAQ, ARMED FORCES AFRICA, CANADA, EUROPE & MIDDLE EAST 09342; XZ ; [UNDETERMINED MANNER OF DEATH]

INVESTIGATIVE SUMMARY:

THIS IS AN OPERATION IRAQI FREEDOM INVESTIGATION

This office was notified by SSG (b)(6),(b)(7)(C) 11th MP BDE OPS, Camp Cropper, Iraq of a detainee death while under medical care at the Air Force Theater Hospital, Joint Base Balad, Iraq.

Investigation determined Mr. MARUSH sustained a penetrating gunshot wound to the head well before his capture by the Iraqi Army for insurgent activity, and died after his medical condition deteriorated while under the care of Coalition Medical Personnel.

An autopsy conducted by the Office of the Armed forces Medical Examiner, (OAFME) revealed Mr. MARUSH's manner of death to be undetermined and his cause of death to be complications from a penetrating head injury. The circumstances surrounding how Mr. MARUSH received the initial gunshot wound to his head were unknown as the information was not documented when he was in processed at the TIF med center. As such, the death will remain as undetermined.

STATUTES:

N/A

EXHIBITS:

Attached:

1. Agent's Investigation Report (AIR) of SA (b)(6),(b)(7)(C) 20 Dec 08.

2. CD containing Medical Records pertaining to Mr. MARUSH, various dates.

3. Chronological Records of Medical Care pertaining to Mr. MARUSH, 1 Nov 07-2 Dec 08. (USACRC and file copies only)

4. AIR of SA (b)(6),(b)(7)(C) 9 Dec 08.

5. Medical Records pertaining to Mr. MARUSH, 7 Dec 08-8 Dec 08.

6. AIR of SA (b)(6),(b)(7)(C) 13 Jan 09.

7. AIR of SA (b)(6),(b)(7)(C) 29 Dec 08.

8. AIR of SA (b)(6),(b)(7)(C) 5 Dec 08.

9. AIR of SA 4 Feb 09.

10. FBI Fingerprint Analysis of Mr. MARUSH, 10 Dec 08.

11. Autopsy Examination Report, 6 Feb 09.

12. CD containing original images associated with Exhibit 12 (USACRC and file copies only).

13. Certificate of Death (Overseas) pertaining to Mr. MARUSH, 10 Feb 09.

Not Attached:

None.

The originals of Exhibits 1, 4, 6 through 8 and 9 are forwarded with the USACRC copy of this report. The originals of Exhibits 2-3 are retained in the files of 115th Combat Support Hospital, Camp Cropper, Iraq. The original of Exhibit 5 is retained in the files of the Patient Administration Department, Air Force Theater Hospital, Joint Base Balad, Iraq. The original of Exhibits 10-13 are retained in the files of the Armed Forces Institute of Pathology, 1413 Research Blvd., Building 102, Rockville, MD.

STATUS: This is a Final Report. Commander's Report of Disciplinary or Administrative Action is not required.

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

Report Prepared By:

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

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
CDR, 3D MP GRP (CID), FT GILLEM, GA 30297
Commander, 10th MP BN (CID) (FWD), Camp Victory, Baghdad, Iraq, APO AE 09342
DIR, AFIP, OAFME WASH
Dover Facility, Dover Air Force Base, DE
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
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 0035-08-CID789-53215

DETAILS

BASIS FOR INVESTIGATION: About 1112, 8 Dec 08, SSG (b)(6), (b)(7)(C) 11th MP BDE OPS, Camp Cropper, Iraq (IZ), reported Mr. Muhammad Fahdil Khamat MARUSH, (b)(6), (b)(7)(C) Theater Internment Facility (TIF), Camp Cropper, IZ, died while under medical care at the Air Force Theater Hospital, Joint Base Balad, IZ. SSG (b)(6), (b)(7)(C) stated medical authorities suspected Mr. MARUSH died as a result of an abscess on the front of his brain.

About 1212, 8 Dec 08, SA (b)(6), (b)(7)(C) coordinated with CPT (b)(6), (b)(7)(C) Registered Nurse, Intensive Care Unit (ICU), 115th CSH, Camp Cropper, who stated Mr. MARUSH was admitted by Dr. (CPT) (b)(6), (b)(7)(C) Emergency Room (ER), 115th CSH, Camp Cropper, after it was determined Mr. MARUSH had an abscess on his brain.

About 1242, 8 Dec 08, SA (b)(6), (b)(7)(C) interviewed Dr. (b)(6), (b)(7)(C) who stated he was the first physician in the CSH to evaluate Mr. MARUSH. Mr. MARUSH was brought to the CSH from the TIF after he continuously complained of a persistent headache. Dr. (b)(6), (b)(7)(C) ordered a CT scan of Mr. MARUSH's head, which revealed an abscess on the front of Mr. MARUSH's brain. Dr. (b)(6), (b)(7)(C) coordinated with an unknown neurologist at the Air Force Theater Hospital, who initially agreed to accept the transfer of Mr. MARUSH for treatment; but later declined, stating they would only treat him with intravenous antibiotics. Dr. (b)(6), (b)(7)(C) stated Mr. MARUSH was moved to the ICU where he became increasingly combative, his mental stated rapidly deteriorated, and he eventually became unresponsive. Dr. (b)(6), (b)(7)(C) intebated Mr. MARUSH and ordered he be medically evacuated to the Air Force Theater Hospital, which occurred at 0800, 7 Dec 08.

About 1252, 8 Dec 08, SA (b)(6), (b)(7)(C) coordinated with SAC (b)(6), (b)(7)(C) Balad CID Office, Joint Base Balad, IZ, and submitted a telephonic Request For Assistance (RFA) for their office to conduct an examination of Mr. MARUSH's remains, interview the attending physician and key medical staff, and collect medical records and notes pertaining to Mr. MARUSH's medical care while in the Air Force Theater Hospital.

About 1510, 8 Dec 08, SA (b)(6), (b)(7)(C) coordinated with SA (b)(6), (b)(7)(C) Balad CID Office, who provided his office case number: 0146-08-CID919, and stated that Mr. MARUSH's remains were airlifted to Dover Air Force Base, DE, for autopsy, before he was able to examine the remains. SA (b)(6), (b)(7)(C) stated he was scheduled to interview Dr. (LTC) (b)(6), (b)(7)(C) attending physician that pronounced Mr. MARUSH deceased, on 9 Dec 08.

About 1734, 8 Dec 08, SA (b)(6), (b)(7)(C) coordinated with SFC (b)(6), (b)(7)(C) Battle NCO, 744th MP BN, Camp Cropper, IZ, who confirmed Mr. MARUSH's identity was not verified through the use of biometrics following his death. SFC (b)(6), (b)(7)(C) requested CID notify him upon verification of Mr. MARUSH's identity so his status in the Detainee Management System can be changed to "DECEASED".

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
SA (b)(6), (b)(7)(C), (b)(7)(F)	24th/348th MP DET (CID) CAMP CROPPER, IRAQ APO AE 09342
SIGNATURE (b)(6), (b)(7)(C)	DATE 20 Dec 08 / EXHIBIT

DETAILS

About 1739, 8 Dec 08, SA (b)(6), (b)(7)(C) submitted an RFA to SA (b)(6), (b)(7)(C) Aberdeen CID Office, and requested they attend the autopsy of Mr. MARUSH and obtain fingerprints suitable for identification and photographs.

About 1910, 8 Dec 08, SA (b)(6), (b)(7)(C) received RFA receipt confirmation from SA (b)(6), (b)(7)(C) Aberdeen CID Office, who provided his office's case number: 0250-08-CID112.

About 2055, 8 Dec 08, SA (b)(6), (b)(7)(C) coordinated with SGT (b)(6), (b)(7)(C) PAD, 115th CSH, Camp Cropper, and obtained all medical records on file pertaining to Mr. MARUSH. A review of the records revealed that Mr. MARUSH was brought into the CSH after he complained of a severe headache, that progressively became worse over the three days prior, and dizziness. During the interview of Mr. MARUSH, it was discovered he sustained a gunshot wound to the front right lobe of his brain. A subsequent CT scan of Mr. MARUSH's head revealed an abscess on the right frontal lobe, as well as multiple metallic shrapnel fragments in the anterior and midportion of the frontal lobe of Mr. MARUSH's brain.

About 0941, 9 Dec 08, SA (b)(6), (b)(7)(C) coordinated with SFC (b)(6), (b)(7)(C) and obtained the BATS record fingerprint card of Mr. MARUSH, and forwarded it to SA (b)(6), (b)(7)(C) CID Liaison, Armed Forces Institute of Pathology (AFIP), Dover Air Force Base, DE, for comparison and identity verification of Mr. MARUSH.

About 0716, 10 Dec 08, SA (b)(6), (b)(7)(C) coordinated with SGT (b)(6), (b)(7)(C) who researched all detainee medical records and verified there were no medical records on file with the 115th CSH for Mr. MARUSH that dated back to his capture in Oct 2007.

About 1045, 10 Dec 08, SA (b)(6), (b)(7)(C) coordinated with SPC (b)(6), (b)(7)(C) Detainee Medical Center (DMC), TIC, Camp Cropper, and obtained the rescreen medical records pertaining to Mr. MARUSH. SPC (b)(6), (b)(7)(C) stated a medical rescreen of Mr. MARUSh was conducted on 24 Nov 08, after he was transferred from Camp Bucca without medical records. SPC (b)(6), (b)(7)(C) coordinated with SGT (b)(6), (b)(7)(C) PAD, Camp Bucca, IZ, and verified that Mr. MARUSH's medical records were not on file there. SPC (b)(6), (b)(7)(C) stated it was likely that Mr. MARUSH's medical records were lost during the transfer.

About 1945, 10 Dec 08, SA (b)(6), (b)(7)(C) received email confirmation from SA (b)(6), (b)(7)(C) that Mr. MARUSH's identity was verified against his record print card by FBI technicians during autopsy.

About 1245, 11 Dec 08, SA (b)(6), (b)(7)(C) coordinated with SFC (b)(6), (b)(7)(C) and reviewed all available documentation pertaining to Mr. MARUSH since his date of capture. Mr. MARUSH was captured at a checkpoint by Iraqi Army patrols after Mr. MARUSH was reportedly involved with terroristic activities to include kidnappings, setting up false checkpoints, Murder, and IED emplacement. IA patrols released Mr.

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0035-08-CID789-53215

DETAILS

MARUSH to 1/7 CAV, and was subsequently in-processed into the Taji Detainee Holding Area (DHA), Camp Taji, IZ. Photographs of Mr. MARUSH taken during the in-process revealed that he was in-processed with a healed scar/deformity on his forehead. A medical screening of Mr. MARUSH was conducted 23 Oct 07, during which none of Mr. MARUSH's prior injuries were documented. A Scars and Marks report pertaining to Mr. MARUSH was completed 31 Oct 07, and documented a scar on Mr. MARUSH's forehead, chest, and left arm, but did not explain the origin of the scars.

About 1500, 12 Dec 08, SA (b)(6), (b)(7)(C) coordinated with SA (b)(6), (b)(7)(C) Camp Bucca CID Office, and submitted an RFA for him to canvass detainees within the compound Mr. MARUSH was assigned while at Camp Bucca, in attempts to identify detainees that may have knowledge of Mr. MARUSH's head injury.

About 1600, 20 Dec 08, SA (b)(6), (b)(7)(C) received the Final Information Report from the Balad CID Office, Joint Base Balad, IZ.

///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
SA (b)(6), (b)(7)(C), (b)(7)(F)	24th/348th MP DET (CID) CAMP CROPPER, IRAQ APO AE 09342
SIGNATURE (b)(6), (b)(7)(C)	DATE 20 Dec 08 / EXHIBIT

0035-08-CID789- 53215

(b)(6)

 EXHIBIT 2 8

MEDICAL RECORD - NURSING HISTORY AND ASSESSMENT

18. Additional Assessment Data. SpO2 - 100% R.A. Temp. - 98.3°F

Admission: 5 DEC 2008 @ 1635 TPR 73 BP 106/88 WT 137.8 lbs HT ≈ 5ft 6in

1. Pt lethargic ED Reported Fentanyl 50mcg given PO. Opens eyes to verbal stimuli. Pupils = 4mm. will c TM. Denies ability to move ext's on command but does move against gravity. Per interpreter pt states he has Diplopia all other neuro check WNL
2. Resting HR 40-50's when awake HR 70s. abnormal heart sounds @ Pulmonic valve. IV fluid D5 ½ NS @ 100ml/° Denies pain low-normotensive. Rocephin 2gm IV.
3. LCTA 100% RA. on R/O TB. Mask on pt c neg pressure Pt claims had night sweats no cough and nonproductive c cough.
4. Pt has 1-2/10 AB pain c palpation. BS+ x4 will c TM. Round soft nonDistended.
5. Pt urinated in urinal denies pain grimacing noted w/ urination urine clear yellow ø odor. ø discharge noted.
6. Does have purposeful mov't of all ext. generalized weakness. [illegible] Flat affect low motivation lethargic [illegible] denies [illegible] comments.

19. Typed or Printed Name of RN. (b)(6)

20. Signature of RN and Date/Time (b)(6) @ 12/05/2008

ASSESSMENT CATEGORIES:

1. Growth and Development
2. Neurological
   a) Orientation
   b) Level of Consciousness: alert, drowsy, lethargic, comatose; responses: to verbal and painful stimuli; ability to follow commands; reflexes.
   c) Describe abnormalities
3. Eyes, Ears, Nose, and Throat
   a) Eyes: Pupils, vision
   b) Ears: Hearing, drainage
   c) Rhinorrhea, nasal surgery/trauma
   d) Throat: Sore, difficulty swallowing, appearance on inspection, lymph nodes
   e) Describe abnormalities
4. Cardiovascular
   a) Skin: Color, temp, turgor, moisture
   b) Peripheral Circulation: Pulses, edema, extremities
   c) IV's: Contents of bottle hanging, bottle number, condition of site
   d) Pain: Location, radiation, duration,
   e) Intrathoracic tubes and/or dressing
5. Pulmonary
   a) Respirations: Rate, regularity, effectiveness, depth, use of accessory muscles, nocturnal/external dyspnea. Chest movement associated with respirations
   b) Breath sounds: Clear to auscultation, Rales, Rhonchi, Wheezes, etc.
   c) Oxygen: Percent given, liters/min, method of administration continuous or PRN
   d) Cough, sputum, suctioning
6. Gastrointestinal
   a) Abdominal: Auscultation (bowel sounds present), palpitation, abdominal girth measurement (if applicable)
   b) Dressings and/or drains
7. Genitourinary
   a) Urination: Continence, pattern change
   b) Female: Vaginal Discharge, LMP, last PAP smear (if applicable) etc.
   c) Male: Abnormal discharge, swelling, pain
8. Integumentary
   a) Lesions, pressure points, contractures
   b) Color, moisture, edema, turgor, change in pigmentation
9. Musculoskeletal
   a) Movement Purposeful/Non-purposeful, ROM, muscle strength, level of usual activity
   b) Foot care (as applicable), TED hose
10. Psycho-Social
   a) Adjustment to hospitalization and illness, manner, mood, behavior, relation to persons around them

REFERENCE: DA Pam 40-5
AMEDD Stds of Nursing Practice

MEDICAL RECORD - NURSING HISTORY AND ASSESSMENT

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

1. Date *(YYYYMMDD)* and Time of Admission.	2. Admission Diagnosis.
[illegible] @ 10:55	Brain Abscess

	YES	NO	Patient's own words when possible.
3. Tell me what you know about your illness/injury/hospitalization.			Headache
4. Do you have any other health problems?	☐	☑	
5. Have you been hospitalized before? If so, when and for what?	☑	☐	GSW
6. What medications have you been taking? (to include prescription and over-the-counter drugs) For how long?	☐	☑	
7. Are you allergic to anything? If so, what? What reaction?	☐	☑	
8. Do you have any special needs that require assistance with daily activities? (e.g. diet, eating, bathing, elimination, ambulating, sleeping.) Prosthetics: dentures, reading glasses, contacts.	☐	☑	
9. What other concerns do you have?			"10 out of 10 pain in head, chest pain
10. How can we be most helpful?			

11. Name of Local Contact/NOK.	12. Relationship.	13. Telephone Number.
MP's		

14. Interviewer's Signature, Rank & Title.	15. Informant/Relationship.
(b)(6)	Pt self c̄ translator

16. Patient Identification.

(b)(6)

17. Personal Articles and Valuables. *(Indicate disposition of each item by initials.)* c̄ MP's

Item:	Bedside	Home	Treasurer	Other *(specify)*

10-L-0126 ACLU DDII CID ROI 19795

A

MEDICAL RECORD | EMERGENCY CARE AND TREATMENT | LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

CHIEF COMPLAINT: HEADACHE X3 days (+) Dizziness

DATE: 5DEC 08 (b)(6)

AGE: 40 MALE

AIRWAY: PATENT / OBSTRUCTED
BREATHING: UNLABORED / LABORED / ABSENT
MENTAL STATUS: ALERT / VERBAL / PAINFUL / UNRESPONSIVE
TRANSPORTATION TO FACILITY / CARE ENROUTE: VG.

TOURNIQUET | NONE | C-SPINE IMMOB

CURRENT MEDICATIONS: None

IMMEDIATE INTERVENTIONS: O2 / CARDIAC MONITOR / EKG / FSBG / IV / C-SPINE PRECAUTION / BACK BOARD REMOVED @ / PRESSURE DRESSING / TOURNIQUET

EMERGENCY ROOM VISIT
DATE LAST VISIT | 24 HOUR RETURN: YES / NO

ALLERGIES: NKDA

TAGS

MEDICATION	DOSE	ROUTE	TIME	INT	RESPONSE
REGLAN	10MG	IVP	1339	(b)(6)	
Benadryl	25MG	IVP	1339		
TORADOL	30MG	IVP	1416		
Rocephin	2GM	IVP	1558		
Fentanyl	50MCG	IVP	1558		

CATEGORY OF TREATMENT: EMERGENT / URGENT / NON-URGENT
TIME
RN (b)(6)

IV SITE	SIZE	TIME	INT	D/C'D	INT
(L) LAT AC	18G	1325	(b)(6)		

VITAL SIGNS | HT | WT

TIME	1316	1349
BP	110/57	114/73
PULSE	53	64
RESP	18	16
TEMP	97.4	97.6
SpO2	100	98
PAIN	8/10	10/10

ORDERS
- TORADOL 30 mg IV x1
- COMPAZINE 10mg IV x1
- BENADRYL 25mg IV x1
- IV 1L NS BOLUS
- REGLAN 10 MG IVP
- ~~CT HEAD~~ c̄ IV CONTRAST
- CBC CMP
- Blood cultures
- CEFTRIAXONE 2 grams IV
- METRONIDAZOLE 7.5 mg/kg IV
- FENTANYL 50mcg IV x1

MEDIC NOTE: Pt. is a 40 y/o MALE detainee Presented c̄ c/o H/A. Pt. dizziness x 3 day. Pt. states p̄ HEAD INJURY HEADACHE HE GETS MANY

MED HX: D
SURG HX: (+) Headinjur
SOCIAL HX: YES Few per d

CONTACT METHOD/INFORMATION

IV FLUID INTAKE: IVF NSS 1/1000 | OUTPUT

PATIENT'S IDENTIFICATION (Civilian: Last name, First Name, MI, ID no., DOB and Unit) (Detainee: ISN #)

(b)(6)

Dr. MARCOUX

Patient: DETAINEE, ISN: (b)(6)
Facility: TF 115th CSH (NORTH)
(b)(6)

Date: 05 Dec 2008 1310 AST
Clinic: CROPPER HOSPITAL

Appt Type: ROUTN
Provider: (b)(6)

AutoCites Refreshed by (b)(6) @ 05 Dec 2008 1618 AST
Problems
headache
dizziness

Active Medications
No Active Medications Found.
Allergies
No Allergies Found.

Screening Written by (b)(6) @ 05 Dec 2008 1310 AST

Appointment Reason For Visit: headache severity [see also, modifiers]:

Selected Reason(s) For Visit:
headache severity [see also, modifiers] (New) Comments:

Vitals Written by (b)(6) @ 05 Dec 2008 1349 AST
BP: 110/57, HR: 53, RR: 18, T: 97.4 °F, O2: 100, Tobacco Use: Yes, Alcohol Use: No, Pain Scale: 8/10 Severe, Pain Scale Comments: Headache
Comments: Pt is a 40 y/o male presented with c/o headache and dizziness x 3 days. Pt states he has been getting bad headaches since he had his head injury 1 year ago. Translator at bedside pt. AAOX3, follows commands approp. Lungs CTA, Abdomen wnl, MAE equal and b/l. Pt. urgent./olr

Vitals Written by (b)(6) @ 05 Dec 2008 1525 AST
BP: 114/73, HR: 66, RR: 16, T: 98 °F, Tobacco Use: Yes, Alcohol Use: No, Pain Scale: 10/10 Totally Disabling, Pain Scale Comments: Headache
Comments: Pt received Reglan 10mg IVP, Benadryl 25mg IVP,

Vitals Written by (b)(6) @ 05 Dec 2008 1529 AST

Comments: Toradol 30mg IVP given. Pt had CT of head with contrast, reviewed by (b)(6). Pt stable.

Vitals Written by (b)(6) @ 05 Dec 2008 1608 AST

Comments: Pt. received Fentanyl 50mcg IVP for pain, Blood culture x2 done, and Rocephin 2GM started. Pt stable./olr

Vitals Written by (b)(6) @ 05 Dec 2008 1615 AST

Comments: Report given to (b)(6) in ICU, Pt will be transported to ICU with RN, medic, stable./olr

S/O Note Written by (b)(6) @ 05 Dec 2008 1614 AST

History of present illness
The Patient is a 40 year old male.
* Encounter Background Information: History obtained from interpretor. Patient states that he has had a headache for about a year after a gunshot injury to the head. Headache is worse throughout the day. Pain was increased today.

Physical findings
General appearance:
* Normal.
Head:
* Normal.
Eyes:

General/bilateral:
* Eyes: normal.

Ears, Nose, Throat:
* ENT: normal.

Neck:
* Normal.

Chest:
* Normal.

Lungs:
* Normal.

Cardiovascular system:
* Normal.

Abdomen:
* Normal.

Neurological:
* System: CN II-XII grossly intact, ataxic gait with ambulation, 5/5 muscle strength, sensation intact.

Tests

Urinalysis:
Urinalysis was performed CT with probable brain abscess.

A/P Written by (b)(6) @ 05 Dec 2008 1620 AST

1. BRAIN ABSCESS

Comments: Pt initially accepted by (b)(6), Neurosurgery, at Balad. Pt was later discussed with both (b)(6) and (b)(6) and recommended admission here for at least a week of Ceftriaxone 2 grams q12h and Metronidazole 15mg/kg q12h. Then re-imaging of the head with and without contrast. They can be called at Balad if there are any changes or other concerns. They recommended using (b)(6)

Note Written by (b)(6) @ 05 Dec 2008 1409 AST

reval
Pt reval after CT results discussed with MD and Radiologist he is to have labs and a CT with contrast
pt is asleep at present

BRADEN SCALE FOR PREDICTING PRESSURE ULCER RISK

					Date of Assessment: 5/1[illegible]			
...sory ...ception ...lity to respond ...ningfully to ...ssure-related ...comfort	**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	3		
...isture ...gree to which ...is exposed to ...isture	**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	4		
...ivity ...gree of ...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	2		
...bility ...lity to change ...control body ...ition	**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.	4	4		
...rition ...al food intake ...ern	**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	UTA [illegible] (3)	1 ([illegible])		
...ed ...r	**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	3		
				Total Score	~~16~~ 19	16		

...ent Name: ______________________

...pital Number: ______________________

...ture 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 X
Nutrition Consult Ordered: Date: N/A ____________ Initial: (b)(6)

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

4 April 2008

10-L-0126 ACLU DDII CID ROI 19799

000014

7 December 05

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
2345	pt intubated — 100mg Sux X 50mg prop
	P53 BP 115/61 O2 70%
0341	O2 100%
0401	5-versed
	P46 BP 114/62 O2 98% — F:O2 100, Peep-5, Rate-14

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

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

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

PROGRESS NOTES
Medical Record

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

CAMP CROPPER

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

Report requested by (b)(6)

17 Dec 2004 0638 INPT Register # (b)(ENT NURSE

NURS NOTES

-Assessed pt at 0300 and found pt non-responsive. VS were stable, but pt was non responsive to sternal rub and other obnoxious stimuli. Pt also had a dramatic papillary change of 5mm from an earlier finding of 3mm and pt had urinated on himself. (b)(6) was alerted in ER and came immediately to bedside. It was given 0.4mg narcan to reverse morphine given at 2200, but pt did not respond much. Blood glucose was 141. Dr Schwab ordered a CT scan of the head. Took pt to CT with two ICU nurses and guard, but pt was not cooperating in CT. Was acting very inappropriate. (b)(6) decided to intubate pt and paralyze him. Pt returned to ICU from CT, RT came to bedside, and pt was intubated. PT was given 50mg propofol and 100mg succylcoline. Dr Schwab intubated with a 7.5 ETT, 21cm @teeth, and placed on 100% oxygen, mode of CMV, rate 14, Peep 5, and TV 500. Equal and bilateral breath sounds ausculated throughout lung fields. Pt was then started on a vercuronium gtt running at 5mg/hr and versed 5mg/hr with an initial 5mg IVP versed. TOF was tested on left upper limb and temporal region, and pt was 0. Pt is completely paralyzed. An 18F foley was placed as well. After pt settled and cleaned from earlier urination, pt taken to CT for scan and chest x-ray. Continue to await results. Plan is to air evac patient to bilaud for further neurological assessment and testing. Awaiting air evac helipcopter. NO further changes to report at this time. Will continue to monitor.

