DEPARTMENT OF THE ARMY
UNITED STATES ARMY CRIMINAL INVESTIGATION COMMAND
10TH MILITARY POLICE BATTALION (CID)
76TH MILITARY POLICE DETACHMENT (CID)
APO AE 09342

CIRF-ZA-BD 5 Jan 06

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION – FINAL-SSI– 0096-2005-CID789-39265-5H6 (Death)

DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 26 JUN 05, 0715; BAGHDAD CENTRAL CONFINEMENT FACILITY (BCCF); GRID: 38S MB 130 840; ABU GHRAIB, IRAQ (IZ)

DATE/TIME REPORTED: 26 JUN 05, 0730

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

SUBJECT: 1. NONE; COMBAT DEATH

VICTIM: 1. INTERNMENT SERIAL NUMBER (ISN) (b)(6), (b)(7)(C) (DECEASED) UNKNOWN, IZ; MALE; WHITE; DETAINEE; BCCF, ABU GHRAIB, IZ; XZ; COMBAT DEATH (NFI)

INVESTIGATIVE SUMMARY

THIS IS AN "OPERATION IRAQI FREEDOM" INVESTIGATION.

On 26 Jun 05, this investigation was initiated when SPC (b)(6), (b)(7)(C) Patient Administration Department (PAD), Task Force Medical (TF MED) 115th Field Hospital, BCCF, Abu Ghraib, IZ, notified this office of a detainee death which occurred in the hospital.

Investigation disclosed Detainee (b)(6), (b)(7)(C) had been pronounced dead by MAJ (b)(6), (b)(7)(C) Medical Doctor, TF MED 115th Field Hospital, BCCF, Abu Ghraib, IZ, at 0715, 26 Jun 05. According to MAJ (b)(6), (b)(7)(C) the cause of death was unknown, but significant conditions were Pneumopericardium (air between the heart and heart membrane) and Pneumothorax (collapsed lung). Further, detainee (b)(6), (b)(7)(C) received his injuries as a result of an altercation with U.S. Forces.

The Armed Forces Institute of Pathology (AFIP) final autopsy report listed the cause of death as gunshot wounds to the chest and abdomen with complications; and the manner of death as homicide. Therefore, the death is listed as combat related.

STATUTES: NONE

EXHIBITS/SUBSTANTIATION:

ATTACHED:

1. Agent's Investigation Report (AIR) of SA (b)(6), (b)(7)(C) 08 Jul 05, detailing the initial notification; receipt of medical file; coordination's with medical personnel; and receipt of the detainee's dossier.

2. AIR of SA (b)(6), (b)(7)(C) 14 Oct 05, detailing the receipt of the Final Autopsy Report; Arrival of Undocumented Detainee Worksheet; and coordination with medical personnel.

3. Medical file pertaining to Detainee (b)(6), (b)(7)(C) 26 Jun 05.

4. Arrival of Undocumented Detainee Worksheet, 18 June 05.

5. Final Autopsy Report ME05-0608, 07 Sep 05.

6. AIR of SA (b)(6), (b)(7)(C) 3 Jan 05, detailing the receipt of the autopsy photo disc from AFIP.

7. Compact Disc ME 05-0608, containing autopsy photographs of Detainee 174574.

NOT ATTACHED:

NONE.

The originals of Exhibits 1, 2 and 6 are forwarded with the USACRC copy of this report. The original of Exhibit 4 is maintained in the files of Task Force 134, Camp Victory, Baghdad, IZ. The original of Exhibit 3 is maintained in the files of the patient administration system and bio statistics activity (PASBA) Fort Sam Houston, TX. The original of Exhibits 5 and 7 are maintained in the files of the Office of the Armed Forces Medical Examiner (OAFME), (AFIP), 1413 Research Blvd, Bldg 102, Rockville, MD 20850.

STATUS: This is a Final Report.

Report Prepared By:

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

Report Approved By:

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

Special Agent in Charge

Distribution:

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1 - File

AGENT'S INVESTIGATIVE REPORT
CID Regulation 195-1

ROI NUMBER 0096-2005-CID789-39265

DETAILS:
About 0730, 26 Jun 05, this office was notified by SPC (b)(6), (b)(7)(C), Patient Administration (PAD), Task Force MED 115th (TF MED 115th), Baghdad Central Confinement Facility (BCCF), Abu Ghraib, Iraq (AGI), a detainee died. SPC (b)(6), (b)(7)(C) identified the detainee as Internment Serial Number (ISN) (b)(6), (b)(7)(C)

About 0847, 26 Jun 05, the undersigned coordinated with 1LT (b)(6), (b)(7)(C), TF MED 115th, BCCF, AGI, who related ISN (b)(6), (b)(7)(C) was brought into the TF MED 115th hospital on 18 Jun 05 in a comma, and already had surgeries performed on him. 1LT (b)(6), (b)(7)(C) related ISN (b)(6), (b)(7)(C) was pronounced dead at 0715, 26 Jun 05.

About 0850, 26 Jun 05, the undersigned coordinated with SPC (b)(6), (b)(7)(C) PAD, TF MED 115th, BCCF, AGI, who related ISN (b)(6), (b)(7)(C) came in with no paperwork and had no name.

About 0855, 26 Jun 05, the undersigned photographed the body of ISN (b)(6), (b)(7)(C)

AGENT'S COMMENT: About 1000, 27 Jun 05, the undersigned unintentionally deleted the photographs pertaining to ISN (b)(6), (b)(7)(C) when transferring them from one folder to another. The files were not recoverable.

About 0911, 26 Jun 05, the undersigned obtained a copy of ISN (b)(6), (b)(7)(C) medical file from SPC (b)(6), (b)(7)(C) (b)(6), (b)(7)(C), TF MED 115th, BCCF, AGI. The medical record contained daily medical logs, the Hospital Report of Death detailing the detainee's time of death at 0715, 26 Jun 05, and the detainee's Certificate of Death, 26 Jun 05, detailing the detainee's Cause of Death as unknown, but significant conditions were Pheumopericardium and Pneumothorax. (See Medical File, Hospital Report of Death, and Certificate of Death of ISN (b)(6), (b)(7)(C)

About 1419, 26 Jun 05, the undersigned coordinated with SSG (b)(6), (b)(7)(C) In-processing Holding Area (IHA), 306th MP Bn, BCCF, AGI, who provided a copy of ISN (b)(6), (b)(7)(C) dossier. (See Dossier of ISN (b)(6), (b)(7)(C)

About 1645, 27 Jun 05, the undersigned obtained a copy of the medical paperwork shipped to Abu Ghraib with ISN (b)(6), (b)(7)(C) from SSG (b)(6), (b)(7)(C), NCOIC, PAD, TF MED 344th, BCCF, AGI. The original papers from Ramadi MED were not included in the copy of the medical papers given this office on 26 Jun 05. (See Medical papers from Al Ramadi)

TYPED NAME, SEQUENCE NUMBER	ORGANIZATION	
SA (b)(6), (b)(7)(C), (b)(7)(F)	48th MP Det (CID)(FWD)(-), BCCF, AGI, APO AE 09342	
SIGNATURE (b)(6), (b)(7)(C)	DATE 8 Jul 05	EXHIBIT 1

CID FORM 94-E
(Automated)

EXHIBIT 1/4

AGENT'S INVESTIGATIVE REPORT

CID Regulation 195-1

ROI NUMBER 0096-2005-CID789-39265

DETAILS:

About 2015, 8 Jul 05, the undersigned obtained a copy of the Certificate of Death pertaining to ISN (b)(6), (b)(7)(C) from SSG (b)(6), (b)(7)(C) The Certificate of Death listed the Cause of Death as a gunshot wound. (See Certificate of Death, 4 Jul 05)

----------LAST ENTRY----------

TYPED NAME, SEQUENCE NUMBER	ORGANIZATION
SA (b)(6), (b)(7)(C), (b)(7)(F)	48th MP Det (CID)(FWD)(-), BCCF, AGI, APO AE 09342

SIGNATURE	DATE	EXHIBIT
(b)(6), (b)(7)(C)	8 Jul 05	

CI

(Automated)

EXHIBIT 5

AGENT'S INVESTIGATIVE REPORT

CID Regulation 195-1

ROI NUMBER 0096-2005-CID789-39265

DETAILS: BASIS FOR INVESTIGATION:

About, 1200, 13 Sep 05, the undersigned received the Final Autopsy Report from AFIP listing the cause of death as gunshot wounds to the chest and abdomen with complications. The manner of death is listed as homicide. Additionally, the ME noted fragments were found during the autopsy. The fragments will be forwarded to the Evidence Custodian, 11th MP BN (CID). See Final Autopsy Examination Report, 07 Sep 05.

About 0900, 14 Sep 05, the undersigned received a copy of the Arrival of Undocumented Detainee Worksheet from the Military Police Station, 344th Field Hospital, BCCF, Abu Ghraib, IZ.

About 1000, 03 Oct 05, the undersigned coordinated with LTC (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) Deputy Surgeon, Multi National Forces Iraq (MNFI), concerning the unknown Detainee. LTC (b)(6), (b)(7)(C) related he had no information, but directed requests to MAJ (b)(6), (b)(7)(C) Surgeon, Baghdad, Iraq.

About 1100, 11 Oct 05, the undersigned coordinated with MAJ (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) MNFI Surgeons Office, who related he could not locate any further information concerning the Detainee at the local facilities.

About 0800, 14 Oct 05, the undersigned coordinated with MAJ (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) Supervising Physician, Ramadi Med, Ramadi, Iraq, who said the Detainee was detained at a local Ramadi hospital (NFI) by 1st of the 5th Marines after he was found there suffering from gunshot wounds (NFI). There was no name or ID with the patient. He has no further information.///LAST ENTRY///

TYPED NAME, SEQUENCE NUMBER	ORGANIZATION	
SA (b)(6), (b)(7)(C), (b)(7)(F)	48th MP Det (CID), BCCF, AGI, APO AE 09342	
SIGNATURE (b)(6), (b)(7)(C)	DATE 14 Oct 05	EXHIBIT 2

CID FORM 94-E

(Automated)

EXHIBIT 2

Admission and Coding Information

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

1. Reporting MTF	2. MTF Location			
(b)(6)	IZ			
3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex
(b)(6)	UNKNOWN, UNKNOWN		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
		OTH	9	MUSLIM
10. Length of Service	ETS	11. FMP	12. Social Security Number	
		20	(b)(6)	

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
IHA		01:01	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
	K78-ENEMY PRISONER OF WAR/DETAINEE	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		DIS	

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Transfer Army MTF	ICU	Address of Emergency Addressee
Name and Location of Medical Treatment Facility: 1623 - Task Force 115th Field Hosp; Abu Ghraib Prison		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
AAA - INTERNAL MEDICINE		2005-06-18
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Diagnosis Narrative: GSW CHEST , L HIP

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
(b)(6)	

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
(b)(6)	UNKNOWN, UNKNOWN					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M		OTH	MUSLIM				
11. FMP	12. SSN	13. Organization				14. Ward	
20	(b)(6)	IHA				ICU	
15. FlyStatus	17. Dept / Ben		18. BranchCorps	19. UIC / ZIP		20. Type Case	
	K78-ENEMY PRISONER OF WA					DIS	
21. Source of Admission			22. Hour Of Adm:	23. Clinic Service			
Transfer Army MTF			01:01	AAA - INTERNAL MEDICINE			
24. Name/Relation of Emergency Addressee			25. Type Disp	26. Date of Disp			
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm:		AdmittingOfficer:	
				2005-06-18		(b)(6)	
29. ReportingMTF				30. Date Init Adm		32. Units Blood Components	
1623 - Task Force 115th Field Hosp							

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW CHEST , L HIP

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

Signature of Attending Medical Officer	Signature of PAD or Medical Records Officer
(b)(6)	(b)(6)

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 Sociale
UNKNOWN, UNKNOWN	DETAINEE		
ORGANIZATION Organisation: (b)(6)	NATION *(e.g., United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe: [✓] MALE Masculin [ ] FEMALE Féminin

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

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

MEDICAL STATEMENT Declaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)			INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [1] Maladie ou condition directement responsable de la mort [1]		GUNSHOT WOUND TO LEFT THORAX & ABDOMEN	9 DAYS
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	UNKNOWN	
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS [2] Autres conditions significatives [2]		PNEUMOPERICARDIUM PNEUMOTHORAX	9 DAYS

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
[ ] NATURAL Mort naturelle	[ ] YES Oui [✓] NO Non	
[ ] ACCIDENT Mort accidentelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
[ ] SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste: (b)(6)	
[ ] HOMICIDE Homicide	SIGNATURE Signature: (b)(6)	DATE Date: (b)(6) 05
		AVIATION ACCIDENT Accident à Avion: [ ] YES Oui [✓] NO Non

DATE OF DEATH *(Hour, day, month, year)* Date du décès *(l'heure, le jour, le mois, l'année)*: (b)(6) 05 @ 0715 HR

PLACE OF DEATH Lieu de décès: ABU GHRAIB, IRAQ

I HAVE VIEWED THE REMAINS OF (b)(6) AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci dessus

NAME OF MEDICAL OFFICER Nom du médicin militaire ou du médicin sanitaire	TITLE OR DEGREE Titre ou diplômé
GRADE Grade	INSTALLATION OR ADDRESS Installation ou adresse
DATE Date	SIGNATURE Signature

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

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-400; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL

Instructions - Medical Officer in attendance will:

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

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

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

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

(b)(6)

(b)(6)

UNKNOWN, UNKNOWN
H O DETAINEE

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)*

0715 HR (b)(6) 05

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)* GUNSHOT WOUND TO LEFT THORAX & ABDOMEN	9 DAYS
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) UNKNOWN	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a. PNEUMOPERICARDIUM	9 DAYS
	b. PNEUMOTHORAX	9 DAYS

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE
(b)(6) 05 @ 0745HRS	(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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	I. GSW T- (L) THORACOABDOMEN (6/17) & BACK
	II. METABOLIC ACIDOSIS - RESOLVED
	III. SIRS / ARDS - STILL REQUIRING 100% FiO_2 & ↑ PEEP
	(1) DIURESIS ONGOING
	(2) WILL WEAN PEEP DOWN ONCE DIURESIS PERMITS
	IV. PNEUMOPERICARDIUM / PNEUMOTHORAX
	(1) W.U. INCIDENT CT ON @ SAME GIVEN ↑ AIRWAY PRESSURES REQUIRED FOR OXYGENATION
(b)(6) 05 (0730hr)	DEATH NOTE

I WALKED INTO ICU THIS A.M. AS NURSE WAS ROLLING CRASH CART TOWARD PATIENT'S BED. PATIENT APNEIC ON VENTILATION & ECG REVEALED AGONAL RHYTHM. PUPILS FIXED & DILATED (DESPITE BEING ON FENTANYL INFUSION). THERE WAS NO PALPABLE CAROTID PULSE OR BREATHING OVER VENTILATOR RATE UPON INITIAL EXAM @ APPROXIMATE 0702 HRS. CPR INITIATED & ACLS PROTOCOL AFTER AGONAL RHYTHM CONFIRMED ON MULTIPLE LEADS. PATIENT GIVEN ACLS MEDS AS FOLLOWS: IVF WIDE,

0703 ~~[redacted]~~ ATROPINE 1MG & EPINEPHRINE 1MG IV PUSH.

0706 ATROPINE 1MG, EPINEPHRINE 1MG, CaCl 1 AMP, & DEXTROSE 50 10 UNITS INSULIN IV.

0710 EPINEPHRINE 1MG IV PUSH

0715 EPINEPHRINE 1MG IV PUSH.

DESPITE THESE INTERVENTIONS, THERE WAS NO PULSE, SPONTANEOUS RESPIRATIONS & HIS PUPILS REMAINED FIXED & DILATED. HE WAS PRONOUNCED DEAD @ 0715 HRS ON 26 JUN 05. DCCS NOTIFIED AS WELL AS CDR & CID.

(b)(6)

(b)(6)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	ICU MEDICINE
(b)(6) 05	
(0850 HRS)	ISSUES LAST NIGHT : HYPOXIA / HYPOXEMIA
VERSED 10MG/HR	NEURO: SEDATED & PARALYZED ; PUPILS 2-3mm MINIMALLY REACTIVE
VECURONIUM, 3mcg/kg/min	CV: SINUS TACH 140's BP 120-130s / 70s (L) SCV TLC (DAY)
FENTANYL 150mcg/HR	NEO 60 mcg/min NS c 20mEq KCl @ 125cc/hr
	DOPAMINE 2.5 mcg/kg/min (R) FV TLC (DAY)
	RESP: AC PCV 14/14 VT 800 (644) P 33 P 15 100% FiO2
	O2 SAT 88-90%
	2 CT's c 75 cc/24° DRAINAGE
	CXR: (B) ALVEOLAR INFILTRATES WORSE (R) THAN (L) ; ETT # 7.5 @ 25cm
	ARMS
CARAFATE 1G Q6°	GI: OPEN ABDOMEN TO WOUND VAC NOT RECORDED 75 cc/24°
	G-TUBE TO SYRINGE
	2 JP DRAINS
	GU: FOLEY c CLEAR URINE (p LASIX) 13
	I/O 4550/3440 140 | 112 < 120 Mg 2.1
	U.O.P. 2700/24° 4.4 | 25 > 1.2 Ca 3.3
LOVENOX	HEME/ID:
LEVAQUIN (DAY 3)	Tmax 100 17.0 > 9.7 < 103,000 INR 1.6
FLAGYL (DAY 7)	Tcurr 99.4 11.3 ↗ / 30.1 \

(b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NO. (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; grade) (b)(6)

(b)(6)

REGISTER NO.	WARD NO.

UNKNOWN, UNKNOWN
M O DETAINEE
PCCF

PROGRESS NOTES
Medical Record

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

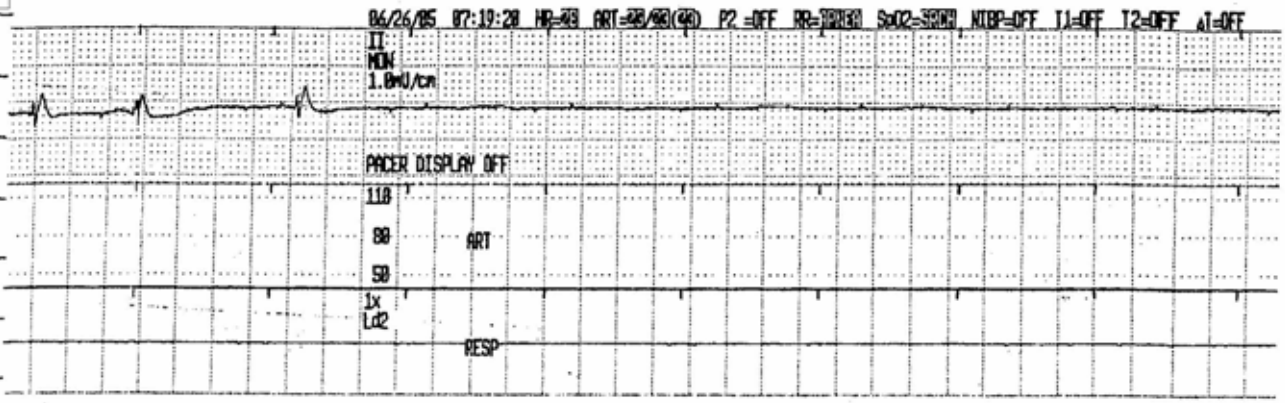
(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
PCCF

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
(b)(6)	



(b)(6)

from Cobb Court.

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

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE

(b)(6)

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19
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PJ/PTT (b)(6)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Surgery 17 > 30 < 103
25 JUN	1 M TOO.5 HR 142 BP 114/68 140/112 < 18 1.2 4.4/25
	SIMV 500 x 14 12 PEEP 2.6 PS I:E/2.7 [illegible]
	4600/3400
25 Jun 06 0250	Pt c noted O2 sat 90%-91% (b)(6) at bedside ordered stat lasix 20mg IVP and ↑ Neo drip to 30 cc/hr (200mcg/min). Same watch. Pt [illegible] [illegible] [illegible] Return. Suction ORAL airway c moderate amt of yellowish [illegible]. Need to watch O2 sat. Observe
25 Jun 06 2300	Pt c noted improved O2 sat to 96-97%. Continues observed noted no acute signs of acute resp distress. Observation ongoing. (b)(6)
26 Jun 05 2405	Pt c noted. ↑ temp. 101. Tylenol given as ordered. Observe. (b)(6)
26 Jun 05 0300	Temp ↓ 100.9. Cool washcloth placed to forehead. Observe no acute distress. (b)(6)
26 Jun 05 0600	Dressing D/I to (R) hip + posterior back appropriately no acute distress. Suction oral airway [illegible] small secretion. Oral airway c yellowish secretion. Safety maintained. See flowsheet. (b)(6)
26 Jun 05 0655.	Pt c noted desat. to 60% [illegible] 91%-90%. Resp therapy on hand. Ambu 100% [illegible]. E [illegible] improvement. (b)(6) called to [illegible] of pt status. [illegible] continue on Vec drip. Neo drip, [illegible] drip, fentanyl drip, Versed drip. Continue observation. (b)(6)
26 Jun 05	[illegible] drop in BP 50/20. to flat line. Code called c ACLS protocol started c CPR compression. See code sheet. (b)(6)
	Code call. at death at 0715 — (b)(6)

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 June 05	V.S - 128 144/82 14 87 Temp 99.4 Received pt sedated on paralytic vecaronium 0.1mg/kg/min, on versed for 1-5mg/hr TV titrated 10mL. peripheral pulses palpable (+) bilat, dorsalis pedis (+) bilat, bilat wheezing noted on vent FIO2 100 Rate 14, VT 800, PEEP 12, PS 26, Suction mod, ETT 25 @ 26cm, bowel sounds noted, Abd firm distended, colostomy (R) lower abd, NGT (R) nare, Foley BSD, amber clear, GT to residual flushed, ordered, JP x2 CTx2 Dsg (R) hip w->D vac dsg x abd, back x2 w->D. @ 8 AM Lasix given IV 1200cc output 8AM-9AM, Sat improved noted - chest tube insertion (R) chest @ this
1000	time @ bed side. (b)(6)
1015AM	Chest x-ray, ✓ insertion, to suction ABG blood gases pH 7.323 (L) PCO2 52.84, PO2 56 (L), TCO2 29 HCO3 27.4 (H)
1100	SO2 86% (L) - ~~Chest~~ tube advanced from 24-26 @ tip -
1230	Lasix 20mg IV @ 1200, 520cc's the Urine V/S Stable - Cont monitor B/P for drops, (b)(6)
1400	bed bath, dsg D'ed w->Dry (R) hip x3, (L) back x2, D's noted (b)(6)

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RECORDS MAINTAINED AT

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(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
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PT/OTT (b)(6)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

17/30 (103
140/112 (18, 1.2
4.4/25 (

DATE	NOTES
	Surgery
25JUN	1 m 100.5 HR 142 BP114/68
	SIMV 500 x14 12 PEEP 26 PS I:E/2.4 [illegible]
	4600/3400
25 Jun 06	Pt c noted O2 sat 90%-91% (b)(6) at
0250	bed side ordered stat lasix 20mg IVP and ↑ Neo
	drip to 30 cc/hr (200mcg/min). Sensi watch, pt [illegible]
	[illegible] c [illegible] return. Suction oral airway c moderate
	amt of yellowish [illegible]. Need to watch O2 sat. Observe
25 Jun 05	Pt c noted improved O2 sat to 96-97%. Continue to
2300	observed noted no acute s/s of acute resp
	distress. Observation ongoing. (b)(6)
26 Jun 05	Pt c noted. Pt temp. 101°. Tylenol prn given as
2405	ordered. Observe. (b)(6)
26 Jun 05	Temp ↓ 100°. Cool washcloth placed to forehead. Observe
0300	no acute distress. (b)(6)
26 Jun 05	Dressing D/I to (R) hip + posterior back appropriately
0600	no acute distress. Suction oral airway, ETT [illegible] minimal secretion,
	oral airway c yellowish secretion. Safety maintained - See
	flowsheet. (b)(6)
26 Jun 05	Pt c noted desat. to 60% fr 91% - 93%. Resp therapy
0655	on hand. Ambu 100% permit. c minimal improvement. (b)(6)
	called to [illegible] of pt status. [illegible] continue on Vec drip,
	Neo drip, Dopamine drip, fentanyl drip, Versed drip. Continue
	observation. (b)(6)
26 Jun 05	Sudden drop in BP 50/20 to flat line. Code called c ACLS protocol
	started c CPR compression. See code sheet. (b)(6)
	Code Call. at [illegible] death at 0715 (b)(6)

STANDARD FORM 509 (REV. 5/1999) BACK

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24Jun05	1140 ① SC TLC placed by (b)(6) ; x ray requested
24Jun05	1310 hrs Both pleuravac drains changed they were kinked over during bedside procedure (b)(6)
24 Jun 05	Respiratory therapy
	pt found on the following settings A/C P/C 18
	.80/ +10 BS: Bilateral upper lobes exp. wheez
	with good aeration. Lower lobes ⊖ wz. SpO2
	on .80 was 92-93%. At one point pt
	desaturated to mid 80's. FIO2 ↑ 100. pt
	sat 97%. Unable to find written order
	for "Pressure Control", awaiting further written
	confirmation from MD. pt comfortable
	No Acute Respiratory Distress. Chest tubes
	in proper order. pt Sx with only small
	amount of secretions, thick yellow in nature.
	(b)(6)
24 Jun 05. 0630.	Pt c̄ noted desaturation from 96%-98% to 84%-86% c̄ small
	FIO2 Levels 100%. Ambu manual c̄ gradual Response.
	Pt on Vecuronium drip 1cc rate, versed drip, neomycin ...
	drip, no drip, fentanyl drip, TPN Tx N c̄ ... @ 100ml/hr
	See flow sheet. ... out of ... for ...
	moderate amount oral cavity. (b)(6) (major) notified + at
	bedside c̄ resp therapist. Patent Ⓛ central ... CVP +
	Ⓡ ... CVP line. Safety maintained ... (b)(6)

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	ICU MEDICINE
1 JUN 05	GI. Open abdominal to wound VAC
	Dusky (R) stoma c olive colored stool 50cc/24°
	2 JP drains ~400cc/24° (L)-tract to syringe
	GU: Foley c amber urine
	I/O -2558 ; 140 | 112 / 14 ; 137
	UOP ~4300 ; 3.6 | 24 \ 1.2
	HEME/ID: Tmax 100.4 ; (11.3) 9.8 / 74,000
	Tcurr 99.2 ; 30.7
	(6/7) ; 6/19 s/p transverse colon resection c (R) end colostomy
	I. GSW to (L) thoracoabdominal & back - stable
	II. Metabolic acidosis - resolved
	III. SIRS / ARDS -
	(1) cont. current care
	(2) place new TLC in (L) SCV.
	(3) to OR today
	(4) keep on dry side & bolus c NS if UOP either
	> 4000cc q24 or UOP < 100cc/hr.

(b)(6)

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REGISTER NO. | WARD NO.

(b)(6)

UNKNOWN, UNKNOWN
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RCCF

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PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	(A/P) I.
	Gsw. to (L) thoracoabdominal —
	Metabolic acidosis — resolved
	(1) wean pressors ; then continue weaning vent
	(b)(6)
	Surgery
23JUN	Tm 101[6] 97 136/75
cardizem	5500/3700 — /34 (50)
lovenox	VAC in place — 135/112 / 4.6/22 — 15 / 1.3
levoflox	stoma healthy w/ stool in bag
neo 03	(1) Neuro - Decreased verbal
Dopa 2	(2) Resp - SATs in low 90s on 60% O2
fentanyl 75	CXR looks OK. CT minute output 8 A/C
versed 15	will diurese 2 liter
Flagyl	(3) CV — hemodynamics improved
	continue to wean ...
	(4) HEME PLT sl ↑ p D/C of ...
	(5) GI Increase TF as tol
	(6) ID low grade temp ... w/ ... levoflox
	(7) ...

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	ICU MEDICINE (CONT.)
23 JUN 05	
(0944 hrs)	NEURO: SEDATED ē VERSED 12mg/hr & FENTANYL 75mcg/hr ; MIOTIC PUPILS
	CV: RRR - TACHY P 100s BP 150s/70-80s 1+ GEN EDEMA
	DOPAMINE 2.5 mcg/kg/min
	NEOSYNEPHRINE 37 mcg/min
	(DAY 3) (R) FEM TLC & (L) RAD A-LINE (DAY 4)
	PULMONARY: TRACHEOSTOMY #7.5 ETT @ 26cm TO TEETH
	MINIMAL ETT SECRETIONS ; COARSE BS (B)
	CXR: (R) LUNG CONSOLIDATION, NGT NEAR DIAPHRAGM, SQ AIR (B)
	2 (L) CT's NEAR APEX 200 cc/24°
	SIMV 16/31 .80 VT 950 PS 15 PEEP 10
	GI: NGT TO SUCTION , NAUSEA Ø RESIDUALS Ø BS
	OPEN ABDOMEN TO FUNCTIONING WOUND VAC
	DUSKY (R) STOMA ē BROWN/YELLOW STOOL - SCANT
	2 J-P DRAINS ē SEROSANG OUTPUT ~ SCANT OUTPUT
	G-TUBE ē OSMOLYTE TF's @ 20cc/HRS
	GU: FOLEY ē AMBER (CLOUDY URINE)
	I/O 5520/3657 (+1900cc)
	U.O.P 2800 cc/24° 139 / 112 / 15 / 167 ; 4.6 / 22 / 1.3
	HEME/ID: TMAX 101.4
	TCUR 99.2 8.1 \ 11.3 / 50,000 ; 34.7 FIBRIN (1.7)

(b)(6)

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
22 JUN 1330	See flowsheet for VS & assessment. Patient; CT placed on H_2O Seal. Air leak noted. CT site redressed with vaseline gauze. Minimal leak noted. Patient with NO distress. Started TF osmolite @ 20cc/hr via GT. ∅ residuals noted.
	1545 Patient given 1g tylenol PR for temp 101.6. (b)(6)
23 June 0600	Pt in no acute distress see flowsheet for VS. Afebrile during shift. Suction given oral + ETT site. Chest tubes #1 + #2 to H2O seal. no air leak noted. wound vac to suction intact. Abx patent + A/P Ⓡ femoral intact + patent. GT feed tolerated osmolyte c minimal residual. wound care provided to Ⓡ leg + mid back + Ⓛ back region. Safety maintained. (b)(6)
23 JUN 05 (0920 Hrs)	ICU MEDICINE
	No problems overnight
	HAD PNEUMOPERICARDIUM WHICH HAS IMPROVED SINCE REPOSITIONING & REGAINING PLEURAL SUCTION. (b)(6)
	← CONT. →

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REGISTER NO. | WARD NO.

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
PCCF

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STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21JUN05	2130: Pt brought to CT @ 1900 @ beginning of shift. VSS. 2CT's readjusted by MD Tauf upon return back to unit. CXR done. CT's intact, dsg. Δ'd. CT's put back to Suction. (b)(6)
21JUN05	2140: BP 180's/100's. 100 mcg Fentanyl IV given. BP ↓ 150's/90's. Dopamine ↓ to 1mcg/kg/min. Phenylephrine on standby. (b)(6)
22JUN05	0200. BP 90's/50's. Phenylephrine ↑ 50mcg/min. Dopamine ↑ 2 mcg/kg/ (b)(6)
22JUN05	0600: Pt O2 sats dropped to 80% c FiO2. Increased to 94% c FiO2 .70. VSS for approx 15 min. Desatted to 80% again @ 0615. FiO2 ↑ to 100%. Will cont to monitor. (b)(6)
22JUN	Surgery Trauma Day 5.
	Tmax 103.1 HR 113 BP 135/80
Neo 100	SIMV 950 x 16 5 PEEP 10 PS 40%
Dopa 2	7200/4600
Levo	① Neuro sedated. ↓ versed.
	② CV - Wean Neo for SBP >100 MAP >60
Fentanyl	Continue dopa
Versed	③ Resp ~ CXR [illegible] oxygenating & vent well.
	CT ~ 1 small leak. pneumopericard. -
	less prominent.
	④ REN Gd U.O. [illegible] BUN/creat stable
	⑤ GI ~ good stool output. Start TF
	⑥ [illegible]
	⑥ ID High [illegible] WBC [illegible]. Plt remain
	low. DC [illegible]
	⑦ [illegible]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

21 JULY 0730 — See flow sheet for Vital Signs + assessment. Pt intubated and on Vec. (b)(6) Movement.

0900 — ET Chest tubes switched to water seal. one with air leak (b)(6) aware of change in treatment. (b)(6)

1300 — Pt given Lasix to aid urine output, Neuro at baseline. (b)(6) (b)(6) aware

1900 — Pt has temp 103.1, Rectal tylenol given, cooling for effect (b)(6)

21 JAN 05 (1923 hrs)

ICU MEDICINE

ASKED TO ASSESS PATIENT FOR DESATURATIONS DESPITE FiO2 ~ 50%
SOME IMPROVEMENT IN VITALS AFTER SUCTIONING
PCXR IS SUGGESTIVE OF PNEUMOPERICARDIUM.
UNABLE TO ASSESS NON-INVASIVELY i ECHOCARDIOGRAM GIVEN
LACK OF ADEQUATE WINDOWS 2° (L) CT's, ABDOMINAL WOUND VAC
& SUPINE POSITION ON VENTILATOR.
CT OF CHEST ORDERED, DAS DAVAT & SAUVAGEAU AWARE,
? TRAUMA FROM INITIAL INJURY or CT PLACEMENT.