Signed: (b)(6)

(b)(6) DETAINEE, (b)(6)
(b)(6)
Reg # (b)(6 Loc: (b)(6
Spon: DETAINEE (b)(6)
Unit:

Automated version of SF509

CAMP CROPPER

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

Report requested by: (b)(6)

06 Dec 2[illegible]249 INPT Register # 5558 EMT NURSE

PROG NOTES

V/S: Afebrile. Pt uncomfortable and moving around in bed a lot. Was given 4mg morphine for his headache. pain remains constant. no episodes of emesis thus far. will continue to monitor patient status...

Signed: (b)(6)

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

(b)(6)

Reg #: (b)(

Loc: (b)(6)

Spon: DETAINEE (b)(6)

Unit:

Automated version of SF509

Report requested by: (b)(6)

06 Dec 2003@1947 INPT Register # 5558 EMT NURSE

PROG NOTES

Neurological:
Left Pupil: WNL Size: 3 mm
Right Pupil: WNL Size: 3 mm
LOC: A/OX3
Motor: MAE well
Speech: Clear
Memory: See Note
Gag reflex: WNL
GCS:
Eye Opening: 4- Spontaneous
Verbal: 5- Oriented
Motor: 6- Obeys commands
Total GCS: 15
RASS Score: N/A
Note:
pt unaware of where he is here. pt notes he is dizzy and nauseous. has already had two epsidoes of emesis. unable to keep food down. continues to report diplopia. pt more anxious and uneasy this evening.

Respiratory:
Sounds: RUL: WNL no adv sounds RLL: WNL no adv sounds
Sounds: LUL: WNL no adv sounds LLL: WNL no adv sounds
Secretions: N/A Color: N/A
ETT: N/A Position: N/A
Trach: N/A Type: N/A
Oxygen: Room Air Rate: WNL
CT: N/A Pleura VAC: N/A
CT: N/A Pleura VAC: N/A
Note:

Cardiac:
Rhythm: Sinus Rhythm
Sounds: Audible S1/S2
Neck Veins flat at 45 degrees Yes
Capillary Refill <2 sec
LLE peripheral pulses +1 WNL Edema: None
RLE peripheral pulses +1 WNL Edema: None
Note:

Gastrointestinal:
Abdomen: Soft Non-Tender
Bowel Sounds: Positive
Diet: Regular
BM: N/A Color:None
Colostomy: N/A
NG: N/A To: N/A
OG: N/A To: N/A
DHT: N/A

(b)(6) DETAINEE (b)(6)
(b)(6)
Reg #: (b)(Loc: (b)(6)
Spon: DETAINEE (b)(6)
Unit:

Automated version of SF509

Report requested by: (b)(6)

PAIN: N/A
Note:
pt. has had two episodes of emesis.unable to keep foods down.
Genitourinary:
Void: Yes Catheter Size: N/A
Color: Yellow
Character: Clear
Note:

Skin:
General Appearance: WNL
Color and Pigmentation: NFR
Temperature: Warm
Turgor: WNL
Moisture: WNL
Integrity: Intact
Note:

Drain 1: N/A Drain 2: N/A
Drain 3: N/A Drain 4: N/A
Balad Pack: N/A
Note:

Wound 1:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 2:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 3:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 4:
Location: N/A
Dressing: N/A

(b)(6) DETAINEE (b)(6)
(b)(6)
Reg #: (b)(6) Loc: (b)(6)
Spon: DETAINEE (b)(6)
Unit:

Automated version of 8F509

Report requested by: (b)(6)

Drainage: None
Note:

Central Lines:
Location: N/A Type: N/A
Location: N/A Type: N/A
Flushed correctly daily with MD: N/A
Note:
OT:
Note:
headache worsening. receiving morphine hourly for pain. last received 4mg morphine at 1930.
VAP precautions:
HOB >30 degrees at all times: N/A
Sedation interruption: N/A
GI prophylaxis ordered: N/A
DVT prophylaxis: N/A
Oral care: N/A
Subglottic suctioning: N/A
Restraints: N/A
CMO: N/A
Note:
restraints remain applied and pt is monitored by guard because of his detainee status.
Psych/MH:
Plan of Care: Pt/family aware
Teaching done: N/A
Note:
VSS. afebrile. pt is more uncomfortable and uneasy this evening. off going nurse reported patient has been nauseated and has had two episodes of emesis. unable to keep food down. pt been given zofran for relief, but pt still remains agitated and nauseated. continues to report dizziness and diplopia, but dizziness has worsened from last shift. headache has not decreased in intensity. continues to receive morphine QIH pin. last given morphine at 1940. remainder of assessment is WNL. will continue to monitor patient's status.
Signed: (b)(6)

(b)(6) DETAINEE, (b)(6)
(b)(6)
Req #: (b)(6) Loc: (b)(6)
Spon: DETAINEE, (b)(6)
Unit:
Automated version of 87509

CAXI CROPPER

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

Report requested by: (b)(6)

08 Dec (b)(6) INPT Register # (b)(6) NURSE PRACTITIONER
Subj: NOTES
pt restless, interpreter called. interpreter called and pt
stated he felt like he had
to vomit. r began to vomit, solid particles from dinner.
vss further assess
with pt input due to interpreter needing top leave
[illegible] pt continued to reach and grab at iv he is having periods
of confusion or hallucinations. interpreter to return for oncoming nurse.
morphine given for ha 10/10 to frontal lobe, is effective at this time. pt
pulled out iv while restless in bed, new 18g started to right hand/wrist
area. no other changes noted. report given to oncoming nurse
Signed: (b)(6)

(b)(6)

DETAINEE (b)(6)
(b)(6)
Reg #: (b)(
Loc: (b)(6)
Upon: DETAINEE (b)(6)
Unit:

Automated version of SF509

CAMP CROPPER

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

Report requested by: (b)(6)

04 DOC 200841905 INPT Register # (b)(NURSE PRACTITIONER
PROG NOTES
1730 pt medicated for frontalHA 10/10 when awake. 5mg morphne given.
effective pt resting at this time. no change from previous assessment.
Signed: (b)(6)

(b)(6) DETAINEE, (b)(6)
(b)(6)
Reg #: (b)(6 Loc: ICU 1
Spon: DETAINEE, (b)(6)
Unit:
Automated version of SF509

Report requested by: (b)(6)

06 Dec 2008@1440 INPT Register # (b) PHYSICIAN
ADMISSION NOTE
Attending Physician: (b)(6)
Patient: Detainee ISN (b)(6)

Admission Date: 5 December 2008

Allergies: NKDA

HPI:
40 year old Detainee with chronic headaches following GSW to frontal lobe presented to sick call medic with HA increasing over 3 day period. Evaluated in DMC and sent to ED for further evaluation due to increased pain and nausea not relieved with patients usual piroxicam. In ED, patient noted to have normal neurologic exam. CT of head notable for possible mass vs abscess of right frontal lobe. ED physician contacted Balad neurosurgeons who recommended IV antibiotics as outlined below

PMH: chronic headaches following GSW to frontal lobe one year ago
PSH: none reported
SH: nonsmoker

FH: noncontributory

Meds: piroxicam 20mg PO QD

PE: Temp 97.4 BP 110/57 HR 53 RR 18 O2 sat100% RA
GEN: Alert and Oriented X3
HEENT- Pupils 4mm bilaterally, reactive to light and accommodation. GSW entry right frontal area
Pulm - CTA bilaterally, without wheezing or rhonchi
CV - RRR, no carotid bruits
Abd - BS+, soft, mild TTP upper abd no rebound or guarding
Ext - no edema, good peripheral pulses
Neuro - CN II-XII grossly intact. Normal strength and reflexes.

LABS:
WBC 8.9
H/H 13/39
PLT 256
Chemistry normal except albumin 3.1
RPR NR
Blood cultures pending
HIV pending
Hepatitis panel pending
UA Normal

CT head: Left frontal lobe and corpus callosum vasogenic edema with mild intracranial mass effect. Effacement of anterior horn of left lateral

Report requested by: (b)(6)

cerebral ventricle. Possible abscess of right frontal lob 8X20mm. Shrapnel from prior GSW.

Assessment/Discussion:

1. Likely abscess of frontal lobe in area of previous GSW. Patients presentation and films discussed between ED physician and neurosurgeons (b)(6) (b)(6) at Balad. Consensus neurosurgery opinion is that this is [illegible] and pt should have [illegible] of antibiotics followed by re-imaging of the lesion
2. Acute on chronic headaches with no clinical features of herniation

Plan:

1. Admit to ICU with vital signs and neurochecks per protocol including papillary exam
2. Ceftriaxone 2000mg IV q 12hrs
3. Metronidazole 100mg IV q 12hrs
4. IV morphine, Tylenol and Naprosyn in combination for HA
5. Plan to re-image head with contrast CT in one week following IV antibiotics
6. Neurosurgery contacts at Balad: (b)(6)

(b)(6)

(b)(6) DETAINEE (b)(6)
(b)(6)
Reg #: (b)(6) Loc: (b)(6)
Spon: DETAINEE (b)(6)
Unit:

Automated version of SF509

Report requested by: (b)(6)

Pt Type 2000s1420 INPT Register # 5558 NURSE PRACTITIONER

PROV NOTES
N: Neurological:
Left Pupil: WNL Size: 3 mm
Right Pupil: WNL Size: 3 mm
LOC: A-OX3
Motor: NAL well
[illegible]
Memory: Memory intact
Gag reflex: WNL
GCS:
Eye Opening 4- Spontaneous
Verbal 5- Oriented
Motor 6- Obeys commands
Total GCS 15
RASS Score: N/A
Respiratory:
Sounds: RUL: WNL no adv. sounds RLL: WNL no adv. sounds
Sounds: LUL: WNL no adv sounds LLL: WNL no adv. sounds
Secretions: N/A Color: N/A
ETT: N/A Position: N/A
Trach: N/A Type: N/A
Oxygen: Room Air Rate: WNL
CT: N/A Pleura VAC: N/A
CT: N/A Pleura VAC: N/A
Cardiac:
Rhythm: Sinus Bradycardia
Sounds: Audible S1/S2
Neck Veins flat at 45 degrees Yes
Capillary Refill < 3 sec
LLE peripheral pulses +2 WNL Edema: None
RLE peripheral pulses +2 WNL Edema: None
Gastrointestinal:
Abdomen: Soft Non-Tender
Bowel Sounds: Positive
Diet: Regular
BM: N/A Color:None
Colostomy: N/A
NG: N/A To: N/A
OG: N/A To: N/A
DHT: N/A
PEG: N/A
Genitourinary:
Void: Yes Catheter Size:N/A
Color: Yellow
Character: Clear
Skin:
General Appearance: WNL
Color And Pigmentation: NFR

(b)(6) DETAINEE (b)(6)
(b)(6)
Reg #: (b)(Loc: (b)(6
Spon: DETAINEE (b)(6)
Unit:

Automated version of SF509

Report requested by: (b)(6)

Temperature: See Note
Pulse: WNL
Moisture: WNL
Integrity: Intact

Drain 1: N/A Drain 2: N/A
Drain 3: N/A Drain 4: N/A
Chest Tube: N/A

Wound 1:
Location: N/A
Dressing: N/A
Drainage: None
Wound 2:
Location: N/A
Dressing: N/A
Drainage: None
Wound 3:
Location: N/A
Dressing: N/A
Drainage: None
Wound 4:
Location: N/A
Dressing: N/A
Drainage: None
Central lines:
Location: N/A Type: N/A
Location: N/A Type: N/A
Assess necessity daily with MD: N/A
Arterial Line: N/A Assess: N/A
IV Lines:
Site Left: Forearm Peripheral IV Line In Place Site Right: Forearm
Peripheral IV Line In Place Status: Patent No S/S of Infection
IV Lines:
Site Left: N/A Site Right: N/A Status: N/A

VAP Precautions:
HOB > 40 degrees at all times: N/A
Sedation Interruption: N/A
GI Prophylaxis ordered: N/A
DVT Prophylaxis: N/A
Oral Care: N/A
Subglottic suctioning: N/A

Restraints: N/A CMS: N/A

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

(b)(6) DETAINEE, (b)(6)
(b)(6)
Reg # (b)(Loc: ICU 1
Spon: DETAINEE (b)(6)
Unit:
Automated version of (b)(6)

CAMP CROPPER

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

Report requested by: (b)(6)

[illegible]:
Care and assessment assumed at 1300. Pt sleeping with resting HR 35-40. Pedal pulses strong with cap refill wnl. Neuro check completed, pt has no notable change in neuro status, uta to fully assess due to language barrier. PERRLA. Off going nurse reported that pt vomited and was given zofran for nausea. Naproxen ordered, awaiting pharmacy. bs:x4 lsq slightly tender to palpation no change from previous assessment. L'DA, 18ot on RA in good order. IVF infusing per order. will ctm.
-pt denies pain at this time. off going nurse stated pt was medicated with 4mg morphine prn x4. Remains effective at this time.

Signed: (b)(6)

(b)(6) DETAINEE (b)(6)
(b)(6)
Reg #: (b)(
Loc: ICU 1
Spon: DETAINEE (b)(6)
Unit:

Automated version of BF509

Form requested by: (b)(6)

Date 20040758 INPT Register # (b) EMT NURSE

17:01 NOTE:
Neurological:
Left Pupil: WNL Size: 3 mm
Right Pupil: WNL Size: 3 mm
LOC: A/OX4
Motor: NAD well
Speech: Clear
Memory: Memory Intact
Gag reflex: WNL
GCS:
Eye Opening 4 Spontaneous
Verbal 5 Oriented
Motor 6 Obeys commands
Total GCS 15
RASS Score: N/A
Respiratory:
Sounds: RUL: WNL no adv. sounds RLL: Decreased Breath Sounds
Sounds: LUL: WNL no adv sounds LLL: Decreased Breath Sounds
Secretions: N/A Color: N/A
ETT: N/A Position: N/A
Trach: N/A Type: N/A
Oxygen: Room Air Rate: WNL
CT: N/A Pleura VAC: N/A
CT: N/A Pleura VAC: N/A
Cardiac:
Rhythm: Sinus Rhythm
Sounds: Audible S1/S2
Neck Veins flat at 45 degrees Yes
Capillary Refill < 2 sec
LUE peripheral pulses +2 WNL Edema: None
RUE peripheral pulses +2 WNL Edema: None
LLE peripheral pulses +2 WNL Edema: None
RLE peripheral pulses +2 WNL Edema: None

Gastrointestinal:
Abdomen: Soft Non-Tender
Bowel Sounds: Positive
Diet: Regular
BM: N/A Color:None
Colostomy: N/A
NG: N/A To: N/A
G: N/A To: N/A
IVIT: N/A
PEG: N/A
Genitourinary:
Void: Yes Catheter Size:N/A
Color: Yellow
Character: Clear

(b)(6) DETAINEE (b)(6)
(b)(6)
Reg #: (b) Loc: ICU 1
Upon: DETAINEE (b)(6)
Unit:

Automated version of SF509

Report requested by: (b)(6)

Skin:
General Appearance: WNL
Color and Pigmentation: NFY
Temperature: Warm
Turgor: WNL
Moisture: WNL
Integrity: See Note

Wound 1:
Location: Head
Dressing: N/A
Drainage: None
IV Lines:
Site Left: Forearm Peripheral IV Line In Place Site Right: N/A
Status: Patent No S/S of Infection
IV Lines:
Site Left: N/A Site Right: Forearm Peripheral IV Line In Place
Status: Patent No S/S of Infection

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

Notes:
Assume care of pt @ 0700. Lying in bed resting. C/O pain @ head & neck. Tylenol given. C/O blurr vision & double vision. Able to follow command, moves all extremities. Scab over Lt eye d/t old GSW. Afebrile. VSS. Will continue to monitor.
Signed: (b)(6)

20/300-32 (b)(DETAINEE, ISN (b)(6)
(b)(6)
Req #: (b)(Loc: ICU 1
Upon: DETAINEE, ISN (b)(6)
Unit:
Automated version of (b)(6

CAMP CROPPER

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

Report requested by: (b)(6)

Visit 2008@0436 INPT Register # (b)(6) CLINICAL NURSE

PROG NOTES

Pt slept most of night w/o c/o, VSS, no change in neuro status. IV Abx given as ordered. POC continue neuro monitor and provide comfort measures as needed for pt c/o pain/HA. Also, provide pt el and psycho soc supp as needed.

Signed (b)(6)

(b)(6)

DETAINEE, ISN (b)(6)
(b)(6)

Reg #: (b)(6)

Unit: ICU 1

Room: DETAINEE (b)(6)

Bed:

Automated version of AF509

CAMP CROPPER

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

Report requested by: (b)(6)

04 [illegible] 20080823 INPT Register # (b)(6) EMT NURSE

PROG NOTES

[illegible] results returned from JOC and U/A. no significant findings found. will

[illegible] Dr. Dean. will continue to monitor.

Signed: (b)(6)

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

Doc #: (b)(6 Loc: ICU 1
Spec: DETAINEE (b)(6)
Unit:

Automated version of SF509

Report originated by: (b)(6)

-- Dec 2009:0017 INPT Register #(b)(EMT NURSE

ADDC NOTES

ADDS: VSS. afebrile. Pt continues to complain of pain in his right frontal [illegible] with a rating of 7/10. given 4mg morphine to increase comfort and help patient to sleep throughout night. neural assessment remains unchanged. pupils 3mm,PERRLA. still has diplopia and blurred vision. pt has been urinating frequently this evening. Total output was [illegible]ml since [illegible], observed his intake. [illegible] spoke to Dr Tran about this due to concern about pt developing DI. last CMP revealed a sodium level of 150. uncharacteristic of PI. Thus Dr Tran verbally ordered a CMP, urine osmolality and serum osmolality for 0100. will continue to monitor patient's progress...

Signed: (b)(6)

(b)(6) DETAINEE,(b)(6)

(b)(6)

Reg #: (b)(Loc: ICU 1

Spcn: DETAINEE(b)(6)

Unit:

Automated version of SF509

Report requested by: (b)(6)

DT Date 2008-2015 INPT Register # (b)(EMT NURSE

FROM NOTES

Neurological:
Left Pupil: WNL Size: 3 mm
Right Pupil: WNL Size: 3 mm
LOC: A/OX3
Motor: MAE well
Speech: Clear
Memory: Memory intact
Gag reflex: WNL
GCS:
Eye Opening: 4- Spontaneous
Verbal: 5- Oriented
Motor: 6- Obeys commands
Total GCS: 15
RASS Score: N/A
Note:
pt reports diplopia and blurred vision and is unable to see objects close up. was not able to follow my finger to assess for nystagmus, etc. able to follow commands, is oriented.
Respiratory:
Sounds: RUL: WNL no adv sounds RLL: WNL no adv sounds
Sounds: LUL: WNL no adv sounds LLL: WNL no adv sounds
Secretions: N/A Color: N/A
RTT: N/A Position: N/A
Trach: N/A Type: N/A
Oxygen: Room Air Rate: WNL
CT: N/A Pleura VAC: N/A
CT: N/A Pleura VAC: N/A
Note:
pt admitted partially for rule out TB. chest x-ray is pending in CHCS.
Cardiac:
Rhythm: Sinus Rhythm
Sounds: Audible S1/S2,
Neck Veins flat at 45 degrees Yes
Capillary Refill <2 sec
LLE peripheral pulses +1 WNL Edema: None
RLE peripheral pulses +1 WNL Edema: None
Note:
pulse drops below 60 when resting
Gastrointestinal:
Abdomen: Soft Non-Tender
Bowel Sounds: Positive
Diet: Regular
BM: N/A Color:None
Colostomy: N/A
NG: N/A To: N/A
OG: N/A To: N/A
GHT: N/A

(b)(6) DETAINEE,(b)(6)
(b)(6)
Reg # (b)(Loc: ICU 1
Spon: DETAINEE,(b)(6)
Unit:

Automated version of SF509

Report requested by: (b)(6)

I/O: N/A
Note:

Genitourinary:
Void. Yes Catheter Size: N/A
Color: Yellow
Character: Clear
Note:
Voids via urinal & bedside
Skin:
General Appearance: WNL
Color and Pigmentation: NFR
Temperature: Generalized Coolness
Turgor: WNL
Moisture: WNL
Integrity: Intact
Note:

Drain 1: N/A Drain 2: N/A
Drain 3: N/A Drain 4: N/A
Salad Pack: N/A
Note:

Wound 1:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 2:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 3:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 4:
Location: N/A
Dressing: N/A

(b)(6)

DETAINEE (b)(6)
(b)(6)
Loc: ICU 1
Spon: DETAINEE (b)(6)
Unit:

Reg #: (b)(6

Automated version of SF509

Report requested by: (b)(6)

Drainage: None
Note:

Central Lines:
Location: N/A Type: N/A
Location: N/A Type: N/A
Flushed q shift daily with 4% N/A
Note:
Pal IV Line In Place Site Right: N/A Status: Patent w/ no S/S of infection
Note:
18G, receiving D5 1/2 NS at 120ml/hr and antibiotics
IV Line 2:
Site Left: N/A Site Right: Forearm Peripheral IV Line In Place
Status: N/A
Note:
18G heplock
Pain:
Location: right side of head radiating down right side of neck
Intensity: 8
Onset: unknown
Tolerable: N/A
Treatment: given 4mg morphine
Re-Assessment:
Note:

VAP precautions:
HOB >30 degrees at all times: N/A
Sedation interruption: N/A
GI prophylaxis ordered: N/A
DVT prophylaxis: N/A
Oral care: N/A
Subglottic suctioning: N/A
Restraints: N/A
CMS: N/A
Note:

Psych/Ed:
Plan of care: Pt/family aware
Teaching done: N/A
Note:
VSS. Afebrile. pt admitted to ICU for rule out TB and brain abscess. chest x-ray revealed no acute cardipresPiratory disease, but dr tran ordered sputum culture x3. pt started on antibiotics ceftriaxone 2gm BID and metronidazol 15mg BID. first sputum culture will be done in AM. pt did report 8/10 headache in right frontal lobe region radiating down right side of neck. given 4mg morphine for relief. continues to have symtoms of diplopia and blurred vision. no other abnormal physical findings. will continue to

(b)(6) DETAINEE (b)(6)
(b)(6)
Reg #: (b)(6) Loc: ICU 1
Spon: DETAINEE (b)(6)
Unit:
Automated version of SF509

Report requested by: (b)(6)

monitor.
Signed: (b)(6)

(b)(6) DETAINEE, (b)(6)
(b)(6)
Reg #: (b)(Loc: ICU 1
Spon: DETAINEE, (b)(6)
Unit:
Automated version of SF509

CAMP CROPPER

Personal Data - Privacy Act of 1974 (PL 93-579)
Discharge Summary for DETAINEE, (b)(6)

Report requested by: (b)(6)

Attending Physician: (b)(6)
Admission Date: 05 Dec 2008 Discharge Date: 07 Dec 2008

Admitting Diagnosis:
CONGENITAL REDUCTION DEFORMITIES OF BRAIN (ICD 742.2)

Discharge Diagnosis:
CONGENITAL REDUCTION DEFORMITIES OF BRAIN (ICD 742.2)

ICD Operations/Procedures:

Active Problem List:

Principal Diagnosis:

Secondary Diagnosis:

Principal Procedures/Operations:

Patient's condition at time of Discharge:

Active Outpatient Medications:
PIROXICAM--PO 20MG CAP TAKE ONE CAPSULE EVERY DAY BY MOUTH

Pending at time of Discharge:

Lab Tests	Ordered for	Status
HIV-1/2 AB	05 Dec 2008	PENDING
HEPATITIS PANEL	05 Dec 2008	PENDING

Radiology Exams
No pending Radiology Exams

Future Appointments:

Clinic/Div	Provider	Date/time	Type	Status

Activity Limitations:
No driving for:
No jogging for:
No swimming for:
No golf, tennis, similar sports for:
No sexual intercourse for:
No long walks for:
No stair climbing for:
No shower/bath for:

Do not return to work until:

(b)(6) DETAINEE, (b)(6)
(b)(6)
DOB:
Spon: DETAINEE, (b)(6)
Unit:
Automated version of SF502

Report requested by: (b)(6)

Diet:

Patient Instructions:

Physician Responsible for Dictation:

Discharge Summary:
Attending Physician: Roubeck, Joel H. LTC MC
Patient: Detainee ISN (b)(6)

Admission Date: 5 December 2008
Transfer Date 7 December 2008

Allergies: NKDA

HPI:
40 year old Detainee with chronic headaches following GSW to frontal lobe presented to sick call medic with HA increasing over 3 day period. Evaluated in DMC and sent to ED for further evaluation due to increased pain and nausea not relieved with patients usual piroxicam. In ED, patient noted to have normal neurologic exam. CT of head notable for possible mass vs abscess of right frontal lobe. ED physician contacted Balad neurosurgeons who recommended IV antibiotics as outlined below

PMH: chronic headaches following GSW to frontal lobe one year ago
PSH: none reported
SH: nonsmoker

FH: noncontributory

Meds: piroxicam 20mg PO QD

PE: Temp 97.4 BP 110/57 HR 53 RR 18 O2 Sat100% RA
GEN: Alert and Oriented X3
HEENT Pupils 4mm bilaterally, reactive to light and accommodation. GSW entry right frontal area
Pulm - CTA bilaterally, without wheezing or rhonchi
CV - RRR, no carotid bruits
Abd - BS+, soft, mild TTP upper abd no rebound or guarding
Ext - no edema, good peripheral pulses
Neuro - CN II-XII grossly intact. Normal strength and reflexes.