(b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST

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PROGRESS NOTES
Medical Record

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(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
CCF

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	ICW MEDICINE NOTES
	(A)(P) I. GSW TO (L) THORACOABDOMEN & BACK (6/17)
	- s/p TRANSVERSE COLON RESECTION c̄ (R) END COLOSTOMY (6/19)
	- s/p G-TUBE & PELVIC DRAINS
	II. METABOLIC ACIDOSIS ~ RESOLVED
	III. COAGULOPATHY & THROMBOCYTOPENIA - IMPROVING
	IV. HYPOPHOSPHATEMIA / HYPOKALEMIA - ACTIVELY REPLACING
	(1) ALLOW AUTO DIURESIS AS ~3L YESTERDAY
	(2) REPLACE c̄ K_2PO_4
	(3) REPLACE Ca^{++}
	(4) CHEST TUBE TO WATER SEAL
	(5) TITRATE OFF NEOSYNEPHRINE GTT, THEN RENAL DOPA.
	(6) CONT IV ABX
	(7) CONT. CARAFATE (ANTACID + PCTS) & LOVENOX FOR GI / DVT PROPHYLAXIS
	(b)(6)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	ICU MEDICINE
21 JUN 05	
(0945 HRS)	NO PROBLEMS OVERNIGHT; STILL ↓ CARDIAC BP REQUIRING DOPAMINE & NEOSYNEPH
	NEURO: SEDATED & PARALYZED ON FENTANYL 150 mcg/hr & VERSED 10 mg/hr; VEC HELD
	CV: SINUS TACH P 100–110s BP 90–100s/60s NURSE @ (B)(B)
	RFV TLC (DAY 1) – SITE OK DOPA @ 2 mcg/kg/min; NEO @ 150 mcg
	Resp: INTUBATED (DAY 3) #7.5 ETT @ 24 TO RACK 2 LT CTs (100)
	SIMV 16 VT 950 .40 PS 15 PEEP 10 99–100%
	CXR: ETT & NGT OK, CUFF OFF @ CPA, @ ANTERIOR INTERCOSTALS – INFLATED
K-Phos Infusion 45 mmol/4°	GU: OPEN ABDOMEN TO WOUND VAC Ø; @ STOMA DUSKY ↓ SCANT STO
	NGT TO LIS 200 cc/
CEFAZOLIN 1g Q8°	2 J-P DRAINS 600 cc/24°
	C-CATH TO GRAVITY 75 cc/24°
	GI: FOLEY ↓ AMBER URINE
	F/O 6200/4400 (-3.2L) 136 | 110 / 97 Mg 1.9
	U.O.P 3.5 | 22 / 1.2 PO4 1.6
UNASYN 3g Q6°	HEME/ID:
FLAGYL 500 mg Q6°	TMAX 101.6 9.2 | 11.3 / (47,000) INR 1.4
LOVENOX 30 mg Q12°	TCURR 99.6 | 34.3 PTT 64

(b)(6)

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PROGRESS NOTES
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(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
PCCF

ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
[illegible]	Surgery 137/110/12 1.0 4.4/24
	TM 101.4 HR 110 BP 122/76 Mg 1.9 Phos 2.3
[illegible]	11,000/5000
[illegible]	(1) Neuro - paralyzed & sedated 7.3/37/223 (35)
[illegible]	(2) Resp - adequate oxygenation 7.4/37/223
[illegible]	& ventilation. CXR looks pretty
[illegible]	bad.
[illegible]	(3) CV - somewhat labile on renal
[illegible]	dopa & low dose neo transfused
	an pRBC
	(4) FEN: [illegible] lytes ok. Still plan
	[illegible]. Adequate U/O.
	(5) GI - stoma looks dusky. Continue
	to monitor. May have to return
	(6) ID Low grade fever [illegible]
	on unasyn/flagyl
[illegible]	Surgery (b)(6)
	TM 101.4 HR 124 BP 96/58
[illegible]	6200/9400 U.O. 200cc/h Mg 1.9 phos 1.6
[illegible]	(1) Neuro: Paralyzed/Sedated, DC vec 93/34 (47)
[illegible]	(2) Resp: oxygenating & vent well
[illegible]	CXR improved ET to release 136/104/11 3.5/22 1.2
[illegible]	(3) CV: Still require neo. Renal dopamine
[illegible]	Hct ok plt still low
[illegible]	(4) GI: Small amount of stool in bag
[illegible]	OR Friday for VAC D
	(5) FEN Replace lytes [illegible] U.O. on renal dose
	(6) ID Low grade fever on Unasyn [illegible]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

Ilu Medicine

A/P

I. GSW TO (L) THORACOABDOMINAL & MACIC (6/17)
- S/P EX-LAP & INTRAABDOMINAL FOREIGN BODY REMOVAL
- S/P TRANSVERSE COLON RESECTION & (R) END COLOSTOMY (6/19)
- S/P G-TUBE, & CHEST DRAINS

II. METABOLIC ACIDOSIS - RESOLVED & $NaHCO_3$ INFUSION

III. ANEMIA & Hgb 9.0/ HCT 27.3
① TRANSFUSING 2 UNITS PRN's

III. COAGULOPATHY & THROMBOCYTOPENIA - LIKELY CONSUMPTIVE
① MONITOR FOR NOW.

IV. HYPOMAGNESEMIA | HYPOPHOSPHATEMIA | HYPOKALEMIA - RESOLVED
① WILL REPLACE PRN DURING DIURESIS

VII. CONTINUE LINES & WILL USE FEMORAL ACCESS GIVEN ↓ PLTS TO AVOID COMPLICATIONS.
CONT. FLAGYL & UNASYN.

(b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME | LAST | FIRST

DEPARTMENT/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name, Last, First, Middle Initial)

(b)(6)

REGISTER NO.

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20 JUN 05	0230: 1000 cc NS bolus given @ 0100. BP still 80's/50's. (b)(6) notified. Phenylephrine ↑ 200mcg/min. 500 cc Hespan ordered & given. 500 cc Bolus NS ordered & given. Urine output @ 0200: 100cc dark amber. Will wean phenylephrine back down when BP improves. HR still @ 114. O2 sats 100% on FiO2 100%. (b)(6)
20 JUN 05	0300: BP 110/74, HR 106, O2 sats 100% on FiO2 100. Phenylephrine weaned down to 100mcg/min. (b)(6)
20 JUN 05	0600: Pt desatted to 70% on FiO2. Gradually increased to 80% with 2-3 minutes. Suctioned ETT. ∅ chng noted. O2 sats rose to 90% within 2-3 more minutes. Holding steady @ 90% on FiO2 100.
20 JUN 05	0610: Bolus of Fentanyl & Versed Given. O2 sats now 93% on FiO2 100. (b)(6)
20 JUN 05	0645: O2 sats 96-97% on FiO2
20 JUN 05	ICU MEDICINE
	EVENTS OF LAST EVENING REVIEWED c̄ DRS [illegible] & [illegible].
	HYPOTENSION & HYPOXEMIA - IMPROVED c̄ HESPAN, DOPAMINE, & IV NS. /
	← CONT. →

(b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI

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

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

(b)(6)

UNKNOWN
M O DETAINEE
RCCF

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	NEURO: SEDATED c̄ VERSED 10 MG/HR & FENTANYL 150 mcg/hr
	MIOTIC PUPILS c̄ MINIMAL RESPONSE TO LIGHT (+) SCLERAL EDEMA
	CV: SINUS TACH P 137 BP 160/70 [illegible]
	DOPAMINE @ 2 mcg/kg/min
	PHENYLEPHRINE @ 75 mcg/min → WEAN
	LINES: (R) IJV CORDIS; (L) SCV CORDIS c̄ TLC; (L) RADIAL A-LINE → PLACED IN O.R. — DAY 3 - SITES OK "FIELD LINES"
	PULM: INTUBATED (DAY 3) # 7.5 ETT 26 cm @ [illegible]
	SIMV 16 VT 850 100% PS 20 PEEP 10
	COARSE BREATH SOUNDS BILATERALLY c̄ MODERATE BLOODY SECRETIONS
	CXR: TUBES & LINES OK, BILATERAL ALVEOLAR INFILTRATES
	ABG: 7.43/36.7/233/26/100% 2 CT's ON (L) 70 cc/12
	GI: OPEN ABDOMEN TO FUNCTIONAL WOUND VAC 500 cc
	(R) SIGMA [illegible], ∅ STOOL ∅
	2 JP DRAINS TO CONT. SUCTION 200 cc
	G-TUBE TO GRAVITY c̄ BILIOUS DRAINAGE 10 cc
	NGT TO LIS 250 cc
D5 c̄ 150 mEq	GU: FOLEY c̄ CLEAR COLORLESS URINE — Ca 9.0
NaHCO3 @ 125cc/hr	I/O 11328/4500 (+6.8L) 137 / 110 / 12 — 131 — Mg 1.9
	U.O.P. ~4,000 cc 4.4 / 24 / 1.0 — PO4 2.3
	HEME/ID:
	Tmax 102.3 — 7.2 (9.0) 38,000 — PT 16.5
	Tcurr 100.6 — 27.2 — PTT (67.5)
	INR 1.2
	← CONT. →

(b)(6)

(REV. 5/1999) BACK
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 Jun 05 1100	Now using double-concentrated phenylephrine @ 200 mcg/min to maintain SBP ? 90 HR 130s OR @ this time (b)(6)
19 JUN	BON Pre Post op dx- open abdomen Procedure ① ex lap w/ intra abdominal packs removed ② transverse colon resection w/ end right colostomy ③ G-J tube ④ Pelvic & Retro-Hepatic drains ⑤ VAC Surgeon TANAF (b)(6)
19 JUN 05	2100: Urine output 10cc dark amber urine. (b)(6) notified. Will give 250 cc NS Bolus as ordered & cont to monitor. (b)(6)
19 JUN 05	2200: Urine output 100 cc dark amber urine & Bolus of 250cc NS. (b)(6) (b)(6) aware.
20 JUN 05	0100: Pt desatted to 91-92% on FiO2 .75. Suctioned x4. Red & Sm. clots & suctioning. Sats up to 93-94% p SX. (b)(6) (b)(6) present Albuterol Neb x1 ordered & given.
20 JUN 05	0100: HR. 140. Dopamine drip d to 1 mcg/kg/min (b)(6)
20 JUN 05	0115: HR 120. BP ↓ 80/40's Dopamine ↑ to 2 mcg/kg/min (b)(6)

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

AUTHORIZED FOR LOCAL REPRODUCTION

DICAL RECORD

PROGRESS NOTES

NOTES

↑ phenylephrine to 200 mcg/min - gave bolus of approx 20 mcg ↑ BP improved to 103/69 (b)(6)

08:54	143	99	94 / 66	76	16
08:52	141	98	103 / 67	79	16
08:50	146	98	78 / 57	65	16
08:48	148	97	86 / 61	69	16
08:46	147	97	95 / 63	74	16
08:44	146	97	97 / 64	75	18
08:42	147	98	123 / 74	89	16
08:40	157	99	162 / 98	109	16
08:38	165	93	75 / 46	59	16
08:36	160	97	92 / 43	64	16
08:34	163	99	172 / 88	112	9
08:32	160	99	151 / 65	97	9
08:30	158	84	173 / 84	113	9
08:28	148	86	165 / 73	104	5
08:26	154	86	177 / 81	113	8
08:24	155	93	168 / 77	107	9
08:22	158	96	99 / 73	97	18
08:20	156	95	186 / 47	73	16
08:18	157	94	181 / 46	68	16
08:16	159	95	119 / 51	78	16
08:14	160	95	93 / 58	88	16
08:12	160	95	185 / 67	99	16
08:10	163	94	138 / 124	137	16
08:08	162	95	139 / 117	126	14
08:06	155	96	97 / 59	94	16
08:04	156	95	166 / 78	104	16
08:02	162	95	199 / 182	133	24
08:00	155	95	141 / 56	98	16
07:58	156	96	137 / 55	89	16
07:56	155	96	143 / 56	98	16
07:54	156	96	158 / 63	108	16
07:52	156	96	158 / 57	94	16
07:50	155	96	156 / 68	97	16
07:48	156	95	175 / 68	186	16
07:46	157	96	165 / 72	185	16
07:44	157	95	185 / 73	111	16
07:42	157	95	188 / 73	112	16
07:40	157	95	192 / 75	114	17
07:38	157	95	199 / 79	118	16
07:36	158	95	196 / 76	117	16
07:34	158	95	187 / 72	113	16
07:32	156	94	205 / 85	123	16
07:30	155	95	186 / 73	111	16
07:28	154	94	183 / 71	108	16
07:26	154	93	178 / 70	107	17
07:24	154	95	179 / 68	106	16
07:22	154	95	178 / 69	106	16
07:20	153	94	179 / 69	105	16
07:18	155	93	171 / 67	102	16
07:16	156	93	177 / 71	106	16
07:14	158	93	175 / 78	110	18
07:12	160	87	185 / 95	121	16
07:10	154	98	160 / 73	104	18
07:08	153	97	145 / 63	95	14
07:06	153	98	112 / 63	98	16
07:04	159	93	162 / 76	105	15
07:02	156	95	109 / 50	95	16
07:00	160	95	174 / 87	116	18

NIBP TREND BA/10/MS

TIME	HR/PR	SpO2	SYS / DIA - MEAN	RR
HH:MM	BPM	%	mmHg	RPM
10:00	127	100	98 / 59 - 71	18
09:45	135	100	88 / 58 - 61	18
09:30	144	100	102 / 63 - 77	18
09:15	144	100	96 / 68 - 79	19
09:00	145	99	110 / 75 - 88	16
08:45	147	97	96 / 63 - 77	16
08:30	162	98	96 / 63 - 77	16
08:30	168	92	130 / 86 - 102	31
08:15	159	95	104 / 64 - 80	16
08:00	154	96	119 / 78 - 89	16
07:45	156	95	142 / 83 - 102	16
07:30	154	94	155 / 88 - 110	16
07:15	157	94	149 / 87 - 109	16
07:01	158	95	156 / 98 - 114	16
06:51	149	95	102 / 63 - 80	22
06:32	156	93	106 / 68 - 85	18
04:41	139	96	126 / 82 - 97	28
04:39	136	98	112 / 82 - 96	17

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SPONSOR'S NAME

FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
PCCF

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 Jun 05 1140	Now using double-concentrated phenylephrine @ 200 mcg/min to maintain SBP > 90 (b)(6)
	1400 To OR @ this time
19 JUN	BON
	Pre / Post op dx - open abdomen
	Procedure ① ex lap w/ intraabdominal pack removal
	② transverse colon resection w/ end right colostomy
	③ G-tube
	④ Pelvic & Rt gutter drains
	⑤ VAC
	Surgeon (b)(6) (b)(6)
19 JUN 05	2100: Urine output 10cc dark amber urine. (b)(6) notified. Will give 250 cc NS Bolus as ordered & cont to monitor. (b)(6)
19 JUN 05	2200: Urine output 100 cc dark amber urine ā Bolus of 250cc NS. (b)(6) aware. (b)(6)
20 JUN 05	0100: Pt desatted to 91-92% on FiO_2 .25. Suctioned x4 Red c̄ sm. clots c̄ suctioning. Sats up to 93-94% p̄ sx. (b)(6) present. Albuterol Neb x1 ordered & given. (b)(6)
20 JUN 05	0100: HR 140. Dopamine drip ↓ to 1 mcg/kg/min (b)(6)
20 JUN 05	0115: HR 13[illegible]. BP ↓ 80's/[illegible]. Dopamine ↑ to 2 mcg/kg/min. (b)(6)

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 Jun 05 1100	Now using double-unmetered phenylephrine @ 200 mcg/min to maintain SBP > 90 (b)(6)
	Has Tx to OR at this time
19 JUN	BON
	Pre Op Dx - open abdomen
	Procedure ① ex lap w/ intra-abdominal packs removed
	② transverse colon resection w/ end right colostomy
	③ G-J tube
	④ Pelvic & Rt gutter drains
	⑤ VAC
	Surgeon (b)(6) (b)(6)
19 JUN 05	2100: Urine output 10cc dark amber urine. (b)(6) notified. Will give 250 cc NS Bolus as ordered & cont to monitor.
	(b)(6)
19 JUN 05	2200: Urine output 100 cc dark amber urine & Bolus of 250cc NS. (b)(6) aware. (b)(6)
20 JUN 05	0100: Pt desatted to 91-92% on FiO2 .75. Suctioned x4. Red & Sm. clots & suctioning. Sats up to 93-94% p SX.
	(b)(6) present. Albuterol Neb x1 ordered & given.
	(b)(6)
20 JUN 05	0100: HR 140. Dopamine drip ↓ to 1 mcg/kg/min (b)(6)
20 JUN 05	0115 ↓ HR 136 BP ↓ 80/50's. Dopamine ↑ to 2 mcg/kg/min
	(b)(6)

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	AP I. GSW TO (L) THORACOABDOMEN & BACK
	II. METABOLIC ACIDOSIS – RESOLVED
	III. COAGULOPATHY – STILL ↓ PTT of 80
	IV HYPOMAGNESEMIA / HYPOPHOSPHATEMIA – ACTIVELY REPLACING
	V ANEMIA – TRANSFUSING 1 UNIT PRBC'S
	VI SIRS / DISTRIBUTIVE SHOCK – REQUIRING MOD-HIGH DOSE NE
	(1) CORRECT FLUID & e⁻ ABNORMALITIES
	(2) DIURESE AS > 5.0 L UP & "WET" BY EXAM/CXR.
	(3) TRANSFUSE 1 UNIT PRBC's
	(4) ↑ VENT RATE TO 18 & PEEP TO 10.
	(5) TITRATE NEOSYNEPHRINE TO KEEP MAP > 80 mm Hg
	(6) HOLD ZANTAC GIVEN PLTS of 51,000. START CHARTAE 1G VIA NGT QID ~~p~~ SUCRAFATE
	(7) TO OR TODAY.
	CURRENTLY: P 141 BP 107/75 MAP 82 R 18 100% on 100% FiO2

(b)(6)

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	ICU MEDICINE
19 JUN 05	
(0800 HRS)	TACHYCARDIC THIS A.M. c̄ TENUOUS BP DROPS REQUIRING ↑ IN NEO TO INC [illegible] 50mcg IV BOLUSES.
	(L) FLANK WOUND DRAINING DARK FLUID CONTINUOUSLY
	NEURO: SEDATED & PARALYZED ON VERSED 3mg/hr, VECURONIUM 0.1mg/kg/HR, FENTANYL 250 mcg
	PUPILS PINPOINT & MINIMALLY REACTIVE ⊕ SCLERAL EDEMA
	CV: SINUS TACHYCARDIA NO M 3 (R)/(R)/(B) APPRECIATED 2° TACHY
	P 148 BP 90s/40s NEOSYNEPHRINE @ 100 mcg/min → 150 m
	PULM: ETT #8.0 @ 26cm / ; VENT. SIMV 16/16 VT 850 100% PS 20 PEEP
	CXR: R > L BILATERAL EFFUSIONS , TUBES & LINES OK ? RETAINED SPONGE
	ABG: 7.34 / 43 / 89 / 25 / 96% 2 LT CT's 670 cc/24°
	EXAM: COARSE BREATH SOUNDS , SYMMETRIC EXPANSION of CHEST WALL c̄ INSP.
	SECRETIONS: BLOOD CLOTS LAVAGED from ETT
NS c̄ 20mEq KCl @125cc/hr	GI: OPEN ABDOMEN TO FUNCTIONING VAC 1000 cc/24° ALB 1.7
	DISTENDED c̄ SOME LEAKAGE NEAR WOUND MARGINS
	GU: FOLEY c̄ CLEAR, COLORLESS URINE Mg 1.1
	I/O 13300/7800 (⊕ 5.5L) 128 / 109 / 9 136 PO4 1.7
	U.O.P. 4100 cc 3.9 / 25 / 1.2 PT [illegible]
UNAs	HEME/ID: TMAX 102.3 8.0 \ 11.1 / 51,000 INR 1.[illegible]
FLAGYL	TCUR 102.3 33.3

(b)(6)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first [redacted]

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
ACCF

REGISTER NO. | WARD NO. U

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	AP I. GSW TO (L) THORACOABDOMEN & BACK
	II. METABOLIC ACIDOSIS – RESOLVED
	III. COAGULOPATHY – STILL ē PTT of 80
	IV HYPOMAGNESEMIA / HYPOPHOSPHATEMIA – ACTIVELY REPLETING
	~~V~~ ANEMIA – TRANSFUSING 1 UNIT PRBC's
	VI SIRS / DISTRIBUTIVE SHOCK – REQUIRING MOD-HIGH DOSE N
	(1) CORRECT FLUID & ē ABNORMALITIES
	(2) DIURESE AS > 5.0 L UP & "WET" BY EXAM/CXR
	(3) TRANSFUSE 1 UNIT PRBC's
	(4) ↑ VENT RATE TO 18 & PEEP TO 10.
	(5) TITRATE NEOSYNEPHRINE TO KEEP MAP > 80 mm Hg
	(6) HOLD ZANTAC GIVEN PLTS of 51,000. ↑, START COUMADINE 1G VIA NGT QID ē SWALLOW
	(7) TO OR TODAY.
	CURRENTLY: P 141 BP 107/75 MAP 82 R 18 100% on 100% FiO

(b)(6)

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 JUN 05	1600 SBP regularly dropping to <90, then returning to >100 (b)(6) ◎ bedside; orders written (b)(6)
18 JUN 05	2030: HR tachycardic high 140's. SBP dropping to <90, then returning to >100. MD (b)(6) notified. 1000cc LR Bolus ordered and given. HR ↓ to 130's, SBP ≈ 120's/60's. (b)(6)
18 JUN 05	2300: HR: high 130's, SBP <90. Phenylephrine ↑ to 75 mcg/min (b)(6) present & notified. 1000cc LR bolus ordered and given. (b)(6)
19 JUN 05	0430: SBP High 80's/50's, (b)(6) notified. Phenylephrine ↑ to 100 mcg/min and 1000cc LR bolus given per MD order. Will cont to monitor. (b)(6)
19 JUN 05	0530: Unable to draw blood from (R) radial art line. Line d/c'd and a new (L) radial art line placed. (L) Line patent, drawn blood easily. Phenylephrine increased to 100 mcg/min @ 0430. Liter of LR bolus given @ 0430. SBP now 120's, DBP 60's. HR: 138. (b)(6)
19 JUN 05	0700 Swift flow sheet for general assessment & (b)(6)
0800	(b)(6) ◎ bedside; orders written based on lab results Informed MD of ↑ temp + Tylenol given PR (b)(6)
0900	Pt BP has been extremely labile; O2 sat have dropped as low as 88%. (b)(6) ◎ bedside, all interventions reviewed & completed. Pt sustained via ETT for mod amt. blood. aputem (b)(6)

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	**NOTES**
18Jun05 1200	SBP trending <90 ↑ phenylephrine started + (b)(6) informed — (b)(6)
18JUN	Surgery POD 2
neo 25mcg	Tm 100.4 HR 130 BP 95/60 141 | 113 | 12 / 1.3
Fentanyl	5800/460 U.O 200cc/hr (6.0) | 21
Versed	Open abdomen. 12/61-PT/PTT
Vec	(1) Neuro - paralyzed & sedated [illegible] 47 / 102
Unasyn	(2) Resp - oxygenating well
Zantac	CXR OK
Flagyl	(3) CV - low dose neo HCT stable
	(4) FEN - [illegible] U.O. K elevated
	Continue Bicarb. Recheck [illegible]
	(5) GI OR tomorrow for ex lap &
	closure
	(6) ID Afebrile WBC [illegible] unasyn flagyl
	D lines tomorrow OR tomorrow
	(b)(6)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENT	REGISTER NO.	WARD NO.
(b)(6)		

UNKNOWN, UNKNOWN
M O DETAINEE
CCF

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

(A)(P) I. FLUID TO (G) THORACOABDOMINAL & BACK – RESUSCITATION ONGOING

(1) REPLACE Mg^{++} & Ca^{++}
(2) FFP TO CORRECT COAGULOPATHY
(3) BICARBONATE DRIP TO NORMALIZE METABOLIC ACIDOSIS.
(4) CONT. IV ABX
(5) SURGERY (ATX) TODAY

(b)(6)

18 Jun 05 0715 Pt V.S. improved rapidly ∈ NS bolus. See MAR for all other fluids, meds received & administered. See ICU flow sheet for general assessment

(b)(6)

18 Jun 05 1030 Pt packed; noted wounds: R flank, posterior; a lg wound constantly draining dk red fluid; a small wound ∈ on ant dk red drg. On R hip ∈ 3 wounds: wound @ iliac crest fairly deep; wound @ trochanter fairly shallow; most distal wound "tunnels" cephalocaudally. All wounds packed ∈ dsgs.

(b)(6)

1035 Noted BP lower & P >140; informed (b)(6) & orders written

(b)(6)

Also orders written & received by (b)(6)

1050 V.S. recovered rapidly ∈ NS bolus. Will cont to monitor closely & keep MO informed

(b)(6)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT (b)(6)
UNKNOWN, UNKNOWN
M O DETAINEE
CCF

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

PROGRESS NOTES

DATE	
18 Jun 05 0655	Noted BP↓ c arterial reading 91/67 + NIBP 96/60 c P 160 - Increased (b)(6)
	IV rate to 200 cc/hr + began 500cc bolus
0700	(b)(6) c bedside; informed of above
	ICU MEDICINE
MEDS / FLUIDS	
	PATIENT ACCEPTED IN TRANSFER FROM TIKRIT p GSW TO (L) CHEST, BACK
	& ABDOMEN, TRANSFUSED c MULTIPLE PRBC'S, FFP CRYSTALLOID, & NAHCO3
	OVERNIGHT. SURGERY PLANNED FOR LATER TODAY. RESUSCITATION ONGOING.
	FENTANYL 200MCG/HR, (9MG/HR)
VERSED & VEC	NEURO: SEDATED & PARALYZED ; VERSED @ 3MG/HR, VECURONIUM 0.1MG/KG
	MIOTIC PUPILS c RESPONSE TO LIGHT
	CV: SINUS TACH IN 140'S BP LABILE 100's - 150's/80 PIV (R) AC
	(R) IJV CORDIS
Ø PRESSORS	(L) SCV CORDIS c TLC ⟩⟩ DAY 1 - SITES OK.
	(R) RADIAL A-LINE
	PULM: INTUBATED (DAY 1)
	VENT: SIMV 16/16 .70 850 PSV 10 PEEP 5
	ABG: 7.29/33/169/16/99%
	CXR: (R) PLEURAL EFFUSION, ETT @ CLAVICLES, TLC @ RA/SVC JCT, ? (L) LL
	2 LEFT CT'S TO PLEURVAC - Ø LEAKS
Famotidine 50mg Q8°	GI: NGT TO LIS
	OPEN ABDOMEN TO WOUND VAC
1 SW c 3 AMPS NaHCO3 @ 125cc/hr	GU: FOLEY c CLEAR URINE
	I/O 233 / 66 ALB 1.7 Ca 7.9
Vancomycin 1G IV Q12°	U.O.P Mg 0.9 Phos 3.
Flagyl 500mg Q6°	HEME/ID: Tmax 9.9 / 15.7 / 47.0 / 122,000, INR 2.2

(b)(6)

(REV. 7-91) BACK USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	

0228 Bag #5 of NS completed, Bag 6 & 7 hanging TKO.

0243 Versed 100mg hung ~~100mg~~ 3mg per hr, Fentanyl 2000 mcg hung 100mcg per hr. (b)(6)

0300 Pt ready for transfer to ICU. Vent Rate 16 Tidal Volume 850 70% ~~50~~ O2 PEEP 5. Urine output 700cc blood tinged. 1200cc drainage from belly wound serosanguinous drainage. 30cc sanguinous drainage pleurevac #1. 60cc sanguinous drainage pleurevac #2. IV bags 6,7,8 hang TKO. NG tube drainage 25cc clear drainage. (b)(6)

(Continue on reverse side)

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

(b)(6)

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

PROGRESS NOTES

DATE	
18 Jun 05 0655	Noted BP↓ = arterial reading 91/67 + NIBP 94/60 = P 160 - Increased (b)(6) [redacted]
	IV rate to 200 cc/hr + began 500cc bolus
0700	(b)(6) [redacted] @ bedside; informed of above
	ICU MEDICINE
MEDS / FLUIDS	
	PATIENT ACCEPTED IN TRANSFER FROM TIKRIT p̄ GSW TO Ⓛ CHEST, BACK & ABDOMEN, TRANSFUSED c̄ MULTIPLE PRBC'S, FFP, CRYSTALLOID, & NAHCO3 OVERNIGHT. SURGERY PLANNED FOR LATER TODAY. RESUSCITATION ONGOING.
	FENTANYL 200mcg/HR, (9mg/HR)
VERSED & VEC	NEURO: SEDATED & PARALYZED, VERSED @ 3MG/HR, VECURONIUM 0.1 mg/kg
	MIOTIC PUPILS c̄ RESPONSE TO LIGHT
	CV: SINUS TACH in 140'S BP LABILE 100's - 150's / 80 PIV Ⓡ AC[illegible]
	Ⓡ IJV CORDIS
∅ PRESSORS	Ⓛ SCV CORDIS c̄ TLC — DAY 1 - SITES OK.
	Ⓡ RADIAL A-LINE
	PULM: INTUBATED (DAY 1)
	VENT: SIMV 16/16 .70 850 PSV 10 PEEP 5
	ABG: 7.29/33/168/16/99%
	CXR: Ⓡ PLEURAL EFFUSION, ETT @ CLAVICLES, TLC @ RA/SVC JCT, ? Ⓛ LL inf[illegible]
	2 LEFT CT'S TO PLEURAVAC - ∅ LEAKS
Famotidine 50mg Q8°	GI: NGT TO LIS
	OPEN ABDOMEN TO WOUND VAC
1.5L c̄ 3 AMPS NaHCO3 @ 125cc/hr	GU: FOLEY c̄ CLEAR URINE
	I/O — 133 / 4.6 — ALB 1.7 Ca+ 7.9
Cefazolin 3G IV Q6°	U.O.P — Mg 0.9 Phos 3.0
Flagyl 500mg Q6°	HEME/ID: Tmax 8.9 \ 15.7 / 122,000, INR (2.2)
	47.0 (b)(6) [redacted]

(REV. 7-91) BACK USAPPC V1.00

LOG 9 MED 115

MEDICAL RECORD — **EMERGENCY CARE AND TREATMENT** *(Patient)*

RECORDS MAINTAINED AT: 115th R,H

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: 115th R,H

CITY: Abu Ghraib — STATE: APO — ZIP CODE: AE 09342

ARRIVAL

DATE *(Day, Month, Year)*: 18 Jun 05 — TIME: 0100

TRANSPORTATION TO FACILITY: TVER

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE	
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES
			PRP				ADDITIONAL INSURANCE	
AGE	HOME PHONE		FLYING STATUS				QD 2568 IN CHART	
	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY	

CURRENT MEDICATIONS: UNKNOWN

ALLERGIES: UNKNOWN

INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
IS THIS AN INJURY?	Y		WHERE	TETANUS	
INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INITIAL SERIES ☐ YES ☐ N
HOW					

CHIEF COMPLAINT: GSW to Chest, back, and hip — Planned 2 3 units blood hanging 0115 blood completed.