LABS:
WBC 8.9
H/H 13/39
PLT 256
Chemistry normal except albumin 3.1
RPR NR
Blood cultures pending
HIV pending
Hepatitis panel pending

(b)(6) DETAINEE (b)(6)
(b)(6)
Log:
Spon: DETAINEE (b)(6)
Unit:

Automated version of SF502

CAMP CROPPER

Personal Data - Privacy Act of 1974 (PL 93-579)
Discharge Summary for DETAINEE (b)(6)

Report requested by: (b)(6)

CA [illegible] Sal

CT h. ad: Left frontal lobe and corpus callosum vasogenic edema with mild intracranial mass effect. Effacement of anterior horn of left lateral cerebral ventricle. Possible abscess of right frontal lob 8X20mm. Shrapnel from prior GSW.

Assessment/Discussion:

1. Likely abscess of frontal lobe in area of previous GSW. Patients presentation and films discussed between ED physician and neurosureons (Drs Marzak and Bakken) at Balad. Consensus neurosurgery opinion is that this is a brain abscess and pt should have one week of antibiotics followed by re-imaging of the lesion
2. Acute on chronic headaches with no clinical features of herniation

Plan:

1. Admit to ICU with vital signs and neurochecks per protocol including papillary exam
2. Ceftriaxone 2000mg IV q 12hrs
3. Metronidazole 100mg IV q 12hrs
4. IV morphine, Tylenol and Naprosyn in combination for HA
5. Plan to re-image head with contrast CT in one week following IV antibiotics
6. Neurosurgery contacts at Balad: (b)(6)

Hospital course: Pt admitted to ICU for neurochecks and IV antibiotics per Balad Neurosurgeons advice. On the evening following discharge, the ED cross cover physician was called for patient having agitation and mental status changes. PT was uncooperative with a physical exam and would not allow a repeat CT scan. For the pts protection and to further evaluate the status of his intracranial process, the ED physican decided to sedate and intubate the pt. Repeat CT scan was largely unchanged from previous with radiologist suspecting cerebritis based on clinical picture and CT images. Arrangements were made for pt to be transferred to Balad by the time I arrived this am. Transfer summary prepared and sent with pt by ED physician.

(b)(6)

Verified by: (b)(6) on 07 Dec 2008

(b)(6)

DETAINEE (b)(6)
(b)(6)
Loc:
Spon: DETAINEE (b)(6)
Unit:

Automated version of SF502

Task Force 31 Medical Respiratory Therapy
Section Ventilator Patient Monitoring Flow sheet

Circuit changed and system checked:
Time: Date: Initials: (b)(6)

DATE: 7Dec08 VENTILATOR (b)(6) VENT #: (b)(6)

Initials	(b)															
Date	7Dec8															
Time	1401															
Mode	CMV															
FiO2	100															
Vol Set	500															
Exh Vol	517															
Spont Exh Vol	/															
Set Rate	14															
Total Rate	21															
Sensitivity	-2															
I: E Ratio	1:2.1															
Peak Flow																
Pressure Support	/															
PEEP/ CPAP	5															
PIP	14															
MAP	9															
Min Vol	7.09															
Press Limit: Hi	50															
Press Limit: Lo	/															
Ve Limit: Hi	9.00															
Ve Limit: Lo	3.50															
High Rate	40															
Low Rate	/															
Humidity	HME															
Cuff Press Q-Shift																
Ck Apnea Parameter																
SpO2	99															
Heart Rate	38															
Breath Sounds																
PSI	1700															
Treatment	/															

NAME: (b)(6)
PT. I.D: (b)(6)
AGE:
GENDER (b)(6)

ABG:

ETT SIZE: 7 ETT
ETT PLACEMENT: 21@

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

(b)(6)

INTAKE

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV D5½NS												120	120	120	120	120	120	
IVPB																		
Ceftriaxone												75						
metronidazole													100	100				
PO/ TF																		
Other																		
TOTAL													220	220	120	120	120	995

OUTPUT

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output/ Total												500	430	350	325	325		1900
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2																		
Jackson Pratt #1/ #2																		
TOTAL												0	0					

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

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

(b)(6)

41

(b)(6)

Hospital Day 1

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP (MAP)								
Pulse								
Respirations								
Temperature								
SaO2								
%O2								
O_2 Delivery								
Mode								
Rate								
Tidal Vol.								
Peep								
PS								
Pain Scale								
Pain Med								
Pt Position								
CVP								

24 Hour Totals	Yesterday	Today
INPUT		
OUTPUT		1755
DIFFERENCE		

(b)(6)

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

(INTAKE) TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
IV D5 ½NS	120	120	120	120	120	120	120	120		
IVPB Cef							100	100		
Met										

ICU FLOW SHEET

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

RESTRAINTS:

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

VASCULAR ACCESS

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

PREPARED BY: (signature & Title)	DEPARTMENT/SERVICE/CLINIC (b)(6)	DATE 7 Dec 08
PATIENT'S INDENTIFICATION		
(b)(6)	☐ HISTORY/PHYSICAL ☐ OTHER EXAMINATION OR EVALUATION ☐ DIAGNOSTIC STUDIES ☐ TREATMENT	☐ FLOWCHART ☐ OTHER

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

INTAKE

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

OUTPUT

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

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

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

RELIEF	23	24	01	02	03	04	05	06
NIBP/ ABP (MAP)								
Pulse								
Respirations								
Temperature								
SaO2								
%O2								
O_2 Delivery								
Mode								
Rate								
Tidal Vol.								
Peep								
PS								
Pain Scale								
Pain Med								
Pt Position								
CVP								

24 Hour Totals	Yesterday	Today
INPUT		
OUTPUT		
DIFFERENCE		

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

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

OUTPUT

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

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

Name	Signature	Init.

ICU FLOW SHEET

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

RESTRAINTS: Femoral Only

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

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(L) FA prox	5 Dec	NA	OK 9 Sx 10 8		
(L) FA dist	5 Dec	NA	OK 9 Sx 10 8		
(R) hand	6 Dec		OK		

P (b)(6)

DEPARTMENT/SERVICE/CLINIC DCN-ICU

DATE 6 Dec 08

PATIENT'S IDENTIFICATION

(b)(6)

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

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
NIBP/ ABP (MAP)																
Pulse																
Respirations																
Temperature																
SaO2																
%O2																
O_2 Delivery																
Mode																
Rate																
Tidal Vol																
Peep																
PS																
Pain Scale																
Pain Med																
Pt Position																
CVP																

(b)(6)

INTAKE

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV D5½NS	120	120	120	120	120	120	120	120	1250	120	100	120	120	120	120	120	120	1380
IVPB																		
PO/ TF	50					240				120		200	100					
Other																		
TOTAL																		

OUTPUT

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output/ Total	325								1625			400						400
NG output																		
Emesis						x1							x1					
Stool						(≈ 300 ml)												
Chest tube #1/ #2																		
Jackson Pratt #1/ #2																		
TOTAL																		

ASPECT	TIME/INITIALS	
Bath/Skin Care		
Oral Care		
Foley Care	N/a	N/a
Trach Care	N/A	N/A
Range of Motion	self	

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

(b)(6)

ICU FLOW SHEET

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

RESTRAINTS: Extremity only

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

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
Rt femoral	5 DEC 08	new	N/C/D	✓ SXS	✓ SXS
16G IV	5 DEC 08	new	N/C/D	✓ SXS	✓ SXS

PREPARED BY: (signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
(b)(6)	ICU	5 DECEMBER 08

PATIENT'S INDENTIFICATION

ICU
Bed #7
(b)(6)

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

Report requested by: (b)(6)

DETAINEE: (b)(6) (b)(6) (b)(6)

Ch:

URINE

DA [illegible] 0139 (Cell)

STAT COLOR . . . . . YELLOW
CLARITY . . . . . CLEAR
GLUCOSE . . . . . NEGATIVE
BILIRUBIN . . . . . NEGATIVE
KETONES . . . . . NEGATIVE
SG. 1.015
BLOOD . . . . . NEGATIVE
PH. 6.5
PROTEIN . . . . . NEGATIVE
UROBILINOGEN. . . . 0.2 mg/dL
NITRITE . . . . . NEGATIVE
LEUKO EST . . . . . NEGATIVE

L-Lo H-Hi **Critical R-Resist S-Susc MS-Mon Susc I-Intermed
(I)Incert /A-Amended Comments- (O)rder, (I)nterpretations, (R)esult

CAMP CROPPER

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

PATIENT LAB INQUIRY

For: 05 Dec 08 - 06 Dec 08

Report requested by: (b)(6)

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

				SERUM
05 Dec 08 @ 0107 (0711)				
STAT NA+		140	(123-145)	mmol/L
Interpretations:				
PERFORMED ON PICCOLO ANALYZER				
K+		4.7	(3.5-5.7)	mmol/L
CO2		22	(18-33)	mmol/L
CL		102	(98-108)	mmol/L
GLUCOSE		105	(73-118)	mg/dl
Interpretations:				
PERFORMED ON PICCOLO CHEMISTRY ANALYZER				
CA		8.6	(8.0-10.3)	mg/dL
BUN		8	(7-22)	mg/dL
CREAT		0.5	L (0.6-1.2)	mg/dL
ALK PHOS		62	(26-184)	U/L
Interpretations:				
PERFORMED ON PICCOLO CHEMISTRY ANALYZER				
ALT		15	(10-47)	U/L
AST		26	(16-55)	U/L
TBILI		0.4	(0.2-1.6)	mg/dL
ALBUMIN		3.1	L (3.3-5.5)	g/dL
PROTEIN TOTAL		6.5	(6.4-8.1)	g/dL

L-Lo H-Hi *-Critical R-Resist S-Susc MS-Mod Susc I-Intermed

[]-Uncert /A-Amended Comments (O)rder, (I)nterpretations, (R)esult

CAMP CROPPER

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

PATIENT LAB INQUIRY

For: 06 Sep 08 - 05 Dec 08

Report requested by (b)(6)

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

Ph:

				SERUM
05 Dec 08 @ 1825 (Coll)				
HEP PANEL	PENDING			
				BLOOD
05 Dec 08 @ 1825 (Coll)				
[illegible]	[illegible]			
				BLOOD
05 Dec 08 @ 1825 (Coll)				
RPR	NON-REACTIVE		(NON REAC)	
ALK PHOS	74		(26-184)	U/L
Interpretations:				
PERFORMED ON PICCOLO CHEMISTRY ANALYZER				
ALT	20		(10-47)	U/L
AST	32		(11-55)	U/L
TBILI	0.5		(0.2-1.6)	mg/dL
ALBUMIN	3.6		(3.3-5.5)	g/dL
PROTEIN TOTAL	8.1		(6.4-8.1)	g/dL
AMYLASE	39		(14-110)	U/L
Interpretations:				
PERFORMED ON PICCOLO CHEMISTRY ANALYZER				
GGT	11		(5-65)	U/L
Interpretations:				
PERFORMED ON PICCOLO ANALYZER				
HBsAG NEUT	PENDING			
HCV AB	PENDING			
HIV 1/2 AB	PENDING			
HBs AG	PENDING			
HIV ELISA	PENDING			
				BLOOD(BLOOD)
05 Dec 08 @ 1610 (Coll)				
BCD CULT	PENDING			
				BLOOD(BLOOD)
05 Dec 08 @ 1610 (Coll)				
ANAP BLD CULT	PENDING			
				BLOOD
05 Dec 08 @ 1535 (Coll)				
STAT WBC	8.9		(4.8-10.8)	x10 3/uL
RBC CNT	4.15	L	(4.20-6.10)	x10 6/uL
HGB	13.0		(12.0-18.0)	g/dL
HCT	39.1	L	(42-52)	%
MCV	94.1		(80.0-99.0)	fl
MCH	31.4	H	(27.0-31.0)	pg
MCHC	33.4		(33.0-37.0)	g/dL
PLATELETS	256		(130-400)	x 10(3)/uL
LYMPH%	14	L	(20.0-44.0)	%
LYMPH#	1.2		(0.7-4.3)	x10 3/uL

L=Lo H=Hi *-Critical R-Resist S-Susc MS-Mod Susc I-Intermed

(L=Uncat /A-Amended Comments- (O)rder, (I)nterpretations, (R)esult

CAMP CROPPER

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

PATIENT LAB INQUIRY

For: 06 Sep 08 - 05 Dec 08

Report requested by: (b)(6)

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

Pt..

SERUM

01 DEC 08 @ 1535 (Coll)			
STAT NA+	140	(129-145)	mmol/L
Interpretations:			
PERFORMED ON PICCOLO ANALYZER			
K	4.1	(3.5-5.3)	mmol/L
CO2	29	(18-34)	mmol/L
Cl	100	(98-108)	mmol/L
GLUCOSE	113	(73-118)	mg/dl
Interpretations:			
PERFORMED ON PICCOLO CHEMISTRY ANALYZER			
CA	8.9	(8.0-10.3)	mg/dL
BUN	13	(7-22)	mg/dL
CREAT	0.4 L	(0.6-1.2)	mg/dL
ALK PHOS	70	(26-184)	U/L
Interpretations:			
PERFORMED ON PICCOLO CHEMISTRY ANALYZER			
ALT	21	(10-47)	U/L
AST	23	(16-55)	U/L
TBILI	0.4	(0.2-1.0)	mg/dL
ALBUMIN	3.9	(3.3-5.5)	g/dL
PROTEIN TOTAL	7.4	(6.4-8.1)	g/dL

L=Lo H=Hi *=Critical R=Resist S=Susc I=Mod Susc I=Intermed

(I)=Incert (A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

RADIOLOGIC EXAMINATION REPORT

Patient: DETAINEE,(b)(6) FMP/SSN: (b)(6)

CAMP CROPPER
Procedure: CT, HEAD (W/CONTRAST)
Requested by: (b)(6)
Ward/Clinic: ER CLINIC

COMPUTERIZED TOMOGRAPHY
Exam Date: 05 Dec 2008@1548
Status: COMPLETE
Exam #: (b)(6)
Pregnant:

Reason for Order:
r/o [illegible]

Order Comment:

CAMP CROPPER
Procedure: CT, HEAD
Requested by: (b)(6)
Ward/Clinic: ER CLINIC

COMPUTERIZED TOMOGRAPHY
Exam Date: 05 Dec 2008@1311
Status: COMPLETE
Exam #: (b)(6)
Pregnant:

Reason for Order:
Headaches, dizziness

Order Comment:

Result Code: ABNORMALITY, ATTN. NEEDED

Report:

HEAD CT WITH AND WITHOUT CONTRAST
PROCEDURE: Helical CT of brain and 3 mm slice thickness with and without intravenous contrast.

FINDINGS AND IMPRESSION:
1. Vasogenic edema involving the left frontal lobe and corpus callosum. This results in mild intracranial mass effect with effacement of the anterior horn of the left lateral cerebral ventricle.

2. Possible cerebral abscess. On image number 18 of the contrast-enhanced series there is a small area of rim enhancement near the midline of the right frontal lobe. This measures approximately 8 mm by 20 mm in size. Given that the patient has had a prior gunshot wound to the right frontal lobe, the region of rim enhancement and the vasogenic edema and could be explained by an infectious process such as a cerebral abscess.

3. Prior gunshot wound to the right frontal lobe. There is a small anterior calvarial defect and/or multiple metallic shrapnel fragments in the anterior and midportion of the frontal lobe. These could serve as a nidus

(b)(6) DETAINEE (b)(6)
(b)(6)
(b)(6)
Loc:
Spon: DETAINEE,(b)(6)
Unit:

FOREIGN NATIONAL - POW/INTERN

H: W:
RR:

RADIOLOGIC EXAMINATION REPORT

Patient: DETAINEE (b)(6) FMP/SSN: (b)(6)

for information.

1. No evidence for acute intracranial hemorrhage

Transcription Date/Time: 05 Dec 2008@1548

Transcribed by: [illegible]
Supervised by:

Approved by: (b)(6) 05 Dec 2008@1549
Supervised by:

(b)(6) DETAINEE (b)(6) FOREIGN NATIONAL POW/INTERN
(b)(6)
/(b)(6)
Loc: B: W:
Spon: DETAINEE (b)(6)
Unit: RR:

SF519-B

U.S. Army Hospital Cropper

Department of Radiology
APO, AE 09342, (314) 485-0095

RADIOLOGY REPORT

PATIENT NAME	(b)(6)
DATE OF BIRTH	
PATIENT NUMBER	(b)(6)
REFERRING PHYSICIAN	
MODALITY TYPE	CR
INSTITUTION NAME	Initial Hospital Name
EXAM DATE	20081205
EXAM TYPE	Portable Chest

STUDY COMMENTS

HISTORY

COMPARISON EXAMINATIONS

FINDINGS AND IMPRESSION

There is no evidence of acute cardiopulmonary disease.

(b)(6)
2008-12-5 16:42
Cropper Medweb 1
DIGITAL SIGNATURE
Signer name: (b)(6)
Organization: Cropper Medweb 1
Signed: 2008/12/05.16:43:09

Reply

000-108

NSN7540-00-634-4176

MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATEMENT, TREATING ORGANIZATION (Sign each entry)
6 Dec 2007	**Nutrition Risk Screening**
S/O:	Active Duty Coalition Force Contractor (Detainee) Civilian
	Ward: IU Bed Number 1
	Diagnosis: RG TB, Brain Abcess
	Nausea: Y / (N) Vomiting: Y / (N) Diarrhea: Y / (N) Recent Weight Loss: Y / (N)
	Amputee: (NO) YES (list)
	Age: Gender: (b) Ht: Wt: BMI: UBW:
	Diet: Reg American Food (if authorized): YES (NO)
	Special Dietary Needs:
	Meds:
	Labs: Glucose 105 NA+ K+ 4.5 Albumin 3.1 Total Pro 6.5
	BUN 8 Creatine 0.5
A/P:	
Nutrition Risk:	Patient determined to be at (low) nutrition risk; will be re-screened in one week
	Patient determined to be at nutrition risk secondary to :
	Further intervention by RD needed within 72 hours
	Re-Screen Date: 13 Dec 2007

(b)(6)

PATIENT'S IDENTIFICATION (Use this space for Mechanical

(b)(6)

RECORDS MAINTANED AT

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

RELATIONSHIP TO SPONSOR STATUS RANK/GRADE

SPONSOR'S NAME ORGANIZATION

DEPARTMENT DATE OF BIRTH

10-L-0126 ACLU DDII CID ROI 19841

56

CHRONOLOGICAL RECORD OF MEDICAL CARE STANDARD FORM 600 (REV. 7-74)

(b)(6)

MEDICAL RECORD - SUPPLEMENTAL MEDIC. DATA

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

OTSG APPRO

REPORT TITLE: **PROVIDER ORDERS**

DATE: 5 DEC 08 TIME: 1810

SERVICE: (X) MED ( ) SURG ( ) CRTH

DIAGNOSIS: RT I ABSCESS

CONDITION: (X) STABLE ( ) CRITICAL (

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

Allergies: _____

Activity: OUT OF BED WITH ASSIST

Weight Bearing Status: _____

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

Dressing Change: ( ) PO/IV ( ) Daily ( ) BID ( ) PRN ( ) Debris ( ) Wet Dry ( ) Xe

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

Drains: ( ) NGT to LIWS ( ) Chest Tube to _____ ( ) Hemovac ( ) JP ( ) Foley ( ) Record

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

X-Rays: _____

MEDICATIONS

(X) Saline Lock w/flush q 8 hrs ( ) NS ( ) LR @ _____ ml/hr (X) D5 1/2 NS @ 120 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

( ) 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

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

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

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

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

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

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

ADDITIONAL ORDERS

( ) Sign and Witness Consent

(X) CEFTRIAXONE 2 gram IV Q12H

(X) METRONIDAZOLE 15mg/kg IV Q12H

( ) TAPER 2

( ) (b)(6)

( )

(b)(6)

24/5 DEC 08 20

(b)(6)

PREPARED BY (Signature & ...)