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 0100

INITIAL: (b)(6)

VITAL SIGNS

TIME	0104	~~0118~~ 0118	0135	0150	0205
BP	122/81	153/82	159/91	157/83	158/83
PULSE	158	156	112	108	103
RESP	15	15	15	15	15
TEMP		100.1	100.1		
WT 02	100%	100%	100%	100%	100%

LAB ORDERS

☒	CBC/DIFF	☒	ABG		PT/PTT	☒	BHCG/URINE/BLOOD/QUANT
☒	URINE C&S	☒	UA MSCC/CATH			☒	CHEM: BMP
	BLOOD C&S X						

X-RAY ORDERS

	CXR PA & LAT/PORTABLE		C-SPINE
	ACUTE ABDOMEN		LS SPINE
	SINUS		HEAD CT
	ANKLE R/L		

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL:

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY: 0300

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE: ICU

TIME OF RELEASE: 1

REFERRED ▶ TO: WHEN:

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION — *(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)*

(b)(6)

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.303(b)(10)
USAPA V1.00

B:
IT/CAMP:
RANK/STATUS:

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATI *(sign each entry)*
2005-06-18 00:46	Complaint: GSW TO L CHEST AND HIP BP: _____ Weight: _____ Temp: _____
	B/P
0100	Vent Rate 15 I.E 1 to 2 tital vol. 700 100% O2 (b)(6)
0110	PTs lines flushed and vitals taken. (b)(6) (b)(6)
0112	A Line (R) radial Art. (b)(6) (b)(6)
0115	3 units of blood hung and completed, 1 liter NS completed
0120	2nd bag of NS hung (b)(6) (b)(6)
0122	Labs drawn CBC, Coag, ABG, BMP (b)(6)
0130	Foley bag changed - 100cc amber/tea color urine total output
0131	2 chest tubes (L) chest pleurevacs replaced. 50cc and 150 CC sanguinous drainage from Pleurevacs (old). New pleurevacs connected to suction (L) functional (b)(6)
0140	2nd bag of NS completed (b)(6)
0141	Abdominal Pressure monitored, bulb drainage attatched. (b)(6) (b)
~~0143~~	DSD Applied over Abdumen. 3rd bag NS hung Bolus (b)(6) (b)(6)
0147	New Tubing to central line, 4th bag NS hung, New tubing for the IJ. 5th bag hung TKO (b)(6) (b)(6)
0159	Sodium Bicarbonate @ 3 days of 50mg IV Completed
0200	#3 bag NS bolus completed. NG tube to low intern. suction. #4 bag NS bolus completed. #5 bag running bolus. (b)(6)

PATIENT'S IDENTIFICATION:

NAME: UNKNOWN, UNKNOWN
SSN: (b)(6)
SEX: M
Unit / Org: IHA

GRADE: FGN

DOB:

REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 - Automated Facsimile

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 June 05 0210	47yo BPW GSW (L) Chest and (R) Hip at Approx. 2100 17 June Seen in Ramstein hospital initial CT scanned 2500 cc Blood transfused SST intubated, CT (#2) placed to LAP done findings 1) Perforated Proximal descending colon 2) Capsular Laceration (L) Kidney 3) (L) Hemopneumothorax 4) Frag. (R) Shoulder Pt: Packed, segmented colon resection Exam: HEENT: (+) corneal reflex, Pupils fixed constricted Lungs: (B) BS scattered rales/rhonchi CV: Tachy R 142. Ext: Good Range of motion ABG: 6.55/51/244/992 144/113/1.7 Ca: 6.7 5.9 / 16 / 10 RP: GSW (L) Chest (R) Hip PTT: 126 PT: 26 INR 2.4 CXR: (L) Pulm Contusion 1) Acidosis - gave total 5 amps Bicarb - started Bicarb drip - Vent settings changed app + CO_2 2) DIC - gave 3 units FFP - Typed + Crossed 4 units See Surgical notes for further care 3) Hypocalcemia - gave 2 amps Ca. Cl (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.

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
DCCE

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

ARRIVAL

Date: 18 JUN 05 ☑ Immediate
Time of arrival: 0100 ☐ Delayed
Time of injury: ☐ Minimal
Transit time: ☐ Expectant
C-spine immob: YES / NO
Intubated: YES / NO
T: 100.1 BP: ___/___ HR: ___ RR: ___ O_2Sat: ___
PAIN: 0 1 2 3 4 5 6 7 8 9 10
Last Tetanus: GCS:

☐ Unknown
☐ Enemy
☑ Friendly
☐ Civ (Host nation)
☐ Training
☐ Self accident
☐ Self non-accident
☐ Sports recreation
☐ Other:

☐ Walked
☐ Carried
☐ USMC CASEVAC
☐ Non-med ground
☐ Ground Ambulance
☑ Air Ambulance
☐ Ship EVAC
☐ Other:

Nation:
☐ US
☐ Host nation
☐ Coalition: ___
☐ Enemy: ___
Service:
☐ USA
☐ USN
☐ USMC
☐ USAF
☐ SOF
☐ Civilian
☐ Combatants
☐ Contractor
☐ Non-gov't org
☐ Other:

TOURNIQUET

☐ Yes ☑ No
Time on: ___
Time off:

☐ Yes ☑ No
Time started: ___
Time ended:

GENDER

☐ Male
☐ Female

COOLING

☐ Remove clothes
☐ Warm blanket
☐ Cooling blanket
☐ Bear hugger
☐ Radiant warmer
☐ IV bag warmer
☐ Other:

PROTECTION

☐ Helmet Kevlar or ACH (circle one)	☐ Worn	☐ Struck	☐ Penetrated
☐ Flak vest	☐ Worn	☐ Struck	☐ Penetrated
☐ Ceramic plate	☐ Worn	☐ Struck	☐ Penetrated
☐ Eye protection	☐ Worn	☐ Struck	☐ Penetrated
☐ Deltoid/axilla	☐ Worn	☐ Struck	☐ Penetrated
☐ Groin/leg	☐ Worn	☐ Struck	☐ Penetrated

PRIMARY SURVEY

AIRWAY
☐ Patent
☐ Stridor
☐ Drooling
☐ Obstructed
☐ Oral/Nasal Airway
☐ BVM
☑ Chest tube(s)
☑ Intubated
☐ Other:

BREATHING — Breath Sounds: Right / Left
☐ Unlabored
☑ Labored
☐ Absent
☐ Retraction
☐ Flaring
☐ Clear ☐
☐ Rales ☐
☐ Flail ☐
☐ Wheeze ☐
☐ Absent ☐
Trachea: ☐Midline ☐Deviated
Chest symmetry: (circle one)
Left> Equal <Right

CIRCULATION
Skin:
☑ Warm ☐ Cool ☐ Hot
☐ Pink ☐ Pale ☐ Cyanotic
☐ Dry ☑ Moist ☐ Diaph
Heart Sounds:
☐ Clear ☐ Muffled
Capillary Refill:
☐ <2 seconds (normal)
☐ >2 seconds (delayed)

DEFICIT
☐ Alert
☐ Responds to verbal
☐ Responds to pain
☐ Unresponsive
GCS: ___
Eyes ___ Verbal ___
Motor ___
Sphincter Tone:
☐ WNL ☐ Weak ☐ None

SECONDARY SURVEY

HEAD/NECK/ENT
Drainage:
Nose (color): ___
CSF: Halo sign ___
Glucose ___
Eyes: Equal R / L
Fixed R / L
Reactive R / L
Dilated R / L
Other: ___
C-Spine tender:
☐ Yes ☑ No
Dental injury:
☐ Yes ☑ No
Tympanic Membrane:
☐ Clear R L
☐ Blood R L

HEART
Rhythm:
☐ NSR
☐ Sinus tachycardia
☐ Sinus bradycardia
☐ Asystole
☐ Other
Pulses:
S = Strong D = Doppler
P = Palpable A = Absent

Carotid	Right ___	Left ___
Femoral	Right ___	Left ___
Brachial 5	Right 5	Left
Radial	Right ___	Left ___
Pedal	Right ___	Left ___

JVD Distension:
☐ Right
☐ Left

ABDOMINAL/GU
☐ Flat
☑ Distended
☐ Obese
☐ Non-tender
☐ Tender
☐ Rigid
☐ Guarding
☐ Rebound tenderness
☐ Unable to assess
Bowel sounds:
☐ YES ☐ NO
Last Meal @ ___
Pelvis stable:
☐ YES ☐ NO
Hemorrhage:
☐ YES ☐ NO
Blood at meatus/vagina:
☐ YES ☐ NO
Prostate:
☐ WNL
☐ Abnormal

EXTREMITIES
ROM: ☐ YES ☐ NO
Fracture/dislocation:
☐ RUE
☐ RLE
☐ LUE
☐ LLE

	Motor		Sensation	
RUE	+	-	+	-
LUE	+	-	+	-
RLE	+	-	+	-
LLE	+	-	+	-

Back Exam:
☐ WNL ☐ ABNL
Time logrolled: 0120

PATIENT IDENTIFICATION
Name/Rank: (b)(6)
SSN/Patient Id #:
DOB: (ddmmyy)
Deployed unit:
MTF transferred from: Tikrit

ALLERGIES
☑ Unknown
☐ NKDA
☐ PCN
☐ Sulfa
☐ Morphine
☐ Codeine
☐ Other:

PAST MEDICAL HX
☐ Unknown
☐ None
☐ Respiratory hx
☐ Seizure hx
☐ Cardiac hx
☐ HTN
☐ DM
☐ Ulcers
☐ Other:

CURRENT MEDICATIONS
☐ UNKNOWN
☐ NONE
☐ OTHER ___
LAST MED GIVEN @:
☐ Morphine ___
☐ Fentanyl ___
☐ Antibiotic ___
☐ Other:

Date: 18 JUN 05	☑ Immediate	☐ Unknown	☐ Walked	Nation:
Time of arrival: 0100	☐ Delayed	☐ Enemy	☐ Carried	☐ US
Time of injury:	☐ Minimal	☑ Friendly	☐ USMC CASEVAC	☐ Host nation
Transit time:	☐ Expectant	☐ Civ (Host nation)	☐ Non-med ground	☐ Coalition:
C-spine immob: YES / NO		☐ Training	☐ Ground Ambulance	☐ Enemy:
Intubated: YES / NO		☐ Self accident	☑ Air Ambulance	Service:
T: 100.1 BP: ___/___ HR: ___ RR: ___ O_2Sat: ___		☐ Self non-accident	☐ Ship EVAC	☐ USA
PAIN: 0 1 2 3 4 5 6 7 8 9 10		☐ Sports recreation	☐ Other:	☐ USN
Last Tetanus: GCS:		☐ Other:		☐ USMC
				☐ USAF
				☐ SOF
				☑ Civilian
				☐ Combatants
				☐ Contractor
				☐ Non-gov't org
				☐ Other:

TOURNIQUET

☐ Yes ☑ ~~No~~
Time on:
Time off:

PROCEDURES IN PROGRESS

☐ Yes ☑ No
Time started:
Time ended:

GENDER

☐ Male
☐ Female

EXPOSURE

☐ Remove clothes
☐ Warm blanket
☐ Cooling blanket
☐ Bear hugger
☐ Radiant warmer
☐ IV bag warmer
☐ Other:

PROTECTION ☐ Unknown

☐ Helmet	☐ Worn	☐ Struck	☐ Penetrated
Kevlar or ACH (circle one)			
☐ Flak vest	☐ Worn	☐ Struck	☐ Penetrated
☐ Ceramic plate	☐ Worn	☐ Struck	☐ Penetrated
☐ Eye protection	☐ Worn	☐ Struck	☐ Penetrated
☐ Deltoid/axilla	☐ Worn	☐ Struck	☐ Penetrated
☐ Groin/leg	☐ Worn	☐ Struck	☐ Penetrated

AIRWAY

☐ Patent
☐ Stridor
☐ Drooling
☐ Obstructed
☐ Oral/Nasal Airway
☐ BVM
☑ Chest tube(s)
☑ Intubated
☐ Other:

BREATHING Breath Sounds

☐ Unlabored ☑ Labored ☐ Absent ☐ Retraction ☐ Flaring

Right	Left
☐ Clear	☐
☐ Rales	☐
☐ Flail	☐
☐ Wheeze	☐
☐ Absent	☐

Trachea: ☐ Midline ☐ Deviated
Chest symmetry: (circle one)
Left> Equal <Right

CIRCULATION

Skin:
☑ Warm ☐ Cool ☐ Hot
☐ Pink ☐ Pale ☐ Cyanotic
☐ Dry ☑ Moist ☐ Diaph
Heart Sounds:
☐ Clear ☐ Muffled
Capillary Refill:
☐ <2 seconds (normal)
☐ >2 seconds (delayed)

DEFICIT

☐ Alert
☐ Responds to verbal
☐ Responds to pain
☐ Unresponsive
GCS: ___
Eyes ___ Verbal ___
Motor ___
Sphincter Tone:
☐ WNL ☐ Weak ☐ None

HEAD/NECK ENT

Drainage:
Nose (color): ___
CSF: Halo sign ___
Glucose ___
Eyes: Equal R / L
Fixed R / L
Reactive R / L
Dilated R / L
Other: ___
C-Spine tender:
☐ Yes ☑ No
Dental injury:
☐ Yes ☑ No
Tympanic Membrane:
☐ Clear R L
☐ Blood R L

HEART

Rhythm:
☐ NSR
☐ Sinus tachycardia
☐ Sinus bradycardia
☐ Asystole
☐ Other
Pulses:
S = Strong D = Doppler
P = Palpable A = Absent

Carotid ___	Right ___	Left
Femoral ___	Right ___	Left
Brachial S	Right S	Left
Radial ___	Right ___	Left
Pedal ___	Right ___	Left

JVD Distension:
☐ Right
☐ Left

ABDOMINAL/GU

☐ Flat
☑ Distended
☐ Obese
☐ Non-tender
☐ Tender
☐ Rigid
☐ Guarding
☐ Rebound tenderness
☐ Unable to assess
Bowel sounds:
☐ YES ☐ NO
Pelvis stable:
☐ YES ☐ NO
Hemorrhage:
☐ YES ☐ NO
Blood at meatus/vagina:
☐ YES ☐ NO
Prostate:
☐ WNL
☐ Abnormal
Last Meal @ ___

EXTREMITIES

ROM: ☐ YES ☐ NO
Fracture/dislocation:
☐ RUE
☐ RLE
☐ LUE
☐ LLE

	Motor		Sensation	
RUE	+	-	+	-
LUE	+	-	+	-
RLE	+	-	+	-
LLE	+	-	+	-

Back Exam:
☐ WNL ☐ ABNL
Time logrolled: 0120

PATIENT IDENTIFICATION

Name/Rank: (b)(6)
SSN/Patient Id #:
DOB: (ddmmyy)
Deployed unit:
MTF transferred from: Tikrit

ALLERGIES

☑ Unknown
☐ NKDA
☐ PCN
☐ Sulfa
☐ Morphine
☐ Codeine
☐ Other:

PAST MEDICAL HISTORY

☐ Unknown
☐ None
☐ Respiratory hx
☐ Seizure hx
☐ Cardiac hx
☐ HTN
☐ DM
☐ Ulcers
☐ Other:

CURRENT MEDICATIONS

☐ UNKNOWN
☐ NONE
☐ OTHER ___

LAST MED GIVEN @:
☐ Morphine ___
☐ Fentanyl ___
☐ Antibiotic ___
☐ Other:

ARRIVAL

Date: 18 JUN 05 ☑ Immediate
Time of arrival: 0100 ☐ Delayed
Time of injury: ☐ Minimal
Transit time: ☐ Expectant
C-spine immob: YES / NO
Intubated: YES / NO
T: 100.1 BP: ___/___ HR: ___ RR: ___ O_2Sat: ___
PAIN: 0 1 2 3 4 5 6 7 8 9 10
Last Tetanus: GCS:

☐ Unknown
☐ Enemy
☑ Friendly
☐ Civ (Host nation)
☐ Training
☐ Self accident
☐ Self non-accident
☐ Sports recreation
☐ Other:

☐ Walked
☐ Carried
☐ USMC CASEVAC
☐ Non-med ground
☐ Ground Ambulance
☑ Air Ambulance
☐ Ship EVAC
☐ Other:

Nation:
☐ US
☐ Host nation
☐ Coalition: ___
☐ Enemy: ___
Service:
☐ USA
☐ USN
☐ USMC
☐ USAF
☐ SOF
☐ Civilian
☐ Combatants
☐ Contractor
☐ Non-gov't org
☐ Other:

CRITICAL CARE

☐ Yes ☑ ~~No~~
Time on: ___
Time off: ___

☐ Yes ☑ ~~No~~
Time started: ___
Time ended: ___

☑ Male
☐ Female

☐ Remove clothes
☐ Warm blanket
☐ Cooling blanket
☐ Bear hugger
☐ Radiant warmer
☐ IV bag warmer
☐ Other:

PROTECTION

☐ Helmet Kevlar or ACH (circle one)	☐ Worn	☐ Struck	☐ Penetrated
☐ Flak vest	☐ Worn	☐ Struck	☐ Penetrated
☐ Ceramic plate	☐ Worn	☐ Struck	☐ Penetrated
☐ Eye protection	☐ Worn	☐ Struck	☐ Penetrated
☐ Deltoid/axilla	☐ Worn	☐ Struck	☐ Penetrated
☐ Groin/leg	☐ Worn	☐ Struck	☐ Penetrated

AIRWAY / NECK
☐ Patent
☐ Stridor
☐ Drooling
☐ Obstructed
☐ Oral/Nasal Airway
☐ BVM
☑ Chest tube(s)
☑ Intubated
☐ Other:

BREATHING / Breath Sounds
☐ Unlabored ☑ Labored ☐ Absent ☐ Retraction ☐ Flaring
Right / Left
☐ Clear ☐
☐ Rales ☐
☐ Flail ☐
☐ Wheeze ☐
☐ Absent ☐
Trachea: ☐ Midline ☐ Deviated
Chest symmetry: (circle one)
Left> Equal <Right

CIRCULATION
Skin:
☑ Warm ☐ Cool ☐ Hot
☐ Pink ☐ Pale ☐ Cyanotic
☐ Dry ☑ Moist ☐ Diaph
Heart Sounds:
☐ Clear ☐ Muffled
Capillary Refill:
☐ <2 seconds (normal)
☐ >2 seconds (delayed)

DEFICITS
☐ Alert
☐ Responds to verbal
☐ Responds to pain
☐ Unresponsive
GCS: ___
Eyes ___ Verbal ___
Motor ___
Sphincter Tone:
☐ WNL ☐ Weak ☐ None

HEAD/NECK EENT
Drainage:
Nose (color): ___
CSF: Halo sign ___
Glucose ___
Eyes: Equal R / L
Fixed R / L
Reactive R / L
Dilated R / L
Other: ___
C-Spine tender:
☐ Yes ☑ No
Dental injury:
☐ Yes ☑ No
Tympanic Membrane:
☐ Clear R L
☐ Blood R L

HEART
Rhythm:
☐ NSR
☐ Sinus tachycardia
☐ Sinus bradycardia
☐ Asystole
☐ Other
Pulses:
S = Strong D = Doppler
P = Palpable A = Absent
Carotid ___ Right ___ Left
Femoral ___ Right ___ Left
Brachial 5 Right 5 Left
Radial ___ Right ___ Left
Pedal ___ Right ___ Left
JVD Distension:
☐ Right
☐ Left

ABDOMINAL/GU
☐ Flat
☑ Distended
☐ Obese
☐ Non-tender
☐ Tender
☐ Rigid
☐ Guarding
☐ Rebound tenderness
☐ Unable to assess
Pelvis stable: ☐ YES ☐ NO
Hemorrhage: ☐ YES ☐ NO
Blood at meatus/vagina: ☐ YES ☐ NO
Prostate: ☐ WNL
Bowel sounds: ☐ Abnormal
☐ YES ☐ NO
Last Meal @ ___

EXTREMITIES
ROM: ☐ YES ☐ NO
Fracture/dislocation:
☐ RUE
☐ RLE
☐ LUE
☐ LLE

	Motor		Sensation	
RUE	+	-	+	-
LUE	+	-	+	-
RLE	+	-	+	-
LLE	+	-	+	-

Back Exam:
☐ WNL ☐ ABNL
Time logrolled: 0120

PATIENT IDENTIFICATION
Name/Rank: (b)(6)
SSN/Patient Id #:
DOB: (ddmmyy)
Deployed unit:
MTF transferred from: Tikrit

ALLERGIES
☑ Unknown
☐ NKDA
☐ PCN
☐ Sulfa
☐ Morphine
☐ Codeine
☐ Other:

PAST MEDICAL HX
☐ Unknown
☐ None
☐ Respiratory hx
☐ Seizure hx
☐ Cardiac hx
☐ HTN
☐ DM
☐ Ulcers
☐ Other:

CURRENT MEDICATIONS
☐ UNKNOWN
☐ NONE
☐ OTHER ___
LAST MED GIVEN @:
☐ Morphine ___
☐ Fentanyl ___
☐ Antibiotic ___
☐ Other:

VITAL SIGNS

Estimated Weight: _____ kg

Time	Temp	HR	B/P	RR	Rhythm	SPO2	Mode	E	V	M	T	Pain	Initials
			/										
			/										
			/										
			/										
			/										
			/										
			/										
			/										

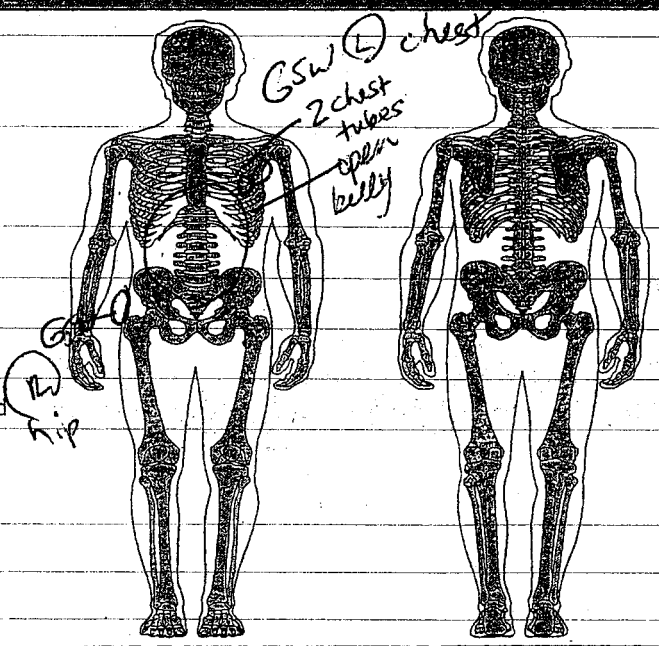
See SF558

INTUBATION/TRACHEOSTOMY

FIO2: 100% Time: _____
PEEP: 5 Mode: SIMV
ET/NT Size: Rate: 15
_____ cm at the
☐ Teeth ☐ Lips
_____ cm at nare
☐ R ☐ L
Tidal Volume: 700

SECONDARY SURVEY

(AB)rasion
(AMP)utation
(AV)ulsion
(BL)eeding
(B)urn
(C)repitus
(D)eformity
(DG)Degloving
(E)cchymosis
(FX)Fracture
(F)oriegn Body
(GSW)Gun Shot Wound
(H)ematoma
(LAC)eration
(PW)Puncture Wound
(P)ain
(SS)Seatbelt Sign
(SW)Stab Wound

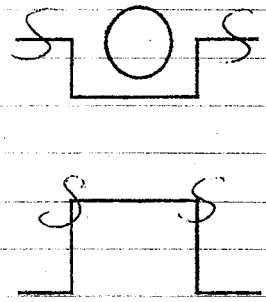


MECHANISM OF INJURY

- ☐ GSW/Bullet
- ☑ Blunt trauma
- ☐ Single fragment
- ☐ Multi-fragment
- ☐ MVC
- ☐ Aircraft crash
- ☐ Knife/edge (stab)
- ☐ Mortar/RPG/Grenade
- ☐ CBRNE
- ☐ Blast
- ☐ Burn
- ☐ Crush
- ☐ Fall
- ☐ IED
- ☐ Other:

Burn:
☐ 1st ☐ 2nd ☐ 3rd
%TBSA = _____

VASCULAR ASSESSMENT



S Strong
P Palpable
D Doppler
A Absent

LAB / X-RAY / CT / PROCEDURES

Time	Lab test	Time	Xray	Time	CT	Proced	Size	Location
	Hct		C-spine		Head	Foley		
	pH		Chest		Chest	NG		
	pO2		Abd		Abd	Ch tube-1		
	pCO2		Pelvis		Pelvis	Ch tube-2		
	BE		Extrem		Other:	Cent Ln		
	Glucose		Other:			A-Line		
	HCG					FAST		
	Other:					Other:		

Already placed upon arrival

(R)adial

GLASGOW COMA SCALE

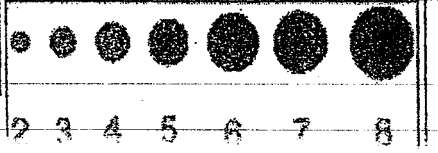
Best Eye Opening		Best Verbal Response		Best Motor Response	
Spontaneous	4	Oriented	5	Obeys commands	6
To speech	3	Confused	4	Localizes pain	5
To pain	2	Inappropriate words	3	Withdraws from pain	4
None	1	Incomprehens sounds	2	Flexion to pain	3
		None	1	Extension from pain	2
				No response	1

TOTAL GCS = _____

Pupil Size

R = _____ mm L = _____ mm

☐ Brisk ☐ Brisk
☐ Sluggish ☐ Sluggish
☐ Non-reactive ☐ Non-reactive



PATIENT IDENTIFICATION

Name:

VITAL SIGNS

Estimated Weight: _____ kg

Time	Temp	HR	B/P	RR	Rhythm	SPO2	Mode	E	V	M	T	Pain	Initials
			/										
			/										
			/										
			/										
			/										
			/										
			/										
			/										

See SF 558

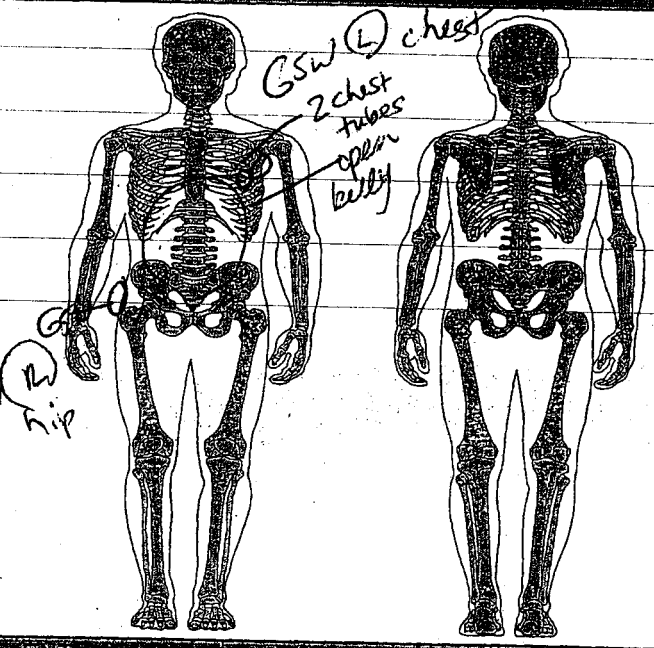
INTUBATION/TECHNIQUE

FIO2: 100%
PEEP: 5
ET/NT Size:
_____ cm at the
☐ Teeth ☐ Lips
_____ cm at nare
☐ R ☐ L
Tidal Volume:
700

Time:
Mode: SIMV
Rate: 15

SECONDARY SURVEY

(AB)rasion
(AMP)utation
(AV)ulsion
(BL)eeding
(B)urn
(C)repitus
(D)eformity
(DG)Degloving
(E)cchymosis
(FX)Fracture
(F)oriegn Body
(GSW)Gun Shot Wound
(H)ematoma
(LAC)eration
(PW)Puncture Wound
(P)ain
(SS)Seatbelt Sign
(SW)Stab Wound

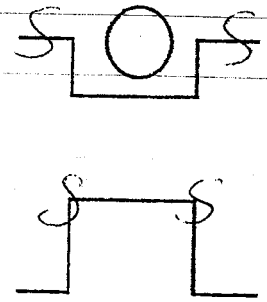


MECHANISM OF INJURY

- ☑ GSW/Bullet
- ☑ Blunt trauma
- ☐ Single fragment
- ☐ Multi-fragment
- ☐ MVC
- ☐ Aircraft crash
- ☐ Knife/edge (stab)
- ☐ Mortar/RPG/Grenade
- ☐ CBRNE
- ☐ Blast
- ☐ Burn
- ☐ Crush
- ☐ Fall
- ☐ IED
- ☐ Other:

Burn:
☐ 1st ☐ 2nd ☐ 3rd
%TBSA = _____

VASCULAR ASSESSMENT



S Strong
P Palpable
D Doppler
A Absent

LAB

Time	Lab test
	Hct
	pH
	pO2
	pCO2
	BE
	Glucose
	HCG
	Other:

X-RAY

Time	Xray
	C-spine
	☒ Chest
	☒ Abd
	Pelvis
	Extrem
	Other:

CT

Time

PROCEDURES

CT	Proced	Size	Location
Head	Foley		
Chest	NG		
Abd	Ch tube-1		
Pelvis	Ch tube-2		
Other:	Cent Ln		
	A-Line		(R) Radial
	FAST		
	Other:		

Already placed by Medic on arrival

GLASGOW COMA SCALE

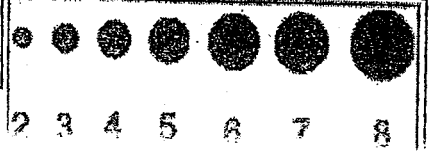
Best Eye Opening		Best Verbal Response		Best Motor Response	
Spontaneous	4	Oriented	5	Obeys commands	6
To speech	3	Confused	4	Localizes pain	5
To pain	2	Inappropriate words	3	Withdraws from pain	4
None	1	Incomprehens sounds	2	Flexion to pain	3
		None	1	Extension from pain	2
				No response	1

TOTAL GCS = _____

PUPILS

R = _____ mm L = _____ mm

☐ Brisk	☐ Brisk
☐ Sluggish	☐ Sluggish
☐ Non-reactive	☐ Non-reactive



PATIENT IDENTIFICATION

Name:

(b)(6)

Last Name	UNKNOWN
First Name	UNKNOWN
Middle	UNKNOWN
Category	CI-CIVILIAN INTERNEE
Power	IZ-Iraq
Arm of Service	
MOS	
COS	
Service No	(b)(6)
Grade	
Geneva Cat.	
ICRC	
Camp Name	BCF
Enclosure	04-115 CASH
Holding/Cel	115 CSH

Height	Nationality	IZ-Iraq	Sex M
Weight			Blood Type
Hair Color	Religion		DOB 2005 (b)(6)
Eye Color	Race		Complexion
	Marks		

(b)(6)

CI-CIVILIAN INTERNEE

Grade | Geneva Cat

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

Date Of Birth 2005 (b) | Blood Type | ICRC

Signature

Name UNKNOWN, UNKNOWN UNKNOWN

Issuing Facility: BCF

Issuing UIC: WYTNAA Date Issued: 2005/09/26

ID Particulars (b)(6) Marks

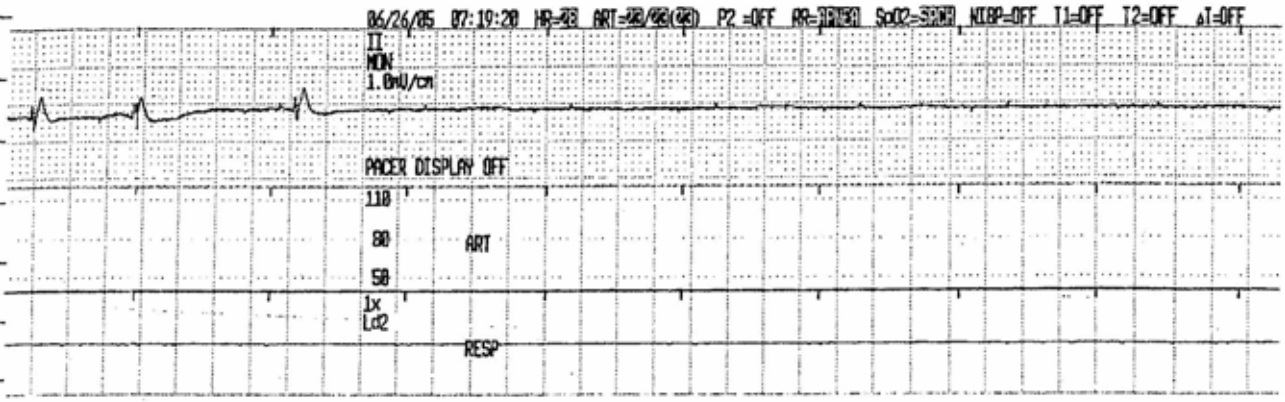
Left Index | Right Index

(b)(6)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

26 Jun 05



(b)(6)

from Cobb Court.