115th Combat Support Hospital

DEPARTMENT/ SERVICE/ CLINIC

DCCS

20080701

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

(b)(6)

PSUEDO ISN: ISN

AGE

LOCATION ( ) ICU ( ) ICW BED #

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

( ) FLOW CHART
(X) OTHER (specify)
Provider Orders

0126 ACLU DDII CID ROI 19842

57

ACLU-RDI 5594 p.57

000057

THERAPEUTIC DOCUMENTATION CARE PLA...
(MEDICATIONS)

Mo 12 Yr 06

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
DEC 06	(b)(6)	Morphine 2-5 mg IV q 1HR PRN for severe pain or while NPO	(b)(6)
-----	-----		
-----	-----		
DEC 06	(b)(6)	Tylenol 650mg PO q4HR PRN for pain, fever, headache, do not give within 4 HRS of percocet.	
-----	-----		
-----	-----		
DEC 06	(b)(6)		
DEC 06	(b)(6)	ZOFRAN 4mg IV q6HRS PRN Nausea	
-----	-----		
-----	-----		
-----	-----		
-----	-----		

DA FORM 4678, 1 FEB 79

USAPA V1.01

THERAPEUTIC DOCUMENTATION

Month 12 year 03

Start	Init	Medication	Times	5	6	7	8	9	10	11	12	13	14	15	16	17	18
7DEC03	(b)(6)	D5½NS @ 120ml/hr	07 15 23	(b)(6)	(b)(6)												
5DEC03	(b)(6)	Ceftriaxone 2 grams IV Q12 HR.	10 22	Hold			Δ'd.					(b)(6)					
5DEC03	(b)(6)	Metronidazole 15mg/Kg IV Q12 H	18 22														
5DEC03	(b)(6)	Ceftriaxone 2grams IV Q12 HR	05 17	(b)(6)	(b)(6)												
5DEC03	(b)(6)	Metronidazole 15mg/Kg IV Q12H	06 18														
5DEC03	(b)(6)	Naprosyn 500mg po BID	05 15														

ALLERGIES ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: (b)(6)

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO ______

PATIENT IDENTIFICATION

(b)(6)

DISPENSING TIMES

USE PENCIL CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 4678

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 12 Yr 05

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	(b)(6)	Drowsiness & Pain Assess	5 DEC	NOW	1745	(b)(6)
		Service & Med	5 DEC	NOW	1745	
		Condition & Status	5 DEC	NOW	1745	
		Allergies - NKDA	5 Dec	NOW	2045	
		Urine osmolality, serum osmolality and CMP	6 Dec	0100	0040	

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo 12 Yr 08

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8
5DEC08	(b)(6)	Vital Signs q 8H Protocol	07 15 23 /	(b)(6)	(b)(6)		
5DEC08	(b)(6)	Activity: Out of bed with assistance.	07 15 23 /				
5DEC08	(b)(6)	Diet: Regular	08 12 17 *				
5DEC08	(b)(6)	Sputum culture X3 Days (done by Respiratory)	03 / *				

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

(b)(6)

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION

(b)(6)

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

16 17 18 19 20 21 22 23

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER 5 Dec 06 TIME OF ORDER 2314 HOURS

LIST TIME ORDER NOTED AND SIGN

AFB SPUTUM X 3

(b)(6)

(b)(6)

NURSING UNIT ICU ROOM NO. BED NO. (b)(6)

PATIENT IDENTIFICATION (b)(6)

24°V SDEC08 2200hrs

(b)(6)

DATE OF ORDER 5 Dec 06 TIME OF ORDER 2330 HOURS

(b)(6)

Verbal order by (b)(6)

urine osmolality, serum osmolality and CMP x1 0100

- taken by (b)(6)

(b)(6)

(b)(6)

NURSING UNIT ICU ROOM NO. BED (b)(6)

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER 6DEC08 TIME OF ORDER 1305 HOURS

(b)(6)

1) Naproxyn 500mg PO BID

(b)(6)

(b)(6)

NURSING UNIT ICU ROOM NO. BED NO. (b)(6)

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER DEC08 TIME OF ORDER 1220 HOURS

(b)(6)

nsfer to BAMD

(b)(6)

(b)(6)

NURSING UNIT ICU ROOM NO. BED NO. (b)(6)

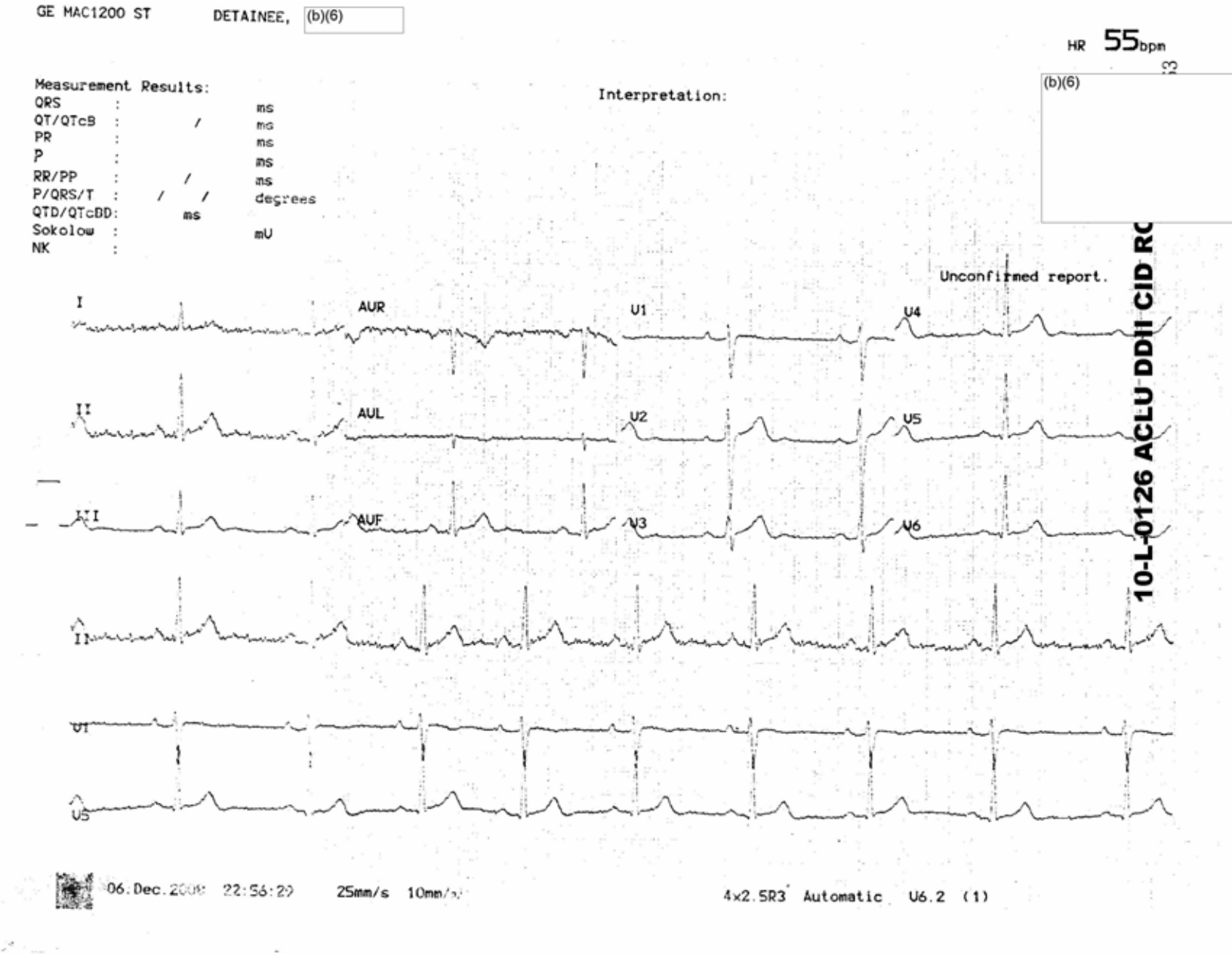
1 JT26 ACLU DDII CID ROI 19847

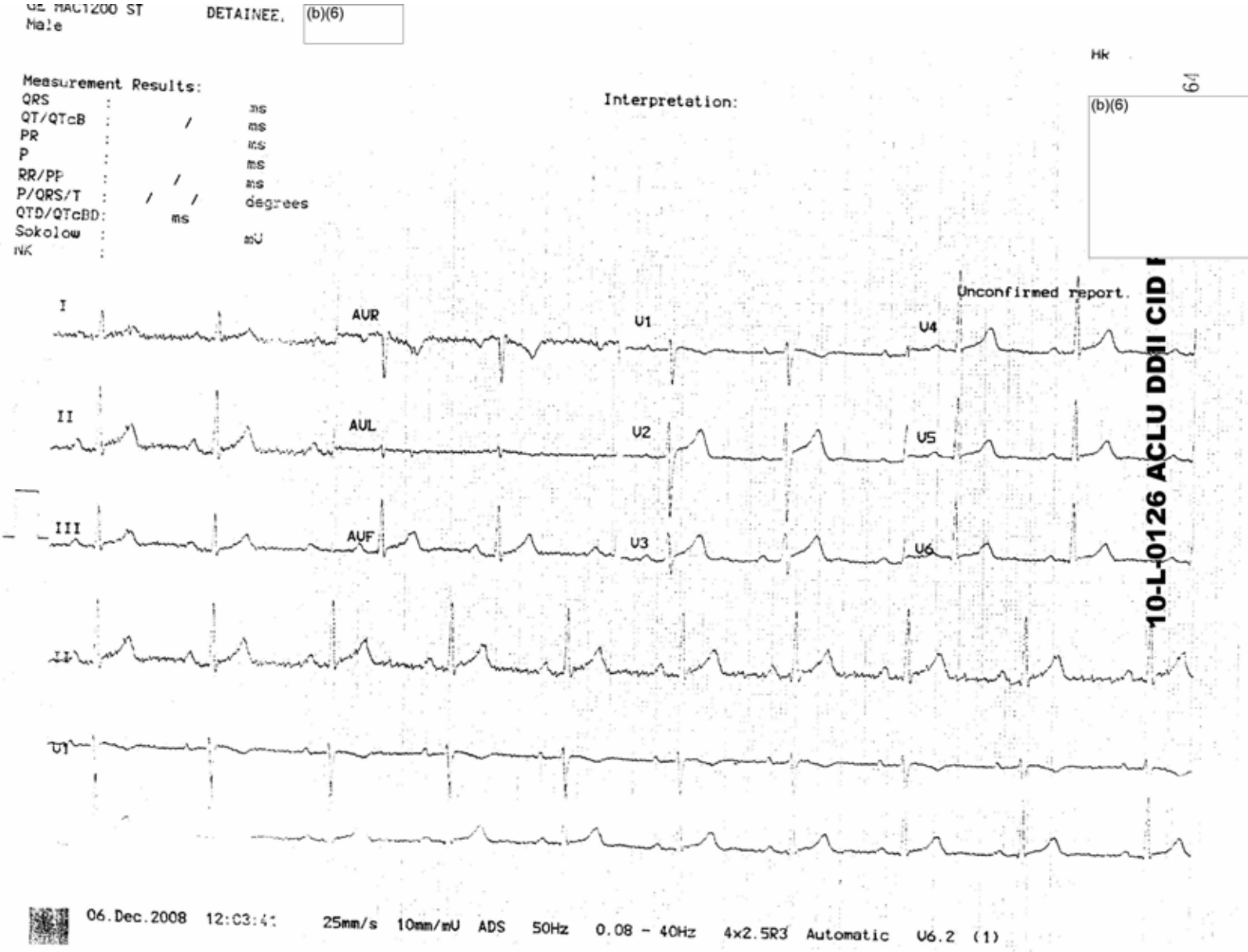
62

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

ACLU-RDI 5594 p.62

000062


GE MAC1200 ST
DETAINEE, (b)(6)
HR 55bpm
(b)(6)
Measurement Results:
QRS :
QT/QTcB :
PR :
P :
RR/PP :
P/QRS/T :
QTD/QTcBD:
Sokolow :
NK :
Interpretation:
Unconfirmed report.
I
AUR
U1
U4
II
AUL
U2
U5
III
AUF
U3
U6
II
V1
V5
06.Dec.2008 22:56:29
25mm/s 10mm/mV
4x2.5R3 Automatic U6.2 (1)
10-L-0126 ACLU DDII CID RC



Date: 8 Dec 2008 TF 115 MED, ICU Discharge Note

	Initials
Discharge order written by MD (Order to Balad) yes	(b)(6)
D/C prescriptions to pharmacy ___	
Pharmacy notified of discharge	
D/C meds received from pharmacy	
Detainees: Manilla Copy Physician's Order to MP N/A (to Balad) / 1 Copy of Discharge Summary to chart ___ / 1 Copy of DC Summary to ER (blue bin) ___ / 1 Copy of last EKG (chest pain patients only) N/A — US/Coalition/Contractors: Unit Called ___ / Transportation Arranged ___ / 1 Copy of DC Summary to chart ___ / 1 Copy of DC Summary to patient ___	
D/C'd from ICU Admissions/Discharges Book	(b)(6)
D/C'd from CHCS	
D/C'd off Patient Status Board	
Discharge Summary to future consults as needed	
Wire Medical Team e-mailed (b)(6)	
(b)(6)	
Transferred to another facility: Balad	
Physician's Transfer Summary on chart ✓ A/E Handoff Communication on Chart ___	
Report to receiving unit called ✓ e-mailed ___	
D/C meds w/ PT, not guard: Versed, Vecuronium, Flagyl, Morphine, D5 ½ NS KCl 20	
Medication and d/c teaching completed ___ With ___ Without Translator Intubated sedated	N/A
Verbalized understanding: Yes No Unable to verbalize Intubated sedated	N/A
All lines and drains d/c'd unless instructed otherwise. IV: Location R ... CA Size: 18g Time d/c'd: ___ all lines remain in place. Condition of catheter tip: ___	
Foley: ___ Time d/c'd: ___ Time Due to Void: ___	N/A
JP #1: ___ Time d/c'd: ___ JP #2: ___ Time d/c'd: ___	
Wound Vac: ___ Time d/c'd ___ Wet-Dry Dsg applied: Yes No / Location ___	
Dressings: Location ___ Type ___ Last Changed ___ / Location ___ Type ___ Last Changed ___ / Location ___ Type ___ Last Changed ___	N/A
Last Set of VS: T: ___ P: 43 R: ___ BP: ___ SpO₂: ___	(b)(6)
Time Departed ICU: ___	
Method of transportation: Wheel Chair Ambulatory W/Crutches (b)(6)	
Accompanied by: ___	
Additional Note: Pt D/C'd by (b)(6) ... [illegible]	
ICU Personnel Signature (b)(6) (b)(6)	

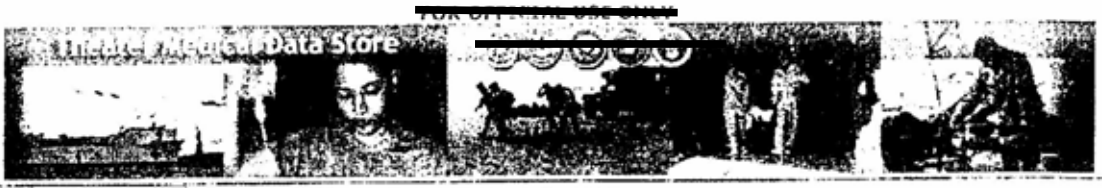
(b)(6)

ISN:

PISN:

10-L-0126 ACLU DDII CID ROI 19850

ICU Bed#



Welcome back, (b)(6) - viewing 115th CSH CROPPER (JPTA_WBH6A1)
You are currently logged as **FACILITY GROUP** with PHI Access

Patient Registration | Reports | Patients By Service | Patient Search | Other Health History | Patient Info | Guidelines/Info | Links | Help | Logout

Your Location: Patient Search

Patient Search

Search For Patient

SSN:	Last Name:	First Name:	Register #:

Full SSN or Last Four Digits

[redacted]

Patient Information

PATIENT NAME: DETAINEE (b)(6)

PATIENT SSN: (b)(6)

LATEST DIAGNOSIS: INTRACRANIAL ABSCESS (324.0)

[redacted]

View SF 502 Narrative Summary (PDF)

Other Treatment Data

No additional treatment data available for display for patient DETAINEE, (b)(6)

Tracking Status

No administrative notes for patient DETAINEE, (b)(6)

Facility Treatment History

No treatment notes for patient DETAINEE, (b)(6)

Medical Events History

Disposition	Data Source	Location	Encounter Date	Reporting Facility	Author
EXPIRED	TMDS		12/07/2008 00:00	332 EMDG-BALAD (JPTA_IRA1)	(b)(6)
REFERRED	TC2	INPATIENT	12/05/2008 16:58	115th CSH CROPPER (7457)	
ADMISSION	AHLTA-T		12/05/2008 13:10	MC4-POD1(WBH6A1)	
TRANSFERRED TO ARMY MTF	TMDS	10th CSH - N. Baghdad(JPTA_IR24)	12/05/2008 00:00	115TH CSH CROPPER (JPTA_WBH6A1)	(b)(6)

Trac2es

No Trac2es records for patient DETAINEE, (b)(6)

Ancillary Services

Laboratory Results

Date	Unit Name (UIC)	Name	Type	Status
12/06/2008 00:26 hrs	115th CSH CROPPER (b)(6	URINALYSIS	Observations to follow	Order complete

Results

Name	Results	Ref. Range	Status	Certified By	Certified Date

SPECIFIC GRAVITY	1.015	Final Results	(b)(6)	12/06/2008 01:40
NITRITE	NEGATIVE	Final Results		12/06/2008 01:40
LEUKOCYTE ESTERASE	NEGATIVE	Final Results		12/06/2008 01:40
KETONES	NEGATIVE	Final Results		12/06/2008 01:40
PH	6.5	Final Results		12/06/2008 01:40
BILIRUBIN UA	NEGATIVE	Final Results		12/06/2008 01:40
BLOOD UA	NEGATIVE	Final Results		12/06/2008 01:40
GLUCOSE UA	NEGATIVE	Final Results		12/06/2008 01:40
PROTEIN UA	NEGATIVE	Final Results		12/06/2008 01:40
UROBILINOGEN	0.2 mg/dl	Final Results		12/06/2008 01:40
CLARITY	CLEAR	Final Results		12/06/2008 01:40
COLOR	YELLOW	Final Results		12/06/2008 01:40

12/05/2008 23:29 hrs | 115th CSH CROPPER (7457) | COMPREHENSIVE METABOLIC PANEL | Observations to follow | Order complete

Results

Name	Results	Ref. Range	Status	Certified By	Certified Date
CARBON DIOXIDE	29	18-33 mmol/L	Final Results	(b)(6)	12/06/2008 01:08
CREATININE	0.5 L	0.6-1.2 mg/dL	Final Results		12/06/2008 01:08
UREA NITROGEN	8	7-22 mg/dL	Final Results		12/06/2008 01:08
GLUCOSE	105	73-118 mg/dl	Final Results		12/06/2008 01:08
Comments: INTERPRETATION(S): PERFORMED ON PICOLLO CHEMISTRY ANALYZER^^^					
SODIUM	140	128-145 mmol/L	Final Results	(b)(6)	12/06/2008 01:08
Comments: INTERPRETATION(S): PERFORMED ON PICOLLO ANALYZER^^^					
POTASSIUM	4.5	3.3-4.7 mmol/L	Final Results	(b)(6)	12/06/2008 01:08
CHLORIDE	102	98-108 mmol/L	Final Results		12/06/2008 01:08
CALCIUM	8.6	8.0-10.3 mg/dL	Final Results		12/06/2008 01:08
ALANINE AMINOTRANSFERASE	15	10-47 U/L	Final Results		12/06/2008 01:08
ALKALINE PHOSPHATASE	62	26-184 U/L	Final Results		12/06/2008 01:08
Comments: INTERPRETATION(S): PERFORMED ON PICCOLO CHEMISTRY ANALYZER^^^					
ASPARTATE AMINOTRANSFERASE	26	15-55 U/L	Final Results		12/06/2008 01:08
PROTEIN TOTAL	6.5	6.4-8.1 g/dL	Final Results		12/06/2008 01:08
ALBUMIN	3.1 L	3.3-5.5 g/dL	Final Results		12/06/2008 01:08
BILIRUBIN TOTAL	0.4	0.2-1.6 mg/dL	Final Results		12/06/2008 01:08

12/05/2008 18:25 hrs | 115th CSH CROPPER (b)(6) | NEEDLESTICK SOURCE | Observations to follow | Order complete

Results

Name	Results	Ref.	Status	Certified By	Certified

		Range			Date
RAPID PLASMA REAGIN	NON-REACTIVE	NON REAC	Final Results	(b)(6)	12/05/2008 18:30
ALANINE AMINOTRANSFERASE	20	10-47 U/L	Final Results		12/05/2008 18:30
ALKALINE PHOSPHATASE	74	26-184 U/L	Final Results		12/05/2008 18:30
Comments: INTERPRETATION(S): PERFORMED ON PICCOLO CHEMISTRY ANALYZER^^^					
AMYLASE	39	14-110 U/l	Final Results	(b)(6)	12/05/2008 18:30
Comments: INTERPRETATION(S): PERFORMED ON PICCOLO CHEMISTRY ANALYZER^^^					
ASPARTATE AMINOTRANSFERASE	32	11-55 U/L	Final Results	(b)(6)	12/05/2008 18:30
PROTEIN TOTAL	8.1	6.4-8.1 g/dL	Final Results		12/05/2008 18:30
ALBUMIN	3.6	3.3-5.5 g/dL	Final Results		12/05/2008 18:30
BILIRUBIN TOTAL	0.5	0.2-1.6 mg/dL	Final Results		12/05/2008 18:30
G GLUTAMYL TRANSFERASE	11	5-65 U/L	Final Results		12/05/2008 18:30
Comments: INTERPRETATION(S): PERFORMED ON PICOLLO ANALYZER^^^					

12/05/2008 15:49 hrs 115th CSH CROPPER (b)(BLD CULT Observations to follow Order complete

Results

Name	Results	Ref. Range	Status	Certified By	Certified Date
BACT RESULT	NO GROWTH TO DATE		Preliminary Results		12/06/2008 11:48
BLD CULT			Preliminary Results	(b)(6)	12/06/2008 11:48

12/05/2008 15:48 hrs 115th CSH CROPPER (b)(6) BLD CULT Observations to follow Order complete

Results

Name	Results	Ref. Range	Status	Certified By	Certified Date
BACT RESULT	NO GROWTH TO DATE		Preliminary Results		12/07/2008 06:40
BLD CULT			Preliminary Results	(b)(6)	12/07/2008 06:40

12/05/2008 14:08 hrs 115th CSH CROPPER (b)(6 CBC Observations to follow Order complete

Results

Name	Results	Ref. Range	Status	Certified By	Certified Date
PLATELETS	256	130-400 x 10(3)/uL	Final Results	(b)(6)	12/05/2008 16:25
LYMPHOCYTES	14 L	20.0-44.0 %	Final Results		12/05/2008 16:25
HEMATOCRIT	39.1 L	42-52 %	Final Results		12/05/2008 16:25
RBC COUNT	4.15 L	4.20-6.10 x10 6/uL	Final Results		12/05/2008 16:25
WBC COUNT	8.9	4.8-10.8 x10 3/uL	Final Results		12/05/2008 16:25
MCV NUMERIC	94.1	80.0-99.0 fl	Final Results		12/05/2008 16:25
MCH NUMERIC	31.4 H	27.0-31.0 pg	Final Results		12/05/2008 16:25

MCHC NUMERIC	33.4	33.0-37.0 g/dL	Final Results	(b)(6)	12/05/2008 16:25
ABSOLUTE LYMPHS	1.2	0.7-4.3 x10 3/uL	Final Results		12/05/2008 16:25
HEMOGLOBIN	13.0	12.0-18.0 g/dL	Final Results		12/05/2008 16:25

12/05/2008 14:08 hrs	115th CSH CROPPER (b)(	COMPREHENSIVE METABOLIC PANEL	Observations to follow	Order complete

Results

Name	Results	Ref. Range	Status	Certified By	Certified Date
CARBON DIOXIDE	29	18-33 mmol/l	Final Results	(b)(6)	12/05/2008 15:55
CREATININE	0.41	0.6-1.2 mg/d	Final Results		12/05/2008 15:55
UREA NITROGEN	13	7-22 mg/dL	Final Results		12/05/2008 15:55
GLUCOSE	113	73-118 mg/dl	Final Results		12/05/2008 15:55
Comments: INTERPRETATION(S): PERFORMED ON PICOLLO CHEMISTRY ANALYZER^^^					
SODIUM	130	128-145 mmol/L	Final Results	(b)(6)	12/05/2008 15:55
Comments: INTERPRETATION(S): PERFORMED ON PICOLLO ANALYZER^^^					
POTASSIUM	4.5	3.3-4.7 mmol/L	Final Results	(b)(6)	12/05/2008 15:55
CHLORIDE	100	98-108 mmol/L	Final Results		12/05/2008 15:55
CALCIUM	8.9	8.0-10.3 mg/dL	Final Results		12/05/2008 15:55
ALANINE AMINOTRANSFERASE	21	10-47 U/L	Final Results		12/05/2008 15:55
ALKALINE PHOSPHATASE	70	26-184 U/L	Final Results		12/05/2008 15:55
Comments: INTERPRETATION(S): PERFORMED ON PICCOLO CHEMISTRY ANALYZER^^^					
ASPARTATE AMINOTRANSFERASE	23	16-55 U/L	Final Results	(b)(6)	12/05/2008 15:55
PROTEIN TOTAL	7.4	6.4-8.1 g/dL	Final Results		12/05/2008 15:55
ALBUMIN	3.9	3.3-5.5 g/dL	Final Results		12/05/2008 15:55
BILIRUBIN TOTAL	0.4	0.2-1.6 mg/dL	Final Results		12/05/2008 15:55

Radiology Result

Date	Unit Name (UIC)	Name	Type	Status
12/07/2008 06:20 hrs	115th CSH CROPPER (b)(6)	CHEST, PA/LAT	Observations to follow	Order complete

RAD Information

Imaging Type: **RADIOLOGY**
Exam Status: **COMPLETE**
Exam Performing: **RADIOLOGY ROOM**
Transcription Date: **12/07/2008 06:20**
Transcription Report Status: **V**
Transcription Approved by: (b)(6)
Comments:
9\SEE RADIOLOGIST'S REPORT\99RRC PORTABLE CHEST
FINDINGS AND IMPRESSION:
1. Status post placement of an endotracheal tube.

2. No acute cardiopulmonary abnormality.

12/07/2008 06:20 hrs	115th CSH CROPPER (b)(6)	CT, HEAD	Observations to follow	Order complete

RAD Information

Imaging Type: **COMPUTERIZED TOMOGRAPHY**
Exam Status: **COMPLETE**
Exam Performing: **CT ROOM**
Transcription Date: **12/07/2008 06:18**
Transcription Report Status: **V**
Transcription Approved by: (b)(6)
Comments:
9\SEE RADIOLOGIST'S REPORT\99RRC HEAD CT WITHOUT CONTRAST
FINDINGS AND IMPRESSION:
1. No significant change in left frontal lobe and corpus callosal edema as compared to 5 Dec 08. The history and exam findings favor a cerebritis (PLEASE SEE 5 DEC REPORT) but additional etiologies to include low grade glioma / lymphoma are not excluded.

12/05/2008 15:49 hrs	115th CSH CROPPER (b)(6	CT, HEAD	Observations to follow	Order complete

RAD Information

Imaging Type: **COMPUTERIZED TOMOGRAPHY**
Exam Status: **COMPLETE**
Exam Performing: **CT ROOM**
Transcription Date: **12/05/2008 15:48**
Transcription Report Status: **V**
Transcription Approved by: (b)(6)
Comments:
4\ABNORMALITY, ATTN. NEEDED\99RRC HEAD CT WITH AND WITHOUT CONTRAST
PROCEDURE: Helical CT of brain and 3 mm slice thickness with and without intravenous contrast.

FINDINGS AND IMPRESSION:
1. Vasogenic edema involving the left frontal lobe and corpus callosum. This results in mild intracranial mass effect with effacement of the anterior horn of the left lateral cerebral ventricle.

2. Possible cerebral abscess. On image number 18 of the contrast-enhanced series there is a small area of rim enhancement near the midline of the right frontal lobe. This measures approximately 8 mm by 20 mm in size. Given that the patient has had a prior gunshot wound to the right frontal lobe, the region of rim enhancement and the vasogenic edema and could be explained by an infectious process such as a cerebral abscess.

3. Prior gunshot wound to the right frontal lobe. There is a small anterior calvarial defect and/or multiple metallic shrapnel fragments in the anterior and midportion of the frontal lobe. These could serve as a nidus for infection.

4. No evidence for acute intracranial hemorrhage.

12/05/2008 15:49 hrs	115th CSH CROPPER (b)(6	CT, HEAD (W/CONTRAST)	Observations to follow	Order complete

RAD Information

Imaging Type: **COMPUTERIZED TOMOGRAPHY**
Exam Status: **COMPLETE**
Transcription Date: **12/05/2008 15:48**
Transcription Report Status: **V**
Transcription Approved by: (b)(6)
Comments:
4\ABNORMALITY, ATTN. NEEDED\99RRC HEAD CT WITH AND WITHOUT CONTRAST
PROCEDURE: Helical CT of brain and 3 mm slice thickness with and without intravenous contrast.

FINDINGS AND IMPRESSION:
1. Vasogenic edema involving the left frontal lobe and corpus callosum. This results in mild intracranial mass effect with effacement of the anterior horn of the left lateral cerebral ventricle.

2. Possible cerebral abscess. On image number 18 of the contrast-enhanced series there is a small area of rim enhancement near the midline of the right frontal lobe. This measures approximately 8 mm by 20 mm in size. Given that the patient has had a prior gunshot wound to the right frontal lobe, the region of rim enhancement and the vasogenic edema and could be explained by an infectious process such as a cerebral abscess.

3. Prior gunshot wound to the right frontal lobe. There is a small anterior calvarial defect and/or multiple metallic shrapnel fragments in the anterior and midportion of the frontal lobe. These could serve as a nidus for infection.

4. No evidence for acute intracranial hemorrhage.

Medications

Date	Unit Name (UIC)	Type	Name	Status
12/07/2008 07:52 hrs	115th CSH CROPPER (b)(6)	CUSTOM IV	CUSTOM IV	Discontinue order

Medication Name: **CUSTOM IV**
Message Report Date: **12/07/2008 00:00**
Message Encounter Date: **12/07/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/19/2008 00:00**
IV Component Indicator: **N**
Medication Route: **INJ**
Requested AMT: **2 ML**
Pharmacy Delivery Location: **23, ICU 1**

Medication Name: **SODIUM CHLORIDE 100ML--IV 0.9% SOLN**
Alt Medication Name: **NORMAL SALINE (SODIUM CHLORIDE) 0.9% INTRAVEN. IV SOLN.**
Message Report Date: **12/07/2008 00:00**
Message Encounter Date: **12/07/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/19/2008 00:00**
IV Component Indicator: **Y**
IV Additive Component Type: **Base**
IV Additive Component Units: **ML**

Medication Name: **CEFTRIAXONE--INJ 1GM SOLR**
Alt Medication Name: **CEFTRIAXONE SODIUM (ROCEPHIN) 1G INJECTION VIAL**
Message Report Date: **12/07/2008 00:00**
Message Encounter Date: **12/07/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/19/2008 00:00**
IV Component Indicator: **Y**
IV Additive Component Type: **Additive**
IV Additive Component Units: **GM**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D14**
Start Date: **12/05/2008 22:00**
End Date: **12/19/2008 21:59**
Entered By: (b)(6)
Ordering Provider: (b)(6)

12/07/2008 07:52 hrs	115th CSH CROPPER (b)(6)	INPATIENT MEDICATION	NAPROXEN--PO 500MG TAB	Discontinue order

Medication Name: **NAPROXEN--PO 500MG TAB**
Alt Medication Name: **NAPROXEN 500MG ORAL TABLET**
Message Report Date: **12/07/2008 00:00**
Message Encounter Date: **12/07/2008 00:00**
Order Qty Timing Start Date: **12/06/2008 00:00**
Order Qty Timing End Date: **03/15/2009 00:00**
IV Component Indicator: **N**

Medication Route: **PO**
Requested AMT: **500 MG**
Instructions to Pharmacy: **500**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D99**
Start Date: **12/06/2008 14:36**
End Date: **03/15/2009 14:35**
Entered By: (b)(6)
Ordering Provider: (b)(6)

12/07/2008 07:52 hrs	115th CSH CROPPER (b)(6)	INPATIENT MEDICATION	ONDANSETRON--INJ 2MG/ML SOLN	Discontinue order

Medication Name: **ONDANSETRON--INJ 2MG/ML SOLN**
Alt Medication Name: **ONDANSETRON HCL (ZOFRAN) 2MG/ML INTRAVEN. VIAL**
Message Report Date: **12/07/2008 00:00**
Message Encounter Date: **12/07/2008 00:00**
Order Qty Timing Start Date: **12/06/2008 00:00**
Order Qty Timing End Date: **03/15/2009 00:00**
IV Component Indicator: **N**
Medication Route: **INJ**
Requested AMT: **4 MG**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D99**
Start Date: **12/06/2008 06:00**
End Date: **03/15/2009 05:59**
Entered By: (b)(6)
Ordering Provider: (b)(6)

12/07/2008 07:52 hrs	115th CSH CROPPER (b)(6)	INPATIENT MEDICATION	MORPHINE--INJ 4MG/ML SYRN	Discontinue order

Medication Name: **MORPHINE--INJ 4MG/ML SYRN**
Alt Medication Name: **MORPHINE SULFATE 4MG/ML INJECTION DISP SYRIN**
Message Report Date: **12/07/2008 00:00**
Message Encounter Date: **12/07/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/12/2008 00:00**
IV Component Indicator: **N**
Medication Route: **INJ**
Requested AMT: **2 MG**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D7**
Start Date: **12/05/2008 19:00**
End Date: **12/12/2008 18:59**
Entered By: (b)(6)
Ordering Provider: (b)(6)

12/07/2008 07:52 hrs	115th CSH CROPPER (b)(6	INPATIENT MEDICATION	MORPHINE--INJ 10MG/ML SOLN	Discontinue order

Medication Name: **MORPHINE--INJ 10MG/ML SOLN**
Alt Medication Name: **MORPHINE SULFATE 10MG/ML INJECTION DISP SYRIN**
Message Report Date: **12/07/2008 00:00**
Message Encounter Date: **12/07/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/12/2008 00:00**
IV Component Indicator: **N**
Medication Route: **INJ**
Requested AMT: **8 MG**

Requesting Location: **ICU 1, CAMP CROPPER**

Order Duration: D7
Start Date: **12/05/2008 19:00**
End Date: **12/12/2008 18:59**
Entered By: (b)(6)
Ordering Provider: (b)(6)

F 12/07/2008 07:52 hrs | 115th CSH CROPPER (b)(6 | INPATIENT MEDICATION | ACETAMINOPHEN--PO 325MG TAB | Discontinue order

Medication Name: **ACETAMINOPHEN--PO 325MG TAB**
Alt Medication Name: **ACETAMINOPHEN (TYLENOL) 325MG ORAL TABLET**
Message Report Date: **12/07/2008 00:00**
Message Encounter Date: **12/07/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **03/14/2009 00:00**
IV Component Indicator: **N**
Medication Route: **PO**
Requested AMT: **650 MG**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D99**
Start Date: **12/05/2008 00:00**
End Date: **03/14/2009 17:59**
Entered By: (b)(6)
Ordering Provider: (b)(6)

G 12/07/2008 07:52 hrs | 115th CSH CROPPER (b)(6) | CUSTOM IV | CUSTOM IV | Discontinue order

Medication Name: **CUSTOM IV**
Message Report Date: **12/07/2008 00:00**
Message Encounter Date: **12/07/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/19/2008 00:00**
IV Component Indicator: **N**
Medication Route: **IV**
Requested AMT: **1000 ML**
Pharmacy Delivery Location: **23, ICU 1**

Medication Name: **NO SOLUTION REQUIRED--IV SOLN**
Message Report Date: **12/07/2008 00:00**
Message Encounter Date: **12/07/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/19/2008 00:00**
IV Component Indicator: **Y**
IV Additive Component Type: **Base**
IV Additive Component Units: **ML**

Medication Name: **METRONIDAZOLE (FLAGYL) PREMIX--IV 500MG**
Alt Medication Name: **METRONIDAZOLE/SODIUM CHLORIDE (METRONIDAZOLE) 500MG/0.1L INTRAVEN. PIGGYBACK**
Message Report Date: **12/07/2008 00:00**
Message Encounter Date: **12/07/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/19/2008 00:00**
IV Component Indicator: **Y**
IV Additive Component Type: **Additive**
IV Additive Component Units: **MG**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D14**
Start Date: **12/05/2008 22:00**
End Date: **12/19/2008 21:59**
Entered By: (b)(6)
Ordering Provider: (b)(6)

12/06/2008 14:36 hrs | 115th CSH CROPPER (b)(6) | INPATIENT MEDICATION | NAPROXEN --PO 500MG TAB | New Order

Medication Name: **NAPROXEN--PO 500MG TAB**
Alt Medication Name: **NAPROXEN 500MG ORAL TABLET**
Message Report Date: **12/06/2008 00:00**
Message Encounter Date: **12/06/2008 00:00**
Order Qty Timing Start Date: **12/06/2008 00:00**
Order Qty Timing End Date: **03/15/2009 00:00**
IV Component Indicator: **N**
Medication Route: **PO**
Requested AMT: **500 MG**
Instructions to Pharmacy: **500**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D99**
Start Date: **12/06/2008 14:36**
End Date: **03/15/2009 14:35**
Entered By: (b)(6)
Ordering Provider: (b)(6)

12/05/2008 18:07 hrs | 115th CSH CROPPER (b)(6) | INPATIENT MEDICATION | MORPHINE--INJ 4MG/ML SYRN | New Order

Medication Name: **MORPHINE--INJ 4MG/ML SYRN**
Alt Medication Name: **MORPHINE SULFATE 4MG/ML INJECTION DISP SYRIN**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/12/2008 00:00**
IV Component Indicator: **N**
Medication Route: **INJ**
Requested AMT: **2 MG**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D7**
Start Date: **12/05/2008 19:00**
End Date: **12/12/2008 18:59**
Entered By: (b)(6)
Ordering Provider: (b)(6)

12/05/2008 18:07 hrs | 115th CSH CROPPER (b)(6) | INPATIENT MEDICATION | MORPHINE--INJ 10MG/ML SOLN | New Order

Medication Name: **MORPHINE--INJ 10MG/ML SOLN**
Alt Medication Name: **MORPHINE SULFATE 10MG/ML INJECTION DISP SYRIN**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/12/2008 00:00**
IV Component Indicator: **N**
Medication Route: **INJ**
Requested AMT: **8 MG**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D7**
Start Date: **12/05/2008 19:00**
End Date: **12/12/2008 18:59**
Entered By: (b)(6)
Ordering Provider: (b)(6)

12/05/2008 18:07 hrs | 115th CSH CROPPER (b)(6) | INPATIENT MEDICATION | ONDANSETRON--INJ 2MG/ML SOLN | New Order

Medication Name: **ONDANSETRON--INJ 2MG/ML SOLN**
Alt Medication Name: **ONDANSETRON HCL (ZOFRAN) 2MG/ML INTRAVEN. VIAL**
Message Report Date: **12/05/2008 00:00**

Message Encounter Date: **12/05/2008 00:00**
Order Qty Timing Start Date: **12/06/2008 00:00**
Order Qty Timing End Date: **03/15/2009 00:00**
IV Component Indicator: **N**
Medication Route: **INJ**
Requested AMT: **4 MG**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D99**
Start Date: **12/06/2008 06:00**
End Date: **03/15/2009 05:59**
Entered By: (b)(6)
Ordering Provider: (b)(6)

12/05/2008 17:43 hrs | 115th CSH CROPPER (b)(6) | CUSTOM IV | CUSTOM IV | Order replace request

Medication Name: **CUSTOM IV**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
IV Component Indicator: **N**
Medication Route: **IV**
Requested AMT: **1000 ML**
Pharmacy Delivery Location: **23, ICU 1**

Medication Name: **NO SOLUTION REQUIRED--IV SOLN**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
IV Component Indicator: **Y**
IV Additive Component Type: **Base**
IV Additive Component Units: **ML**

Medication Name: **NO SOLUTION REQUIRED--IV SOLN**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
IV Component Indicator: **Y**
IV Additive Component Type: **Base**
IV Additive Component Units: **ML**

Medication Name: **METRONIDAZOLE (FLAGYL) PREMIX--IV 500MG**
Alt Medication Name: **METRONIDAZOLE/SODIUM CHLORIDE (METRONIDAZOLE) 500MG/0.1L INTRAVEN. PIGGYBACK**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
IV Component Indicator: **Y**
IV Additive Component Type: **Additive**
IV Additive Component Units: **MG**

Requesting Location: **ICU 1, CAMP CROPPER**
Entered By: (b)(6)
Ordering Provider: (b)(6)

12/05/2008 17:21 hrs | 115th CSH CROPPER (b)(6) | CUSTOM IV | CUSTOM IV | New Order

Medication Name: **CUSTOM IV**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/19/2008 00:00**
IV Component Indicator: **N**
Medication Route: **INJ**
Requested AMT: **2 ML**
Pharmacy Delivery Location: **23, ICU 1**

Medication Name: **SODIUM CHLORIDE 100ML--IV 0.9% SOLN**

Alt Medication Name: **NORMAL SALINE (SODIUM CHLORIDE) 0.9% INTRAVEN. IV SOLN.**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/19/2008 00:00**
IV Component Indicator: **Y**
IV Additive Component Type: **Base**
IV Additive Component Units: **ML**

Medication Name: **CEFTRIAXONE--INJ 1GM SOLR**
Alt Medication Name: **CEFTRIAXONE SODIUM (ROCEPHIN) 1G INJECTION VIAL**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/19/2008 00:00**
IV Component Indicator: **Y**
IV Additive Component Type: **Additive**
IV Additive Component Units: **GM**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D14**
Start Date: **12/05/2008 22:00**
End Date: **12/19/2008 21:59**
Entered By: (b)(6)
Ordering Provider: (b)(6)

12/05/2008 17:17 hrs	115th CSH CROPPER (b)(6)	CUSTOM IV	CUSTOM IV	New Order

Medication Name: **CUSTOM IV**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/19/2008 00:00**
IV Component Indicator: **N**
Medication Route: **IV**
Requested AMT: **1000 ML**
Pharmacy Delivery Location: **23, ICU 1**

Medication Name: **NO SOLUTION REQUIRED--IV SOLN**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/19/2008 00:00**
IV Component Indicator: **Y**
IV Additive Component Type: **Base**
IV Additive Component Units: **ML**

Medication Name: **METRONIDAZOLE (FLAGYL) PREMIX--IV 500MG**
Alt Medication Name: **METRONIDAZOLE/SODIUM CHLORIDE (METRONIDAZOLE) 500MG/0.1L INTRAVEN. PIGGYBACK**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **12/19/2008 00:00**
IV Component Indicator: **Y**
IV Additive Component Type: **Additive**
IV Additive Component Units: **MG**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D14**
Start Date: **12/05/2008 22:00**
End Date: **12/19/2008 21:59**
Entered By: (b)(6)
Ordering Provider: (b)(6)

12/05/2008 17:16 hrs | 115th CSH CROPPER (b)(6) | INPATIENT MEDICATION | ACETAMINOPHEN--PO 325MG TAB | New Order

Medication Name: **ACETAMINOPHEN--PO 325MG TAB**
Alt Medication Name: **ACETAMINOPHEN (TYLENOL) 325MG ORAL TABLET**
Message Report Date: **12/05/2008 00:00**
Message Encounter Date: **12/05/2008 00:00**
Order Qty Timing Start Date: **12/05/2008 00:00**
Order Qty Timing End Date: **03/14/2009 00:00**
IV Component Indicator: **N**
Medication Route: **PO**
Requested AMT: **650 MG**

Requesting Location: **ICU 1, CAMP CROPPER**
Order Duration: **D99**
Start Date: **12/05/2008 00:00**
End Date: **03/14/2009 17:59**
Entered By: (b)(6)
Ordering Provider: (b)(6)

11/26/2008 11:34 hrs | 115th CSH CROPPER (b)(6 | PHARMACY DISPENSE ACTION | PIROXICAM--PO 20MG CAP | New Order

Medication Name: **PIROXICAM--PO 20MG CAP**
Alt Medication Name: **PIROXICAM (FELDENE) 20MG ORAL CAPSULE**
Message Report Date: **11/26/2008 00:00**
Message Encounter Date: **11/26/2008 00:00**
Dispense AMT: **30 - 3**
Refill Most Recent Date: **11/26/2008 11:34**
Instructions to Patient: **TAKE ONE CAPSULE EVERY DAY BY MOUTH**
RX#: **AA155074**

Requesting Location: **DMC, CAMP CROPPER**
Entered By: (b)(6)
Ordering Provider: (b)(6)

11/26/2008 10:14 hrs | 115th CSH CROPPER (b)(6) | OUTPATIENT PRESCRIPTION | PIROXICAM--PO 20MG CAP | New Order

Medication Name: **PIROXICAM--PO 20MG CAP**
Alt Medication Name: **PIROXICAM (FELDENE) 20MG ORAL CAPSULE**
Message Report Date: **11/26/2008 00:00**
Message Encounter Date: **11/26/2008 00:00**
Order Qty Timing Start Date: **11/26/2008 00:00**
Order Qty Timing End Date: **11/26/2009 00:00**
IV Component Indicator: **N**
Dispense AMT: **30 - 3**
Instructions to Pharmacy: **CD PO #30 RF3**
Instructions to Patient: **TAKE ONE CAPSULE DAILY BY MOUTH**

Requesting Location: **DMC, CAMP CROPPER**
Order Duration: **D30**
Start Date: **11/26/2008 10:14**
End Date: **11/26/2009 10:14**
Entered By: (b)(6)
Ordering Provider: (b)(6)

Attached Files
View or Add Attached Files - 0 Current

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE: 2 DEC 06

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

COMPOUND: 3B

MEDIC: (b)(6)

GUARD: (b)(6)

TIME OF CALL: 1830

COMPLAINT: elevated BP + headache

VITALS

TIME MEDIC ARRIVES: 1845

BP: 102/70

SYMPTOMS: 41 y/o male complains of headache from forehead down his face. Went to sick call 2 days ago. Says he was not given meds. C/O left eye pain w/ difficulty seeing. Says cannot eat. Drank 2 bottles H2O.

P: 78

RESP: 18

PAST MEDICAL HISTORY: 2 yrs ago car explosion and he had pieces hit his head. Has had chronic headaches since.

TEMP

PAIN: 8

QUALITY: Radiates occipital up @ his face

P O2

RADIATION: 12

SEVERITY:

ALLERGIES

TIME OF ONSET: 3 days ago

BGL (IF NEEDED)

MEDICATIONS:

DISPOSITION: Tylenol x2 81mg sick call

TIME OF DISPOSITION: 1907

ER PROVIDER(DR / RN ONLY) (b)(6)

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

ISN (b)(6)

DATE OF BIRTH / AGE

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. JUN 1997)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
APD PE v2.00

~~FOR OFFICIAL USE ONLY~~
~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE: 12/02/08

COMPOUND: 3B

MEDIC: (b)(6)

GUARD: (b)(6)

TIME OF CALL: 2215

COMPLAINT: SOB

VITALS

TIME MEDIC ARRIVES: 2220

BP: 110/70

SYMPTOMS: 41 y/o c/o SOB, headache, generalized body ache x 3 days. Got an worse on last 2 hours. Pt cannot walk

P: ~~90~~ 92

22:35 - 66

RESP: 22

PAST MEDICAL HISTORY:

TEMP: 98.0

PAIN:

QUALITY:

P O2: ~~75~~ 90 R: 99

RADIATION:

SEVERITY:

ALLERGIES: NKA

TIME OF ONSET:

BGL (IF NEEDED)

MEDICATIONS: Piroxicam 20mg

DISPOSITION:

Pt refused 800 mg motrin. Pt advised to see sick call if symptoms persist.

TIME OF DISPOSITION: 2240

ER PROVIDER(DR / RN ONLY)

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

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

REGISTER NO.

WARD NO.

ISN (b)(6)

DATE OF BIRTH / AGE

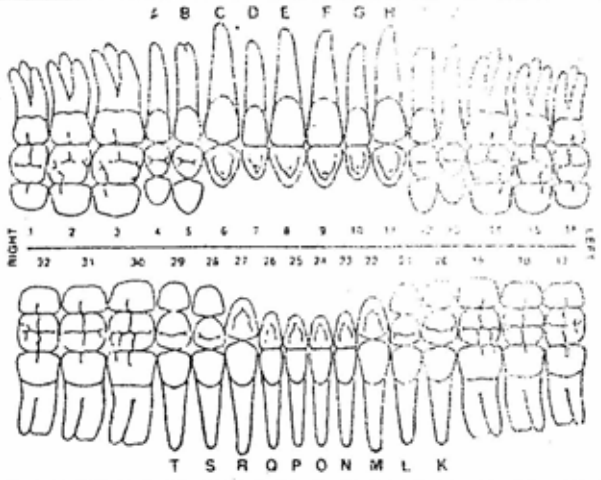
CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. JUN 1997)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

APD PE v2.00

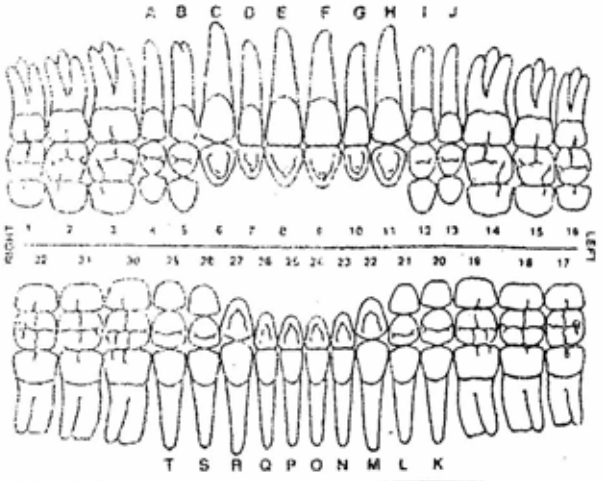
0035-08-CID789-53215

SECTION II. CHRONOLOGICAL [illegible] DENTAL CARE PAGE:

8 RESTORATIONS AND TREATMENTS (Completed during service)



9 SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

REMARKS

10. SERVICES PROVIDED

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TREATMENT FACILITY (Sign each entry)	CLASS
27,	EXT: 3,4,5,6, 12, 13, 14 DX: retained root tips	
	BP: 95 / 62	
	~~Reviewed medical history with translator including current~~ medications and allergies. 1 PA taken.	
	LA: 3 Carpules 2% Lidocaine w/ 1:100k epi	
	~~0~~ Carpules 3% Mepivicaine w/o epi	
	2 Carpules 4% Articaine w/ 1:100k epi	
	Other:	
	~~Removed tooth with suitable instruments. Curretted socket and~~ irrigated with sterile water. Placed Alvogyl in socket.	
	Surgical Narrative (if applicable): N.S removed all root tips	
	~~Post-op instructions given through translator. Patient ambulatory and~~ bleeding controlled.	
	Medications:	
	✓ Amoxicillin 500 DISP: 21tabs SIG: 1 tab TID	
	___ Augmentin 875 DISP: 20 tabs SIG: 1 tab BID	
	___ Clindamycin 150 DISP: 28 tabs SIG: 1 tab QID	
	___ Naproxen 500 DISP: 20 tabs SIG: 1 tab BID	
	___ Tramadol 50 DISP: 10 tabs SIG: 1 tab QID	
	Other: Motrin 800 mg Disp 21 tabs TTID	

(b)(6)

~~10-I-0126 ACLU DDII~~ CID ROI 19865

~~LAW ENFORCEMENT SENSITIVE~~ EXHIBIT 3 80

000080

0035-08-CID789-53215

RADIOLOGY REPORT

PATIENT NAME	(b)(6)
DATE OF BIRTH	
PATIENT NUMBER	(b)(6)
REFERRING PHYSICIAN	
MODALITY TYPE	CR
INSTITUTION NAME	Initial Hospital Name
EXAM DATE	20071101
EXAM TYPE	Chest

STUDY COMMENTS

HISTORY

COMPARISON EXAMINATIONS

None.