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

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

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE

DCCF

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(
USAPA V1.

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **ICU FLOW SHEET**

OTSG APPROVED (Date)

EKG STRIPS

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(L) Subclavian CVP	24 June 05	29 June 05		NOS IS of pectrai	
(R) Femoral CVP	24 June 05	29 June 05		NOS IS of pectrai	
(L) Radial A-line	22 June 05	26 June 05		NOS IS of pectrai	

PREPARED BY (Last, First, MI) (b)(6)

DEPARTMENT/SERVICE/CLINIC: ICU

(Continue on reverse)

DATE: 25 June 05

PATIENT'S IDENTIFICATION (For typed or written entries give: first, middle; grade; date; hospital or medical facility)

Name – last,

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

DATE	DIAGNOSIS									HOSPITAL DAY							
Time	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22
~~NIBP/~~ ABP	120/70	145/81	121/70	114/68	112/66	102/63	112/61	101/63		124/58	124/57	112/53	165/61	108/60	90/57	104/63	94/57
Pulse	126	136	143	142	137	135	131	132		124	124	122	136	131	136	134	135
Respirations	21	24	15	15	14	14	14	15		14	14	15	14	14	14	18	11
Temperature	99.4	99.4	98.4	98	98.6	99.4	99	99		100.4	99.7		100.6		100.8		
SaO2	89	89	93	93	94	95	95	97%		96%	95%	98	96	95	91	91	92
%O2 FIO2	100	100	100	100	100	100	100	80		80	80	100	100	100	100	100	100
O_2 Delivery	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT		VENT	VENT	vent	vent	VENT	vent	vent	vent
~~CVP~~ mode														A/C			
Rate	18	18	14	14	14	14	14	14		14	14	14	14	14	14	14	14
VT	800	800	800	800	800	800	800	800		800	800	800	800	800	800	800	800
PEEP	12	12	15	15	15	15	15	15		15	15	15	15	15	15	15	15
PS	26	26	26	26	26	26	26	26		26	26	26	26	26	26	26	26
Pain Scale																	
Pain Med	Sedated			/		Sedated				/ Sedated		Sedated		SED	SED	SED	SED
Pt Position																	

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV NS c 20mEq KCl	125	125	HOLD	HOLD	HOLD	HOLD	HOLD	75	325	75	75	75	75	75	75	75	75	600
IVPB Flagyl						~~100~~			100									
Phenylephrine	150	150	150	150	15.0	15	15	15	120	15	15	15	15	15	17.5	20	20	132.5
Diprivan	9.4	9.4	9.4	9.4	9.4	9.5	9.4	9.4	75.2	9.4	9.4	9.4	9.4	9.4	9.4	9.4	9.4	75.2
Fentanyl	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60
Versed	10	10	10	10	5	5	5	5	60	5	5	5	5	5	5	5	5	40
~~PO~~ Vec	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	38.4	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	38.4
Other H_2O and NGT	~~0~~	10	~~0~~	~~0~~	~~0~~	60	—	—	70	—			60					60
TOTAL	171.7	~~343.4~~ 390.1	~~400.1~~ 436.8	~~581.8~~ 483.5	~~622.7~~ 548.2	~~824.5~~ 632.9	~~866.2~~ 758.6	~~982.9~~ 848.6		116.7	~~233.4~~	~~350.1~~	464	116.7	119.2	121.7	121.7	906.1

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 Hour/Total	158/158	742/900	445/1345	150/1495	250/1985	580/2293	180/2365	180/2545	2545	180/180	44/164	130/194	90/284	32/316	75/391	80/471	75/546	546
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2	18/—	→/—	→/—	→/—	18/—	—/—	—/—	26/—	62/—	—/—	—/—	—/—	10/2				88/33	88/35
Jackson Pratt #1/ #2	—/—	50/45	—/—	—/—	—/25	—/—	—/—	100/45	150/115	—/—	—/—	—/—	25/25				30/32	55/57
GT Residual		⊖								⊖								
Chest tube #3	started		@ 1000		83	—	—	30	113	~~12~~	—	—	—	—	—	—	—	2cc
TOTAL	176	1613	1458	1588	~~1967~~ 1986	~~2298~~ 2466	2586	2867	2985	~~132~~	~~194~~	388	~~737~~					783cc

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

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

POST OPERATIVE DAY	PHYSICIAN

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP	97/57	131/65	137/67	125/70	104/59	102/59	103/60	99/60
Pulse	130	127	130	140	133	131	130	131
Respirations	19	19	20	14	14	14	14	14
Temperature		101.5			100.9		100.4	
SaO2	92	93	91	91	91	90	92	92
%O2 F_{IO2}	100	100	100	100	100	100	100	100
O_2 Delivery	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT
~~CVP mode~~	A/C	A/C	A/C	A/C	A/C	A/C	A/C	A/C
Rate	14	14	14	14	14	14	14	14
VT	800	800	800	800	800	800	800	800
PEEP / PS.	15/26	15/26	15/26	15/25	15/25	15/25	15/25	15/25
Pain Scale	Sed	SED	Sed.	SED	SED	SED	SED.	Sed.
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT	4553.9	3163.5
OUTPUT	3444.0	4599
DIFFERENCE	1109.9	1435.5

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV	75	75	75	75	75	75	75	75	600	1525
IVBP		100						100	200	300
Phenylephrine	50	50	50	31.3	31.3	31.3	31.3	50	175.2	427.7
Dopamine	9.4	9.4	9.4	9.4	9.4	9.4	9.4	9.4	75.2	225.6
Fentanyl	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60	180
Versed	5	5	5	5	5	5	5	5	40	140
~~PO~~ Vee	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	38.4	115.2
~~Other~~ H2O Enteral Nutrit		60						60	120	250
TOTAL	151.7	311.7	151.7						1308.8	3163.5

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total	60/60	255/315	140/455	90/545	60/605	60/665	45/710	45/755	755	3846
NG output										
Emesis										
Stool										
Chest tube #1/ #2									10cc/4cc	162/39
Jackson Pratt #1/ #2									30/30	235/202
~~Chest Tube #3~~	—	—	—	—	—	—	—	—	0cc	115
TOTAL										4599

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

Name	Signature	Init

SYSTEM	DAYS	NIGHTS
NEURO	25 June 05 0800	1900 25 June 05
Level of consciousness	Sedated Fentanyl @ 150mcg/hr	Sedated paralyzed receiving
Extremities: Movement	(−) Versed @ 10mg/hr	[illegible]. Pupils slow to respond
Strength	(−) Vec @ 0.6mg/kg/min	to light - equal.
PAIN ASSESSMENT	sedated	Sedated.
CARDIOVASCULAR		
Rhthym/Lead		Sinus tachycardia.
Heart Sounds	clear	muffled
Skin	cool -	warm to touch.
Edema	(+) bilat LE	Bilat UE + Bilat LE,
JVD/ Capillary refill	(−) JVD	+ JVD. good cap refill less than 3 sec.
Pulses: Radial	+ bilat	(+) Radial
Posterior Tibial		
Dorsalis Pedis	+ Bilat	(+) dorsalis pedis.
RESPIRATORY		
Breath Sounds	bilat wheezing	Bilat wheeze / 2 chest (L) side / 1 (R) side side to
Oxygen Delivery	40% vent SIMV	Vent 100% A/C Pleural suction.
Suctioning/Sputum	min .	min ETT, oral moderate product yellowish secretions
ETT/Trach tube	7.5 @ 26cm	ETT lip level. 25cm
Size: Placement:		
Cough:	Suction -	Suction [illegible]
Treatments:		Ø Tx.
GASTROINTESTINAL		
Bowel Sounds	Ø noted	Neg BS. colostomy (R) side ē min drainage Ø
Abdomen	firm distended midline incision	mid line semi closed wound ē wound vac suction system
Date of last BM	colostomy vac suct	colostomy.
NG tube: Placement	NGT (R) nare	NGT (R) nare, placement check + confirmed by auscultation
Suction	NG	
Drainage		Ø.
GENITOURINARY		
Urine: Color	Amber clear	Amber
Void/Foley	Foley BSD	FC → BSD.
INTEGUMENTARY		
Integrety		moist / [illegible], (R) [illegible] to touch
Dressings	(R) hip W→D VAC DX Abd	(R) Hip. [illegible] / posterior and lower back
	back x2 W→D	
Dressing Condition		[illegible] soiled. Reinforced.
Drains/Tubes	JP x2 CT x2	(L) + (R) JP to bulb suction ABD.
Drainage	serous ē CT x2	ABD. drainage .
Signature		(b)(6)

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **ICU FLOW SHEET**

OTSG APPROVED (Date)

EKG STRIPS

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(L) SubClavian CVP.	24 June 05	29 June 05			
(R) Femoral CVP	24 June 05	29 June 05			
(L) Radial Aline	26 June 05	29 June 05			

PREPARED BY (b)(6)

DEPARTMENT/SERVICE/CLINIC: Den

(Continue on reverse)

DATE: 29 June 05

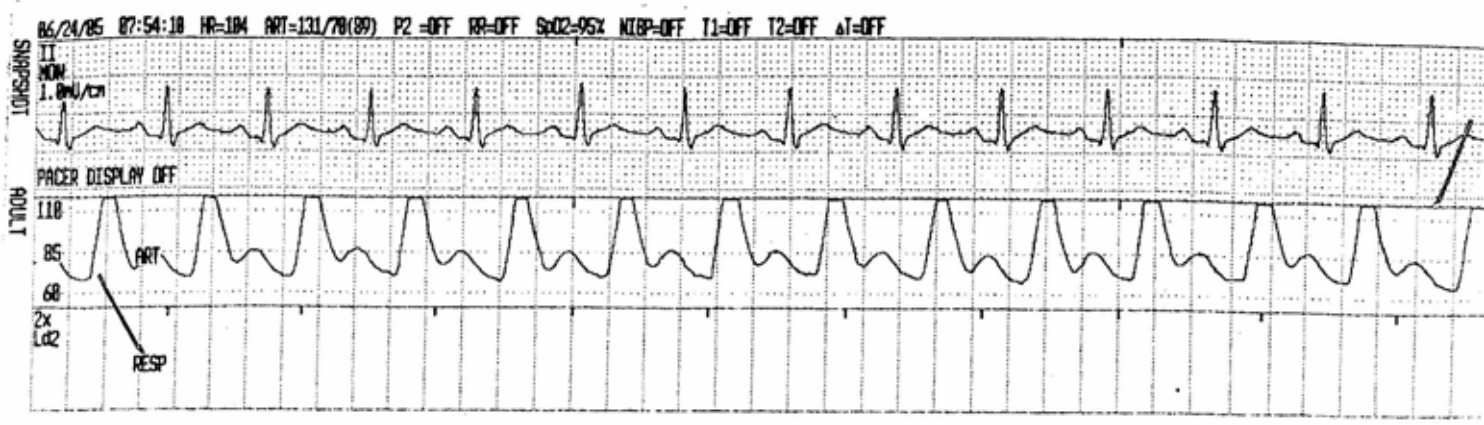
PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, (b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE

CCF

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

~~MEDICAL~~ RECORD-SUPPLEMENTAL MEDICAL DATA



VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
Left Subclavian CVP.	24 June 05	1 July 05		no sls of infection	
Right femoral CVP	24 June 05	1 July 05		no sls of infection	

(b)(6) DEPARTMENT/SERVICE/CLINIC ICU DATE (b)(6) 05

(Continue on reverse)

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

(b)(6)

UNKNOWN, UNKNOWN
NO DETAINEE
CCF

(b)(6)

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2 (59

DATE	DIAGNOSIS									HOSPITAL DAY							
Time	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22
NIBP/ ABP	133/72	117/70	115/67	140/60	121/65	122/72	114/67	117/70		144/86	124/71	102/66	124/65	126/66	108/54	106/53	120/68
Pulse	102	108	108	109	104	94	114	112		110	120	118	104	117	115	110	103
Respirations	24	28	27		16	18	18	20		18	18	19	18	18	18	18	18
Temperature		98.2								97.9						100.5	
SaO2	96	97	96	98	98	83	93	94		95	95	96	100	98	95	97	97
%O2	40	100	90		100	100	100	100		100	100	100	90	FiO2	FiO2	FiO2	FiO2
O_2 Delivery	VENT	VENT	VENT		Vent	Vent	vent	Vent		Vent	Vent	vent	Vent	80 SIMV	80 SIMV	80 SIMV	70
CVP																	
~~Bi~~-dir	SIMV	SIMV	SIMV	SIMV	SIMV	A/C	A/C	A/C		A/C	A/C	A/C	A/C				
peep	10	10	10	10	10	10	10	10		10	11	11	11				
PSV	15	15	15	15	15	—	—	—		—							
V_T	900	900	880	880	880	880	880	880		880	880	880	880				
Pain Scale																	
Pain Med																	
Pt Position																	

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV D5NS+Lidocaine	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	→			1000
IVPB					65	100		100	265									
Dopamine	9.4	9.4	9.4	9.4	9.4	9.4	9.4	9.4	75.2	9.4	9.4	9.4	9.4	→				75.2
Neo	10	10	10	10	7.5	7.5	7.5	7.5	70	7.5	7.5	7.5	7.5	→				60
VERSED	10	10	10	10	10	10	10	10	80	10	10	10	10	→				80
Fentanyl	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60	7.5	7.5	7.5	7.5	→				60
~~PO~~ Vec					6	6	6	6	24	6	6	6	6	→				48
Other																		
TOTAL									1614.2									1323.2

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 Hour/Total	140/140	170/170	200/200		370/370	120/120	150/150	160/160	1600	130/130	80/80	150/150	190/190	70/470	60/530	70/600	60/660	660
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2								Chest tube #2										18
Jackson Pratt #1/ #2			~~900~~		50/50			250/300	300									100
TOTAL									1900 (+)									~~2045~~ 1778 cc

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

Safety	D	E	N
High risk for falls	Y N	Y N	Y (N)
Call bell in reach	Y N	Y N	(Y) N
Bed position/Locked	Y N	Y N	(Y) N
Protective device	Y N	Y N	(Y) N
Cardiac Monitor	(Y) N	Y N	60 N

POST OPERATIVE DAY | **PHYSICIAN**

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP	109/43	96/47	129/58	90/52	109/56	104/63	129/69	129/100
Pulse	107	112	103	114	128	127	117	123
Respirations	18	18	18	19	19	20	18	22
Temperature		100°				99.8		
SaO2	96%	97%	98	99	99	97	98	92
%O2	100%	100%	100	100	100	100	100	100
O_2 Delivery	VENT	VENT	VENT	VENT	VENT	VENT	VENT	VENT
CVP								
mode	A/C	A/C	A/C	A/C	A/C	A/C	A/C	A/C
PEEP / PS	10/26	10/26	10/26	10/26	10/26	10/26	10/26	10/26
VT	800	800	800	800	800	800	800	800
Pain Scale	Sed	Sed.	Sed.	Sed.	Sed.	Sed.	Sed.	Sed
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT	5591.5	1653.5
OUTPUT	8150	3944.5
DIFFERENCE	-2558.5	-1109.9

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV NS 20KE	125	→	→	→	→	→	→	→	1000	3000
IVBP		100						100	200	465
Phenylephrine	9.5	12.5	10.0	12.5	12.5	12.5	12.5	12.5	92.5	222.5
Dopamine	9.4	9.4	9.4	9.4	9.4	9.4	9.4	9.4	75.2	225.6
Fent	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60	180
Versed	10	10	10	10	10	10	10	10	80	240
PO Vec	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	28.8	100.8
Other H2O Flush		60						60	120	1660
TOTAL									1656.5	4658.8

(b)(6)

(b)

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total	70/70	60/130	40/170	40/210	90/300	80/380	60/440	60/500	500	2760
NG output										
Emesis										
Stool										
Chest tube #1/ #2								56/0	56/8	56/8
Jackson Pratt #1/ #2 (L)		80/40						60/30	140/70	210
TOTAL										

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

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

Name	Signature	Init.
(b)(6)		

SYSTEM	DAYS	NIGHTS
NEURO		24 JUN 05 @ 1900
Level of consciousness	Sedated	Sedated
Extremities: Movement	Nominal c suctioning	Fentanyl @ 150 mcg/hr
Strength	1/5	Versed @ 10 mg/hr
PAIN ASSESSMENT		Ver @ 0.16 mg/k/hour
CARDIOVASCULAR		
Rhthym/Lead	RSR - some V (IL)	ST
Heart Sounds	S, S, ø Mur	S1 S2
Skin	PINK	Dry, cool
Edema	1(+) B. Ext - peripheral	+1 bilat UE
JVD/ Capillary refill	(-) JVD < 2 sec	ø, <3 sec
Pulses: Radial	(+) B. rad	+1 +1
Posterior Tibial		
Dorsalis Pedis	(+) B. DP	+1 +1
RESPIRATORY		
Breath Sounds	BRS, B. Ext Rales/wheeze	Coarse bilat
Oxygen Delivery	Vent SIMV	Vent SIMV FiO2. 80
Suctioning/Sputum	min. mod	PRN
ETT/Trach tube	7.5 @ 26cm	7.5 @ 26cm
Size: Placement:		
Cough:		ø
Treatments:	RESP	NA
GASTROINTESTINAL		
Bowel Sounds	ø noted	active
Abdomen	distended	slightly distended
Date of last BM	colostomy	colostomy - med brown semi-formed
NG tube: Placement	Nght (B) NONE	NG @ nare
Suction	right clamped	clamped
Drainage		NA
GENITOURINARY		
Urine: Color	Dk. Hazy amber	amber
Void/Foley		Foley
INTEGUMENTARY		
Integrety		
Dressings	VAC. dsg stable	WN to abd S'd today
		@ hip W→D
		back x2 · W→D
Dressing Condition	CDI	CDI
Drains/Tubes	JP x2 CT x2	JP x2 lower abd CT x2 (L) chest
Drainage	(b)(6)	(b)(6)
Signature		

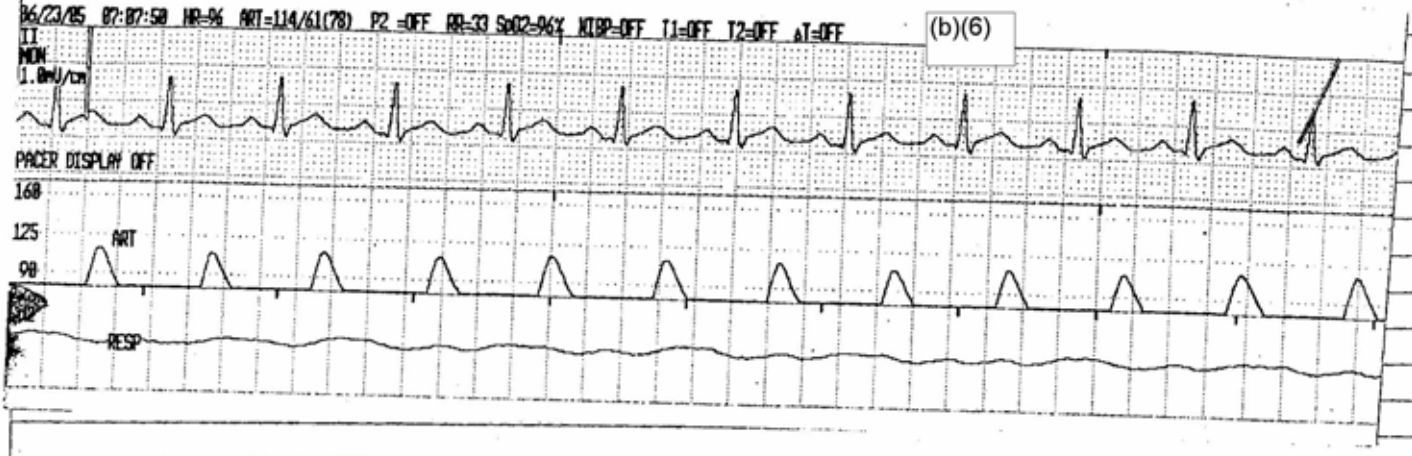
MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **ICU FLOW SHEET**

OTSG APPROVED (Date)

EKG STRIPS



(b)(6)

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(R) femoral TLC	22 June 05	24 June 05	clean dressing		patent
(L) RADIAL A-LINE	22 June	24 June 05	clean dressing		patent

(b)(6)

PREPARED BY (b)(6) UNKNOWN, UNKNOWN

DEPARTMENT/SERVICE/CLINIC: ICU.

(Continue on reverse)

DATE: (b)(6) 05

PATIENT'S IDENTIFICATION (For typed or written entries print: last, first, middle; grade; date; hospital or medical facility)

(b)(6) EE

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
PCCF

Res #6

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700, MAY 78

DATE	DIAGNOSIS									HOSPITAL DAY								
Time	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22	
NIBP/ ABP	134/77	153/R	143/75	135/77	118/71	116/73	105/63	129/72		146/72	132/64	140/68	134/83	132/75	100/59	102/59	132/69	
Pulse	93	93	97	112	118	115	107	100		108	111	113	/	139	131	112	114	
Respirations	29	26	28	30	32	31	28	28		27	25	22	29	28	26	21	23	
Temperature	97.1				97.6					99.2				/	/	99.2	/	
SaO2	93	94	92	96	92	93%	94	99		98	96	96	92	95	92	95	96	
%O2 FIO2	80	80	80	80	80	80	80	80		80	80	70	70	70	70	70	70	
O_2 Delivery																	Suctioned/ coughing	
~~CVP~~ mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV		SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	→	→	
RATE	16	16	16	16	16	16	16	16		16	16	16	16	16	16	→	→	
VT	950	950	950	950	950	950	950	950		950	950	950	950	950	950	→	→	
PEEP / PS	6 / 15	6 / 15	6 / 15	10 / 20	10 / 15	10 / 25	10 / 25	10 / 26		10 / 25	10 / 25	10 / 20	10 / 20	10 / 20	10 / 20	→	→	
Pain Scale																		
Pain Med																		
Pt Position																		

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 20K	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
IVPB						100									200 (B)		1000 (B)	1200
Dopamine 400 mg	5.6	9.4	9.4	9.4	9.4	9.4	9.4	9.4	71.4	9.4	9.4	9.4	9.4	9.4	9.4	9.4	9.4	75.2
Fentanyl	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	30.4	3.8	3.8	3.8	3.8	3.8	5.0	5.0	5.0	34
Neo 4/040	10	10	9.8	7.5	7.5	7.5	7.5	7.5	67.3	7.0	7.0	7.0	7.5	7.5	12.5	12.5	12.5	73.5
versed	12.5	11.5	12.5	5	5	5	5	5	62.5	5	5	5	5	5	7	7	7	46
~~PO~~ 6T (20 meq/hr)	20	20	20	20	20	20	20	20	160	20	20	20	20	20	20	20	20	160
Other meds c Hx																		
TOTAL									1391.6									2588.7

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 Hour/Total		200	45	520	1600	2350	2600	2730	2730	2890	3020	3120	3220		3440	3540	3660	3660
NG output	-	-	-	-	-													
Emesis	-	-	-	-	-													
Stool	-	-	-	-														
Chest tube level at 240 #1/ #2								10/5	15									
Jackson Pratt (B) #1/ #2 (B)								90/10	190				100/50	150		60	60/90	300
Q4 6T Resident	0				0				190	0				0				
TOTAL									2746 (2935)									3960

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

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

POST OPERATIVE DAY	PHYSICIAN

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP	120/66	139/69	143/70	106/56	131/66	130/64	140/72	142/73
Pulse	107	106	110	95	94	92	89	91
Respirations	25	25	25	26	24	23	26	26
Temperature	—	100.4	—	—	—	99.1	—	—
SaO2	91%	94	93	96	98	98	94	95
%O2	70%	70%	70%	70%	70%	70%	70%	70%
O_2 Delivery	Simv	Simv	→	→	→	→	→	→
~~CVP~~								
Pain Scale		Swallowed						
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT	5528	~~5591.5~~ 1611.2 (b)
OUTPUT	3657	8150
DIFFERENCE	1971	-2558 5

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS.
IV	125	125	125	125	125	125	125	125	1000	
IVBP		100						100	~~200~~ 200	
Dopamine	9.4	9.4	9.4	9.4	9.4	9.4	9.4	9.4	75.2	
Fentanyl	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60	
neo	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	100	
Versed	7	7	7	7	7	7	7	7	56	
~~PO~~ GT ~~cmeds~~	20	20	20	~~HOLD~~	~~HOLD~~	~~HOLD~~	FOR	OR	60	
Other GT meds		60							60	
TOTAL									~~1511.2~~ 1611.2	

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total	200/800	200/400	/	130/530	/	120/650	/	120/770	770	
NG output										
Emesis										
Stool								50	50	
Chest tube #1/ #2	/	/	/	/	/	/	/	60/45	105	/
Jackson Pratt #1/ #2	80/50	/	/	/	/	/	/	80/120	160/170	/
GT Residual	0				0				0	
TOTAL									1255	

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

Name	Signature	Init
(b)(6)		

SYSTEM	DAYS	NIGHTS
NEURO		@ 1930 23JUN05
Level of consciousness	Sedated Versed & fentanyl	PS
Extremities: Movement	minimal c sedation	PS
Strength	1/5	PS
PAIN ASSESSMENT	Sedated	fentanyl & versed drip
CARDIOVASCULAR		
Rhthym/Lead	NSR / II	ST / II
Heart Sounds	S1 S2 ø M&G	S1 S2
Skin	Dry	WD & Dry & Pink mm
Edema	(+) peripheral 1(+)	+1 generalized non pitting
JVD/ Capillary refill	-/< 2 sec.	ØJVD/< 3 sec
Pulses: Radial	+ = b.l.t +	⊕ 2 (B)
Posterior Tibial		
Dorsalis Pedis	(+) = b.l.t	⊕ 2 (B)
RESPIRATORY		
Breath Sounds	BBS, rales throughout expirtheeze ALL	coarse sounds throughout
Oxygen Delivery	ET Tube Vent SIMV	VENT / SIMV
Suctioning/Sputum	PRN minimal	PRN
ETT/Trach tube	7.5	ETT
Size: Placement:	7.5 @ 26cm	7.5a - 26 cm @ holder
Cough:	ø	PRN - non-productive
Treatments:		
GASTROINTESTINAL		
Bowel Sounds	none noted	Absent
Abdomen	Sft	soft, palpable
Date of last BM	colostomy ⊕ stool	colostomy ⊕ stool
NG tube: Placement	(R) nare / clamped	(R) nare
Suction	NGT clamped	clamped
Drainage	JP x 2	
GENITOURINARY		
Urine: Color	Dark amber	dark amber
Void/Foley	✓	foley
INTEGUMENTARY		
Integrety		lg. abd wound; (R) hip wounds, 2 back ~~four~~ wounds
Dressings	VAC dsg abd.	wound vac to abd; gauze to others
Dressing Condition	CDI / VAC dsg	CDI
Drains/Tubes	chest tube L) chest x 2	CT x 2 / JP x 2 (lower abd)
Drainage		
Signature	(b)(6)	(b)(6)

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

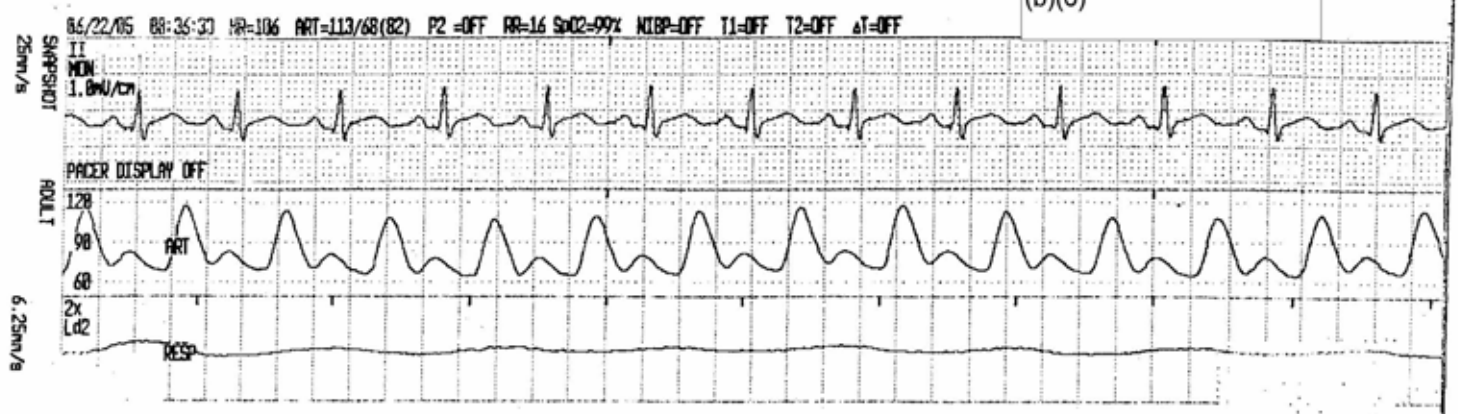
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: **ICU FLOW SHEET**

DTSG APPROVED (Date)

EKG STRIPS

(b)(6)



VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(R) Fem TLC	20 Jun	22 Jun 0930	clean, & Redness Line patent		clean & Redness
(L) Rad. AL	19 Jun	22 Jun 0930	clean, & Redness Line patent		clean & Redness

PREP (b)(6) DEPARTMENT/SERVICE/CLINIC ICU (Continue on reverse) DATE (b)(6) 05

PATIENT (b)(6) (first, m... last,

UNKNOWN, UNKNOWN
M 0 DETAINEE
PCCF Bed 6

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700, MAY 78 USAPPC V2 01 67

ACLU-RDI 5500 p.67

DATE 22 Jun 05 DIAGNOSIS									HOSPITAL DAY							
Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
NIBP/ ABP	115/68	120/73	112/67	128/78	89/58	128/78	103/65	103/64	135/76	135/78	153/68	134/77	132/78	123/74	136/73	161/90
Pulse	109	111	106	113	109	109	110	110	118	114	119	118	109	107	106	105
Respirations	15	16	16	16	16	16	16	16	21	18	23	22	20	20	24	28
Temperature		100.2				100.8		101.6			101.6		99.4			
SaO2	100	100	98	97	100	98	99	99	94	96	94	94	96%	95%	95%	96%
%O2 (FIO2)	100	100	80	80	80	↓70	70	70	70	70	70	70	70	70	70	70
O_2 Delivery	vent	vent	vent	vent	vent	vent	vent	vent	vent	vent	vent	vent	vent	vent	vent	vent
~~MODE~~	Simv	Simv	Simv	Simv	Simv	Simv	Simv	Simv	Simv	Simv	Simv	Simv	Simv	Simv	Simv	Simv
RATE	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
V_T	950	950	950	950	950	950	950	950	950	950	950	950	950	950	950	950
PEEP	5	5	5	5	5	5	5	5	5	5	5	6	6	6	6	6
PS	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
Pain Scale	Sed.	Sed.	Sed.	Sed.	Sed	Sed	Sed	Sed	Sed	Sed	Sed	Sed	Sed.	Sed.	Sed	Sed
Pain Med																
Pt Position																

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV	125	125	125	125	125	125	125	125	1200	125	125	125	125	125	125	125	125	1200
IVPB						100		100	200				100					100
Dopamine	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60	7.5	7.5	7.5	7.5	7.5	7.5	7.5	5.5	58.0
Fentanyl		7.5	↓4	4	4	4	4	4	31.5	4	4	4	4	4	4	4	4	32
NEO	25	25	↓5	25	↑31	31	31	31	224	31	31	31	↓25	25	25	25	25	218
Versed	10	10	↓5	5	5	5	5	5	50	5	5	5	5	↑7	7	13	15	61
~~POTF~~ (Rocuronium)	-	-	-	-	-	20	20	20	60	20	20	20	20	20	20	20	20	160
Other																		
TOTAL									~~1825~~ 1825.5									1829

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 Hour/Total	/	120/180	180/300	100/400	70/470	80/550	80/630	100/730	730	120/850	100/950	100/1050	140/1190	140/1330	70/1400	115/1515	155/1670	1040
NG output																		
Emesis																		
Stool		100							100									
Chest tube #1/ #2 (R)	/	/	/	/	/	/	/	20/44	20/44	/	/	/	/	/	/	/	/	40/20
Jackson Pratt #1/ #2	/	100/25	/	/	/	/	/	100/50	200/75	75/0	/	25/5	25/5	/	/	80/28	/	205/38
Residual GT														2cc				
TOTAL									949									1283