FINDINGS AND IMPRESSION

Asymmetric configuration of the upper thoracic cage is likely congenital. No acute findings.

(b)(6)

2007-11-1 16:59

Cropper Medweb 1

(b)(6)

DIGITAL SIGNATURE
Signer name: (b)(6)
Organization: Cropper Medweb 1
Signed: 2007/11/01.16:59:47

Reply

0035-08-CID789-53215

AUTHORIZED FOR LOCAL REPRODUCTION

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

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

DETAINEE HEALTH AND MEDICAL RECORD OF SCREENING EXAMINATION
(SF600 OVERPRINT, VER 13, IAW AR 190-8)

24 Nov 2004 ALLERGY: FOOD - MEDICINES - INSECTS - PLANTS NKDA

GENERAL INFORMATION(CHECK ALL THAT APPLY IN THE DETAINEE HEALTH HISTORY)

"TRANSLATOR PRESENT"

SURGERIES ( )
CONVULSIONS/SEIZURES ( )

Med Illness Migraine

HEMOPHILIA ( )
MALARIA ( )

IMMUNIZATION GIVEN AT INTAKE?
TB/BLOOD IN SPUTUM/NIGHT SWEATS ( )

ASTHMA ( )
DIABETES (X) NIDDM

LIST ALL MEDICATIONS TAKEN
IN THE 30 DAYS PRIOR TO TODAY:

HIGH BLOOD PRESSURE ( )
CANCER/LEUKEMIA ( )

Surg Left Arm

HEART TROUBLE ( )
KIDNEY DISEASE ( )

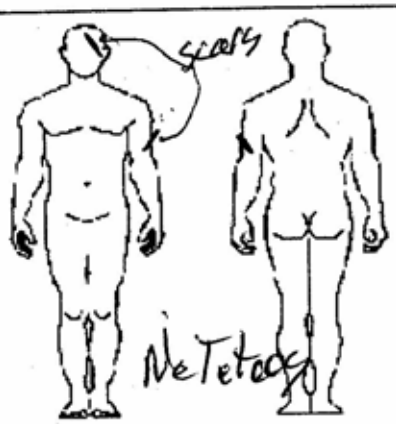
Allergy to

VISUAL IMPAIRMENT ( )
HIV/AIDS ( )

TOBACCO USE Y / N 1 PP DAY X 10 YRS
ETOH: None

STD ( )

Medications for Migraines Not at Baccy

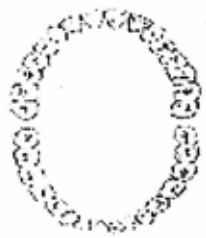


T ____ BP 119 / 60 PULSE 68 BICEPS CIRC ____
HEIGHT ____ WEIGHT 138 BMI ____

( )DETAINEE HAS OVERALL ( )GOOD ( )FAIR ( )POOR STATE OF NUTRITION

VISION: NORMAL (X) GLASSES ( )
HEARING: NORMAL (X) ABNORMAL ( ) EXPLAIN:

DENTAL



Poor

OVERALL APPEARANCE WNL

HEENT WNL

HERNIA dot

SKIN/SCARS/BRUISING No

GENITAL (b)(6)

CARDIOPULMONARY SYSTEM WNL

NEUROBEHAVIORAL

MUSCULOSKELETAL Age/Skeletal-wnl

DETAILS ON REVERSE SIDE

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

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

REGISTER NO.	WARD NO.

ISN ____ CAMP ____

NAME (b)(6)

DOB ____ AGE ____ SEX ____

PROVIDER (b)(6)

DACA RS SCREEN

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

24 Nov 2004

CONTINUATION OF CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 11-91)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

000082 USAPA V2.00

82 3

EXHIBIT

ACLU-RDI 5594 p.82

ACLU-RDI 19867

0035-08-CID789-53215

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	DETAINEE HEALTH AND MEDICAL RECORD OF SCREENING EXAMINATION (SF600 OVERPRINT, VER 13, IAW AR 190-8)
	CONTINUATION: No Complaints
	IMMUNIZATION GIVEN TODAY (CIRCLE):
	MMR POLIO HEPA HEPB TYPHOID OTHER:_____
	LABS(CIRCLE): CBC CHEM 7 UA PPD OTHER:_____
	CHEST XRAY: NAD ( )
	LIMITATIONS: ACTIVITY RESTRICTIONS: None DIET RESTRICTIONS: OTHER RESTRICTIONS:
	TRAVEL: GO / NO-GO (IF NO-GO LIST REASONS)
	ISN_____ CAMP_____ NAME DOB_____ AGE SEX PROVIDER_____

EXHIBIT 3

10-L-0126 ACLU RDII CID ROI 19868

29 Nov 2005

(b)(6)

83

000083

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

STANDARD FORM 600 REV. 6-97 BACK
USAPA V2.00

ACLU-RDI 5594 p.83

(b)(6)

Eye Health Questionnaire

(b)(6)

0035-08-CID789-53215

AUTHORIZED FOR LOCAL REPRODUCTION

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

DETAINEE HEALTH AND MEDICAL RECORD OF SCREENING EXAMINATION
(SF600 OVERPRINT, VER 13, IAW AR 190-8)

EXAMINATION PER AR 190-8 6-6	DATE	TRAVEL GO / NO-GO	CORRECTED TO GO	COMMENTS
MEDICAL EXAMINATION WAS COMPLETED				
DENTAL SCREENING WAS COMPLETED				
CHEST XRAY / TB SCREEN WAS COMPLETED				
NUTRITION SCREENING WAS COMPLETED				
BEHAVIORAL HEALTH SCREENING WAS COMPLETED				

LIMITATIONS:
ACTIVITY RESTRICTIONS:
DIET RESTRICTIONS:
OTHER RESTRICTIONS:

Ward

TRAVEL: GO / NO-GO
(IF NO-GO LIST REASONS)

(b)(6)

PROVIDER SIGNATURE AND DATE

24 Nov 2008

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

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

ISN_____CAMP_____
NAME_____
DOB_____AGE_____SEX_____
PROVIDER_____

REGISTER NO.	WARD NO.

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

10-L-0126 ACLU DDII CID ROI 19870

85

EXHIBIT

000085

(b)(6)

~~FOR OFFICIAL USE ONLY~~
~~LAW ENFORCEMENT SENSITIVE~~

0035-08-CID789-53215

Detainee Health Mental Screen

DATE 24 Nov 06

ISN_____

Everyone here is asked these questions. They are used to determine if you need to be seen for treatment and will not affect whether or not you stay here.

Current Concerns

1. Are you currently being treated for a psychological problem? (if the answer is NO, skip question #2) _____ Yes ___X___ No
2. Are you presently taking a prescribed medication for a mental illness or a psychological problem? _____ Yes ___X___ No
3. Do you have psychological problems right now that need treatment? _____ Yes ___X___ No
4. Do you presently have thoughts of killing yourself? _____ Yes ___X___ No

Past Concerns

5. Have you ever been treated for a psychological problem in the past? (if the answer is NO, skip question #6) _____ Yes ___X___ No
6. Have you ever been a patient in a psychological hospital? _____ Yes ___X___ No
7. Have you ever been treated for illegal drug abuse? _____ Yes ___X___ No
8. Have you ever tried to kill yourself? _____ Yes ___X___ No

Open-Ended(if time permits: vary as appropriate)

9. Do you have any other psychological concerns that you want to mention?

OBSERVATION

General appearance unusual for setting	_____ Yes	___X___ No
Behavior unusual for setting	_____ Yes	_____ No
Auditory or visual hallucinations reported or apparent	_____ Yes	_____ No
Appears anxious	_____ Yes	_____ No
Appears depressed	_____ Yes	_____ No
Aggressive	_____ Yes	_____ No
Behavior inconsistant with reported complaints	_____ Yes	_____ No
Physical trauma evident during interview (wound,bruise,etc.)	_____ Yes	_____ No

DISPOSITION

___X___ If detainee answers no to all of the above questions, no psych consult is needed.
_____ If detainee answers yes to questions 1,2,3 or 4 contact mental health team ASAP.
_____ If detainee answers yes to questions 5,6,7 or 8 fill out consult form for psych.
_____ If observations are inconsistant with responses and clinical concern exists, consult with mental health team.

SCREENER: (b)(6)

(b)(6)

863

EXHIBIT

000086

0035-08-CID789-53215

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	****LIST ANY YES RESPONSES IN REMARKS SECTION PROVIDED****

Y N

( ) ( ) Hx of EtOH abuse/treatment (Date)

( ) ( ) Current physical complaints:

1. Rash 3. Pain: (indicate level)_____ 5. Contagious disease in past 12 months

2. Diarrhea/vomiting 4. Lice/other infestation 6. Other

TUBERCULOSIS QUESTIONNAIRE

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

Y	N		Y	N	
( )	( )	Persistent cough/shortness of breath	( )	( )	Cough with blood and/or dry cough
( )	( )	Unexplained weight loss/diarrhea x 2 wks	( )	( )	Unexplained persistent fever
( )	( )	Night sweats	( )	( )	Swollen glands/lymph nodes
( )	( )	Prolonged fatigue or run down feeling	( )	( )	Loss of appetite and/or pustules in mouth
( )	( )	Recent exposure to someone with TB	( )	( )	Past abnormal x-ray (Date)
( )	( )	Hepatitis B series completed	( )	( )	Previous TB infection or treatment
( )	( )	Stomach surgery, kidney failure, blood disorder			

Notes or remarks:

(b)(6)

4 Nov 2008

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

ISN (b)(6)

CAPTURE /HOSPITAL NUMBER

RECORDS MAINTAINED AT:

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

RELATIONSHIP TO SPONSOR: | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

DOD ID NUMBER | SSN (IF DIFFERENT) | DATE OF BIRTH

AGENT'S INVESTIGATION REPORT

ROI NUMBER 0219-08-CID919

CID Regulation 195-1

PAGE 1 OF 1 PAGES

DETAILS

BASIS FOR INVESTIGATION: On 8 Dec 08, this office received a Request For Assistance (RFA) from the Camp Cropper CID Office to obtain medical records, interview medical personnel, and to photograph a deceased Mr. Muhammad F. MARUSH.

About 1340, 8 Dec 08, SA (b)(6), (b)(7)(C) coordinated with MSg (b)(6), (b)(7)(C) Patient Administration Department (PAD), Air Force Theater Hospital (AFTH), Joint Base Balad (JBB), Iraq, who provided medical records pertaining to Mr. MARUSH. A review of the medical records revealed Mr. MARUSH was pronounced deceased at 2245, 7 Dec 08, by Dr. (LTC) (b)(6), (b)(7)(C) ICU DR, 332 Expeditionary Medical Group, JBB, Iraq.

About 1400, 8 Dec 08, SA (b)(6), (b)(7)(C) coordinated with Dr. (MAJ) (b)(6), (b)(7)(C) Neurosurgeon, AFTH, JBB, Iraq, who related the Camp Cropper hospital forwarded Mr. MARUSH's CT scan and gave a brief diagnosis of Mr. MARUSH symptoms. Dr. (b)(6), (b)(7)(C) MAJ (b)(6), (b)(7)(C) conferred with Dr. (b)(6), (b)(7)(C) Neurosurgeon, and Dr. (b)(6), (b)(7)(C) Infectious Disease, both of AFTH, JBB, which all concluded he was doing fine and not of need for transfer. MAJ (b)(6), (b)(7)(C) nstructed Camp Cropper medical staff to put Mr. MARUSH on medication and schedule another CT scan in 7-10 days unless Mr. MARUSH got worse, in which case MAJ (b)(6), (b)(7)(C) was to be notified. MAJ (b)(6), (b)(7)(C) related according to Mr. MARUSH's CT scan, he wasn't worried Mr. MARUSH would get worse. The sudden decline in health of Mr. MARUSH was completely unexpected. MAJ (b)(6), (b)(7)(C) related when Mr. MARUSH arrived at the AFTH, he had no brain function, and his body was cold. MAJ (b)(6), (b)(7)(C) erformed a Bi-lateral Craniotomy Ventriculosomy on Mr. MARUSH, and after the surgery, MAJ (b)(6), (b)(7)(C) eleased Mr. MARUSH to the recovery room.

About 1430, 8 Dec 08, SA (b)(6), (b)(7)(C) coordinated with SSG (b)(6), (b)(7)(C) Mortuary Affairs, JBB, who related Mr. MARUSH arrived at Mortuary Affairs at 0015, 8 Dec 08, and was processed and shipped out at 0331, 8 Dec 08, to Dover Air Force Base. SSG (b)(6), (b)(7)(C) provided all records pertaining to Mr. MARUSH.

About 1610, 9 Dec 08, SA (b)(6), (b)(7)(C) interviewed Dr. (b)(6), (b)(7)(C) who related when Mr. MARUSH arrived in the emergency room, his pupils were fully dialated, fixed and unresponsive to light. Further, the CT scans Mr. MARUSH arrived with showed he was in Uncle Herniation, a condition in which the patient's brain swelled pushing the brain down the spinal cord, severing vital bodily functions, such as breathing and motor skills. Dr. (b)(6), (b)(7)(C) related Dr. (b)(6), (b)(7)(C) would have pronounced Mr. MARUSH dead at the time of his arrival, but he was hypothermic. D (b)(6), (b)(7)(C) lated they are taught in medical school not to pronounce anyone dead who is hypothermic, due to the fact hypothermia can mimic other conditions. Dr. (b)(6), (b)(7)(C) instructed the patient be put in ICU and warmed up, at which time, Dr (b)(6), (b)(7)(C) would re-assess the situation. Around 2300 the patient's blood pressure and heart rate became hypotensive, and then bradycardiac, and then finally stopped. Dr (b)(6), (b)(7)(C) related any life saving measures taken would have been futile, because the injuries were not compatible with life. Dr. (b)(6), (b)(7)(C) lated since he was the doctor on duty in the ICU, he was the one who pronounced Mr. MARUSH dead. ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	SIGN	DATE
SA (b)(6), (b)(7)(C), (b)(7)(F) 38th MP DET (CID), Joint Base Balad	(b)(6), (b)(7)(C)	9 Dec 08

0219-08-CID419

0035-08-CID789-53215

MILITARY OPERATIONS
RECORD OF PERSONAL EFFECTS OF DECEASED PERSONNEL

1. DATE (YYYYMMDD): 2008(b)(6)

2. PAGE 1 OF 1 PAGES

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC Sections 1481 through 1488, EO 9397, Nov 1943 (SSN)

PURPOSE AND USE: This form is used to establish initial identification of deceased personnel

DISCLOSURE: Personal information provided on this form is given on a voluntary basis. Failure to provide this information, however, may result in improper identification of the deceased person and person making visual identification.

3. TENTATIVELY IDENTIFIED DECEDENT

a. NAME (Last, First, Middle Initial) (or Unidentified)	b. GRADE	c. SSN	d. ORGANIZATION	e. STATUS	f. DATE OF STATUS (YYYYMMDD)
BTB: UNKNOWN	N/A	(b)(6)	IRAQI DETAINEE	Deceased	2008(b)(6)

4. PLACE OF RECOVERY (Include grid coordinates)	5. DATE OF RECOVERY (YYYYMMDD)	6. EVACUATION NUMBERS a. #1	b. #2
332 EMDG BALAD AB, IRAQ	2008(b)(6)	(b)(6)	

7. INVENTORY OF EFFECTS

a. QUANTITY	b. DESCRIPTION	c. RECEIVED	d. CONDITION	e. DISPOSITION
	----------NONE FOUND----------	----------	----------	----------

8. FUNDS/NEGOTIABLE INSTRUMENTS/OTHER HIGH VALUE ITEMS TRANSMITTED WITH EFFECTS

a. QUANTITY	b. DESCRIPTION	c. RECEIVED	d. CONDITION	e. DISPOSITION
	----------NONE FOUND----------	----------	----------	----------

9. EFFECTS INVENTORIED ABOVE REPRESENT (X as appropriate)

[ ] ALL KNOWN EFFECTS [ ] ALL KNOWN EFFECTS RECOVERED FROM UNIT [X] ALL KNOWN EFFECTS RECOVERED FROM REMAINS

10. PREPARING OFFICIAL

a. NAME (Last, First, Middle Initial)	b. GRADE	c. ORGANIZATION	e. DATE SIGNED
(b)(6)	(b)(	111TH QM CO.	

d. SIGNATURE

For Official Use Only
Law Enforcement Sensitive

5
89

0219-08-CID919

0035-08-CID789-53215

RECORD OF IDENTIFICATION PROCESSING
(Effects and Physical Data)

DATE: 2008(b)(6)

LAST NAME - FIRST NAME - MIDDLE INITIAL (Or alias - known number)	GRADE	SERVICE NO.	SSAN	OLC CASE NUMBER (If applicable)
BTB: UNKNOWN	NA	(b)(6)		NA

NAME OF CEMETERY, EVACUATION NUMBER, OR SEARCH AND RECOVERY NUMBER	PLOT	ROW	GRAVE
(b)(6)	NA	NA	NA

RECEIVED FROM
332 EMDG BALAD AB, IRAQ

IMPRINT OF IDENTIFICATION TAG

OFFICIAL IDENTIFICATION FOUND WITH REMAINS *(Include personal effects aiding identification)*
----------NONE FOUND----------

ITEMS OF CLOTHING AND EQUIPMENT FOUND WITH REMAINS *(Indicate type, color, size, markings, service, etc. If laundry marks are indistinct, follow procedures outlined inTM10-286)*
----------NONE FOUND----------

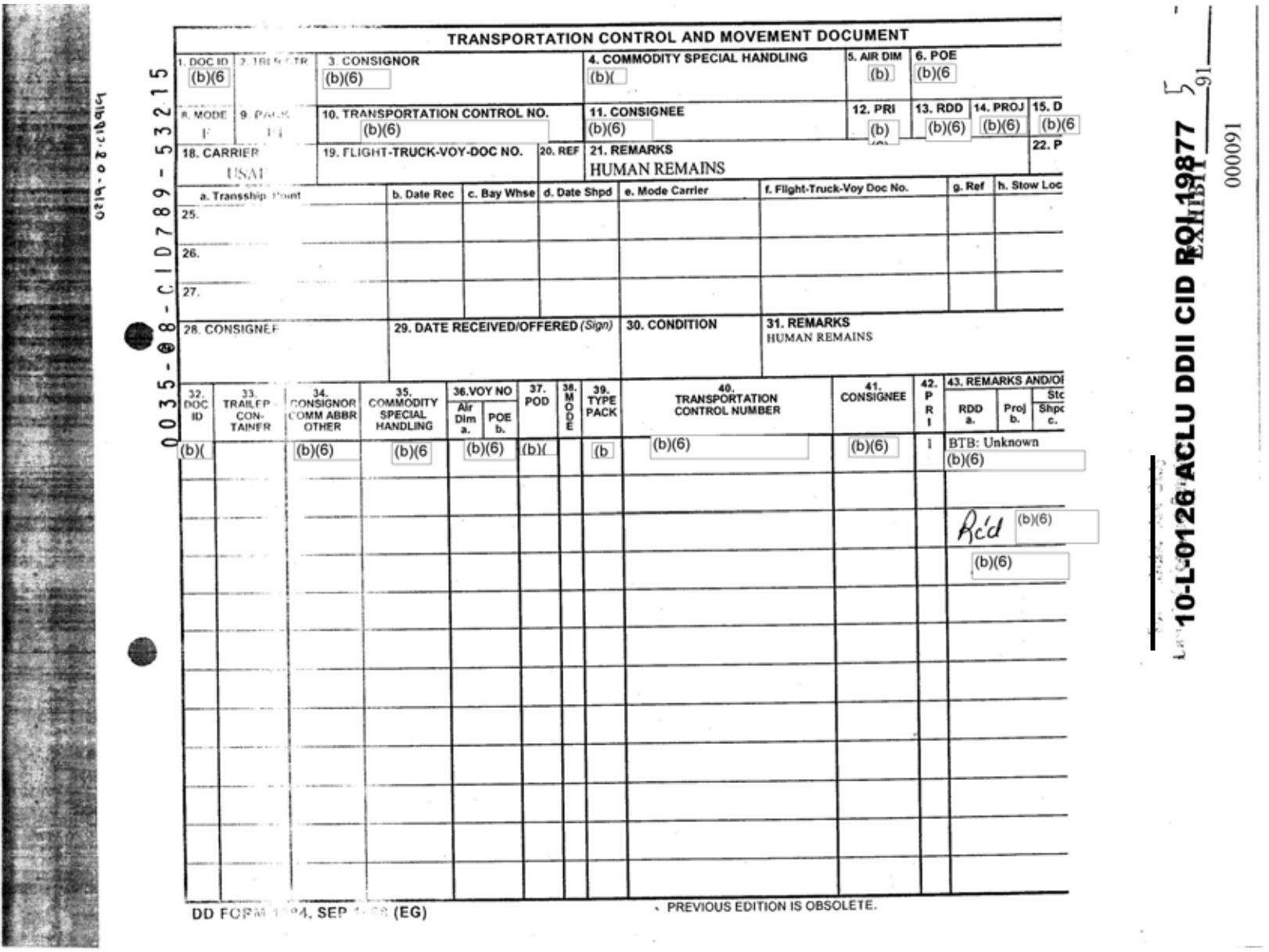
FINGERPRINTS TAKEN	X-RAYS MADE	FLUOROSCOPE STATEMENT ATTACHED
☐ YES ☒ NO	☐ YES ☒ NO	☐ YES ☒ NO
PHOTOGRAPHS TAKEN	**ANTHROPOLOGICAL STATEMENT MADE**	**CHEMICAL STATEMENT ATTACHED**
☐ YES ☒ NO	☐ YES ☒ NO	☐ YES ☒ NO

PHYSICAL DESCRIPTION

ESTIMATED HEIGHT	MUSCULARITY	COLOR OF HAIR	RACE OR NATIVITY
71"	SLENDER	BLACK	MONGOLOID

TATTOOS, SCARS OR MARKS ON BODY
LEFT ARM- VERTICAL SCAR APPROX. 1 IN. ABOVE ELBOW/ RIGHT ARM- 1 IN. OVAL SCAR/ INSIDE RIGHT FOREARM- TATTOO OF ARABIC WRITING/ BEND OF LEFT ARM- 1 IN. SCAR EXTENDING TO INSIDE OF LEFT ARM/ SMALL TATTOO ON TOP OF RIGHT HAND----------NOTHING FOLLOWS----------

EXHIBIT 5



TRANSPORTATION CONTROL AND MOVEMENT DOCUMENT

1. DOC ID	2. [illegible]	3. CONSIGNOR	4. COMMODITY SPECIAL HANDLING	5. AIR DIM	6. POE
(b)(6		(b)(6)	(b)(	(b)	(b)(6

8. MODE	9. PACK	10. TRANSPORTATION CONTROL NO.	11. CONSIGNEE	12. PRI	13. RDD	14. PROJ	15. D
F	[illegible]	(b)(6)	(b)(6)	(b)	(b)(6)	(b)(6)	(b)(6

18. CARRIER	19. FLIGHT-TRUCK-VOY-DOC NO.	20. REF	21. REMARKS	22. P
USAI			HUMAN REMAINS	

a. Transship Point	b. Date Rec	c. Bay Whse	d. Date Shpd	e. Mode Carrier	f. Flight-Truck-Voy Doc No.	g. Ref	h. Stow Loc
25.							
26.							
27.							

28. CONSIGNEE	29. DATE RECEIVED/OFFERED (Sign)	30. CONDITION	31. REMARKS
			HUMAN REMAINS

32. DOC ID	33. TRAILER CONTAINER	34. CONSIGNOR COMM ABBR OTHER	35. COMMODITY SPECIAL HANDLING	36. VOY NO Air Dim a.	36. VOY NO POE b.	37. POD	38. MODE	39. TYPE PACK	40. TRANSPORTATION CONTROL NUMBER	41. CONSIGNEE	42. PRI	43. REMARKS AND/OR RDD a.	Proj b.	Shpc c.
(b)(		(b)(6)	(b)(6	(b)(6)		(b)(		(b	(b)(6)	(b)(6)	1	BTB: Unknown (b)(6)		
												Rc'd (b)(6)		
												(b)(6)		

DD FORM [illegible]4, SEP [illegible] (EG) PREVIOUS EDITION IS OBSOLETE.