ASPECT	TIME/INITIALS	(b)(6)
Bath/Skin Care	1500	
Oral Care	1500	
Foley Care	1500	
Trach Care		
Range of Motion		

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

~~OST~~ OPERATIVE DAY

PHYSICIAN

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP	138/78	127/79	132/82	139/82	134/74	133/78	119/66	110/64
Pulse	112	105	104	106	106	111	108	115
Respirations	20	28	26	27	27	27	28	24
Temperature	99.4			99.4			99	
SaO2	96%	97%	96	95	94	94	94	94%
%O2 FIO2	70	70	70	70	70	70	70	100%
O_2 Delivery	VENT	VENT	VENT	V	VENT	V	VENT	VENT
~~CVP mode~~	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
RATE	16	16	16	16	16	16	16	16
Vt	950	950	950	950	950	950	950	950
PEEP /PS	6/15	6/15	6/15	6/15	6/15	6/15	6/15	6/15
Pain Scale	SED	SED	SED	SED	SED	SED	SED	SED
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT	7181	5528
OUTPUT	4566	3657
DIFFERENCE	+2615	1971

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV	125	125	125	125	125	125	125	125	1200	
IVBP		100						100	200	
DOPAMINE	5.6	5.6	5.6	5.6	5.6	5.6	5.6	5.6	44.8	
FENTANYL	4	4	4	3.8	3.8	3.8	3.8	3.8	35.0	
NEO	16	16	14	14	10	7.5	5.0	5.0	87.5	
VERSED	12	10	10	10	10	10	12.5	12.5	87	
POST (Osmolyte)	20	20	20	20	20	20	20	20	160	
Other meds Etc		60						60	60	
TOTAL									1874.3	5528

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total	80/80	160/240	75/315	155/470	120/590	155/745	125/970	125/1095	1095	
NG output										
Emesis										
Stool						100			100	
Chest tube #1/ #2								60/60	60/60	
Jackson Pratt (R) #1/ #2 (L)	80/25							100/40	85/35	
POST Residual	5cc				5cc					
TOTAL									1425	3657

level at 690 = 1
level at 240 = 2

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

Name	Signature	Init
(b)(6)		

SYSTEM	DAYS	NIGHTS
NEURO	22 Jun 05 1100	22 Jun 05 1900
Level of consciousness	arousable to Pain, pupils equal brisk 3/3	Responsive to pain, PERL 2cm.
Extremities: Movement	moves to tactile stimuli; R>L B/L extrem	moves upper extrems.
Strength	R > L	R > L
PAIN ASSESSMENT	Patient sedated versed	patient sedated - versed
CARDIOVASCULAR		
Rhthym/Lead	NSR Lead II	Sinus tachy.
Heart Sounds	S1 S2	S1 S2 faint
Skin	warm & dry, various wounds	warm / dry wounds covered c̄ dressing
Edema	General. +3 B/L LE +2-+3 B/L UE	(+) Edema B/UE + BLE
JVD/ Capillary refill	ø / < 3 sec	< 3 sec / no JVD
Pulses: Radial	(R) +1 Doppler (L) +1 / AL	R (+) / (L) (+)
Posterior Tibial	(R) +1 Doppler (L) +2 Doppler	R (+) doppler / (L) (+) doppler
Dorsalis Pedis	(R) +1 Doppler (L) +2 Doppler	R (+) / L (+)
RESPIRATORY		
Breath Sounds	clear upper, (R) upper chest, neck Crepitus	Rhonchi bilat c̄ crepitus to skin
Oxygen Delivery	Vent / intubated	ventilator.
Suctioning/Sputum	PRN / Scant yellow	prn thick yellow secretion
ETT/Trach tube	#7.5 ETT ≈ 24 (R) lip	ET level 23 cm.
Size: Placement:	—	
Cough:	—	
Treatments:		
GASTROINTESTINAL		
Bowel Sounds	Absent	Absent
Abdomen	Abdominal wound open to vac Dsg	open wound c̄ vac dressing to suction
Date of last BM	Colostomy patent drk gr. stool	(L) side colostomy - dark secretion
NG tube: Placement	NGT (R) Nare, (+) placement with air bolus	NGT (R) nare placement check + confirmed
Suction	~~Below~~ 's error LS	by auscultation
Drainage	~~Lw~~ error bilious	
GENITOURINARY		
Urine: Color	Adequate / Amber	dark Amber
Void/Foley	Foley SBD	FC → SBD
INTEGUMENTARY		
Integrity	Intact Sacral area	wound stated
Dressings	(R) (L) back/side wounds packed NS	(R) side (L) leg, ABD,
	dsg, cov c̄ dry dsg	Back
Dressing Condition	Clean & dry	mild drainage & stain
Drains/Tubes	B/L lower abd. JP to self suction	ABD vac drain; 2 chest tubes - (L) & (R)
Drainage	(R) lateral Prox/distal CTs H2O Seal	chest tubes to H2O suction
Signature	(b)(6)	(b)(6)

#1. (b)(6)

DICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

ICU FLOW SHEET

OTSG APPROVED (Date)

EKG STRIPS

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
Q Radial Aline	19 JUNE	NO	(b)(6)		
Q General TLC	20 JUNE	NO			

(Continue on reverse)

PREP (b)(6)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: (b)(6) 05

PATIENT (Identification) (If typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

#6

(b)(6)

UNKNOWN, UNKNOWN
NO DETAINEE

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4709, MAY 78

USAPPC V2.00

EXHIBIT 3

DATE		DIAGNOSIS								HOSPITAL DAY							
Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
NIBP/ ABP	145/90	131/74	96/58	100/59	86/60	90/60	98/64	131/80	99/60	96/50	134/84	138/78	113/68	147/90	138/78	135/80	
Pulse	106	110	124	117	114	113	104	106	114	112	121	123	117	111	115	113	
Respirations	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	
Temperature	99.6						100			101		103.1		99			
SaO2	100	100	100%	100	100	100	100	100	100	100	99%	99	95	99%	97%	97%	
%O2	40%	40%	40%	40	40%	40%	40%	40%	40%	40%	40%	40%	SPK	FiO2	FiO2	FiO2	
O_2 Delivery SMV	vent	vent	vent	vent	vent	vent	vent	vent	vent	vent	vent	vent	FiO2	.40	.40	.40	
~~CVP~~ rate	16	16	16	16	16	16	16	16	16	16	16	16	.40				
~~Peep~~ PS	15	15	15	15	15	15	15	15	15	15	15	15					
~~PS~~ Peep	10	10	10	10	10	10	10	10	5	5	5	5					
TV	1000	1000	950	950	950	950	950	950	950	950	950	950					
Pain Scale																	
Pain Med																	
Pt Position																	

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV NS & 20mEq	125	125	125	125	125	125	625	625	2000	625	125	125	125	125	→	→	→	1000
IVPB		100	66	66	66	66	200	66	550	66			200					200
Neo 75mcg	18.8	18.8	18.8	37.5	62.5	62.5	62.5	62.5	343.9	62.5	62.5	62.5	62.5	12.5	→	X	X	500
Vec 1mg/kg/hr	~~105~~ 5.1	5.1	5.1	5.1														
Vecuro	10	10	10	10	10	10	10	10	80	10	10	10	10	10	→	→	→	80
Fentanyl 150mcg	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60	7.5	7.5	7.5	7.5	7.5	→	→	→	60
~~PO~~ Dopamine Enteral tube	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60	7.5	7.5	7.5	7.5	7.5	→	→	→	60
Other																		
TOTAL									3093									1900

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 Hour/Total	200	250/450	100/550	70/620	10/630	10/640	28/668	200/868	868	40	120/160	80/240	120/360	200/560	80/640	100/740	90/830	830
NG output																		
Emesis																		
Stool												200						200
Chest tube #1/ #2	/	/	/	/	/	/	/	/	/	/	/	/	20	/	/	/	/	20
Jackson Pratt #1/ #2	/	/	/	/	/	/	/	/	/	/	/	500	/	/	80/40	/	/	620
Wound vac						500			500									
TOTAL									1300									1670

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

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

POST OPERATIVE DAY | **PHYSICIAN**

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP	133/83	132/84	112/73	100/60	101/54	130/74	84/66	102/52
Pulse	113	113	111	119	125	116	123	120
Respirations	16	16	16	16	17	16	16	16
Temperature			98.4					99
SaO2	98%	98%	98%	96%	96%	97%	95%	97%
%O2	FiO2	FiO2	FiO2	FiO2	FiO2	FiO2	FiO2	FiO2
O_2 Delivery	.40	.40	.40	.40	.40	.40	.40	.40
CVP								
Pain Scale								
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT	7181	6198.5
OUTPUT	4566	9387
DIFFERENCE	+2615	-3188.5

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV	125	125	→	→	→	→	→	→	1000	
IVBP		200			500			200	900	
Neo	held	held	held	25	→	→	→	→	125	
Fent	7.5	→	→	→	→	→	→	→	60	
Versed	10	→	→	→	→	→	→	→	80	
Dopamine	3	held	held	3	→	→	→	→	23	
PO										
Other NG Flush		100								
TOTAL									2188	7181

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total	110/110	60/170	60/230	80/310	90/400	140/540	110/650	150/800	800	
NG output								300	300	
Emesis										
Stool	200								200	
Chest tube #1/ #2	/	/	/	/	/	/	/	56/60	116	/
Jackson Pratt #1/ #2	100	/	/	/	/	/	/	50/130	180	/
TOTAL									1596	4566

Legend

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

Name	Signature
(b)(6)	

SYSTEM	DAYS	NIGHTS
NEURO	0700 21 sure	21 JLWOS @ 2100
Level of consciousness	Pharmacologically sedated	Versed @ 10 mg/hr
Extremities: Movement	" "	Fentanyl @ 150 mcg/hr
Strength	" "	pharmacologically sedated
PAIN ASSESSMENT	Ø	UTA - Ø mnt
CARDIOVASCULAR		
Rhthym/Lead	ST II	ST
Heart Sounds	S1S2	S1S2
Skin	Warm, Dry	Warm, cool
Edema	Generalized	slightly, generalized
JVD/ Capillary refill	Ø / < 3 sec	Ø, < 3 sec
Pulses: Radial	(R) +2 (L) +1	(R) +1 (L) +2
Posterior Tibial	+1 +1	
Dorsalis Pedis	+2 +2	+2 +2
RESPIRATORY		
Breath Sounds	Clear to auscultation	Rhonchi (B) lat, dim bases
Oxygen Delivery	Vent	Vent SIMV
Suctioning/Sputum	Occasional	FiO2 40 PRN - reddens
ETT/Trach tube	ETT	ETT
Size: Placement:	7.5 23 lips	7.5 26 cm @ holder
Cough:	—	—
Treatments:	—	—
GASTROINTESTINAL		
Bowel Sounds	Absent	hypo
Abdomen	Obese, non-tender	distended, soft,
Date of last BM	colostomy	(R) LQ ileostomy brown liq dsg
NG tube: Placement	(R) nare	(R) nare
Suction	LIS	LIS
Drainage	green/Brown	dark green
GENITOURINARY		
Urine: Color	Yellow	dark amber
Void/Foley	Foley	Foley
INTEGUMENTARY		
Integrety	Wound Vac to Abdomen.	Wound Vac to abd
Dressings	Multiple WCT - dry dressings to bleed	drsgs to back CDI
		(R) hip w→D Δ'd
Dressing Condition	good	CDI
Ba—		
Ora— ains/Tubes	2 x JP, 2 x chest tubes	2 JP - (R) & (L) abd, 2 CT to SX
Fol— ainage	Hemovac	
Trac— Signature	(b)(6)	
Rang		

DICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

ICU FLOW SHEET

OTSG APPROVED (Date)

EKG STRIPS

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(R) 65 cordis	12 June	NO	(b)(6)		
(L) SC cordis	12 June	NO			
(J) femoral 4-Lue	19 June	NO			
(L) femoral TLC					

PREP (b)(6)

DEPARTMENT/SERVICE/CLINIC FCU

(Continue on reverse)

DATE (b)(6) 05

PATIENT'S IDENTIFICATION (For typed or written entries enter: Name – last,

(b)(6)

UNKNOWN

H O DETAINEE

RCCF

Bed 6

- [ ] HISTORY/PHYSICAL
- [ ] FLOW CHART
- [ ] OTHER EXAMINATION OR EVALUATION
- [ ] OTHER (Specify)
- [ ] DIAGNOSTIC STUDIES
- [ ] TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

DATE		DIAGNOSIS								HOSPITAL DAY								
Time	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22	
NIBP/ ABP	113/67	140/71	107/43	129/74	180/80	144/77	144/77	94/50		113/65	180/66	108/64	134/73	108/61	114/67	135/72	160/101	
Pulse	110	130	130	106	144	140	140	136		115	120	114	117	105	102	129	129	
Respirations	16	20	16	16	16	16	16	16		16	16	16	16	16	16	16	16	
Temperature	100.6			101.4							100.7	98				101.5		
SaO2	100	95%	98%	96%	98%	97%	97%	99%		100%	100%	100%	98%	100	100	99	99	
%O2	100	100%	100%	45%	45%	45%	45%	40%		40%	40%	40%	40%	.4	40% FiO2	→		
O_2 Delivery SIMV	vent	vent	vent	vent	vent	vent	vent	vent		vent	vent	vent	vent	vent	mV/mV	→		
CVP																		
Resp / PS	5/20		5/20	5/20	10/20	10/20	10/20	10/15		10/15	10/15	10/15	10/15	10/15	10/15	→		
Rate	16		15	15	16	16	16	16		16	16	16	16	16	16	→		
TV	1000		1000	1000	1000	1000	1000	1000		1000	1000	1000	1000	1000	1000	→		
														sedated		paralyzed		
Pain Scale																		
Pain Med																		
Pt Position																		

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
IVPB			100			200			300					200		150 (B)		350
Versed	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	10	10	80
Fentanyl	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60
Phenylephrine	50	50	50	50	50	)			250	50	37.5	37.5	37.5	37.5	37.5	20	25	282.5
Bolus	5.00	VEL		5.1	5.1	5.1	5.1	5.1	525.5	5.1	5.1	5.1	5.1	5'	5.1	5.1	5.1	40.8
2.5 30 Dopamine	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60
Other Blood		Weeks as 081986		330			330		660									
TOTAL	700	900	1200	1730	1940	2295		2954	2954	205	410	615	820					873.3

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 Hour/Total		100	450 550	320 870	1200 2070	1350 3420	320 3740	1780 5520	5570	150 150	150 300	46 346	120 466	180 646	260 906	130 1036	200 1236	1236
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2																		
Jackson Pratt #1/ #2								350	350						21 Bl			100
G-tube																		
Wound Vac																		
TOTAL									5920									1338

ASPECT	TIME/INITIALS (b)(6)
Bath/Skin Care	1000
Oral Care	Q2h
Foley Care	1000
Trach Care	
Range of Motion	

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

POST OPERATIVE DAY								PHYSICIAN
TIME	23	24	01	02	03	04	05	06
NIBP/ ABP	121/71	159/91	140/82	162/93	142/83	148/88	161/94	147/93
Pulse	114	107	111	111	114	110	105	111
Respirations	16	16	16	16	16	16	16	16
Temperature	101.6			101.2				99.9
SaO2	100%	100%	100%	100%	100%	100%	100%	100%
%O2	40%	40%	40%	40%	40%	40	40	40
O_2 Delivery	MV	→						
~~CVP~~ VT	1000	1000	1000	1000	1000	1000	1000	1000
Rate	16	16	16	16	16	16	16	16
PC/PEEP	15/10	15/10	15/10	15/10	15/10	15/10	15/10	15/10
								Suct + bal
Pain Scale								
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT	11328	6198.5
OUTPUT	4495	9387
DIFFERENCE	+6833	-3188.5

@ 2220, Phenyl ↓ to 75 mcg/hr = 18.8 cc/hr (b)(6)
@ 2300 - stable B/P & HR (b)(6)

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV	125	125	125	125	125	125	125	125	1000	
IVBP		200						200	(b)(6)	
VERSED	10	10	10	10	10	10	10	10		80
FENTANYL	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60
PHENYLEPHRINE	18.8	18.8	18.8	18.8	18.8	18.8	18.8	18.8	188	150.4
VECURONIUM	5.1	5.1	5.1	5.1	5.1	5.1	5.1	5.1	51	40.8
~~DOPAMINE~~	7.5	7.5	7.5	7.5	7.5	7.5	7.5	25	7.5	60
Other										
TOTAL										1391.20

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total	200+40 / 250	200 / 450	200 / 650	200 / 850	200 / 1050	200 / 1250	200 / 1450	40 / 1490	1490	
NG output								200	200	
Emesis										
Stool										
Chest tube #1/ #2								85 / 18	85 / 18	
Jackson Pratt #1/ #2	45							104 / 112	104 / 157	
G tube								75	75	
Wound Vac										
TOTAL									2129	9387

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

Name	Signature	Init
(b)(6)		

SYSTEM	DAYS	NIGHTS
NEURO	@ 20 hrs	@ 1930
Level of consciousness	Awake + sedated	Pharm sedated & paralyzed
Extremities: Movement	par movement	|
Strength	very weak	|
PAIN ASSESSMENT	Ø	fentanyl drip
CARDIOVASCULAR		
Rhthym/Lead	II	ST / II
Heart Sounds	S^1S^2	S^1S^2
Skin	HOT, DRY	hot, dry, pink MM
Edema	generalized	generalized +2
JVD/ Capillary refill	Ø / < 3 secs	Ø JVD / < 3 sec
Pulses: Radial	(R) +1 (L) +2	+2 (B)
Posterior Tibial	+1 +1	—
Dorsalis Pedis	+1 +1	+2 (B)
RESPIRATORY		
Breath Sounds	Clear in all fields	abnormal sounds on exp.-suctioned
Oxygen Delivery	vent	mech vent; SIMV
Suctioning/Sputum	occasional	PRN/ white frothy
ETT/Trach tube	ETT	ETT
Size: Placement:		7.5 / 25 @ holder
Cough:	NR	ē suctioning
Treatments:	— Nebulizer	nebs
GASTROINTESTINAL		
Bowel Sounds	Absent	Absent x 4 quads
Abdomen	Obese, non-tender	Obese, round, palpable, open wound
Date of last BM	? colostomy	colostomy / Ø stool
NG tube: Placement	(L) nare	(L) nare
Suction	LIS	LIS
Drainage	green brown	bile colored
GENITOURINARY		
Urine: Color	Yellow	clear yellow
Void/Foley	Foley	foley
INTEGUMENTARY		wound to back
Integrety	Wound vac to Abdmen	midline abd wound, (R) hip wound
Dressings	wound vac to abd + back + (R) side hip	W→D & wound vac
Dressing Condition	good	wound vac intact; back drsg to be C&L
		wet & weeping
Drains/Tubes	2 x JP pts	(2) BL abd JPs
Drainage		blood tinged
Signature	(b)(6)	

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **ICU FLOW SHEET**

OTSG APPROVED (Date)

EKG STRIPS

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(R) EJ Cordis	17 Jan		patent		(b)(6)
(L) SC Cordis @ IJC	17 Jan	18 Jan - Leaking	patent		
(R) Radial Aline	19 Jan	(b)(6)	functioning		

PREPA (b)(6)

DEPARTMENT/SERVICE/CLINIC: ICU

DA (b)(6) 05

(Continue on reverse)

PATIENT IDENTIFICATION (Name - last, first, (b)(6)

UNKNOWN
M O DETAINEE
CCF
Bed 6

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700, MAY 78

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	DIAGNOSIS							HOSPITAL DAY									
	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22
BP/ ABP	174/87	141/56	119/87	93/64	79/54	97/67	117/70					93/59	100/73	104/69	104/72	106/70	111/71
Pulse	160	155	145	128	128	119	135					130	121	131	136	126	128
Respirations	16	16	16	18	18	18	12					15	15	15	15	15	15
Temperature		101.8	100.3	101	99.9							97.8		99.0			98.8
SaO2	95	95	98	100	100	98	100					96	100	100%	100%	100%	100%
%O2	90	80	100	100	100	~~100~~ 35	40						Vent	Vent			
O_2 Delivery	Vent SIMV		Vent SIMV		Vent SIMV	SIMV	SIMV						SIMV 15	SIMV FiO2 .75			
CVP	R 16 TV 850 PS 10 RR 5		18 ~~850~~ 20 10		18 800 20 10	18 850 20 10	12 850 20 5						1000 20 5				
Pain Scale																	
Pain Med																	
Pt Position																	

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV	125	125	~~NS~~		125	125	125		625			1000	125	125	→		→	1625
IVPB		65	65	65	165	200			560			500	200	100	500		500	1800
Vecuronium	5	5	5	5	5	5	5		35				~~NS~~ 5					
Fentanyl	75	75	5	5	5	5	5		80				5	7.5	→		→	35
Versed	3	3	3	3	3	3	3		15				3	3	→		→	15
Phenylephrine	25	25	75	100	50	~~125~~	25		362.5				25	25	→		→	125
PO Blood		1657255			350				350			350						
~~Other~~ Bolus	1000				300				~~1300~~					250	250			500
TOTAL									3285									4100

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 Hour/Total		220 / 220	275 / 495	300 / 795	150 / 945	300 / 1245	800 / 2045	200 / 2245	2245			450 / 450	150 / 600	100 / 700	100 / 800	10 / 810	100 / 910	910
NG output								200	200		~~50~~	50						
Emesis		Dansja 0830																
Stool																		
Chest tube #1/ #2		Dansja			Dansja 1115													
Jackson Pratt #1/ #2												20 / 35			60 / 100		~~100~~	160
Wound vac EBL								500	500			350						
TOTAL									2945									1070

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

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

ST OPERATIVE DAY

PHYSICIAN

ME	23	24	01	02	03	04	05	06
NIBP/ ABP	105/66	102/61	116/49	94/57	107/73	108/60	122/69	158/58
Pulse	128	128	140	121	104	121	112	148
Respirations	15	14	15	15	10	15	19	15
Temperature							99.4	
SaO2	100%	100%	93%	99%	100%	100%	100%	93%
%O2	FiO2	FiO2	FiO2	FiO2	FiO2	FiO2	FiO2	FiO2
O_2 Delivery	.75	.75	.75	100	100	100	100	100
CVP								
Pain Scale								
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT	13,317	11328
OUTPUT	9,845	4495
DIFFERENCE	+5472	+6833

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV	125	→	→	→	→	→	→	→	1000	
IVBP		200						200	400	
Phenylephrine	18	→	→	→	→	→	→	→	150	
Versed	3	→	→	→	→	→	→	→	24	
Fentanyl	75	→	→	→	→	→	→	→	60	
Bolus			500	500	1000	250			2250	
PO										
Other Dopamine	75	→	→	→	→	→	→	→	60	
TOTAL									3944	11328

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total	60	70	140	100	200	200	150	200	200	
~~NG output~~ Chest								10	10	
Emesis										
Stool										
Chest tube #1/ #2								70	70	
Jackson Pratt #1/ #2								100	200	
TOTAL									480	4495

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

Name	Signature	Init
(b)(6)		

SYSTEM	DAYS	NIGHTS
NEURO		19 JUN 05 @ 1930
Level of consciousness	Pharm Sedation + Paralyzed	2
Extremities: Movement	Ø	2 = Ø changes
Strength	Ø	
PAIN ASSESSMENT	Unable to assess	
CARDIOVASCULAR		
Rhthym/Lead	ST II	ST
Heart Sounds	S_1 S_2	S_1 S_2
Skin	Normal dry	cool, dry
Edema	lg, generalized	generalized, facial edema ↓
JVD/ Capillary refill	Ø 3-5 sec	Ø, <3sec
Pulses: Radial	®faint Ⓛ+1	Ⓡ +1 Ⓛ +1
Posterior Tibial		
Dorsalis Pedis	Ⓡ+1 Ⓛ+1	+1 +1
RESPIRATORY		
Breath Sounds	Coarse w/ wheezes	wheezes insp & exp
Oxygen Delivery	Vent	Vent SIMV FiO2 .75
Suctioning/Sputum	prn blood tinged / "clots"	PRN
ETT/Trach tube	ETT	ETT
Size: Placement:	7.5 26@holder	7.5 26 cm @ holder
Cough:	Ø	Ø
Treatments:	Ø	Ø
GASTROINTESTINAL		
Bowel Sounds	absent	Absent
Abdomen	distended/soft	distended, slightly firm
Date of last BM	unk	unknown
NG tube: Placement	Rnare/stomach	Ⓡ nare → stomach
Suction	LIS	LIS
Drainage	Grey	light green
GENITOURINARY		
Urine: Color	Pale amber/clear	dark yellow, min. output
Void/Foley	#16 fr	Foley
INTEGUMENTARY		
Integrety	Multiple wounds	wounds to back x2
Dressings	Saturated & bloody drsg all	Ⓡ hip/thigh x3
	areas x wound vac ↓	wound vac to abd
Dressing Condition	stomach	Ⓡ hip x3 w ↓ D & I'd
	all entact → clsd	Ⓛ chest tube drsg CDI
Drains/Tubes	Chest tubes x 2	JP x2 to lower abd Ⓡ & Ⓛ
Drainage	dk blood	sanguinous
Signature	(b)(6)	

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **ICU FLOW SHEET**

OTSG APPROVED (Date)

EKG STRIPS

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(R) SC Cordis = 3LC	17Jun	none THC 18Jun	patent		patent
(A) EJ Cordis	17Jun	patent 18Jun	patent		patent
(B) AC PIC (?)	17Jun	18Jun + heplock added	patent		patent
(C) radial A line	17Jun	18Jun femstarting	dc 050518Jun		

(b)(6)

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: (b)(6) 05

PATIENT IDENTIFICATION (For typed or written entries give: first, middle, grade; date; hospital or medical facility)

Name – last,

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

DATE	DIAGNO						HOSPITAL DAY										
Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
NIBP/ ABP	135/89	155/94	145/93	122/78	107/56	83/64	94/58	100/58	94/55	138/89/57	106/60	108/64	115/65	119/67	24/70	134/75	
Pulse	158	131	132	136	131	136	133	80	133	138	128	131	143	139	136	140	
Respirations	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	
Temperature	100.4						99.2					100.8	99.0			99.5	
SaO2	100	100	100	98	98	99	100	99	98	99	100	100	99%	97%	97%	98%	
%O2 (b	Vent	40		40 Vent		40%		40%		40%		40%	.35	→			
O_2 Delivery	Vent	SIMV Ctrl 16				SIMV Ctrl 14		SIMV 16		SIMV 16		SIMV 16	SIMV 16	→			
CVP		VT 850 RR 16 PEEP 5				850 10 5		850 10 5		850 10 5		850 10 5	850 10 5	→			
TOR					0/4	0/4	0/4	1/4	4/4		0/4	0/4					
Pain Scale																	
Pain Med																	
Pt Position																	

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV	200	200	200	200	200	200	200	200	1600	200	125	125	125	125	→		→	1075
IVPB		50	100			200			350		50		200					250
Vec	9	9	9	9	5	3	(b)(6)			5	7	5	4	4	→			80
Versed	3	3	3	3	3	3	3	3	24	3	3	3	3	→				24
Fentanyl	10	10	10	10	10	10	10	10	80	10	10	7	7	7.5	→			66
Phenylephrine						125	125	125	375	125	25	25	25	25	→			188
PO FFP			940															
Other Bs/us		2000		1000				1000	4000		1000				1000			2000
TOTAL									6091.5									3645

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 Hour/Total		275/275	360/630	300/930	175/1105	125/1230	150/1380	150/1530	1530	120/120	125/245	275/520	150/670	225/895	100/995	200/1195	250/1445	144
NG output													200					
Emesis																		
Stool																		
Chest tube #1/ #2													140/230 (b)					
Jackson Pratt #1/ #2				→														410
Wound vac				900					900				300					310
TOTAL									2430									1215

ASPECT	TIME/INITIALS
Bath/Skin Care	1000 (b)(6)
Oral Care	1600
Foley Care	1000
Trach Care	NA
Range of Motion	

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

POST OPERATIVE DAY | **PHYSICIAN**

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP	110/64	132/60	138/70	129/68	127/69	121/67	110/63	120/61
Pulse	145	137	140	145	145	144	145	149
Respirations	16	16	16	16	16	16	17	16
Temperature				99.4				
SaO2	95%	95%	96%	96%	97%	98%	97%	94%
%O2	FiO2	→						45
O_2 Delivery	135	→						FM
CVP	SIMV							AC
Pain Scale								
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT	5833	13,317
OUTPUT	4620 ~~3120~~	7,845
DIFFERENCE	~~2713~~ (b)(6)	+5,472

1213

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV D5½NS	125	→						→	1000	
IVBP		250						200	450	
Neo	25	←						~~200~~	20	
Fent	75								60	
Versed	3								24	
Vec	4								32	
PO										
Output B Lwo		1000				1000			~~2000~~	
TOTAL									3586	13317

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total	300/300	200/500	300/800	225/1025	200/1225	250/1475	300/1775	200/1975	1975	
NG output								25	25	
Emesis										
Stool										
Chest tube #1/ #2	/	/	/	/	/	/	/	95/165	260	/
Jackson Pratt #1/ #2	/	/	/	/	/	/	/	/	/	/
Wound vac								1000	1000	
TOTAL									3260	7,845

Legend

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

Name	Signature	Init
(b)(6)		

SYSTEM	DAYS	NIGHTS
NEURO		18 JUN 05 @ 1945
Level of consciousness	Sedated & paralyzed pharmacologically	2
Extremities: Movement	Ø	Ø change
Strength	Ø	
PAIN ASSESSMENT	Ø	
CARDIOVASCULAR		
Rhthym/Lead	ST +T	ST
Heart Sounds	S1 S2	S1 S2
Skin	Warm & dry	warm, dry
Edema	lg/generalized	generalized, slight edema CU
JVD/ Capillary refill	Ø <3	Ø, <3
Pulses: Radial	(R) 4+ (L) extremely faint	(R) +2 (L) +2
Posterior Tibial		
Dorsalis Pedis	(L) + (R) +	+1 +1
RESPIRATORY		
Breath Sounds	Clear	inspiratory wheeze
Oxygen Delivery	Vent	Vent SIMV FiO2 .35
Suctioning/Sputum	prn	PRN
ETT/Trach tube	ETT	ETT
Size: Placement:	7.5 26@holder	7.5 24@holder
Cough:	none	Ø
Treatments:	Ø	Ø
GASTROINTESTINAL		
Bowel Sounds	absent	absent
Abdomen	lgi soft	distended, soft
Date of last BM	unknown	unknown
NG tube: Placement	(R) nare/stomach	(R) nare → stomach
Suction	LIS	LIS
Drainage	pale bilious	pale/clear
GENITOURINARY		
Urine: Color	amber/clear	clear yellow
Void/Foley	#16 fs	Foley - 16 Fr
INTEGUMENTARY		
Integrety	Multiple wounds	(R) hip x 3 W/D
Dressings	Wound vac mid abd. Multiple	dsgs d'd
	smaller wounds	Wound vac to abd to cont Sx
Dressing Condition	Some CDI, others dry	CDI
Drains/Tubes	CTX2 (L)	CTX2 to Sx
Drainage	dk red	sang.
Signature	(b)(6)	

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **ICU FLOW SHEET**

OTSG APPROVED (Date)

EKG STRIPS

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(R) Jugular cordis					
(L) Subclavian cordis					
R4C ~~PICC~~ PICC					
(R) radial A-line					

(Continue on reverse)

(b)(6)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: (b)(6) 05

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

(b)(6)

UNKNOWN, UNKNOWN
H O DETAINEE
BCCF

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

DATE	DIAGNOSIS									HOSPITAL DAY								
Time	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22	
NIBP/ ABP																		
Pulse																		
Respirations																		
Temperature																		
SaO2																		
%O2																		
O_2 Delivery																		
CVP																		
Pain Scale																		
Pain Med																		
Pt Position																		

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																		
Other																		
TOTAL																		

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

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POST OPERATIVE DAY | **PHYSICIAN**

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP				Transferred to Advanced Care	108/67	112/70	103/67	101/67
Pulse					145	150	150	158
Respirations					16	16	16	16
Temperature					98.5	/	/	/
SaO2					100%	100%	100%	100%
%O2					70%	70%	→	
O_2 Delivery					FiO2	FiO2	→	
CVP								
Pain Scale								
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT		5833
OUTPUT		4620 ~~3620~~
DIFFERENCE		~~2713~~ 1213

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV				5000 from ED	125	125	125	125	600	
IVBP								250	250	
FENTANYL					5	10	10	10	35	
VERSED					3	3	3	3	12	
VECURONIUM					9	9	9	9	36	
PO										
Other										
TOTAL										5833