0035-08-CID789-53215

10-L-0126 ACLU DDII CID ROI 19877 EXHIBIT 91

000091

0219-08-CID919

0035-08-CID789-53215

CONVOY LIST OF REMAINS OF DECEASED PERSONNEL

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC Sections 1481 through 1488, EO 9397, Nov 1943 (SSN)

PURPOSE AND USE: This form is used to establish initial identification of deceased personnel.

DISCLOSURE: Personal information provided on this form is given on a voluntary basis. Failure to provide this information, however may result in improper identification of the deceased person and person making visual identification.

1. FROM	2. TO	3. DATE PREPARED (YYYYMMDD)	4. PAGE
BALAD(MACP)	DOVER	2008 (b)(6)	1 OF 1 PAGES

5. VEHICLE/AIRCRAFT ID NUMBER	6. EVACUATION NUMBER	7. TENTATIVELY IDENTIFIED DECEDENT (If unidentified, so state)			
		a. NAME (Last, First, Middle Initial)	b. GRADE	c. SSN	d. ORGANIZATION
(b)(6)	(b)(6)	BTB: UNKNOWN	N/A	(b)(6)	IRAQI DETAINEE
(b)(6)	----------	-----NOTHING FOLLOWS-----	----------	----------	----------
(b)(6)					

EXHIBIT 5

10-L-0126 ACLU DDII CID ROI 19878

92

USE BALL POINT PEN
PRESS HARD

AUTHORIZATION AND TREATMENT STATEMENT

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - See Reverse)

I. ADMISSION *(CLINIC PERSONNEL OR PROVIDER FILL IN CIRCLED ITEMS)*

0835 08 - 10789 - 53215

1. REGISTER NO. (b)(6)	NSSUF	(2.) NAME *(Last, First, Middle Initial)* Unk, Unk					3. RELIGION		
4. FACILITY CODE 5602	5. MEDICAL TREATMENT FACILITY 332 EMDG BALAD AB, IRAQ					6. TIME OF ADM 1150	(7.) DATE OF ADM (b)(6) 08	8. TYPE OF CASE BI / NBI	
9. FMP 20	SSN (b)(6)	10. BENEF TYPE see below	11. GRADE SI	12. AFSC	13. AVIATION SVC CODE	14. RATING	15. LENGTH OF SVC	16. AGE (b)	
17. SEX (b)	18. MARITAL STATUS	19. RACE/ COLOR	20. ZIP CODE	21. CURRENT ORGANIZATION DETAINEE Iraq:				(22.) INPATIENT UNIT ICU	
23. FAC INT ADM CODE		24. FACILITY OF INITIAL ADMISSION		25. DATE INITIAL ADM			26. ROOM	27. B (b)(6)	
28. PRIOR ADM ☐ YES ☐ NO		29. CLINIC SERVICE *(S)* (for same day surgery see below)					30. ADMISSION CLERK (b)(6)		
31. EMERGENCY ADDRESSEE/RELATIONSHIP				32. NAME AND ADDRESS OF SPONSOR					
(33.) PRIMARY ADMISSION DIAGNOSIS (b)(6)				(34.) SECONDARY ADMISSION DIAGNOSIS					
35. (b)(6) / Altered Mental Status from previous GSW									324.0
36A. DEPOSIT VALUABLES FOR SAFEKEEPING ☐ YES ☒ NO	36B. I have read and understand the Privacy Act and Disengagement Statements on the reverse of this form.			SIGNATURE OF PATIENT OR SPONSOR			(37.) ADMITTING PROVIDER		

II. TREATMENT

38. DIAGNOSES - PROCEDURES

Same Day Surgery: Gen Surg Neuro GYN Ophth ENT Ortho Uro OMFS Plastic Med GI

Same Day Surgery Date: _____

Beneficiary Type: US/Coalition: USA USAF USMC USN Coalition Other
Iraqi: Iq Police Iq Army Host Nation Civilian
Detainee: Security Internee
Other: TCN Other

NSI / VSI (SI)

DOB: 1 Jan 68

PATIENT ORIGINATED FROM: Cropper

MEDEVAC COMPANY / CALL SIGN: (b)(6)

LNO:

LOD: ☐ YES ☐ EPTS, LOD not applicable ☐ AF Form 348 (Check ☐ if continued on reverse)

39. PROVIDERS OF CARE

ED Date: 7 Dec 08
ED Time: 0955
ED (b)(6)

(Check ☐ if continued on reverse)

40. ADMINISTRATIVE DATA *(Change in physical profile required ☐ YES (Prepare AF Form 422) ☐ NO)* ...sal Card ☐ YES ☐ NO)

TC-2 Full Reg (b)(6) Admission: TMDS Adm (b)(6) I (b)(6) Discharge (b)(6) TMDS _ I (b)(6)

Bed Status Pending (b)(6) TC-2 Adm (b) TC-2 (b)(6) E

(Check ☐ if continued on reverse)

41. DISPOSITION	42. DATE OF DISPOSITION	43. TIME OF DISPOSITION	44. CC OF WHOLE BLOOD	45. CC OF PACKED CELLS	46. CONVALESCENT LEAVE TAKEN	46. CONVALESCENT LEAVE RECOMMENDED
Expired	(b)(6) 08	0845				

47. SIGNATURE (b)(6) ...IDER | 48. SIGNATURE OF PATIENT AFFAIRS OFFICIAL

AF IMT 560, ..., PREVIOUS EDITION WILL BE USED.

10-L-0126 ACLU DDII CID ROI 19879

EXHIBIT 93 5

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

ACLU-RDI 5504 p.93

000093

0035-08-CID789-53215

~~FOR OFFICIAL USE ONLY~~

TMIP | Theater Medical Data Store

Print Window | Close Window

Inpatient Record

Demographics Information

The demographic information is protected health information, and will not be shown.

Encounter Information

Encounter Date: (b)(6) **2008 00:00**
Report Date: (b)(6) **2008 00:00**
Provider:
Blood Received Transfusion: **N**

Facility: **332 EMDG-BALAD (JPTA_IRA1)**
Data Source: **TMIP (TMDS)**
Report Date: (b)(6) **2008 00:00**

Disposition Information

Disposition: **DECEASED**

Referred/Evac Mode: **CROPPER**

Diagnosis Information

Primary Diagnosis
324.0, INTRACRANIAL ABSCESS

Original DNBI: **Unknown**
Mapped DNBI*: **Neurological**

Circumstance: **BATTLE INJURY**
Initial Visit: **Y**

Admission/Discharge Information

Admission data has not been received for this patient.
Discharge data has not been received for this patient.

Notes

Administration Notes

Date	Type
(b)(6) 2008 09:01	ADMISSION

* Original DNBI refers to the original DNBI category that came in the file. Mapped DNBI category refers to the category that is used for surveillance. In general, the mapped category will be the same as original category, unless 1) this encounter is a follow up, in which case the mapped category will be changed to "Miscellaneous/Administration/Follow-up" or 2) the original category was "Unknown," in which case the DOD ICD9 code to DNBI Category mapping is used.

EXHIBIT 5

Personal Data - Privacy Act of 1974 (PL 93-579)
Progress Notes
0035-08-CID789-53215

Report requested by: (b)(6)

(b)(6) 2008@2105 INPT Register # (b)(6) CLINICAL NURSE
ICU Nursing Note
DATE/TIME OF ASSESSMENT: (b)(6) 08 @ 1900.

Neurological:
Left Pupil: Nonreactive To Light Size: Fixed and dilated Right Pupil:
Nonreactive To Light Size: Fixed and dilated LOC: See Note
Motor: No movement Speech: See Note Memory: UTA, intubated Gag reflex: UTA
GCS:
Eye Opening 1- None Verbal 1- None Motor 1- None
Total GCS 3
RASS Score: N/A
Note:
unresponsive no gag reflex or corneal reflex. ventric z/l to tragus. head wrapped with gauze. jp drain bloody drainage

Respiratory:
Sounds: RUL: WNL no adv. sounds RLL: WNL no adv. sounds
Sounds: LUL: WNL no adv. sounds LLL: WNL no adv. sounds
Secretions: Thin Color: Yellow ETT: 7.5 Position: 22
Trach: N/A Type: N/A Oxygen: Ventilated Rate: WNL
CT: N/A Pleura VAC: N/A CT: N/A Pleura VAC: N/A
Note:
simv 35/700/14/5/ps10. breathing 4-5 over vent.. symmetrical, unlabored.

Cardiac:
Rhythm: Sinus Tachycardia Sounds: Audible S1/S2
Neck Veins flat at 45 degrees Yes Capillary Refill < 2 sec
LUE peripheral pulses +2 WNL Edema: None RUE peripheral pulses +2 WNL
Edema: None
LLE peripheral pulses +2 WNL Edema: None RLE peripheral pulses +2 WNL
Edema: None
Note:

Gastrointestinal:
Abdomen: Soft Non-Tender Bowel Sounds: Positive Diet: NPO
BM: N/A Color:None Colostomy: N/A
NG: N/A To: N/A OG: Yes To: Intermittent suction
DHT: N/A PEG: N/A
Note:

Genitourinary:
Void: Foley Catheter Size:18 Fr Color: Yellow Character: Clear
Note:

Skin:

==========

(b)(6) UNKNOWN,UNKNOWN
(b)(6)
Loc:
Spon: UNKNOWN,UNKNOWN
Unit:

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

Automated version of SF509/SF600

EXHIBIT 5

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

Report requested by: (b)(6) 0035-08-CID789-53215

General Appearance: WNL Color and Pigmentation: NFR
Temperature: Warm Turgor: WNL Moisture: WNL
Note:
Increasing temp of 101.6 notified to (b)(6). No orders given. Continue to update.

Drain 1: JP Drain 2: Ventriculostomy Drain 3: JP Drain 4: N/A
Balad Pack: N/A
Note:
JP 1 left side head. small amount bloody drng. JP 2 right side head small amount bloody drng.

Wound 1:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 2:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 3:
Location: N/A
Dressing: N/A
Drainage: None

Wound 4:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 5:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 6:
Location: N/A
Dressing: N/A
Drainage: None

Central lines:
Location: R SC Type: TLC
Location: N/A Type: N/A
Assess necessity daily with MD: N/A
Note:

Arterial Line:
Location: R femoral Assess: Patent and transducing

IV Lines:
Site Left: N/A Status: N/A Site Left: N/A Status: N/A
Site Right: Forearm Status: Patent No S/S of Infection Site Right:
N/AStatus: N/A
Note:

VAP Precautions:
HOB > 30 degrees at all times: Yes Sedation Interruption: N/A
GI Prophylaxis ordered: Yes DVT Prophylaxis: SCD's
Oral Care: Q4H per protocol
Note:

(b)(6)

UNKNOWN,UNKNOWN
(b)(6)
Loc:
Spon: UNKNOWN,UNKNOWN
Unit:

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

Automated version of SF509/SF600

0035-08-CID789-53215

Report requested by: (b)(6)

Restraints: N/A CMS: N/A
Note:

Psych/ED:
Plan of care: family unavailable to address Teaching done: N/A
Note:

Signed: (b)(6)

(b)(6) 2008@1930 INPT Register # (b)(6) CLINICAL NURSE
ICU Nursing Note
VSS, NAD. Temp increasing 99.5, becoming tachycardic. IV bolus ordered, Bair hugger d/c'ed. ICP WNL. No drng via ventric at 10cmH20. Neurosurg aware JP#2 not charging. Will cont to monitor.
Signed: (b)(6)

(b)(6) 2008@1917 INPT Register # (b)(6 PHYSICIAN
Operative Note
PATIENT ARRIVED MEDEVAC INTUBATED, NO MOTOR RESPONSE TO PAIN, PUPILS 8MM BILATERALLY NONREACTIVE. REPEAT HEAD CT WITHOUT/WITH CONTRAST, CTV SEE RADS REPORT. PATIENT COLD TEMP 90 DEGREES. PROCEDURE: BILATERAL CRANIECTOMY, DURAPLASTY, RIGHT CORONAL VENTRICULOSTOMY, NO PURULENCE OR ABSCESS NOTED. POSTOPERATIVE NEUROLOGICAL EXAM UNCHANGED. WILL REASSESS. BAKKEN.
Signed: (b)(6)

(b)(6) 2008@1635 INPT Register # (b)(6) CLINICAL NURSE
ICU Nursing Note
DATE/TIME OF ASSESSMENT: (b)(6) 08@1500

Neurological:
Left Pupil: Nonreactive To Light Size: Fixed and dilated Right Pupil: Nonreactive To Light Size: Fixed and dilated LOC: See Note
Motor: No movement Speech: UTA: Intubated Memory: UTA, intubated Gag reflex: See Note
GCS:
Eye Opening 1- None Verbal 1- None Motor 1- None
Total GCS 3
RASS Score: N/A
Note:
Ventric for ICP. Bilat JPs to skull

Respiratory:
Sounds: RUL: WNL no adv. sounds RLL: WNL no adv. sounds
Sounds: LUL: WNL no adv. sounds LLL: WNL no adv. sounds
Secretions: N/A Color: N/A ETT: N/A Position:
Trach: N/A Type: N/A Oxygen: Ventilated Rate: WNL
CT: N/A Pleura VAC: N/A CT: N/A Pleura VAC: N/A

(b)(6) UNKNOWN,UNKNOWN
(b)(6)
Loc:
Spon: UNKNOWN,UNKNOWN
Unit:
Automated version of SF509/SF600

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

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

Report requested by: (b)(6) 0035-08-CID789-53215

Note:
ETT w/commercial holder

Cardiac:
Rhythm: Sinus Rhythm Sounds: Audible S1/S2
Neck Veins flat at 45 degrees Yes Capillary Refill < 2 sec
LUE peripheral pulses +2 WNL Edema: None RUE peripheral pulses +2 WNL
Edema: None
LLE peripheral pulses +2 WNL Edema: None RLE peripheral pulses +2 WNL
Edema: None
Note:
Levo gtt.

Gastrointestinal:
Abdomen: Soft Non-Tender Bowel Sounds: Hypoactive Diet: NPO
BM: N/A Color:None Colostomy: N/A
NG: N/A To: N/A OG: N/A To: N/A
DHT: N/A PEG: N/A
Note:

Genitourinary:
Void: Foley Catheter Size:N/A Color: Yellow Character: Clear
Note:

Skin:
General Appearance: WNL Color and Pigmentation: NFR
Temperature: Warm Turgor: WNL Moisture: WNL
Note:

Drain 1: N/A Drain 2: N/A Drain 3: N/A Drain 4: N/A
Balad Pack: N/A
Note:

Wound 1:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 2:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 3:
Location: N/A
Dressing: N/A
Drainage: None

Wound 4:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 5:
Location: N/A
Dressing: N/A
Drainage: None
Note:

Wound 6:
Location: N/A
Dressing: N/A
Drainage: None

(b)(6)

UNKNOWN, UNKNOWN
(b)(6)
Loc:
Spon: UNKNOWN, UNKNOWN
Unit:

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

Automated version of SF509/SF600

Report requested by: (b)(6) 0035-08-CIV789-53215

Central lines:
Location: R SC Type: TLC
Location: N/A Type: N/A
Assess necessity daily with MD: Yes, continue
Note:

Arterial Line:
Location: R femoral Assess: Patent and transducing

IV Lines:
Site Left: Antecubital Status: Patent No S/S of Infection Site Left:
N/A Status: N/A
Site Right: Forearm Status: Patent No S/S of Infection Site Right:
N/AStatus: N/A
Note:

VAP Precautions:
HOB > 30 degrees at all times: N/A Sedation Interruption: N/A
GI Prophylaxis ordered: Yes DVT Prophylaxis: SCD's
Oral Care: Q4H per protocol
Note:

Restraints: N/A CMS: N/A
Note:

Psych/ED:
Plan of care: Pt sedated/intubated unable to address with pt Teaching
done: N/A
Note:
VSS, NAD. Will cont to monitor.
Signed: TOVAR,ERIC

(b)(6) 2008@1514 INPT Register # 5156 PHYSICIAN
ICU Provider Note
(b)(6) IRAQI DETAINEE TRANSFERRED FROM CAMP CROPPER. PT WITH 3 DAY H/O HEADACHES, DIPLOPIA, EMESIS AND DIZINESS. HAD CT SCAN AT CROPPER THAT REVEALED A MASS/EDEMA IN THE FRONTAL LOBE INTE AREA WHERE HE EXPERIECED A GSW ONE YEAR PREVIOUS. THE INITIAL WORKING DIAGNOSIS WAS BRAIN ABCESS SO T PT WAS STARTED ON ABTX. THEPT WAS FOUNDUNRESPONSIVE AT 0300 AND WAS INTUBATED, SEDATED AND PARALYZED THEN TRANSFERRED TO BALAD WHERE HE ARRIVED WITH BOTH PUPILS UNREACTIVE, HYPOTHERMIC AND A CT C/W BILATERAL HERNIATION. HE WAS BRIEFLY IN THE ICU ON HIS WAY TO OR WHERE BILATERAL FRONTAL CRANIECTOMIES WHERE PERFORMED AS WELL AS PLACEMENTOF A RIGHT SUBCLAVAIN TRIPLE LUMEN AND A

(b)(6) UNKNOWN,UNKNOWN
(b)(6)
Loc:
Spon: UNKNOWN,UNKNOWN
Unit:

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

Automated version of SF509/SF600

Report requested by: (b)(6) 0035-08-CID789-53215

RIGHT FEMORAL A LINE.
PE:
VSS EXCEPT FOR HYPOTHERMIA
GEN: SEDATED INTUBATED NONRESPONSIVE TO PAIN
HEENT: HEAD IN DRESSING, B PUPILS FIXED AND DILATED, ET TUBE SECURED
CHEST: R SUBCLAVIAN CENTRAL LINE IN PLACE, LUNG WIH COURSE BRRATH SOUNDS B
HEART: RR&R
ABD: SOFT, NONDISTENDED,NO BS
EXT: R FEMORAL A LINE IN PLACE, NO CLUBBING OR MOVEMENT.
LABS
WBC-17.2; H/H=14.6/44.6; PLT-384. K=2.5; NA=151; INR-1.3; GLU=293
ABG= 7.39/22/309/13.4
RADS
CT SCAN OF HEAD C/W BILATERAL HERNIATION,GLOBAL EDEMA/EARLY ISCHEMIA.
ASSESMENT:
BILATERAL HERNIATION OF UNCLEAR ETIOLOGY (ABCESS VS ISCHEMIA)
PLAN:
-CORRECT HYPOTHERMIA
-CORRECT ELECTROLYTE ABNORMALITIES
-CONT EMPIRIC ANTIBIOTICS
-COMPLETLY REMOVE ALL SEDATIVE AND ANAGESICS TO ASSES NEUROLOGIC STATUS
-CONTINUE WITH EMPIRIC DILANIN TO PREVENT POSSIBLE SIEZURES
-CONTINUE CLOSE MONITORING IN THE ICU
Signed: (b)(6)

(b)(6) 2008@1150 INPT Register # (b)(6 CLINICAL NURSE
ICU Nursing Note
pt arrived from er intubated, on dopamine gtt 20mcg. pt pupils fixed and dialated, hypothermic with temp around 90.0f, blanket warmer on as will as warm fluids infusing. heart rythm is wide complex at rate in 70-80's, doctors at bedside, neuro wanted pt to or before full assessment could be completed.
Signed: (b)(6)

(b)(6) 2008@1124 OUTPT PHYSICIAN
Radiology Note
Date: 07 December 2008

History: History of frontal head trauma, unresponsive.

Technique: Axial CT images were obtained prior to the administration of intravenous contrast and after the administration of 100 cc of iodinated contrast. Images were acquired during a 62nd delay and 8 minute delay. Sagittal and coronal reformatted images were reviewed for further evaluation.

Findings:

Gray white differentiation remains intact, however, overall decreased attenuation of the cerebral hemispheres in comparison to the cerebellar hemispheres consistent with global edema/ischemia.

==========

(b)(6) UNKNOWN,UNKNOWN FOREIGN NATIONAL - POW/INTERNEE
(b)(6)
Loc: H: not on file
Spon: UNKNOWN,UNKNOWN W: not on file
Unit: Rank:
RR:
Automated version of SF509/SF600

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

0035-08-CID789-53215

Report requested by: (b)(6)

Left frontal entrance wound from a prior gunshot with metallic foreign bodies adjacent to the falx cerebri.
Low-attenuation in the white matter in the left frontal lobe consistent with edema.
No intracranial hemorrhage or abscess identified.
Decreased sulcation and effacement of the basilar cisterns consistent with increased intracranial pressure.
Intercranial arteries appear grossly normal with no evidence of aneurysm/pseudoaneurysm.
Slight midline shift to the right which was seen on the prior exam dated 05 December 2008.
Ethmoid and left maxillar sinus disease.
Delayed venogram shows normal flow within the sinuses with no evidence of venous thrombosis.

Impression:
Overall evidence of increased intracranial pressure with decreased sulcation and effacement of the basilar cisterns.
Effacement of the suprasellar cistern consistent with bilateral herniation.
Decreased global attenuation of the cerebral hemispheres versus the cerebellar hemispheres consistent with global edema/early ischemia.

Signed: (b)(6)

(b)(6) UNKNOWN,UNKNOWN
(b)(6)
Loc:
Spon: UNKNOWN,UNKNOWN
Unit:

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

Automated version of SF509/SF600

0035-08-CID789-53215

Death Processing Checklist (American)

POC Name: (b)(6)

Initial & Check Below

☐ **Aircrew members: Call Flight Surgeon: Wait for FS okay to complete process**

(b)(6) **Identification of Remains:**

- ☐ Identified via: Check one:
  - ☐ ID Card ☐ Patient Confirm ☐ Visual Recognition ☐ LNO
- ☑ Unknown patient
  - ☐ Assign pseudo SSN

(b)(6) **Initiate Administrative Death Packet:**

- ☐ Complete CCIR coversheet
- ☐ Complete, Record of Death, DA Form 3894, sections 1-5
  - Provider completes sections 7a, 7b, 8, 9, 10, & 11
- ☐ Provider completes Chronological Record of Medical Care, SF 600
- ☐ Complete Death Tags, AF Form 146, sections 1-7
  - Provider signs section 8
- ☐ Complete Statement of Recognition of Deceased, DD Form 565 (IF applicable)
- ☐ Complete Line of Duty Determination, AF IMT 348 (Air Force AD ONLY)

(b)(6) **Initiate Mortuary Affairs Proceedings:**

- ☐ Medical staff prepares body
- ☐ Death Tag, AF Form 146, placement
  - Patient finger
  - Patient toe opposite of tagged finger
  - Bag zipper, seal bag if possible
- ☐ Ensure use of correct body bag
  - American – Black
  - Host National – White, Yellow, or Blue
- ☐ Ensure patient transfer to morgue
- ☐ Place all property/personal effects with remains

(b)(6) **Make Notifications:**

- ☐ Make three copies of completed death packet
- ☐ Place one copy with body for MA
- ☐ Give one copy to MCC
- ☐ Telephone Mortuary Affairs to arrange pick-up (b)(6)
  - Retain original packet
    - ☐ Admit and disposition patient in JPTA
    - ☐ Create medical record
    - ☐ Create Master roll-up Log
- ☐ Send Electronic Significant Incident Report
- ☐ Reviewed by Casualty Liaison
- ☐ Place Checklist in Medical Record

Distribution List:

Additional Notes: _____

6/21/2008

332 EMDG
CCIR/SIR REPORT 0035-08-CID789-53215

FROM: (DIRECT REPORTING UNIT: 332/AEW/EMDG/MCC
THRU: FRAGO 005 AUG 07
TO: TF MED 62

Subject: Commander Critical Incident Reprot(CCIR) **Significant Incident Report (SIR)**

2. Category: (Listed below are the most common used Refer to FRAGO for more information)

CCIR-FFIR:
1. Bed Status Change
2. Loss Critical Capacity
3. MASCAL
4. Any Disease DNBI Trend
5. Event Involving Pos/Neg political, media or international attention
6. AnyTF62 Med Member Hospitalized SI, WIA, KIA

CCIR-EEFI:
1. Any Death in Facility (US, Detainee or SI Iraqi Security Force, Iraqi Army, Iraqi Civilian) (Circle One): DOW DOA KIA Expired
2. Any Display of Suicide/Attempt Suicide
3. Any US Battalion CC/CSM , DV, SI Person of Command (treated or visiting)
4. All other death's in 332d AFTH (eg. CIV, ISF, IA, IC...)
5. Orphaned Patient (Minor/Child)

CCIR: PIR
1. Events, disturbances or violence that my prevent transfer of Iraqi patients (Civ or ISF)

SIR:
1. Loss, theft or damage mismanagement of sensitive items , controlled crypto items or drugs
2. Loss, thef or damage of Government Damage $ 50, 000
3. Indecent assault of personnel

3. Type of incident: *(if different than above indicated)*

4. Date and time:

5. Location: 332d EMDG

6. Personnel involved:
   1. Rank/Name : Unknown Unknown
   2. SSN/ ID NUM (b)(6)
   3. Race/NATIONALITY: (Circle One) USA; COALITION FORCES; ISF; ISA; LOCAL NATIONAL; TCN; CONTRACTOR; OTHER _____
   4. Gender: F (b)(
   5. Age : (b)
   6. MOS : _____
   7. Clearance : _____
   8. Unit : _____
   9. Component :

7. Diagnosis: (b)(6)

8. Summary of Incident: Altered Mental State from prev. GSW

9. Disposition: _____

10. Impact: _____

11. Next Course of Action: _____

12. Remarks: _____

13 Publicity: _____

14. Commander reporting:

15. PAD POC : L NAME, F NAME (b)(6)
MRO Contacted YES / NO MRO POC Name Notified: _____ Date/Time: _____

16. Report originated by: 332 EMDG

FOR OFFICIAL USE ONLY

17. Released by: 332 EMDG/MCC POC: Submitted througth TF62 MED Shareport: (YES / NO)

18. Notified:

A. Telephone

Position	Name	Time	Instructions

19. Category of incident:

20. Commander Actions:

EXHIBIT 000103 5 103

0035-08-CID789-53215

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40400; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL: 332 EMDG BALAD AB, IRAQ

Instructions - Medical Officer in attendance will:

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.

Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

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

Unknown. Unknown

(b)(6)

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

2. TIME OF DEATH *(Hour-day-month-year)*: 2245 hrs

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

4. RELIGION

5. CHAPLAIN NOTIFIED ☐ YES ☐ NO

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

CAUSE OF DEATH

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

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE
(b)(6) 08	(b)(6)	(b)(6)

SECTION B - ADMINISTRATIVE ACTION

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

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☐ NO	21. AUTOPSY ORDERED BY *(Signature)*
22. PROVISIONAL PATHOLOGICAL FINDINGS	

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

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

0035-08-CID789-53215

NSN 7540-00-634-4176 600-108

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

(b)(6) 08

2305 (b)(6) Iraqi detainee presents to Balad ICU for Brain Injury of unclear etiology. Pt is transferred from Camp Cropper sedated and intubated. Pt c 3 day h/o headaches diplopia emesis & dizziness. CT scan showed significant edema in area where pt was shot approx 1 yr ago. Initial Dx was Brain abcess for which pt was started on empiric antibiotics. He was found unresponsive @ 0300 on 6 Dec 08 and was transferred to Balad. Pt arrived intubated sedated unresponsive c pupils ~~25~~ 2mm reactive to light. CT scan here showed Bilateral uncal herniation. Pt was taken to OR where Bi frontal craniectomies were done but no purulence or abcess was seen intraoperatively. After his arrival to the ICU the pt was warmed (as he was hypothermic upon arrival to Balad) but his BP decreased and eventually so did his heart rate. Pt was pronounced dead at 2245 hrs. Heroic actions were not deemed appropriate due to the severity of his existing Brain Lesion (b)(6)

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

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX (b)(6)
RELATIONSHIP TO SPONSOR: Self	STATUS	RANK/GRADE (b)(6)
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE: detainee	SSN/IDENTIFICATION NO. (b)(6)	DATE OF BIRTH (b)(6)

CHRONOLOGICAL RECORD OF MEDICAL CARE — STANDARD FORM 600 (Rev. 5-84) Prescribed by GSA and ICMR FIRMR 41 CFR 201-45.505

105

EXHIBIT

000105

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER
0035-08-CID789-53215

DETAILS

About 1122, 30 Dec 08, SA [(b)(6), (b)(7)(C)] received an information report from SA [(b)(6), (b)(7)(C)] Camp Bucca CID Office, wherein he reported he was unable to locate any medical records or documentation that explained the origin of Mr. MARUSH's head injury. SA [(b)(6), (b)(7)(C)] stated all detainees that resided with Mr. MARUSH in his compound have since been transferred, and that he had no way of tracking which detainees were present in the compound at the time.

About 1540, 13 Jan 09, SA [(b)(6), (b)(7)(C)] received the Final Information Report from SA [(b)(6), (b)(7)(C)] ///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
SA [(b)(6), (b)(7)(C), (b)(7)(F)]	24th/348th MP DET (CID) CAMP CROPPER, IRAQ APO AE 09342
SIGNATURE	DATE: 13 Jan 09 / EXHIBIT

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

~~For Official Use Only-Law Enforcement Sensitive~~

ROI NUMBER 0091-08-CID579 /0035-08-CID789-53315

PAGE 1 OF 1 PAGES

BASIS FOR INVESTIGATION: About 1925, 12 Dec 08, this office received a Request For Assistance (RFA) from the Camp Cropper CID Office to obtain any information possible in reference to a head injury inflicted to Detainee Muhammad F. MARUSH, Internment Serial Number (ISN) (b)(6), (b)(7)(C) which may have been the cause of his death.

About 1200, 15 Dec 08, SA (b)(6), (b)(7)(C) attempted to obtain medical records for Detainee MARUSH. All medicals records were forwarded with the Detainee when he was evacuated from Camp Bucca. No records were found.

About 1000, 29 Dec 08, SA (b)(6), (b)(7)(C) coordinated with Mr. (b)(6), (b)(7)(C) GS-12, Biometric Automated Tool-set System (BATS) and Detainee Management System (DMS) Administrator, Theater Internment Facility (TIF), Camp Bucca, wherein he related that Detainee MARUSH was reloaded into the system to view all the previous information related to Detainee MARUSH. Mr. (b)(6), (b)(7)(C) stated no information pertaining to a head injury or an assault of any kind could be found.

AGENT'S NOTE: No canvass interviews of Detainee's could be conducted due to all of them being moved. There was a mass move and all detainees within Compound 10 were moved to Camp Cropper, Iraq. A roster of all detainees that were in Compound 10 could not be obtained through DMS. ///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA (b)(6), (b)(7)(C), (b)(7)(F)	41st MP Detachment(CID), Camp Bucca, APO AE 09375	
SIGNATURE (b)(6), (b)(7)(C)	DATE 29 Dec 08	EXHIBIT 7

AGENT'S INVESTIGATION REPORT	ROI NUMBER 0035-2008-CID789-53215
CID Regulation 195-1	PAGE 1 OF 1 PAGES

DETAILS

BASIS FOR INVESTIGATION: About 1130, 15 Nov 08, SA (b)(6), (b)(7)(C) and SA (b)(6), (b)(7)(C) attended the autopsy of Mr. Muhammand Fahdil Khamat MARUSH ME# 08-0821) which was performed by Dr. (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) Office of the Armed Forces Medical Examiner (OAFME), AFIP, 1413 Research Blvd., Bldg 102, Rockville, MD, 20850. The preliminary cause of death is pending and preliminary manner of death is pending. Photographers from AFIP exposed all digital photographs of the autopsy and prepared a compact disc (CD) containing all images exposed. SA (b)(6), (b)(7)(C) and SA (b)(6), (b)(7)(C) obtained the fingerprints of Mr. MARUSH and personnel from the Federal Bureau of Investigation (FBI) conducted fingerprint analysis which produced a positive identification. The FBI Fingerprint Report and a copy of the CD containing all images were obtained. (See FBI fingerprint report, fingerprints, and Photographic CD for details.)

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

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA (b)(6), (b)(7)(C), (b)(7)(F)	75th MP DET (CID) Fort Belvoir, VA 22060	
(b)(6), (b)(7)(C), (b)(7)(F)	DATE 15 Dec 08	EXHIBIT 8

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0035-08-CID789-53215

PAGE 1 OF 1 PAGE(S)

DETAILS

About 1400, 14 Feb 09, SA (b)(6), (b)(7)(C) received the Armed Forces Institute of Pathology Final Autopsy report ME 08-0860 and the Certificate of Death, pertaining to Mr. MARUSH. The report related the cause of Mr. MARUSH's death was complications of penetrating head injury and the manner of death was undetermined.
///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA (b)(6), (b)(7)(C), (b)(7)(F)	24th/348th MP DET (CID), CAMP CROPPER, IRAQ APO AE 09342	
SIGNATURE (b)(6), (b)(7)(C)	DATE 14 Feb 09	EXHIBIT 9

The identifications set out below were identified by (b)(6) through Fingerprint Analysis:

(b)(6) (Signature)

Last Name	First Name	MI	DOB	SSAN	Remains/Case #	ME Number	ID Method
(b)(6)	(b)(6)	F	(b)(6)		(b)(6)	(b)(6)	Fingerprints

Verified by FBI Physical Scientist:
(b)(6)
Signature: (b)(6)
Date: (b)(6) 2008

EXHIBIT 10

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
301-319-0000

FINAL AUTOPSY EXAMINATION REPORT

Name: BTB Marush, Muhammad Fahdil Khamat
SSAN: (b)(6)
Date of Birth: (b)(6)
Date of Death: (b)(6)
Date and time of Autopsy: 10 DEC 2008 9:00 AM
Date of Report: 06 FEB 2009

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

Circumstances of Death: Iraqi detainee with history of remote penetrating head injury found unresponsive

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

Identification: Positive identification by Fingerprint

CAUSE OF DEATH: Complications of penetrating head injury

MANNER OF DEATH: Undetermined

AUTOPSY REPORT (b)(6)
BTB MARUSH, Muhammad Fahdil Khamat 2

EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished male that weighs 139 pounds, is 69 inches in length and appears compatible with the reported age of 40 years. The body is cold after refrigeration. Rigor is present to an equal degree in all extremities. Lividity is present and fixed on the posterior surface of the body, except in areas exposed to pressure. The head shows evidence of medical therapy to be further described below. The scalp hair is black and shaved. Facial hair consists of a black mustache and beard. The irides are brown. The corneae are clear. The conjunctivae are unremarkable. The sclerae are white. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The nasal skeleton and maxilla are palpably intact. The lips are without evident injury. There are multiple remotely missing maxillary and mandibular teeth. The remaining teeth are natural and in fair condition. Examination of the neck reveals no evidence of injury. The chest is unremarkable. No evidence of injury of the ribs or the sternum is evident externally. The abdomen is flat. A healed 7 inch scar is present on the medial surface of the left upper arm and 2 ¼ inch scar is present on the lateral surface. The external genitalia are those of a normal adult circumcised male. The posterior torso and anus are without note. The extremities show evidence of injury to be further described below. The fingernails are intact. A 3 x ½ inch tattoo depicting an unknown symbol is present on the anterior surface of the right forearm. A 1 inch faded tattoo depicting an unknown symbol is present on the dorsal surface of the right hand.

CLOTHING AND PERSONAL EFFECTS

- The body is received nude for examination.

MEDICAL INTERVENTION

- A gauze bandage is present over the head
- An 11 ½ inch stapled incision extends across the biparietal and frontal regions of the scalp
- A 2 ½ inch stapled incision extends posteriorly from the biparietal incision to the right parietal region
- A 2 inch stapled incision extends posteriorly from the biparietal incision to the left parietal region
- Three drains exit the scalp in the occipital vertex region
- Internal examination shows a bilateral craniectomy with removal of the majority of the biparietal regions of the calvarium
- Sutured therapeutic needle puncture sites are present in the right subclavian region and the right inguinal region

RADIOGRAPHS

A complete set of postmortem radiographs is obtained and, in addition to the above demonstrates multiple metallic fragments in the left frontal region. These are not recovered.

AUTOPSY REPORT (b)(6)
BTB MARUSH, Muhammad Fahdil Khamat

EVIDENCE OF INJURY

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

Injuries of the head and neck:

There is an 8 x ¾ inch cluster of punctate abrasions on the forehead. A ⅜ x ¼ inch healing wound is present on the left side of the forehead.

Injuries of the extremities:

Incision of both wrists reveals subcutaneous hemorrhage of the dorsal radial surfaces measuring up to 2 inches on the right and up to 1 ¾ inches on the left.

INTERNAL EXAMINATION

BODY CAVITIES:

The body is opened by the usual thoraco-abdominal incision and the chest plate is removed. The ribs, sternum, and vertebral bodies are visibly and palpably intact. No adhesions or abnormal collections of fluid are present in any of the body cavities. All body organs are present in normal anatomical position. The subcutaneous fat layer of the abdominal wall is ¼ inch thick.

HEAD AND CENTRAL NERVOUS SYSTEM:
(See above "Evidence of Therapy")

The scalp is reflected. The galeal and subgaleal soft tissues of the scalp are free of injury. There are no skull fractures. The remainder of the calvarium is removed. Approximately 1 ml of turbid liquid material is expressed from the anterior region of the remaining central dura. The structures at the base of the brain, including cranial nerves and blood vessels are intact. The brain weighs 1700 grams. The atlanto-occipital joint is stable. The upper spinal cord is unremarkable. (See Neuropathological Consultation)

NECK:

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

CARDIOVASCULAR SYSTEM:

The 340 gram heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show widely patent lumina. The myocardium is homogenous, red-brown, and firm. The valve leaflets are thin and mobile. The endocardium is

smooth and glistening. The aorta gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

RESPIRATORY SYSTEM:

The upper airway is clear of debris and foreign material; the mucosal surfaces are smooth, yellow-tan and unremarkable. The pleural surfaces are smooth, glistening and unremarkable bilaterally. The pulmonary parenchyma is diffusely congested, exuding slight to moderate amounts of blood and frothy fluid; no focal lesions are noted. The pulmonary arteries are normally developed, patent and without thrombus or embolus. The right lung weighs 680 grams; the left 500 grams.

HEPATOBILIARY SYSTEM:

The 1180 gram liver has an intact smooth capsule covering moderately congested tan-brown parenchyma with no focal lesions noted. The gallbladder contains 12 ml of thick green-brown, mucoid bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of formed calculi, however, the bile contains numerous yellowish-tan particles. The gallbladder is mildly distended.

GASTROINTESTINAL SYSTEM:

The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is arranged in the usual rugal folds and the lumen contains 300 ml of tan food material. The small and large bowel are unremarkable. The pancreas has a normal pink-tan lobulated appearance and the ducts are clear. The appendix is present.

GENITOURINARY SYSTEM:

The right kidney weighs 140 grams; the left 160 grams. The renal capsules are smooth, semi-transparent and strip with ease from the underlying smooth, red-brown cortical surface. The cortices are sharply delineated from the medullary pyramids, which are red-purple to tan and unremarkable. The calyces, pelves and ureters are unremarkable. White bladder mucosa overlies an intact bladder wall. The bladder is empty. The testes, prostate gland and seminal vesicles are without note.

LYMPHORETICULAR SYSTEM:

The 180 gram spleen has a smooth, intact capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles are unremarkable. Lymph nodes in the hilar, periaortic and iliac regions are not enlarged.

ENDOCRINE SYSTEM:

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

AUTOPSY REPORT (b)(6)
BTB MARUSH, Muhammad Fahdil Khamat

MUSCULOSKELETAL SYSTEM:

No non-traumatic abnormalities of muscle or bone are identified.

NEUROPATHOLOGICAL CONSULTATION

GROSS DESCRIPTION:

Brain weight: 1528 gm

The specimen consists of an irregular 6 x 4 cm fragment of dura and the brain of an adult. The central portion of the dura is thickened and sclerotic. The subdural surface is covered by a 0.2 - 0.4 cm thick granular red-brown layer of adherent coagulated blood which contains fine shiny particles consistent with metallic fragments. There is a deep groove due to cerebral craniectomy herniation over each cerebral hemisphere. On the right, the area of cerebral herniation is approximately 12 x 8 cm and involves the dorsal/lateral surfaces of the frontal and parietal lobes and the anterior/lateral occipital lobe. On the left the area of the craniotomy herniation is 8 x 6 cm and involves the dorsal/lateral frontal lobe and the anterior and lateral temporal lobe. There are multifocal, small perivascular subarachnoid hemorrhages along the cortical grooves of the craniectomy herniation. The herniated cerebral cortex is markedly swollen, discolored a dusky gray and focally hemorrhagic and necrotic. There is no net midline shift due to the decompressive effect of the craniectomies but there is severe central transtentorial and transforamen magnum herniation. Deep bilateral tentorial grooves indent each uncus approximately 0.8 cm from the medial margins and the herniated cortex is necrotic. The diencephalon and internal capsules are markedly compressed elongated and hemorrhagic due to central transtentorial herniation. These hemorrhages are continuous with Duret hemorrhages in the tegmentum and base of the pons and the midbrain. A deep foramen magnum groove indents each cerebellar tonsil. The leptomeninges are moderately cloudy over the cerebral convexities. Elsewhere, they are thin, delicate and transparent. The perisellar, perimesencephalic and cerebellomedullary cisterns are compressed and effaced due to brain swelling. The arteries at the base of the brain follow a normal distribution and there are no aneurismal dilatations or sites of occlusion.

Coronal sections of the cerebrum reveal the above noted changes. There is cavitary necrosis of the left frontal lobe and disruption of the frontal pole cortex. The cavity causes destruction of the left frontal white matter, the striate body, the anterior corpus callosum, the septum pellucidum and the fornices.

MICROSCOPIC EXAMINATION:

Blocks of tissue for microscopic examination are removed from: (1) left frontal lobe, (2) midcorpus callosum/caudate/internalcapsule, (3) left hippocampus, (4) left thalamus/subthalamus/substantianigra, (5) right parietal lobe, (6) left occipital lobe (calcarinecortex), (7) cerebellum, (8) midbrain and (9) pons Sections from each block are stained with H&E, and LFB techniques and immunostained for GFAP and β-amyloid.

EXHIBIT 116
000116

AUTOPSY REPORT (b)(6)
BTB MARUSH, Muhammad Fahdil Khamat

0035-08-CID 789-52215

MICROSCOPIC FINDINGS:

Sections show generalized acute brain edema, congestion, focal hemorrhages and bland necrosis with no inflammation or granulation tissue. The hemorrhages are related to the craniectomy herniation margins as well as the subthalamic and rostral brainstem (Duret hemorrhages). There is no accumulation of macrophages and there is no leptomeningeal inflammation. This suggests that the severe brain swelling and central herniation resulted in compression of the penetrating blood vessels with necrosis without cellular infiltrate because of compression of regional blood flow. Surrounding the damaged areas there is widespread axonal injury (positive axons) in a vascular pattern.

COMMENT:

The pattern is consistent with a process such as cerebritis associated with metallic foreign bodies due to a penetrating injury resulting in massive brain swelling requiring bilateral craniectomies. The antibiotic treatment with drainage may have obscured the inflammation but the brain swelling progressed to central transtentorial herniation with subthalamic and rostral brainstem herniation hemorrhages.

ADDITIONAL PROCEDURES

1. Documentary photographs are taken by the OAFME photographer.
2. Specimens retained for toxicology testing and/or DNA identification are: vitreous fluid, blood, spleen, liver, lung, kidney, myocardium, bile, gastric contents, adipose tissue and psoas muscle.
3. The brain is retained for further examination. The remaining dissected organs are forwarded with the body.
4. Selected portions of organs are retained in formalin.

EXHIBIT 117

AUTOPSY REPORT (b)(6)
BTB MARUSH, Muhammad Fahdil Khamat

0035-08-CID 787-53215

FINAL AUTOPSY DIAGNOSES

I. History of penetrating head injury
   A. Cavitary necrosis of the left frontal lobe
   B. Cerebral edema
      1. Cerebral craniectomy herniation with focal hemorrhage and necrosis
      2. Central transtentorial herniation with subthalamic and rostral brainstem herniation hemorrhages
   C. Retained intracranial metallic fragments

II. Additional injuries:
   A. Punctate abrasions of the forehead
   B. Healing wound of the left side of the forehead
   C. Blunt force injury of both wrists

III. Additional findings:
   A. Bilateral pulmonary congestion (right 680 mg, left 500 mg)

IV. Toxicology: Lidocaine present in the blood

OPINION

This 40 year old male civilian died of complications arising from penetrating head injury. According to reports, the decedent presented with a history of previous gunshot wound of the head with complaints of headache, diplopia, emesis and dizziness. He underwent CT and bilateral craniectomies for brain edema. The decedent's clinical status steadily declined postoperatively until his demise.

Autopsy examination showed extensive cerebral edema (brain swelling), cavitary necrosis of the left frontal lobe and minute metallic fragments. Additional injuries included punctate abrasions of the forehead (consistent with medical therapy) and evidence of blunt force injury to both wrists. No evidence of additional significant injury or natural disease was identified. Postmortem toxicological examination showed only the therapeutic agent lidocaine.

Since the exact etiology of the penetrating injury and the circumstances under which it occurred are uncertain, the manner of death is best classified as undetermined.

(b)(6)

(b)(6) Medical Examiner (b)(6)

EXHIBIT 118

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

REPLY TO
ATTENTION OF

AFIP-CME-T

TO:

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

PATIENT IDENTIFICATION
AFIP Accessions Number (b)(6) **Sequence** (b
Name BTB MARUSH, MUHAMMAD FAHDI
SSN: (b)(6) **Autopsy:** (b)(6)
Toxicology Accession #: (b)(6)
Date Report Generated: December 23, 2008

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: **Date Received:** 12/15/2008

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

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

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

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

Positive Lidocaine: Lidocaine was detected in the blood by gas chromatography and confirmed by gas chromatography/mass spectrometry.

(b)(6)

(b)(6) Medical Examiner

This document contains information EXEMPT FROM MANDATORY DISCLOSURE under the FREEDOM OF INFORMATION ACT Exemption No. 6c,d Applies

~~FOR OFFICIAL USE ONLY~~

10-L-0126 ACLU DDII CID ROI 19906

EXHIBIT 119

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

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Social
BTB Marush, Muhammad, Fahdil Khamat		Civilian	(b)(6)

ORGANIZATION Organisation	NATION *(e.g. United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe
	Iraq	1 July 1968	[X] MALE [ ] FEMALE

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

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le sus
STREET ADDRESS Domicilé à (Rue)	CITY OR TOWN OR STATE *(Include ZIP Code)* Ville (Code postal compris)

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH (Enter only one cause per line) Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITON DIRECTLY LEADING TO DEATH [1] Maladie ou condition directement responsable de la mort.	Complications of penetrating head injury	Months
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire		
UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire		
OTHER SIGNIFICANT CONDITIONS [2] Autres conditions significatives [2]		

MODE OF DEATH Condition de décès
- [ ] NATURAL Mort naturelle
- [ ] ACCIDENT Mort accidentelle
- [ ] SUICIDE Suicide
- [ ] HOMICIDE Homicide

AUTOPSY PERFORMED Autopsie effectuée [X] YES Oui [ ] NO Non

MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie

NAME OF PATHOLOGIST Nom du pathologiste (b)(6)

SIGNATURE (b)(6) DATE Date (b)(6)

CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
Mode of Death : Undetermined

AVIATION ACCIDENT Accident à Avion [ ] YES Oui [X] NO Non

DATE OF DEATH *(day, month, year)* Date de décès (le jour, le mois, l'année) (b)(6) 2008 2245

PLACE OF DEATH Lieu de décès Air Force Theater Hospital, Joint Base Balad Iraq

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

(b)(6) Nom du médicin militaire ou du médicin sanitaire

TITLE OR DEGREE Titre ou diplôme: Deputy Medical Examiner

GRADE Grade (b)(6)

INSTALLATION OR ADDRESS Installation ou adresse: Dover AFB, Dover DE

DATE Date 2/10/2009

SIGNATURE (b)(6)

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

DD FORM 1 APR 77 2064 REPLACES DA FORM [illegible] 1 JAN 72 AND DA FORM 3565 (PAGE) 26 FEB 75, WHICH ARE OBSOLETE

EXHIBIT

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

DISPOSITON OF REMAINS

NAME OF MORTICIAN PREPARING REMAINS	GRADE	LICENSE NUMBER AND STATE	OTHER

INSTALLATION OR ADDRESS	DATE	SIGNATURE
(b)(6)		

NAME OF CEMETERY OR CREMATORY	LOCATION OF CEMETERY OR CREMATORY

TYPE OF DISPOSTION	DATE OF DISPOSTION

REGISTRATION OF VITAL STATISTICS

REGISTRY *(Town and Country)*	DATE REGISTERED	FILE NUMBER	
		STATE	OTHER

NAME OF FUNERAL DIRECTOR	ADDRESS

SIGNATURE OF AUTHORIZED INDIVIDUAL

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