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total	/	/	/	/	200 ~~650~~	650 ~~650~~	/	200 ~~650~~	850	
NG output								0	0	
Emesis										
Stool										
Chest tube #1/ #2	/	/	/	/	210 ~~150~~	/	/	105 150	255	/
Jackson Pratt #1/ #2	/	/	/	/	/	/	/	/	/	/
Wound vac								1500	1500	
TOTAL										4620 ~~3120~~

(b)(6)

Legend

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

Name	Signature	Init.
(b)(6)		

SYSTEM	DAYS	NIGHTS
NEURO		@0400 18 JUN 05
Level of consciousness		PS
Extremities: Movement		PS
Strength		PS
PAIN ASSESSMENT		Fentanyl drip
CARDIOVASCULAR		
Rhthym/Lead		ST
Heart Sounds		S1S2
Skin		warm, dry, pink
Edema		+2 ABD & BLE
JVD/ Capillary refill		ØJVD / < 3secs
Pulses: Radial		+2 (B)
Posterior Tibial		
Dorsalis Pedis		+2 (B)
RESPIRATORY		
Breath Sounds		abnormal lung sounds throughout
Oxygen Delivery		mech. vent 70% FiO2 SIMV
Suctioning/Sputum		PRN / clear thick
ETT/Trach tube		ETT
Size: Placement:		7.5 / 27cm @ holder
Cough:		Ø
Treatments:		Ø
GASTROINTESTINAL		
Bowel Sounds		Absent
Abdomen		Distended
Date of last BM		?
NG tube: Placement		(R) nare
Suction		LIS
Drainage		Ø
GENITOURINARY		
Urine: Color		red-tinged
~ Void/Foley		foley
INTEGUMENTARY		multiple lacs to (R) UE & LE
Integrety		large ABD wound
Dressings		gauze, tegaderm
Dressing Condition		intact
Drains/Tubes		CT x 2
Drainage		serosanguineous
Signature		(b)(6)

EMERGENCY RESUSCITATION RECORD

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

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

1. DATE: 26 June 05

2. LOCATION OF RESUSCITATION: ☒ Ward: ICU
☒ MICU ☐ SICU ☐ CCU ☐ NICU ☐ PICU ☐ ED ☐ PACU ☐ OR
☐ Diagnostic/Procedure Area:
☐ Outpatient Clinic:
☐ Other (Specify):

3. PATIENT STATISTICS:
Age: ? Gender: M
Height (in): ?
Weight (lbs): ? Weight (kg): 100kg

4. INITIAL CONDITION:
CONSCIOUS? ☐ Yes ☒ No
BREATHING? ☐ Yes ☒ No
PULSE? ~~☒~~ Yes ☒ No Pulse Site: (b)Femoral
WITNESSED ARREST? ☒ Yes ☐ No ☐ Unknown
MONITORED AT ONSET? ☒ Yes ☐ No

5. INITIAL RHYTHM:
☐ Asystole ☐ Pulseless Electrical Activity ☒ Other: Agonal
☐ Bradycardia ☐ Ventricular Fibrillation
☐ Perfusing Rhythm ☐ Ventricular Tachycardia

RETURN OF SPONTANEOUS CIRCULATION (ROSC):
☐ Returned at: ☒ Never Achieved
☐ Unsustained ROSC: ☐ < 20 min ☐ > 20 min

TIME CPR STOPPED: 0715 DUE TO: ☐ ROSC ☐ DNR ☒ Death

6. IMMEDIATE CAUSE OF ARREST/EVENT: (Check One)
☐ Hypotension/Hypovolemia
☒ Lethal Arrhythmias
☐ Metabolic
☐ Myocardial Infarction or Ischemia
☒ Respiratory Depression
☐ Trauma
☐ Unknown
☐ Other:

7. RESUSCITATION ATTEMPTED:
☒ YES (Check all that apply)
☒ Airway Management ☒ Cardiac Massage
☒ Chest Compressions ☐ Defibrillation

☐ NO (Check one)
☐ False Alarm/Arrest (BLS/ALS not needed)
☐ Do Not Resuscitate (DNR)
☐ Pronounced Dead Prior to Resuscitation
☐ Other:

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

	Time (Military)
Collapse/Arrest Onset:	0702
CPR Started:	0702
1st Defibrillation:	—
Airway Achieved:	Already Intubated
1st Dose Epinephrine:	0703
Code Team Called: ☒ Yes ☐ No	
Code Team Arrived:	0703

9. INTERVENTIONS:

(CHECK THOSE IN PLACE AT START OF RESUSCITATION)	(CHECK THOSE INITIATED DURING RESUSCITATION, NOTE TIME)	COMMENTS
☒ IV Access Gauge: TLC Site: (b)Sc	☐ Time(s) ___/___	Already in place
☑ Endotracheal Tube Size: 8-0	☐ Time(s) ___/___	Already in place
☑ Mechanical Ventilation	☐ Time(s) ___/___	Already Intubated
☑ Arterial Line	☐ Time(s) ___/___	Already in place
☑ Central Venous Line	☐ Time(s) ___/___	Already in place
☐ Pulmonary Artery Catheter	☐ Time(s) ___/___	
☑ Nasogastric Tube	☐ Time(s) ___/___	Already in place
☐ Pacing Device (Specify):	☐ Time(s) ___/___	
☐ Implantable Defibrillator/Cardioverter	☐ Time(s) ___/___	
☐ Other (Specify):	☐ Time(s) ___/___	

PATIENT DISPOSITION FOLLOWING RESUSCITATION:
Death

PATIENT IDENTIFICATION
(b)(6)
UNKNOWN, UNKNOWN
M C DETAINEE
DCCF

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

EYE OPENING
4 - Spontaneously
3 - To voice
2 - To pain
1 - No response

VERBAL RESPONSE
5 - Oriented, converses
4 - Disoriented, converses
3 - Inappropriate responses
2 - Incomprehensible sounds
1 - No response

MOTOR RESPONSE
6 - Obeys verbal commands
5 - Localizes painful stimulus
4 - Withdraws from pain stimulus
3 - Flexion, decorticate posturing
2 - Extension, decerebrate posturing
1 - No movement

SCORE: 3

EMERGENCY RESUSCITATION RECORD - PART 2

	TIME (Military):	0703	0704	0705	0706	0708	0709	0712	0714	0715			
VITALS	BLOOD PRESSURE	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø			
	HEART RATE	40	32	20	18	20	14	Ø	Ø	Ø			
	PULSE PALPABLE (Y/N)	N	N	N	N	N	N	N	N	N			
	COMPRESSION (* = CPR)	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	RHYTHM	Agonal	Agonal	Agonal	Agonal	Agonal	Agonal	Agonal	Agonal	Agonal			
	DEFIBRILLATION (Joules: 200, 300, 360)	/	/	/	/	/	/	/	/	/			
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	/	/	/	/	/	/	/	/	/			
	PACING PERFORMED (✓)	/	/	/	/	/	/	/	/	/			
	RESPIRATIONS	Ambu bag	Ambu bag	Ambu bag	Ambu bag	Ambu bag	Ambu bag	Ambu bag	Ambu bag	Ambu bag			
	TEMPERATURE		99.0										
AIRWAY	VALVE MASK w/100% O_2 (✓)	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	INTUBATED (✓)	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	MASK (Specify)												
	% OXYGEN (O_2)	100%	100%	100%	100%	100%	100%	100%	100%	100%			
	PULSE Ox / O_2 SATS	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø			
MEDICATIONS	*Note dose and route.*												
	AMIODARONE												
	ATROPINE	1 mg			1mg		1 mg		+π				
	DOPAMINE												
	EPINEPHRINE	1 mg			1mg		1mg	1mg	1mg				
	LIDOCAINE												
	~~PROCAINAMIDE~~ Calcium				1 amp								
	VASOPRESSIN												
LABS	POTASSIUM (K)												
	GLUCOSE												
	CALCIUM (Ca)												
	MAGNESIUM (Mg)												
ABGS	PH												
	pCO_2												
	pO_2												
	HCO_3												

COMMENTS:

PHYSICI[illegible] (b)(6) N (b)(6)

MEDC[illegible]R (TEST) (MCHO) JUN 03

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. ____ Yr. ____	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
25 Jun 05	(b)(6)	Losec 20mg now IVP	11 30 (b	1130 (b	1130 (b	(b) (6)
25 Jun 05		Losec 20mg now IVPB	25 Jun (b	25 Jun (b	7 Jones	
			2350 25 Jun (b	2300		
	.....					
	.....					
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	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
.....	.....															
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USAPA V1.00

CLINICAL RECORD

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

Mo 06 Yr 05

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21	22	23	24	25	26	27	28	29	30
18 Jun	(b)(6)	Neosynephrine 25 mcg/min	07	(b)(6)												
		titrate keep SBP > 90 MAP > 65	19	(b)(6)												
18 Jun		D5 1/2 NS @ 125 cc/hr	07	(b)(6)												
			19	(b)(6)												
19 Jun		NS + 20 mEq/KCl @ 125/hr	07													
			19													
(b) (6)		Cargate Tgm via	06													
(b) (6) 20 June		NGT Q6°	12													
			18													
			24													
21 June		Lovenox 30 mg SQ	08													
		Q12h	20													
22 Jun		Neosynephrine wean for MAP	1000													
		> 60 SBP > 100	2000													
22 Jun		Levofloxacin 500mg IVPB QD	1400													
19 JUN		Dopamine 2 mcg/kg/	07													
		min	19													
24 June 05		Vecuronium 0.1 mg/kg	07													
		IV 0.1 mcg/kg/min	19													
		NS @ 75 cc/hr	07													
			19													

ALLERGIES: ☐ YES ☐ NO
unk

PRIMARY DIAGNOSIS: S/P Multiple GSW

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

PATIENT IDENTIFICATION:
(b)(6)
UNKNOWN, UNKNOWN
M O DETAINEE
RCCF

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo 06 Yr 05

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18 19 20 21 22 23 24 25 26 27 28 29 30
(b)(6)	Neosynephrine 25 mcg/min titrate to keep SBP > 90 MAP > 80	07	(b)(6) D/C June 22 (b)(6)
		19	(b)(6)
18 Jun	D5 1/2 NS @ 125 cc/hr	07	(b)(6) 19 Jun Sat
		19	(b)(6)
19 Jun	NS + 20 mEq KCl @ 125/hr	07	(b)(6)
		19	(b)(6)
(b)(6)	Carafate 1 gm via NGT Q6°	06	(b)(6)
		12	(b)(6)
		18	
		24	(b)(6)
21 June	Lovenox 30 mg SQ Q12h	08	
		20	
22 Jun	Neosynephrine wean for map > 60 SBP > 100	1000	(b)(6)
		2200	
22 Jun	Levofloxacin 500mg IVPB QD	1400	
19 Jun	Dopamine 2 mcg/kg/min	07	
		19	
24 June 05	Vecuronium 0.1 mg/kg	07	
	prn 0.1 mg/kg/min	19	
	NS @ 75 cc/hr	07	(b)(6)
		19	

ALLERGIES: [X] YES [ ] NO — PRIMARY DIAGNOSIS: S/P Multiple GSW

ADDITIONAL PAGES IN USE: [X] YES [ ] NO — PAGE NO.

PATIENT (b)(6)

UNKNOWN, UNKNOWN
H O DETAINEE
CF

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 4 78-1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. 95 V1.00

Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

0096-05-CID789-39262

Mo. 06 Yr. 05

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVE	Date to be Given	Time to be Given	Time Given	Initials
18Jun	(b)(6)	Sodium Bicarbonate 44.6mEq IV now	18Jun	1012	1015	(b)(6)
18Jun		Bolus 1000cc NS	18Jun	1400	1400	
18Jun		NS Bolus 1L IV	18Jun	1600	1600	
18JUN		1000cc LR Bolus NOW	18 JUN	2300	2300	
18JUN		Give 1 Liter LR Bolus NOW	18 JUN	2030	2030	
19 JUN		Give 1000cc LR Bolus NOW	19 JUN	0430	0430	
19Jun		1L NS Bolus IV now	19Jun	0711	0715	
19Jun		Potassium Phosphate 45mmol IVPB over 5hrs	19Jun	0711	0800	
19Jun		Magnesium Sulfate 4gm IVPB	19Jun	0711	0830	
19Jun		Calcium Gluconate 10cc of 8% soln IV	19Jun	0711	0712	
19Jun		Hold IV fluids	19Jun	0800	0800	
19Jun		Lasix 40mg IV now	19Jun	0800	0800	
19Jun		2 units PRBCs	19Jun	0800	0910	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
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Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

0096-05-CID789-5028

Mo. 06 Yr. 05

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
18 Jun	(b)(6)	Sodium Bicarbonate 44.6 mEq IV now	18 Jun	1012	1015	(b)(6)
18 Jun		Bolus 1000cc NS	18 Jun	1400	1400	
18 Jun		NS Bolus 1L IV	18 Jun	1600	1600	
18 JUN		1000cc LR Bolus NOW	18 JUN	2300	2302	
18 JUN		Give 1 Liter LR Bolus NOW	18 JUN	2030	2030	
19 JUN		Give 1000cc LR Bolus NOW	19 JUN	0430	0430	
19 Jun		1L NS Bolus IV now	19 Jun	0711	0715	
19 Jun		Potassium Phosphate 45 mmol IVPB over 4hr	19 Jun	0711	0800	
19 Jun		Magnesium Sulfate 4gm IVPB	19 Jun	0711	0830	
19 Jun		Calcium Gluconate 10cc of 8% soln IV	19 Jun	0711	0712	
19 Jun		Hard IV fluids	19 Jun	0800	0800	
19 Jun		Lasix 40mg IV now	19 Jun	0800	0800	
19 Jun		Transfuse 2 Unit PRBCs	19 Jun	0800	0910	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
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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 COLUMN INDICATED BY ARROW BELOW.

(b)(6)

UNKNOWN, UNKNOWN
M 0 DETAINEE
BCCF

NURSING UNIT	ROOM NO.	BED NO.
ICU		6

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
25 June 05	0410 HOURS	
LASIX 40mg IV now		

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M 0 DETAINEE
BCCF

NURSING UNIT	ROOM NO.	BED NO.
ICU		6

DATE OF ORDER	TIME OF ORDER
25 JUN 05	1120 HOURS
LASIX 20mg IV NOW.	

(b)(6)

PA (b)(6)

M 0 DET EE
BCCF

NURSING UNIT	ROOM NO.	BED NO.
ICU		6

DATE OF ORDER	TIME OF ORDER
25 JUN 05	1407 HOURS
NS @ 75cc/hr.	

(b)(6)

(b)(6)

UNKNOWN, UNKNOWN
M 0 DETAINEE
BCCF

NURSING UNIT	ROOM NO.	BED NO.
ICU		6

ATE OF ORDER	TIME OF ORDER
25 JUN 05	2250
LASIX 20mg IV now	
↑ Urine 200mg/hr	

(b)(6)

(b)(6)

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION
(b)(6)
UNKNOWN, UNKNOWN
H O DETAINEE
BCCF

NURSING UNIT: ICU | ROOM NO. | BED NO.: 6

DATE OF ORDER: 24 Jun 05 | TIME OF ORDER: 0713 HOURS | LIST TIME ORDER NOTED AND SIGN

1. 1 L NS - Drink

(b)(6)

(b)(6)
UNKNOWN, UNKNOWN
H O DETAINEE
BCCF

NURSING UNIT: ICU | ROOM NO. | BED NO.: 6

DATE OF ORDER: 24 Jun 05 | TIME OF ORDER: 0907 HOURS

1. Potassium Phosphate 45 mmol IVPB over 4°.
2. Calcium Chloride 10 cc of 10% SOLN IV N
3. Vecuronium 10 MG IVP Prosit..
4. Vecuronium 0.1 mcg/kg/min.
5. ABG now.

(b)(6)

PATIENT IDENTIFICATION
(b)(6)
UNKNOWN, UNKNOWN
H O DETAINEE
BCCF

NURSING UNIT: ICU | ROOM NO. | BED NO.: 6

DATE OF ORDER: 24 Jun 05 | TIME OF ORDER: 1142 HRS

1. PCXR (ASSESS LINE PLACEMEN

(b)(6)

PATIENT IDENTIFICATION
(b)(6)
UNKNOWN, UNKNOWN
H O DETAINEE
BCCF

NURSING UNIT: ICU | ROOM NO. | BED NO.: 6

DATE OF ORDER: 25 June 05 | TIME OF ORDER: 0630 HOURS

1. T.O as per May
Albuterol Neb Tx IX 0.5ml
9IV.

(b)(6)

(b)(6)

(b)(6)

DA FORM 4256 REPLACES EDITION OF ... WHICH ... "USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

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)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 22 JUN
TIME OF ORDER: 1000 HOURS

LIST TIME ORDER NOTED AND SIGN: (b)(6)

✓ ↓ fentanyl to 75 mcg
✓ ↓ versed to 5 mg/hr
✓ wean Neo for MAP > 60 SBP > ...
✓ DC ...
✓ Levofloxacin 500 mg IV QD
✓ Start TF @ 20cc/hr ...
– ✓ TF residual q4° &

DATE OF ORDER / TIME OF ORDER HOURS

hold for > 250cc

✓ Stop TF feeds Thursday night for OR on Friday

noted 22 Jun

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

M O DETAINEE
BCCF

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 23 JUN
TIME OF ORDER: 0530 HOURS

20 mg Lasix IVP
↓ versed to 3 mg

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

DATE OF ORDER: 23 JUN 05
TIME OF ORDER: 1907 HOURS

① bolus 3 mg versed IVP
② ... versed gtt to 5 mg/hr
③ ...
④ ✓

(b)(6)

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ @ 0600 24 JUN 05

DA FORM 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 76, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
N O DETAINEE
BCCF

DATE OF ORDER 21 JUN | TIME OF ORDER 09 JN HOURS | LIST TIME ORDER NOTED AND SIGN

Dr Veeraman
NCT to wzensor1.
Lovenox 30mg SQ q12°

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
N O DETAINEE
BCCF

DATE OF ORDER 21 JUN 05 | TIME OF ORDER 1320 HOURS

LASIX 10MG IVP Now.
NS Bolus 500cc now

(b)(6)

(b)(6)

21 JUN 1330

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
N O DETAINEE
BCCF

DATE OF ORDER 21 JUN 05 | TIME OF ORDER 1919 HOURS

NOTED 21 JUN @ 2301

CT SCAN OF CHEST
C R/O PNEUMOPERICARD.
PCXR —

(b)(6)

(b)(6)

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
N O DETAINEE
BCCF

DATE OF ORDER 22 JUN | TIME OF ORDER 0300 HOURS

24° CC 21 JUN @ 2300

500 cc NS Bolus NOW

NOTED 22 JUN @ 0300

(b)(6)

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

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

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

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

PATIENT IDENTIFICATION: (b)(6) UNKNOWN, UNKNOWN M O DETAINEE BCCF

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	0645 HOURS	

Gave 500cc NS bolus IV. NOTED 20 JUN 0645

NURSING UNIT: ICU | ROOM NO.: 24CC | BED NO.: 6 soon @ 0700

PATIENT IDENTIFICATION: (b)(6) UNKNOWN, UNKNOWN M O DETAINEE BCCF

DATE OF ORDER	TIME OF ORDER
20 JUN 05	0709 HOURS

1. TYPE & CROSSMATCH 2 UNITS PRBC's.
2. TRANSFUSE 2 UNITS PRBC's.
3. TYLENOL 1G PR PRIOR TO TRANSFUSION
4. BENADRYL 50 MG IV PRIOR TO TRANSFUSION.
5. CALCIUM GLUCONATE 10cc of 10% SOLN IV
6. MAGNESIUM SULFATE 2G IVPB.

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 6

PATIENT IDENTIFICATION: (b)(6) UNKNOWN, UNKNOWN M O DETAINEE BCCF

DATE OF ORDER	TIME OF ORDER
20 JUN 05	0930 HOURS

Recheck Tgm NG @ 0600

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 6

Type & Xmatch √ @ 0600 21 JUN 05

PATIENT IDENTIFICATION: (b)(6) UNKNOWN, UNKNOWN M O DETAINEE BCCF

DATE OF ORDER	TIME OF ORDER
21 JUN 05	0710 HOURS

1. POTASSIUM PHOSPHATE 45 mmol IVPB over 4 hrs.
2. MAGNESIUM SULFATE 2G IVPB.
3. CALCIUM GLUCONATE 10cc of a 10% soln IV.

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 6

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

*U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

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)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

NURSING UNIT: ICU | ROOM NO. | BED NO.: 6

DATE OF ORDER: 19 Jun | TIME OF ORDER: 2100 HOURS | LIST TIME ORDER NOTED AND SIGN

Dopamine 2mg/kg

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 19 June | TIME OF ORDER | HOURS

1) Albuterol Neb x 1

2) 500cc Bolus NS

NOTED 20 JUN @ 0100

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 JUN | TIME OF ORDER: 0115 HOURS

Give 1000 cc NS Bolus Now

NOTED 20 JUN @ 0120

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

NURSING UNIT: ICU | ROOM NO. | BED NO.: 6

DATE OF ORDER: 20 June 05 | TIME OF ORDER | HOURS

1 unit Heparin

500cc Bolus NS

NOTED 20 JUN @ 0120

(b)(6)

(b)(6)

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

*U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

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)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

DATE OF ORDER 19 JUN | TIME OF ORDER 1600 HOURS | LIST TIME ORDER NOTED AND SIGN

✓ 4gm magnesium sulfate IVPB
✓ 2gm calcium chloride IVP

NOTED 19 JUN (b)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

DATE OF ORDER 19 JUN 05 | TIME OF ORDER 1850 HOURS

✓ ① HOLD 500 cc of 6% soln over 2 hrs

NOTED 19 JUN (b)(6) 1950

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 19 JUN 05 | TIME OF ORDER 2000 HOURS

✓ V.O. Give 250 cc NS bolus now

Noted 19 JUN (b)(6) 2120

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

DATE OF ORDER 19 JUN | TIME OF ORDER 2200 HOURS

✓ 500 cc hespan IVPB

NOTE 19 JUN (b)(6) 2215

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 6

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

☆U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

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

DETAINEE
UNKNOWN

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 6

DATE OF ORDER: 19 Jun | TIME OF ORDER: 1115 HOURS | LIST TIME ORDER NOTED AND SIGN

Lasix 20 mg IVP now

NS bolus 300cc now

(b)(6)

(b)(6)

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

UNKNOWN, UNKNOWN
M O DETAINEE
RCCF

(b)(6)

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

DATE OF ORDER: 19 JUN 05 | TIME OF ORDER: 1245 HOURS

1. CBC, BMP, COAGS, MAG, PHOS Now.

(b)(6)

(b)(6)

19 Jun 1250

PATIENT IDENTIFICATION

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

DATE OF ORDER: 19 JUN 05 | TIME OF ORDER: 1320 HOURS

1. CALCIUM GLUCONATE 10cc of 10% SOLN IV NOW.
2. SODIUM BICARBONATE 44.6 mEq IV NOW.
3. VENT: SIMV 14 Vt 1000 FiO2 .55 PS/20 PEEP 5

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN
M O DETAINEE
RCCF

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 6

DATE OF ORDER: 19 JUN | TIME OF ORDER: 1700 HOURS

Resume previous orders
CBC BMP Mg & phos now DT/PTT
G-tube to gravity
Flush g-tube q shift.
SDs to [illegible] bilat such
VAC 125 cm suction

(b)(6)

(b)(6)

DA FORM 4256, 1 APR 79 REPLACES EDITION OF 1 JUL 77, WI

☆U.S. GOVERNMENT PRINTING OFFICE: 20

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) UNKNOWN, UNKNOWN M O DETAINEE BCCF
NURSING UNIT: ICU | ROOM NO. | BED NO.: 6

DATE OF ORDER: 19 JUN 05 | TIME OF ORDER: 0430 HOURS | LIST TIME ORDER NOTED AND SIGN: NOTED 0430 19 JUN (b)(6)

↑ Phenylephrine IV to
100 mcg/min
Give 1000 cc LR
bolus now.

PATIENT IDENTIFICATION: (b)(6) UNKNOWN, UNKNOWN M O DETAINEE BCCF
NURSING UNIT: ICU | ROOM NO. | BED NO.: 6

DATE OF ORDER: 19 JUN 05 | TIME OF ORDER: 0711 HOURS

PC ZANTAC.
1L NS Bolus IV NOW.
POTASSIUM PHOSPHATE 45mMol IVPB over 4°
MAGNESIUM SULFATE 4G IVPB.
A CHEM-12 to BMP QD.
CALCIUM GLUCONATE 10cc of 10% soln IV
V A IVF TO NS @ 20mL/Hr KCl @ 125 mg/Hr.

PATIENT IDENTIFICATION: (b)(6) UNKNOWN, UNKNOWN M O DETAINEE BCCF
NURSING UNIT: ICU | ROOM NO. | BED NO.: 6

DATE OF ORDER: 19 JUN 05 | TIME OF ORDER: 0230 HOURS

TYLENOL 1G PR Q4-6° PRN T > 101.
Hard IVF.
Lasix 40mg IV NOW.
TYPE & CROSSMATCH 4 units
ABG NOW.
TRANSFUSE 1 UNIT PRBC's.
BENADRYL 50mg IV NOW.
↑ NEOSYNEPHRINE TO 150 mcg/min.
VENT SIMV 18 VT 850 100%
P4.20 PEEP 10

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

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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)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
18 Jun	1600 HOURS	

1 IVF to Rx ½NS @125/hr

16 (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

DATE OF ORDER 18 JUN 05 TIME OF ORDER 1610 HOURS

1 ↑ NEOSYNEPHRINE TO 50 mcg/min; TITRATE TO KEEP MAP >

2 NS BOLUS 1L IV.

3 COAG PANEL @ 1800.

(b)(6)

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 18 JUN TIME OF ORDER 2300 HOURS

1 L NS BOLUS IV

LR @ 200cc/hr

NOTED 18 JUN @ 2310

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

DATE OF ORDER 18 JUN TIME OF ORDER 2030 HOURS

Late Entry

V.O. Give 1 Liter LR Bolus NOW

NOTED 18 JUN @ 2315

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 J

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0096-05-CID789-39265

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)

X Male / Female / STAT / X Routine

SSN: (b)(6)

Signs and Symptoms:

Physician: (b)(6)

Drawn by: (b)(6)

Ward: ICU

Bed: 6

Specimen Date and Time: 26 Jun 05 0500

Reported by (b)(6)

Date and Time: 26 Jun 0657

Hemoglobin A1c Purple Top

X	TEST	RESULT	REF. RANGE
	Hgb A1c		3.5-6.0 %

Urine Microablumin/Creatinine
Urine Cup
Note: Will not perform these samples if protein value of 30 mg/dL or higher on dipstick urine specimens.

X	TEST	RESULT	REF. RANGE
	Albumin		≤10 mg/L
	Creatinine		10-300 mg/dL
	Alb/Creat Ratio		<30 mg/g

C-Reactive Protein / Red Top
Note: ...

X	TEST	RESULT	REF. RANGE
	CRP		

CSF Glucose - Sterile Tube

X	TEST	RESULT	REF. RANGE
	CSF Glucose		40-70 mg/dL
	CSF Protein		12 - 60 mg/dL

Special Chemistries / Urine Cup

X	TEST	RESULT	REF. RANGE
	Glucose		<30 mg/dL
	Protein		<12 mg/dL

Additional Tests

For the tests below, cooridnate with lab OIC or NCOIC

X	TEST	RESULT	REF. RANGE
	Ammonia		9 - 30 umol/L
	Lactate		0.7 - 2.1 mmol/L

Special Chemistries / Tiger Top (SST)

X	TEST	RESULT	REF. RANGE
	Alcohol		<10 mg/dL Negative
			50-400 mg/dL Toxic
			>400 mg/dl Poss. Fatal
	Cholinesterase		M: 5.90-12.22 U/mL
			F: 4.65-10.44 U/mL
	Iron		M: 49-181 ug/dL
			F: 37-170 ug/dL
X	Lipase	698 H	23-300 U/L
X	Phosphorous	6.4 H	2.2-4.5 mg/dL
X	Magnesium	2.4 H	1.6-2.3 mg/dL
	Uric Acid		M: 3.5-8.5 mg/dL
			F: 2.5-6.2 mg/dL
	Lactate Dehydrogenase		313-618 U/L
	HIV		Negative
	PSA Tot		Age Range(ng/ml)
			40-49 0.0-2.5 ng/ml
			50-59 0.0-3.5 ng/ml
			60-69 0.0-4.5 ng/ml
			70-79 0.0-6.5 ng/ml
	HCG Quant		M: <3mIU/ mL
			Cyclic F: <4 mIU/ mL
			MenoP F: <13 mIU/ mL
			Preg F: >20 mIU/ mL
	Bu		0.0 - 1.1 mg/dl
	Bc		0.0 - 0.3 mg/dl

Therap. Drug Monitoring

X	TEST	RESULT	REF. RANGE
	Acetaminophen		
	Digoxin		0.8-2.0 ng/mL Therap.
	Phenytoin		10.0-20.0 ug/mL Therap.
	Salicylate		<2 mg/dL negative
			<20 mg/dL Therap.
			>30 mg/dL Toxic
			>60 mg/dL Lethal

Crit Called Results given to (b)(6)

Thyroid Panel / Red or Tiger Top

X	TEST	RESULT	REF. RANGE
	TSH		0.25 - 5 uIU/mL
			Hyperthy: <0.15 uIU/mL
			Hypothy: >7 uIU/mL
	FT4		9 - 20 pmol/L
	FT3		4.0 - 8.3 pmol/L

Add. Thyroid Tests / Red or Tiger Top

X	TEST	RESULT	REF. RANGE
	T4 Total		60 - 120 nmol/L
	T3 Total		0.92 - 2.33 nmol/L

Hepatitis B / Red or Tiger Top

X	TEST	RESULT	REF. RANGE
	HBsAG		Negative
			Positive
	HBcAG		Positive
			Equivocal
			Negative

115th Field Hosp
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.

Male / Female / STAT / Routine

SSN or ISN: (b)(6)

Specimen Date and Time: 0900 25 June 05

Signs and Symptoms: S/P GSW

Physician:

Drawn by: (b)(6)

Ward: 7A

Bed: 6

Reported by: (b)(6)

Date and Time: 25 June 0905

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.323 L	7.35-7.45
	PCO2	52.8 H	35-45 mmHg
	PO2	56 L	80-100 mmHg
	TCO2	29	18-33 mmol/L
	HCO3	27.4 H	22-26 mmol/L
	sO2	86% L	95-99%
	BEecf	1	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

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

Urine Microscopic

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

Other lab request

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Mono		Negative
H.pylori IgG		Negative
RPR		Negative
HCG (or urine)		Negative
HIV (Purple Top)		Negative
Strep A		Negative
DOA (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C-difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
Wet Mount		Negative
KOH		Negative

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation Studies

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

Cardiac Panel

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

Hemoglobin S	Negative

Body Fluid Panel

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

0096-05-CID789-39265

115th Field Hosp
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)	Male	SSN or ISN: (b)(6)	Signs and Symptoms:
Physician: (b)(6)	Female		
Drawn by: Ward: ICU	STAT	Specimen Date and Time: 25 June 05 0530	Reported by: (b)(6) Date and Time: 25 Jun 0600
Bed: #6	Routine		

Chemistry / ... / Green Top / Syringe — Bld Gas / Bld Gas w/ lytes

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

Urinalysis

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

Urine Microscopic

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

Other lab request:

Chemistry / ... / Green Top — BMP

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	18	7-22 mg/dL
X	Ca	7.5L	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL	112 H	98-109 mmol/L
	TCO2	25	18-33 mmol/L
	Creat	1.2	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	120 H	73-118 mg/dL
	K	4.4	3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	140	128-145 mmol/L
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Test	Result	Ref. Range
Mono		Negative
H.pylori IgG		Negative
RPR		Negative
HCG (or urine)		Negative
HIV (Purple Top)		Negative
Strep A		Negative
DOA (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
Wet Mount		Negative
KOH		Negative

Hematology / Purple Top

X	TEST	RESULT	REF. RANGE
X	WBC	17.0 H	4.8-10.8 x10(3)/uL
X	RBC	3.17 L	4.2-6.1 x10(6)/uL
X	Hgb	9.7 L	12.0-18.0 g/dL
X	Hct	30.1 L	M: 42.0-52.0%
			F: 37-47%
	MCV	95.1	80.0-99.0 fl
	MCH	30.6	27.0-31.0 pg
X	MCHC	32.1 L	33.0-37.0 g/dL
X	Plt	103 L	130-400 x10(3)/uL
X	LY%	6.6 L	20.0-44.0%
X	LY#	1.1 L	0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria

Test	Result	Ref. Range
Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Test	Result	Ref. Range
Sed Rate		1hr = 0-20 mm

Coagulation

X	Test	Result	Ref. Range
X	PT	16.2 H	7.0-14.0 sec
X	APTT	60.5 H	21.0-50.0 sec
X	INR	1.6 H	0.5-1.5/therap 2-3
	D Dimer		Negative

Cardiac Panel

Test	Result	Ref. Range
Myoglobin		0-107 ng/mL
CK-MB		0-4.3 ng/mL
Troponin		0.0-0.4 ng/mL

Hemoglobin S

Test	Result	Ref. Range
Hemoglobin S		Negative

CSF

Panel Includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis test (CSF only)

0098-05-CID789-39265

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)

Male / Female

SSN or ISN: (b)(6)

Signs and Symptoms:

Physician: (b)(6)
Drawn by:
Ward: Zeus
Bed: 6

STAT / Routine

Specimen Date and Time: 25 June 05 0530

Reported by: (b)(6)

Date and Time: 25 June 05 [illegible]

Fasting Lipid Panel / Purple Top

X	TEST	RESULT	REF. RANGE
	Hgb A1c		3.5-6.0 %

Urine Microalbumin/Creatinine Urine Cup

Note: Will not [illegible] samples with [illegible] specimens

X	TEST	RESULT	REF. RANGE
	Albumin		≤10 mg/L
	Creatinine		10-300 mg/dL
	Alb/Creat Ratio		<30 mg/g

[redacted]

X	TEST	RESULT	REF. RANGE
	CRP		[illegible] mg/L

CSF Glucose - Sterile Tube

X	TEST	RESULT	REF. RANGE
	CSF Glucose		40-70 mg/dL
	CSF Protein		12 - 60 mg/dL

Special Chemistries / Urine Cup

X	TEST	RESULT	REF. RANGE
	Glucose		<30 mg/dL
	Protein		<12 mg/dL

Additional Tests

For the tests below, coordinate with lab OIC or NCOIC

X	TEST	RESULT	REF. RANGE
	Ammonia		9 - 30 umol/L
	Lactate		0.7 - 2.1 mmol/L
	[illegible]		

Special Chemistries / Green Top

X	TEST	RESULT	REF. RANGE
	Alcohol		<10 mg/dL Negative
			50-400 mg/dL Toxic
			>400 mg/dl Poss. Fatal
	Cholinesterase		M: 5.90-12.22 U/mL
			F: 4.65-10.44 U/mL
	Iron		M: 49-181 ug/dL
			F: 37-170 ug/dL
	Lipase		23-300 U/L
X	Phosphorous	3.3	2.2-4.5 mg/dL
X	Magnesium	2.1	1.6-2.3 mg/dL
	Uric Acid		M: 3.5-8.5 mg/dL
			F: 2.5-6.2 mg/dL
	Lactate Dehydrogenase		313-618 U/L
	HIV		Negative
	PSA Tot		Age Range(ng/ml)
			40-49 0.0-2.5 ng/ml
			50-59 0.0-3.5 ng/ml
			60-69 0.0-4.5 ng/ml
			70-79 0.0-6.5 ng/ml
	HCG Quant		M: <3mIU/ mL
			Cyclic F: <4 mIU/ mL
			MenoP F: <13 mIU/ mL
			Preg F: >20 mIU/ mL
	Bu		0.0 - 1.1 mg/dl
	Bc		0.0 - 0.3 mg/dl

Therap. Drug Monitoring

Acetaminophen	10-30 ug/mL Therap.
	>150 ug/mL Toxic
Digoxin	0.8-2.0 ng/mL Therap.
Phenytoin	10.0-20.0 ug/mL Therap.
Salicylate	<2 mg/dL Negative
	<20 mg/dL Therap.
	>30 mg/dL Toxic
	>60 mg/dL Lethal

Thyroid Panel

X	TEST	RESULT	REF. RANGE
	TSH		0.25 - 5 ulU/mL
			Hyperthy: <0.15 ulU/mL
			Hypothy: >7 ulU/mL
	FT4		9 - 20 pmol/L
	FT3		4.0 - 8.3 pmol/L

Thyroid Panel

X	TEST	RESULT	REF. RANGE
	T4 Total		60 - 120 nmol/L
	T3 Total		0.92 - 2.33 nmol/L

Hepatitis Panel

X	TEST	RESULT	REF. RANGE
	HBsAG		Negative
			Positive
	HBcAG		Positive
			Equivocal
			Negative

0096-05-CID789-39265

115th Field Hosp
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)
Male / Female: Male
SSN or ISN: (b)(6)
STAT / Routine: STAT
Signs and Symptoms: GSW.
Physician: (b)(6)
Drawn by:
Ward: ICU
Bed: C
Specimen Date and Time: 24 Jun 05 1257
Reported by: (b)(6)
Date and Time: 06/24 13

Chemistry (STAT) / Blue Top Syringe / BldGas / BldGas w/Lytes: Green Top

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.376	7.35-7.45
	PCO2	48.0 H	35-45 mmHg
	PO2	62	80-100 mmHg
	TCO2	30	18-33 mmol/L
	HCO3	28.2 H	22-26 mmol/L
	sO2	91 L	95-99%
	BEecf	3	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	0.92	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

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

Urine Microscopic

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

Other lab request:

Chemistry (Plain Red Top) / Green Top

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Rapid Tests / Red Top

Mono		Negative
H.pylori IgG		Negative
RPR		Negative
HCG (or urine)		Negative
HIV (Purple Top)		Negative
Strep A		Negative
DOA (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
Wet Mount		Negative
KOH		Negative

Hematology / Purple Top

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation Profile / Blue Top

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

Cardiac Panel / Purple Top

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

Hemoglobin S / Purple Top

Hemoglobin S	Negative

Blood Culture Panel / Sterile Cont

Panel Includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis test (CSF only)

Jun 6

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

EAS FIRST MI: (b)(6)
Physician: (b)(6)
Draw by:
Ward: CU
Bed: 6
X Male / Female: (b)(6)
X STAT / Routine
Specimen Date and Time: 24 June 0925
Signs and Symptoms:
Reported by: (b)(6)
Date and Time: 24 June 09

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
X	pH	7.336	7.35-7.45
X	PCO2 H	53.5	35-45 mmHg
X	PO2	92	80-100 mmHg
X	TCO2	28.6-30	18-33 mmol/L
X	HCO3	28.6	22-26 mmol/L
X	sO2	96	95-99%
X	BEecf	3	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

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

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

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

Urine Microscopic

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

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc:		Negative

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

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen
Sed Rate		Thr = 0-20 mm

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

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

Panel Includes: Gram Stain, Cell Count,

0096-05-CID789-39265

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

PATIENT: (b)(6) | Male / Female | STAT / Routine | Specimen Date and Time: 24JUN05@0500 | Signs and Symptoms:

Physician: (b)(6) | Drawn by: | Ward: ICU | Bed: 6 | Reported by: (b)(6) | Date and Time: 06 27 / 24 Jun 05

Chemistry (Blood Gas / Electrolytes)

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

Chemistry (Liver / Renal / Other)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	14	7-22 mg/dL
X	Ca	7.5 L	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL	112 H	98-109 mmol/L
	TCO2	26	18-33 mmol/L
	Creat	1.2	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	137	73-118 mg/dL
	K	3.6	3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	140	138-145 mmol/L

Hematology

X	TEST	RESULT	REF. RANGE
X	WBC	11.3 H	4.8-10.8 x10(3)/uL
X	RBC	3.27 L	4.2-6.1 x10(6)/uL
X	Hgb	9.8 L	12.0-18.0 g/dL
X	Hct	30.7 L	M: 42.0-52.0%
			F: 37-47%
	MCV	93.9	80.0-99.0 fl
	MCH	30.0	27.0-31.0 pg
X	MCHC	32.6 L	33.0-37.0 g/dL
X	Plt	74 L	130-400 x10(3)/uL
X	LY%	10.1 L	20.0-44.0%
	LY#	1.1	0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Urinalysis

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

Urine Microscopic

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

Rapid Screening Test

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

Microbiology

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

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

	PT	11.0	7.0-14.0 sec
X	APTT	55.6 H	21.0-50.0 sec
	INR	1.1	0.5-1.5/therap 2-3
	D Dimer		Negative

Cardiac Panel

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

Body Fluid Panel

Panel includes: Gram Stain, Cell Count,

0096-05-CID789-39265

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.

X Male / Female
SSN or ISN: (b)(6)
X Routine / STAT
Specimen Date and Time: 24JUN05 0530

Signs and Symptoms:

Physician: (b)(6)
Drawn by:
Ward: CCU
Bed: 6

Reported by: (b)(6)
Date and Time: 24 Jun 0638

Hemoglobin A1c / Purple Top

X	TEST	RESULT	REF. RANGE
	Hgb A1c		3.5-6.0 %

Urine Microalbumin/Creatinine
Urine Cup

Note: Will not perform on the samples with a protein value of 30 mg/dl or higher or on visibly bloody specimens.

X	TEST	RESULT	REF. RANGE
	Albumin		≤10 mg/L
	Creatinine		10-300 mg/dL
	Alb/Creat Ratio		<30 mg/g

C Reactive Protein / Red Top

Note: Qualitative Screen performed on serum. If result is positive it will be reported as a quantitative result.

X	TEST	RESULT	REF. RANGE
	CRP		<6 mg/L

CSF Glucose - Sterile Tube

X	TEST	RESULT	REF. RANGE
	CSF Glucose		40-70 mg/dL
	CSF Protein		12 - 60 mg/dL

Special Chemistries / Urine Cup

X	TEST	RESULT	REF. RANGE
	Glucose		<30 mg/dL
	Protein		<12 mg/dL

Additional Tests

For the tests below, coordinate with lab OIC or NCOIC

X	TEST	RESULT	REF. RANGE
	Ammonia		9 - 30 umol/L
	Lactate		0.7 - 2.1 mmol/L

Special Chemistries / Tiger Top (SST)

X	TEST	RESULT	REF. RANGE
	Alcohol		<10 mg/dL Negative
			50-400 mg/dL Toxic
			>400 mg/dl Poss. Fatal
	Cholinesterase		M: 5.90-12.22 U/mL
			F: 4.65-10.44 U/mL
	Iron		M: 49-181 ug/dL
			F: 37-170 ug/dL
	Lipase		23-300 U/L
X	Phosphorous	1.9 L	2.2-4.5 mg/dL
X	Magnesium	2.3	1.6-2.3 mg/dL
	Uric Acid		M: 3.5-8.5 mg/dL
			F: 2.5-6.2 mg/dL
	Lactate Dehydrogenase		313-618 U/L
	HIV		Negative
	PSA Tot		Age Range(ng/ml)
			40-49 0.0-2.5 ng/ml
			50-59 0.0-3.5 ng/ml
			60-69 0.0-4.5 ng/ml
			70-79 0.0-6.5 ng/ml
	HCG Quant		M: <3mIU/ mL
			Cyclic F: <4 mIU/ mL
			MenoP F: <13 mIU/ mL
			Preg F: >20 mIU/ mL
	Bu		0.0 - 1.1 mg/dl
	Bc		0.0 - 0.3 mg/dl

Therap. Drug Monitoring

Acetaminophen		10-30 ug/mL Therap.
		>150 ug/mL Toxic
Digoxin		0.8-2.0 ng/mL Therap.
Phenytoin		10.0-20.0 ug/mL Therap.
Salicylate		<2 mg/dL negative
		<20 mg/dL Therap.
		>30 mg/dL Toxic
		>60 mg/dL Lethal

Thyroid Fare / Red or Tiger Top

X	TEST	RESULT	REF. RANGE
	TSH		0.25 - 5 uIU/mL
			Hyperthy: <0.15 uIU/mL
			Hypothy: >7 uIU/mL
	FT4		9 - 20 pmol/L
	FT3		4.0 - 8.3 pmol/L

Add. Thyroid Tests / Red or Tiger Top

X	TEST	RESULT	REF. RANGE
	T4 Total		60 - 120 nmol/L
	T3 Total		0.92 - 2.33 nmol/L

Hepatic B Fare / Red or Tiger Top

X	TEST	RESULT	REF. RANGE
	HBsAG		Negative
			Positive
	HBcAG		Positive
			Equivocal
			Negative

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

EASTMAN, MI

Physician: (b)(6)
Draw by:
Ward: ICU
Bed: 6

X Male / Female
(b)(6)
STAT / X Routine
Specimen Date and Time: 23JUN05C 2200

Signs and Symptoms:

Reported by: (b)(6)
Date and Time: 23 Jun 2213

Chemistry Profile with Electrolytes

X	TEST	RESULT		REF. RANGE
	Na			138-145 mmol/L
	K			3.3-4.9 mmol/L
	Cl			98-109 mmol/L
	pH	7.353		7.35-7.45
X	PCO2	48.2	H	35-45 mmHg
	PO2	56		80-100 mmHg
	TCO2	28		18-33 mmol/L
X	HCO3	26.8	H	22-26 mmol/L
X	sO2	87	L	95-99%
	BEecf	1		(-2) - (+3)
	AGap			8-16 mmol/L
	iCa			1.12-1.32 mmol/L
	BUN			7-22 mg/dL
	Glu			73-118 mg/dL
	Creat			0.6-1.3 mg/dL
	Hct			37.0-52.0%
	Hgb			12.0-18.0 g/dL
	Lactate			0.90-1.70 mmol/L

Chemistry Profile with eGFR

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0,2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		138-145 mmol/L

Complete Blood Count

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Urinalysis

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

Urine Microscopic

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

Original Results given to (b)(6)

Serology

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

Malaria Parasite

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate Manual

Sed Rate		1hr = 0-20 mm

Microbiology

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

Coagulation Profile Group

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

Cardiac Panel Troponin

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

Body Fluid Panel (CSF)

Panel Includes: Gram Stain, Cell Count,

0096-05-CID789-39265

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

EAST FIRST, MI [redacted] BCCF | Male X | (b)(6) | Signs and Symptoms:

Physician: (b)(6) | Ward: ICU | Female | STAT | Specimen Date and Time: 23JUN05@2000 | Reported by: (b)(6) | Date and Time: 23 Jun 2000

Drawn by: | Bed: 6 | X Routine

Blood Gas and Co-Ox

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
X	pH	7.307 L	7.35-7.45
X	PCO2	59.0 H	35-45 mmHg
X	PO2	49 L	80-100 mmHg
	TCO2	31	18-33 mmol/L
X	HCO3	29.5 H	22-26 mmol/L
X	sO2	79 L	95-99%
	BEecf	3	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Chemistry Profile A w/ Green Top

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

Hematology Profile

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Urinalysis

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

Urine Microscopic

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

STAT Rapid Tests

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Nega
H.pylori IgG		Nega
ETOH/Alc.		Nega

Critical Results Given To: (b)(6)

Microbiology

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

Malaria Rapid Test

Thin		No Plasmodium Seen
		No Plasmodium Seen

ESR Rapid Test

	1hr = 0-20 mm

Coagulation Profile

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

Cardiac Panel

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

Body Fluid Panel - Stat Cell Count

Panel includes: Gram Stain, Cell Count,

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)
Physician: (b)(6)
Drawn by:
Ward: ICU
Bed: 6
X Male / Female
X STAT / Routine
SSN or ISN: (b)(6)
Specimen Date and Time: 23 June 05
Signs and Symptoms:
Reported by: (b)(6)
Date and Time: 0643/23 Jun 05

Chemistry (Electrolytes/Blood Gas)

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

Chemistry (Electrolytes/Blood Gas)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	15	7-22 mg/dL
X	Ca	7.2 L	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL	112 H	98-109 mmol/L
	TCO2	22	18-33 mmol/L
	Creat	1.3	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	167 H	73-118 mg/dL
	K	4.6	3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	139	138-145 mmol/L

CBC/Manual

X	TEST	RESULT	REF. RANGE
	WBC	8.1	4.8-10.8 x10(3)/uL
	RBC	3.69 L	4.2-6.1 x10(6)/uL
	Hgb	11.3 L	12.0-18.0 g/dL
	Hct	34.7 L	M: 42.0-52.0%
			F: 37-47%
	MCV	93.9	80.0-99.0 fl
	MCH	30.7	27.0-31.0 pg
	MCHC	32.6 L	33.0-37.0 g/dL
X	Plt	50 L	130-400 x10(3)/uL
	LY%	12.4 L	20.0-44.0%
	LY#	1.0	0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph:

Plt Abn Morph: 3 per HPF

WBC Abn Morph:

Urinalysis

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

Urine Microscopic

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

Miscellaneous Tests

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

Microbiology

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

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate (Manual)

Sed Rate		1hr = 0-20 mm

Coagulation Tests

X	PT	16.7 H	7.0-14.0 sec
X	APTT	55.2 H	21.0-50.0 sec
X	INR	1.7 H	0.5-1.5/therap 2-3
	D Dimer		Negative

Cardiac Panel/Lab Tests

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

Body Fluid Panel/Cell Count

Panel Includes: Gram Stain, Cell Count,

EXHIBIT 3

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6) | X Male / Female | SSN or ISN: (b)(6) | Signs and Symptoms:

Physician: (b)(6) | Ward: TCU | STAT / X Routine | Specimen Date and Time: 23 Jun 05

Drawn by: | Bed: 6 | Reported by: (b)(6) | Date and Time: 23 Jun 0709

Hemoglobin A1c / Purple Top

X	TEST	RESULT	REF. RANGE
	Hgb A1c		3.5-6.0 %

Urine Microalbumin/Creatinine Urine Cup

Note: Will not be run on urine samples with a urine creatinine of 30 mg/dl or higher or on visibly bloody specimens.

X	TEST	RESULT	REF. RANGE
	Albumin		≤10 mg/L
	Creatinine		10-300 mg/dL
	Alb/Creat Ratio		<30 mg/g

C Reactive Protein / Red Top

Note: Cannot be performed on serum specimens that are positive for gross lipemia.

X	TEST	RESULT	REF. RANGE
	CRP		<6 mg/L

CSF Glucose / Sterile Tube

X	TEST	RESULT	REF. RANGE
	CSF Glucose		40-70 mg/dL
	CSF Protein		12 - 60 mg/dL

Special Chemistries / Urine Cup

X	TEST	RESULT	REF. RANGE
	Glucose		<30 mg/dL
	Protein		<12 mg/dL

Additional Tests

For the tests below, cooridnate with lab OIC or NCOIC

X	TEST	RESULT	REF. RANGE
	Ammonia		9 - 30 umol/L
	Lactate		0.7 - 2.1 mmol/L

Special Chemistries / Tiger Top (SST)

X	TEST	RESULT	REF. RANGE
	Alcohol		<10 mg/dL Negative
			50-400 mg/dL Toxic
			>400 mg/dl Poss. Fatal
	Cholinesterase		M: 5.90-12.22 U/mL
			F: 4.65-10.44 U/mL
	Iron		M: 49-181 ug/dL
			F: 37-170 ug/dL
	Lipase		23-300 U/L
X	Phosphorous	2.5	2.2-4.5 mg/dL
X	Magnesium	2.4 H	1.6-2.3 mg/dL
	Uric Acid		M: 3.5-8.5 mg/dL
			F: 2.5-6.2 mg/dL
	Lactate Dehydrogenase		313-618 U/L
	HIV		Negative
	PSA Tot		Age Range(ng/ml)
			40-49 0.0-2.5 ng/ml
			50-59 0.0-3.5 ng/ml
			60-69 0.0-4.5 ng/ml
			70-79 0.0-6.5 ng/ml
	HCG Quant		M: <3mIU/ mL
			Cyclic F: <4 mIU/ mL
			MenoP F: <13 mIU/ mL
			Preg F: >20 mIU/ mL
	Bu		0.0 - 1.1 mg/dl
	Bc		0.0 - 0.3 mg/dl

Therap. Drug Monitoring

Acetaminophen		10-30 ug/mL Therap.
		>150 ug/mL Toxic
Digoxin		0.8-2.0 ng/mL Therap.
Phenytoin		10.0-20.0 ug/mL Therap.
Salicylate		<2 mg/dL negative
		<20 mg/dL Therap.
		>30 mg/dL Toxic
		>60 mg/dL Lethal

Thyroid Panel / Red or Tiger Top

X	TEST	RESULT	REF. RANGE
	TSH		0.25 - 5 uIU/mL
			Hyperthy: <0.15 uIU/mL
			Hypothy: >7 uIU/mL
	FT4		9 - 20 pmol/L
	FT3		4.0 - 8.3 pmol/L

Add. Thyroid Tests / Red or Tiger Top

X	TEST	RESULT	REF. RANGE
	T4 Total		60 - 120 nmol/L
	T3 Total		0.92 - 2.33 nmol/L

Hepatic B / Red or Tiger Top

X	TEST	RESULT	REF. RANGE
	HBsAG		Negative
			Positive
	HBcAG		Positive
			Equivocal
			Negative

EXHIBIT 3

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI (b)(6)	✓Male / Female	SSN or ISN: (b)(6)	Signs and Symptoms:
Physician: (b)(6) Ward: ICU Drawn by: Bed: 6	STAT / ✓Routine	Specimen Date and Time: 22 JUN 0500	Reported by: (b)(6) / Date and Time: 22 Jun 0551

Hemoglobin A1c / Purple Top

X	TEST	RESULT	REF. RANGE
	Hgb A1c		3.5-6.0 %

Urine Microalbumin/Creatinine Urine Cup

Note: Will not accept urine samples with a glucose value of 30 mg/dl or higher or any visibly bloody specimens.

X	TEST	RESULT	REF. RANGE
	Albumin		≤10 mg/L
	Creatinine		10-300 mg/dL
	Alb/Creat Ratio		<30 mg/g

[illegible]

X	TEST	RESULT	REF. RANGE
	CRP		<6 mg/L

CSF Glucose - Sterile Tube

X	TEST	RESULT	REF. RANGE
	CSF Glucose		40-70 mg/dL
	CSF Protein		12 - 60 mg/dL

Special Chemistries / Urine Cup

X	TEST	RESULT	REF. RANGE
	Glucose		<30 mg/dL
	Protein		<12 mg/dL

Additional Tests

For the tests below, cooridnate with lab OIC or NCOIC

X	TEST	RESULT	REF. RANGE
	Ammonia		9 - 30 umol/L
	Lactate		0.7 - 2.1 mmol/L

Special Chemistries / Tiger Top / SST

X	TEST	RESULT	REF. RANGE
	Alcohol		<10 mg/dL Negative
			50-400 mg/dL Toxic
			>400 mg/dl Poss. Fatal
	Cholinesterase		M: 5.90-12.22 U/mL
			F: 4.65-10.44 U/mL
	Iron		M: 49-181 ug/dL
			F: 37-170 ug/dL
	Lipase		23-300 U/L
✓	Phosphorous	3.0	2.2-4.5 mg/dL
✓	Magnesium	2.1	1.6-2.3 mg/dL
	Uric Acid		M: 3.5-8.5 mg/dL
			F: 2.5-6.2 mg/dL
	Lactate Dehydrogenase		313-618 U/L
	HIV		Negative
	PSA Tot		Age Range(ng/ml)
			40-49 0.0-2.5 ng/ml
			50-59 0.0-3.5 ng/ml
			60-69 0.0-4.5 ng/ml
			70-79 0.0-6.5 ng/ml
	HCG Quant		M: <3mIU/ mL
			Cyclic F: <4 mIU/ mL
			MenoP F: <13 mIU/ mL
			Preg F: >20 mIU/ mL
	Bu		0.0 - 1.1 mg/dl
	Bc		0.0 - 0.3 mg/dl

Therap. Drug Monitoring

TEST	RESULT	REF. RANGE
Acetaminophen		10-30 ug/mL Therap.
		>150 ug/mL Toxic
Digoxin		0.8-2.0 ng/mL Therap.
Phenytoin		10.0-20.0 ug/mL Therap.
Salicylate		<2 mg/dL negative
		<20 mg/dL Therap.
		>30 mg/dL Toxic
		>60 mg/dL Lethal

[illegible]

X	TEST	RESULT	REF. RANGE
	TSH		0.25 - 5 uIU/mL
			Hyperthy: <0.15 uIU/mL
			Hypothy: >7 uIU/mL
	FT4		9 - 20 pmol/L
	FT3		4.0 - 8.3 pmol/L

[illegible]

X	TEST	RESULT	REF. RANGE
	T4 Total		60 - 120 nmol/L
	T3 Total		0.92 - 2.33 nmol/L

[illegible]

X	TEST	RESULT	REF. RANGE
	HBsAG		Negative
			Positive
	HBcAG		Positive
			Equivocal
			Negative

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

Last, First, MI: (b)(6)
Male / Female
Physician: (b)(6)
Drawn by:
Ward: 20
Bed: 6
STAT / Routine
Specimen Date and Time: 22 JUN 0500
Signs and Symptoms:
Reported by: (b)(6)
Date and Time: 0522/22 Jun

Chemistry/Blood Analysis

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

Chemistry/Blood Analysis

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	17	7-22 mg/dL
X	Ca	6.8	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL	110 H	98-109 mmol/L
	TCO2	23	18-33 mmol/L
	Creat	1.1	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	107	73-118 mg/dL
	K	3.9	3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	135	138-145 mmol/L

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	7.1	4.8-10.8 x10(3)/uL
	RBC	3.72 L	4.2-6.1 x10(6)/uL
	Hgb	11.1 L	12.0-18.0 g/dL
	Hct	34.1 L	M: 42.0-52.0%
			F: 37-47%
	MCV	91.6	80.0-99.0 fl
	MCH	29.8	27.0-31.0 pg
	MCHC	32.6 L	33.0-37.0 g/dL
	Plt	40 L	130-400 x10(3)/uL
	LY%	13.1 L	20.0-44.0%
	LY#	0.9	0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph: Done in Diff
Plt Abn Morph: 4 hours
WBC Abn Morph:

Urinalysis

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

Urine Microscopic

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

Serology

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

Microbiology

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

Pt's values PH 7.2 Reported (b)(6)

Malaria

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Hematology

Sed Rate		1hr = 0-20 mm

Coagulation

PT	16.3 H	7.0-14.0 sec
APTT	23.9 H	21.0-50.0 sec
INR	1.6 H	0.5-1.5/therap 2-3
D Dimer		Negative

Cardiac

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

Panel Includes: Gram Stain, Cell Count,

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.

X Male
Female
STAT
X Routine

SSN or ISN: (b)(6)

Specimen Date and Time: 21JUN05@0500

Signs and Symptoms:

Physician: (b)(6)
Drawn by:

Ward: ICU
Bed: 6

Reported by: (b)(6)

Date and: 21 Ju

Hemoglobin A1c / Purple Top

X	TEST	RESULT	REF. RANGE
	Hgb A1c		3.5-6.0 %

Urine Microalbumin/Creatinine
Urine Cup
Note: Will not perform on urine samples with a protein value of 30 mg/dl or higher or on 24 hr. urine specimens.

X	TEST	RESULT	REF. RANGE
	Albumin		≤10 mg/L
	Creatinine		10-300 mg/dL
	Alb/Creat Ratio		<30 mg/g

C Reactive Protein / Red Top
Note: Quantitative Screen performed on serum. Positive results will be confirmed by dilution.

X	TEST	RESULT	REF. RANGE
	CRP		<6 mg/L

CSF Glucose / Sterile Tube

X	TEST	RESULT	REF. RANGE
	CSF Glucose		40-70 mg/dL
	CSF Protein		12 - 60 mg/dL

Special Chemistries / Urine Cup

X	TEST	RESULT	REF. RANGE
	Glucose		<30 mg/dL
	Protein		<12 mg/dL

Additional Tests

For the tests below, cooridnate with lab OIC or NCOIC

X	TEST	RESULT	REF. RANGE
	Ammonia		9 - 30 umol/L
	Lactate		0.7 - 2.1 mmol/L

Special Chemistries / Tiger Top (SST)

X	TEST	RESULT	REF. RANGE
	Alcohol		<10 mg/dL Negative
			50-400 mg/dL Toxic
			>400 mg/dl Poss. Fatal
	Cholinesterase		M: 5.90-12.22 U/mL
			F: 4.65-10.44 U/mL
	Iron		M: 49-181 ug/dL
			F: 37-170 ug/dL
	Lipase		23-300 U/L
X	Phosphorous	1.6 L	2.2-4.5 mg/dL
X	Magnesium	1.9	1.6-2.3 mg/dL
	Uric Acid		M: 3.5-8.5 mg/dL
			F: 2.5-6.2 mg/dL
	Lactate Dehydrogenase		313-618 U/L
	HIV		Negative
	PSA Tot		Age Range(ng/ml)
			40-49 0.0-2.5 ng/ml
			50-59 0.0-3.5 ng/ml
			60-69 0.0-4.5 ng/ml
			70-79 0.0-6.5 ng/ml
	HCG Quant		M: <3mIU/ mL
			Cyclic F: <4 mIU/ mL
			MenoP F: <13 mIU/ mL
			Preg F: >20 mIU/ mL
	Bu		0.0 - 1.1 mg/dl
	Bc		0.0 - 0.3 mg/dl

Therap. Drug Monitoring

Acetaminophen	10-30 ug/mL Therap.
	>150 ug/mL Toxic
Digoxin	0.8-2.0 ng/mL Therap.
Phenytoin	10.0-20.0 ug/mL Therap.
Salicylate	<2 mg/dL negative
	<20 mg/dL Therap.
	>30 mg/dL Toxic
	>60 mg/dL Lethal

Thyroid Panel / Red or Tiger

X	TEST	RESULT	REF. RA
	TSH		0.25 - 5 ul
			Hyperthy: <0.15
			Hypothy: >7 ul
	FT4		9 - 20 pmol/
	FT3		4.0 - 8.3 pmol

Add. Thyroid Tests / Red or Tiger Top

X	TEST	RESULT	REF. RANGE
	T4 Total		60 - 120 nmol/L
	T3 Total		0.92 - 2.33 nmol/L

Hepatic B / Red or Tiger Top

X	TEST	RESULT	REF. RANGE
	HBsAG		Negative
			Positive
	HBcAG		Positive
			Equivocal
			Negative

0096-05-CID789-39265

NSN 7540-01-165-7294

519-

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

CXR

AGE	SEX	SSN	(b)(6)	WARD/CLINIC	REGISTER NO.
				ICU	

FILM NO.

PREGNANT ☐ YES ☒ ~~NO~~

REQUESTED BY (Print)

(b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

(b)(6)

DATE REQUESTED

22 JUN AM

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

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

RADIOLOGIC REPORT

- c/w ARDS, pneumonia

- premo pericardium, subcut air (L) ant chest.

- ~~A~~ ~~NO~~

(b)(6)

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

Bed 6

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
CCF

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

RE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 519R (9-83)
Prescribed by GSA/ICM
FPMR (41 CFR) 101-11.8

EXHIBIT 3

0096-05-CID789-39265

NSN 7540-01-165-7294

519-30

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE / SEX / SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
PCxR		ICU #6	
	FILM NO.		PREGNANT ☒ YES ☐ NO
	REQUESTED BY (Print) (b)(6)		TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR		DATE REQUESTED

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

Low SpO^2, 2 x chest tubes to water seal

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

RADIOLOGIC REPORT

- d/w pneumo pericardium
- multi-lobar pneumonia
- subcut air (L) > out dist.

(b)(6)

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE

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

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
CF

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 515 (83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.000-d

EXHIBIT 3

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)

UNKNOWN, UNKNOWN

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 18 JUL 05 | TIME OF ORDER: 0730 HOURS | LIST TIME ORDER NOTED AND SIGN

1. NS 1L Bolus via Cordis now.
2. PCXR - now.

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 18 Jul | TIME OF ORDER: 0745 HOURS

NS 1L bolus now

2 amps NaHCO3 now

A [illegible] TO 50ml IV Q8°

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 18 JUL 05 | TIME OF ORDER: 1012 HOURS

1. Insulin Regular 10 units IV now
2. Calcium gluconate 10cc of 10% soln IV now
3. Sodium Bicarbonate 44.6 mEq IV now.
4. ✓ Accuchecks in 1°
5. Neosynephrine 25mcg/min, titrate [illegible]
6. BMP Q4° x 3.

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 18 Jul | TIME OF ORDER: 1430 HOURS

Bolus 1000cc NS

(b)(6)

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O, DETAINEE
BCCF

NURSING UNIT | ROOM NO. | BED NO.

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

June 05 0200

KCl Charge IV To
D5W @ 3 Amps NaCa @ 125 cc/hr.
Check Chem 12, Corg, CBC
at 0430
Calcium Chloride (b)(6)
2 Amps IV now.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

18 June 05 0200

Give 2 amps NaCa now
Vent Setting Changes:
PEEP 10 TV 800 Rate 16

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

18 June 05 0200

(b)(6)

Zantac 150 50mg IV q8°
FLAGYL 500mg IV q6°

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

24° Chart @ 0500 18 JUN 05

(b)(6)

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

18 JUN 05 0704

1. MAGNESIUM SULFATE 4G IVPB 0730
2. CALCIUM GLUCONATE 10cc of 10% SOLN IVP. 0730
3. BMP, ABG - Now. 0730
4. TRANSFUSE 4 units of FFP

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

Chart @ 19 Jun 04

(b)(6)

(b)(6)

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

FOR OFFICIAL USE ONLY Law Enforcement Sensitive

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

(b)(6)

UNKNOWN
M O DETAINEE
BCCF

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 18 June 05 TIME OF ORDER: 0130 HOURS

LIST TIME ORDERS NOTED AND SIGN

Admit ICU GSW (R) Chest / Hip (R)
Guarded
NKDA
NPO
IV: NS @ 125 cc/hr
Vent Settings TV: 700 PEEP 5
FIO2 100% [illegible]

DATE OF ORDER: 18 June 05 TIME OF ORDER: 0130 (b)(6)

meds
~~Fentanyl 50-100 mcg~~ [illegible]
~~1-1.5 mcg/hour IV~~
Fentanyl 50-100 mcg IV q 1-2 hours
Titrate To effect
Versed 1-5 mg / hour IV
Titrate To effect (b)(6)

noted by (b)(6) 18 Jun 0[illegible]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 18 June 05 TIME OF ORDER: 0130 HOURS

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

Vecuronium .1 mg / kg / hour
Titrate to II / IV TOF
Unasyn 3 gm IV q 6°
AM Labs
~~CBC~~ BMP Chem 12
(Calcium, PO, Magnesium)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 18 June 05 TIME OF ORDER: 0130 HOURS

(b)(6)

NG To Suction
CT's To Suction
Central Line Care

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

Chart / 18 Jun / 1:00 (b)(6)

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

115th Field Hos[illegible]
Baghdad Central Detention Facility Hospital

0096-05-CID789-39265

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: UNK UNK
Physician: (b)(6)
Drawn by:
Ward: ICU
Bed: 6
Male / Female: X
STAT / Routine: X
SSN or ISN: (b)(6)
Specimen Date and Time: 26 June 0707
Signs and Symptoms: Respiratory arrest
Reported by: (b)(6)
Date and Time: 26 June 0707

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

X	TEST	RESULT	REF. RANGE
	ALB	<1.0	L 3.3-5.5 g/dL
	ALP	117	26-184 U/L
	ALT	6	L 10-47 U/L
	AMY	210	(H) 14-110 U/L
	AST	17	11-38 U/L
	Tbil	0.5	0.2-1.6 mg/dL
	BUN	27	(H) 7-22 mg/dL
	Ca	7.6	L 8.0-10.3 mg/dL
	Chol	95	L 100-200 mg/dL
	CK	286	M: 39-380 U/L
			F: 30-190 U/L
	CL	114	(K) 98-109 mmol/L
	TCO2	28	18-33 mmol/L
	Creat	1.8	(H) 0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	157	(H) 73-118 mg/dL
	K	5.8	(H) 3.3-4.9 mmol/L
	TProtein	4.1	L 6.4-8.1 g/dL
	Na	143	128-145 mmol/L
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

X	TEST	RESULT	REF. RANGE
H	WBC	25.0	4.8-10.8 x10(3)/uL
L	RBC	2.89	4.2-6.1 x10(6)/uL
L	Hgb	8.7	12.0-18.0 g/dL
L	Hct	28.0	M: 42.0-52.0%
			F: 37-47%
	MCV	96.9	80.0-99.0 fl
	MCH	30.1	27.0-31.0 pg
L	MCHC	31.2	33.0-37.0 g/dL
	Plt	184	130-400 x10(3)/uL
L	LY%	10.9	20.0-44.0%
	LY#	2.2	0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph: Diff Done within 24 hrs.
Plt Abn Morph:
WBC Abn Morph:

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

Urine Microscopic

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

Mono	NES	Negative
H.pylori IgG	POS	Negative
RPR	NES	Negative
HCG (or urine)		Negative
HIV (Purple Top)		Negative
Strep A		Negative
DOA (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
Wet Mount		Negative
KOH		Negative

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen
Sed Rate		1hr = 0-20 mm
PT	21.7	7.0-14.0 sec
APTT	66.8	21.0-50.0 sec
INR	2.2	0.5-1.5/therap 2-3
D-Dimer		Negative
Myoglobin	7500	0-107 ng/mL
CK-MB	1.4	0-4.3 ng/mL
Troponin	0.34	0.0-0.4 ng/mL
Hemoglobin S		Negative

Panel Includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis test (CSF)

Collected by: (b)(6)

115th Field Hosp
Baghdad Central Detention Facility Hospital

LAB ORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)

X Male / Female

SSN or ISN: (b)(6)

Signs and Symptoms:

Physician: (b)(6) Ward: ICU

Drawn by: Bed: 6

X Routine / STAT

Specimen Date and Time: 26 June 05 0300

Reported by: (b)(6)

Date and Time: 26 Jun 0630

Chemistry

BG / Gas / BG Gas w/ Test / Glu / Urea

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

Urinalysis

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

Urine Microscopic

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

Other, abnormal

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	TBil		0.2-1.6 mg/dL
X	BUN	27 H	7-22 mg/dL
X	Ca	7.9 L	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
X	CL	113 H	98-109 mmol/L
	TCO2	24	18-33 mmol/L
X	Creat	1.6 H	0.6-1.3 mg/dL
	GGT		5-65 U/L
X	Glu	152 H	73-118 mg/dL
X	K	5.2 H	3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
X	Na	151 H	128-145 mmol/L
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Serology

	Mono	Negative
	H.pylori IgG	Negative

Serology

	RPR	Negative
	HCG (or urine)	Negative

Virology

	HIV (Purple Top)	Negative
	Strep A	Negative
	DOA (urine)	Negative
	Chlamydia	Negative
	Flu A	Negative
	C. difficile (stool)	Negative
	O&P (stool)	No Ova / Parasite
	OccBld	Negative
	Wet Mount	Negative
	KOH	Negative

Critical Results given to (b)(6)

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	29.6 H	4.8-10.8 x10(3)/uL
	RBC	3.30 L	4.2-6.1 x10(6)/uL
	Hgb	10.3 L	12.0-18.0 g/dL
	Hct	31.9 L	M: 42.0-52.0%
			F: 37-47%
	MCV	96.6	80.0-99.0 fl
	MCH	31.34	27.0-31.0 pg
	MCHC	32.44	33.0-37.0 g/dL
	Plt	193	130-400 x10(3)/uL
	LY%	5.1 L	20.0-44.0%
	LY#	1.5	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	85	Mono(4-10%)	7
Bands(1-10%)	5	Eos(0-4%)	
Lymph(20-44%)	3	Baso(0-2%)	
Atyp Ly		Immature cells	

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Thick & Thin

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Westergren

Sed Rate		1hr = 0-20 mm

Coagulation Profile

PT	17.3	7.0-14.0 sec
APTT	84.7	21.0-50.0 sec
INR	1.7	0.5-1.5/therap 2-3
D Dimer		Negative

Cardiac Panel / Profile

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

Hemoglobin S Prep / Test

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont

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

0096-05-CID789-39265

NSN 7540-01-165-7294

519-3

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

NON CONTRAST
CT SCAN OF CHEST

AGE | SEX | (b)(6)

WARD/CLINIC: ICU

REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☑ NO

REQUESTED BY *(Print)*: (b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

DATE REQUESTED: 21 JUN 05

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

R/O PERSUMS PERICARDIUM

DATE OF EXAMINATION *(Month, day, year)* | DATE OF REPORT *(Month, day, year)* | DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

- c/w pneumo pericardium.
- multilobar pneumonia.
- prox post (L) pl drain in lat chest soft tissue.

(b)(6)

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

(b)(6)

UNKNOWN
M O DETAINEE

PCCF

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 519 (Rev. 4-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11

NSN 7540-01-165-7294 519-3

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

CXR

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

WARD/CLINIC ICU

REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☒ NO

REQUE (b)(6)

TELEPHONE/PAGE NO.

SIGNAT (b)(6)

DATE REQUESTED 20 JUN @ 200

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

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

RADIOLOGIC REPORT

Multilobar pneumonia (RUL, RLL

(1) Cut dost not well seen.

(b)(6)

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

Bed 6

(b)(6)

UNKNOWN, UNKNOWN
NO DETAINEE
CCF

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 513 (131-83)
Prescribed by GSA/ICM
FPMR (41 CFR) 101-11.806-8

0096-05-CID789-39265

NSN 7540-01-165-7294

519-3

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
KUB					
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) (b)(6)				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR (b)(6)				DATE REQUESTED 21 Jun

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

Hx of intra-abdominal packs
? if sure none are left behind

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

RADIOLOGIC REPORT

- ? Drain in pelvis.
- Surgical in lateral abdomen.

(b)(6)

PATIENT'S IDENTIFICATION *(Per typed or written entry)*

Name (b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 519 (Rev. 7-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.6

EXHIBIT 3

NSN 7540-01-165-7294

519-

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

CXR

AGE | SEX | SSN (Sponsor) | WARD/CLINIC: ICU | REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☒ NO

REQUESTER (Department): (b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

DATE REQUESTED: 21JUN05 0604

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

intubated

DATE OF EXAMINATION *(Month, day, year)* | DATE OF REPORT *(Month, day, year)* | DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

(L) thorax not fully imaged - 2 pl drain

- c/w ARDS, multilobar pneumonia.

(b)(6)

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

(b)(6)

UNKNOWN, UNKNOWN
M 0 DETAINEE
RCCF

#6

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.8

EXHIBIT 3

NSN 7540-01-165-7294 519-30

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE / SEX / SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
PCxR		HCU # 1	
	FILM NO.		PREGNANT ☒ YES ☐ NO
	REQUESTED BY (Print) (b)(6)		TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR		DATE REQUESTED 21 June

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

S/p (R) Chest tube

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

RADIOLOGIC REPORT

- (R) pl drain, B/L basilar atx/ cufelectas-

- No ptx.

(b)(6)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
(b)(6) UNKNOWN, UNKNOWN M O DETAINEE PCCF	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT 2 — PHYSICIAN

STANDARD FORM 515 (4-83) Prescribed by GSA/ICM FPMR (41 CFR) 101-11.6UU-6

NSN 7540-01-165-7294

519-30

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
CXR				ICU	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY *(Print)* (b)(6)				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED 20JUN05@ 06a

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

intubated

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

RADIOLOGIC REPORT

- B/L atx us pl eff.

- NGT tip ⊘ well seen + rec

reject.

(b)(6)

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

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
CCF

#6

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 513 (1-83)
Prescribed by GSA/ICN
FPMR (41 CFR) 101-11.806-8

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

CXR

AGE | SEX | SSN (b)(6)

WARD/CLINIC: ICU

REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☒ NO

REQUI (b)(6)

TELEPHONE/PAGE NO.

(b)(6)

DATE REQUESTED: 19 JUN 05 AM

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

Intubated

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

RADIOLOGIC REPORT

- New pl drain on (R), Bibasilar atx.

← Tubes / lines unremarkable.

(b)(6)

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

(b)(6)

UNKNOWN, UNKNOWN
NO DETAINEE
CCF
Bed 6

LOCATION OF MEDICAL RECORDS

TION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 511136
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

EXHIBIT 3

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 1 Unit ML

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 19 Jun 05

DATE AND HOUR REQUIRED: 19 Jun ~~0800~~ 1000

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

REQUESTING PHYSICIAN *(Print)*: (b)(6)

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P GSW to back

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)

DATE VERIFIED: 19 Jun 05

TIME VERIFIED: 0852

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

(b)(6)

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6) Exp. 22 Jun 2005

TRANSFUSION NO. 2

PATIENT NO. 13561

DONOR	RECIPIENT
ABO: B	ABO: B
Rh: POS	Rh: POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 19 Jun 05

REMARKS: No antibody screen performed Immediate spin crossmatch only

SECTION III – RECORD OF TRANSFUSION

(b)(6)

AMOUNT GIVEN: 330 ML

TIME/DATE COMPLETED/INTERRUPTED: 20 June @ 1220

AT (Hour): 1020 ON (Date): 20 Jun 05

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100.8	140	120/66

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (b)(6)

2nd VERIFIER (b)(6)

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO [ ] YES *(Specify)*

PRE-TRANSFUSION

TEMP. 101.3 | PULSE 130 | BP 160/60

DATE OF TRANSFUSION: 20 June 05

TIME STARTED: 1030

SIGNATURE: (b)(6)

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank;

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

SEX: M

WARD: ICU #6

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 1 Unit ML

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 19 JUN

DATE AND HOUR REQUIRED: 19 JUN 1000

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

REQUESTING PHYSICIAN *(Print)*: (b)(6)

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P GSW to Back

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)

DATE VERIFIED: 19JUN05

TIME VERIFIED: 0850

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

(b)(6)

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)

Exp 22 Jun 2005

TRANSFUSION NO. 1

PATIENT NO. (b)(6)

TEST INTERPRETATION	
ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)

DONOR	RECIPIENT
ABO B	ABO B
Rh POS	Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 19 Jun 05

REMARKS: No antibody screen performed Immediate Spin [illegible]

(b)(6)

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)

AT *(Hour)*: 0820 ON *(Date)*: 20 Jun 05

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1 (b)(6)

2nd VERIFIER *(Signature)*: (b)(6)

PRE-TRANSFUSION: TEMP. 100.3 | PULSE 130 | BP 147/78

DATE OF TRANSFUSION: 0830 20 June

TIME STARTED: 0830

AMOUNT GIVEN: 320 ML

TIME/DATE COMPLETED/INTERRUPTED: 1015 20 July 05

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	101.4	112	99/60

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)*

SIG (b)(6)

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; [illegible])

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
PCCF

SEX: M

WARD: ICU #6

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* (Unit) ML

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [X] TYPE AND SCREEN
- [X] ~~CROSSMATCH~~

DATE REQUESTED 18 Jun 05

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* (b)(6)

DIAGNOSIS OR OPERATIVE PROCEDURE S/P GSW Abd

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE (b)(6)

DATE VERIFIED 18 Jun 05

TIME VERIFIED 0240

REMARKS:

(b)(6)

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)

TRANSFUSION NO. 3

PATIENT NO. Exp: 22Jun05 135601

DONOR ABO B Rh pos

RECIPIENT ABO B Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	COMP

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

(b)(6)

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 18Jun05

REMARKS: No antibody screen performed Immediate Spin crossmatch only

(b)(6)

SECTION III – RECORD OF TRANSFUSION

(b)(6)

POST-TRANSFUSION DATA

AMOUNT GIVEN ALL ML

TIME/DATE COMPLETED/INTERRUPTED 19 JUN 05 1610

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE 37.2

PULSE 115

BLOOD PRESSURE 124/64

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

(b)(6)

2nd VERIFIER *(Signature)*

(b)(6)

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
[X] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
[X] NO [ ] YES *(Specify)*

PRE-TRANSFUSION TEMP. 37.6 PULSE 126 BP 119/84

DATE OF TRANSFUSION 19 JUN 05 TIME STARTED 1530

(b)(6)

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
DCCF

SEX M WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

EXHIBIT 3

ANESTHESIA RECORD

Procedure: Abd wound exploration / Removal for Colostomy / Drainage / Transverse colon resection

Date: 19 Jun 05 | OR #: 1 | Page 1 of 1

Surgeon: (b)(6)

	START	STOP
Anesthesia	1414	1730
Procedure	1433	1708
Room Time IN:		OUT:

PRE-PROCEDURE

- ☐ Pt Identified ☒ ID Band ☐ Questioned ☐ Guardian
- ☒ Chart reviewed ☐ Permit signed
- ☒ NPO since MN ☐ Full stomach
- ☐ Patient reassessed prior to anesthesia & surgery, surgical site verified - Ready to proceed
- ☒ Peri-operative pain management discussed with patient / guardian, plan of care completed

Pre-Anesthetic state
- ☐ Awake ☐ Anxious ☐ Uncooperative
- ☐ Calm ☐ Lethargic ☒ Unresponsive

PATIENT SAFETY

- ☒ Anesthesia machine # 5000 checked
- ☒ Critical clinical alarms checked & activated
- ☐ Secured with safety belt ☐ Axillary roll
- ☒ Arm(s) secured on armboards L R
- ☐ Arm(s) tucked: L R ☒ Arms < 90°
- ☐ Pressure points checked, padded, monitored
- ☒ Eye Care: ☒ Taped closed ☐ Ointment ☐ By surgeon ☐ Saline ☐ Goggles
- ☐ Prone - no pressure on orbits/nose/ears/genitals

MONITORS AND EQUIPMENT

- Steth: ☐ Esophageal ☐ Precordial ☐ Suprasternal
- ☒ Non-Invasive B/P ☐ V lead ECG
- ☒ Continuous ECG ☐ ST / Dysrhy. analysis
- ☒ Pulse oximeter ☐ Nerve stimulator: ☐ Ulnar ☐ Tibial ☐ Facial ☐
- ☒ End tidal CO_2
- ☒ Oxygen monitor
- ☐ ET agent analyzer ☐ Fluid / Blood warmer
- ☒ Temp Nasopharynx ☐ Cell Saver ☐ BIS
- ☐ Body warmer ☐ TEE ☐ ICP
- ☒ Airway humidifier ☐ CPB ☐ EEG
- ☐ Evoked potential
- ☒ NG / OG tube
- Foley ☐ OR ☒ Ward ☐ Doppler
- ☒ Arterial line ® radial
- ☒ C-line/CVP ® SCV TLC
- ☐ PA line
- ☒ IV(s) ® IJ
- Ⓛ chest tubes x 2

ANESTHETIC TECHNIQUE

- GA Induction: ☒ Intravenous ☒ Pre-O_2 ☐ RSI
- ☐ Cricoid pressure ☐ Inhalation ☐ IM ☐ PR
- GA Maintenance: ☒ Inhalation ☐ Inhalation / IV
- ☐ GA / Regional combination ☐ TIVA
- ☐ Sedation & Analgesia / Monitored Anesthesia Care
- Regional: Epidural - ☐ Thoracic ☐ Lumbar ☐ Caudal
- ☐ SAB ☐ Ankle ☐ Femoral ☐ Axillary ☐ Interscalene
- ☐ CSE ☐ Bier ☐ Continuous Spinal ☐ Cervical Plexus
- ☐ Other:
- Regional Technique: ☐ Position ____
- ☐ See remarks ☐ Prep ____
- ☐ Local ☐ Site ____
- ☐ Needle ☐ Introducer
- ☐ LA
- ☐ Narcotic
- ☐ Additive
- ☐ Test dose Rx
- ☐ Attempts x ____ ☐ Level ____
- ☐ Catheter: ☐ Test dose response: + −
- L.O.R. ____ cm Skin ____ cm ☐ Secured

AIRWAY MANAGEMENT

- ☒ Oral ETT ☐ RAE ☐ LTA ☐ Magill forceps
- ☐ Nasal ETT ☐ LMA #
- ☐ Stylet ☐ LMA Fastrach #
- ☐ DL ☐ LMA ProSeal #
- ☒ Tube size 7.5 ☐ FOI ☐ Awake
- ☐ Blade In situ ☐ Laser ETT ☐ LIS
- ☐ Attempts x ☐ EMG ETT ☐ Bougie
- ☐ Grade I II III IV blind ☐ Armored ETT ☐ TTJV
- ☐ Atraumatic intubation/LMA ☐ DLT
- ☒ Secured at 24 cm ☐ Bronchial blocker system
- ☐ ET CO_2 present
- ☐ Breath sounds = bilateral ☐ Rigid FO laryngoscope
- ☐ Cuffed - min occ pressure
- ☐ Uncuffed ETT - leaks at ____ cm H20 ☐ Nerve blocks / Topical Nebulizer - See Remarks
- ☐ Oral airway ☐ Nasal airway ☐ Bite block
- Mask vent. ☐ Easy ☐ Head-tilt ☐ Max jaw-thrust ☐ Cannot Ventilate
- Circuit ☐ Circle system ☒ NRB ☐ Bain
- ☐ Mask case ☐ Via tracheotomy / stoma
- ☐ Nasal cannula ☐ Simple O_2 mask ☐

Intraoperative chart

TIME	1415	30	45	1500	15	30	45	1600	15	30	45	1700	TOTAL
☐ Des ☒ Iso ☐ Sev ☐ Hal (ET%)	1.5	1.0	0.8	1.5	1.5	1.5	1.0	1.0	1.0	0.8	0.6	0.4	
☐ N_2O ☐ Air (L/min)													
Oxygen (L/min)	4	1	1	1	1	1	1	1	1	1	1	1	
Versed (mg)	5												5mg
Vecuronium (mg)	10												
Fentanyl (mcg)	250	<250		<150	50	<150	>50	<100					
CaCl (mg)	100	100 100	100	100	100	100 100	100						1000mg
NS / 5% ALB				500 / 500									
Phenylephrine gtt @ 100	<150	125	<100	<75		<50		<25					
PRBC 1				417									1000 NS / 1 unit PRBC
Urine Foley (ml)	100												
EBL (ml)			<250 / <150		<250	<350 / <300							450
Gastric NG (ml)	scant	LIS											350 / 50
ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	
% Oxygen Inspired (FiO)	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	
O_2 Saturation (SaO)	94	96	98	98	98	98	99	99	100	100	100	100	
End Tidal CO_2	39	31	32	31	31	31	31	31	32	32	32	32	
Temp: ☒ C ☐ F	38.4	38.2	38	37.9	37	37.5	37.4	37.4	37.2	37.1	37	36.8	
TOF	4/4									4/4			

PERI-OP MEDS | TIME

Preprocedure Vital Signs: Pulse 158 | Resp | BP 135/82 | Temp | Sao 93-95 (placed on 10L NRB)

Tidal Volume (ml)	790	790	780	790	810	770	790	820	780	750	760	780
Respiratory Rate	15	15	15	15	15	15	15	15	15	15	15	15
Peak Pressure (cm H_2O)	32	32	32	32	32	33	32	32	32	32	33	34
☒ PEEP ☐ CPAP (cm H_2O)	5	5	5	5	5	5	5	5	5	5	5	5

Symbols for Remarks

Position: 0

PROVIDER(S): (b)(6) (b)(6)

SYMBOLS: V ^ B/P CUFF PRESSURE; ↓ ↑ ARTERIAL LINE; X MEAN ARTERIAL PRESSURE; • PULSE; VENTILATION: O / SV SPONTANEOUS; Ø / AV ASSISTED; ⊠ / CV CONTROLLED; TOURNIQUET LOCATION; mmHg; UP; DOWN; TOTAL TIME

Patient Identification (Addressograph Card)

(b)(6)

Remarks:

OR - AQ via ETT monitors, VS
1 uPRBC per surg request. Surg aware of H/H
To ICU ventilated c 100% O_2
monitored

10 66383

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Stretcher BY (b)(6)

2. PATIENT ID VERIFIED BY (b)(6) URE

3. DATE 19 JUN 05 TIME PATIENT ARRIVED IN SUITE (b)(6)

4. PATIENT IN ROOM TIME 1415 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☒ OTHER (Specify) Intubated

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)	RELIEF SCRUB	
ASSIGNED CIRCULATOR	(b)(6)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Safety strap over thighs, pillow under knees

8. SKIN PREPARATION

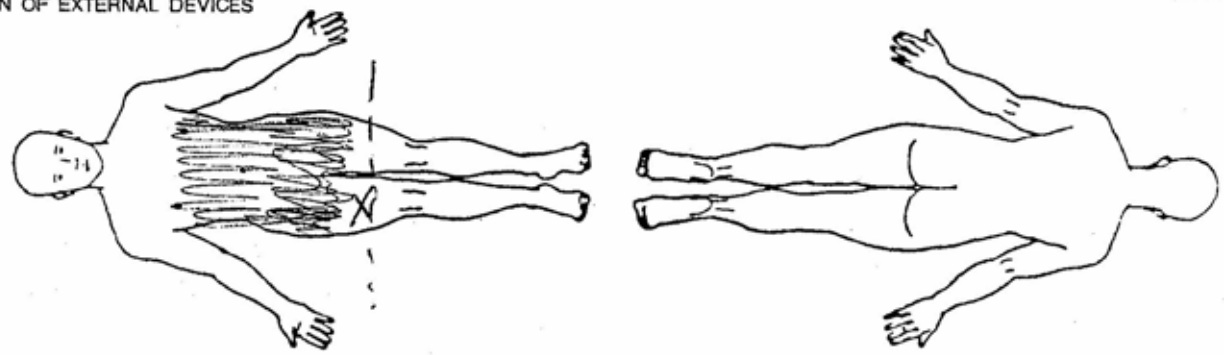
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR (b)(6) ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: ABDomen, no nicks or cuts noted

PREP SOLUTION (Specify) Beta / Beta (b)(6)
SITE: ABDomen BY WHOM:
SITE: BY WHOM:

COMMENTS: no pooling of solutions

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	(b)(6)	(b)(6)
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☒ Yes ☐ No	C	C	C		
Other	☐ Yes ☐ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

(b)(6)

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☐ ESU NO: (b)(6)
GROUND PAD: BRAND Valley Lab
LOT NO: (b)(6)

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 18 JUN 05

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* (b)(6)

DIAGNOSIS OR OPERATIVE PROCEDURE

S/P GSW Abd

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER (b)(6)

DATE VERIFIED 18 JUN

TIME VERIFIED 0740

(b)(6)

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6) EXP: 22 Jun 05

TRANSFUSION NO. 1

PATIENT NO. (b)(6)

DONOR ABO B Rh pos

RECIPIENT ABO B Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	COMP

PREVIOUS RECORD CHECK: [ ] RECORD [ ] NO RECORD (b)(6)

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 18 Jun 05

REMARKS: No antibody screen performed Immediate spin crossmatch only

(b)(6)

SECTION III – RECORD OF TRANSFUSION

(b)(6)

N DATA

19 Jun 05

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 least ML

TIME/DATE COMPLETED/INTERRUPTED 19 Jun 05 1100

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	99	18	92/64

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* (b)(6)

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[X] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE (b)(6)

PRE-TRANSFUSION TEMP. 101 PULSE 144 BP 91/64

DATE OF TRANSFUSION 19 Jun 05 TIME STARTED 0910

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

SEX M WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

EXHIBIT 3

NSN 7540-01-165-7294 519-30

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
PCXR				ICU #6	
	FILM NO.			PREGNANT ☒ YES ☐ NO	
	REQUESTED BY (Print) (b)(6)			TELEPHONE/PAGE NO.	
	SIGNATURE OF REQUESTOR			DATE REQUESTED	

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

Line Placement

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

RADIOLOGIC REPORT

- Tube / line in good position.
- B/L pl eff L > R.
- Swan-Ganz ~~in~~ at possibly inside chest cavity (L) mid lung region & (R) supraclav region.

(b)(6)

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

(b)(6)

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM [illegible] (8-83)
Prescribed by GSA/IC
FPMR (41 CFR) 101 [illegible]6-8

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

CXR - Portable Pelvis - AP
KUB

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

WARD/CLINIC ER-I

FILM NO.

PREGNANT ☐ YES ☐

REQUESTED BY (Print) (b)(6)

TELEPHONE/PAGE NO.

DATE REQUESTED 18 JUN 05

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

GSW Chest / Pelvis

DATE OF EXAMINATION (Month, day, year) | DATE OF REPORT (Month, day, year) | DATE OF TRANSACTION (Month day, year)

RADIOLOGIC REPORT

CXR: Tubes / lines unremarkable. pulm contusion / hemorrhage (L) lung. Likely intrathoracic shrapnel (L); absent air (L) chest wall

KUB: possible retained sponge (L) hemi abdomen. Likely intra-abd shrapnel

Old healing fx (R) mid ulna / radius w/ angulation.

(b)(6)

PATIENT'S IDENTIFICATION (For typed or written entries give. Name - last, first, middle, Medical Facility)

(b)(6)

UNKNOWN UNKNOWN
NO DETAINEE
CCF

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM [illegible]
Prescribed by GSA/ICMR [illegible]
(41 CFR) 201-45.505

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	X Male / Female	SSN or ISN: (b)(6)	Signs and Symptoms:
Physician (b)(6) Ward: 1A	STAT	Specimen Date and Time:	Reported by: (b)(6)
Drawn by: Bed: 6	X Routine	21JUN05@0500	Date and 21 Ju

Hemoglobin A1c / Purple Top

X	TEST	RESULT	REF. RANGE
	Hgb A1c		3.5-6.0 %

Urine Microablumin/Creatinine Urine Cup

Note: Will not give an interpretation on samples with a urine value of 30 mg/dL or higher or on visibly bloody specimens.

X	TEST	RESULT	REF. RANGE
	Albumin		≤10 mg/L
	Creatinine		10-300 mg/dL
	Alb/Creat Ratio		<30 mg/g

C-Reactive Protein / Red Top

Note: Qualitative Screen performed on serum. If results are positive, will be sent out for quantitative testing.

X	TEST	RESULT	REF. RANGE
	CRP		<6 mg/L

CSF Glucose - Sterile Tube

X	TEST	RESULT	REF. RANGE
	CSF Glucose		40-70 mg/dL
	CSF Protein		12 - 60 mg/dL

Special Chemistries / Urine Cup

X	TEST	RESULT	REF. RANGE
	Glucose		<30 mg/dL
	Protein		<12 mg/dL

Additional Tests

For the tests below, cooridnate with lab OIC or NCOIC

X	TEST	RESULT	REF. RANGE
	Ammonia		9 - 30 umol/L
	Lactate		0.7 - 2.1 mmol/L

Special Chemistries / Tiger Top / SST

X	TEST	RESULT	REF. RANGE
	Alcohol		<10 mg/dL Negative
			50-400 mg/dL Toxic
			>400 mg/dl Poss. Fatal
	Cholinesterase		M: 5.90-12.22 U/mL
			F: 4.65-10.44 U/mL
	Iron		M: 49-181 ug/dL
			F: 87-170 ug/dL
	Lipase		23-300 U/L
X	Phosphorous	1.6 L	2.2-4.5 mg/dL
X	Magnesium	1.9	1.6-2.3 mg/dL
	Uric Acid		M: 3.5-8.5 mg/dL
			F: 2.5-6.2 mg/dL
	Lactate Dehydrogenase		313-618 U/L
	HIV		Negative
	PSA Tot		Age Range(ng/ml)
			40-49 0.0-2.5 ng/ml
			50-59 0.0-3.5 ng/ml
			60-69 0.0-4.5 ng/ml
			70-79 0.0-6.5 ng/ml
	HCG Quant		M: <3mIU/ mL
			Cyclic F: <4 mIU/ mL
			MenoP F: <13 mIU/ mL
			Preg F: >20 mIU/ mL
	Bu		0.0 - 1.1 mg/dl
	Bc		0.0 - 0.3 mg/dl

Therap. Drug Monitoring

X	TEST	RESULT	REF. RANGE
	Acetaminophen		10-30 ug/mL Therap.
			>150 ug/mL Toxic
	Digoxin		0.8-2.0 ng/mL Therap.
	Phenytoin		10.0-20.0 ug/mL Therap.
	Salicylate		<2 mg/dL negative
			<20 mg/dL Therap.
			>30 mg/dL Toxic
			>60 mg/dL Lethal

Thyroid Panel / Red or Tiger

X	TEST	RESULT	REF. RANGE
	TSH		0.25 - 5 uI
			Hyperthy: <0.15
			Hypothy: >7 uI
	FT4		9 - 20 pmol/
	FT3		4.0 - 8.3 pmol

Add. Thyroid Tests / Red or Tiger T

X	TEST	RESULT	REF. RANGE
	T4 Total		60 - 120 nmol/L
	T3 Total		0.92 - 2.33 nmol/L

Hepatitis B / Red or Tiger Top

X	TEST	RESULT	REF. RANGE
	HBsAG		Negative
			Positive
	HBcAG		Positive
			Equivocal
			Negative

EXHIBIT 3

NSN 7540-01-165-7214

519-

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

CXR

AGE | SEX | SSN (b)(6)

WARD/CLINIC

REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☒ NO

REQUESTED BY (Print)

(b)(6)

TELEPHONE/PAGE NO.

DATE REQUESTED

22 JUN AM

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

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

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

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

RADIOLOGIC REPORT

- c/w ARDS, premo

- premo pericardium, subcut air (L) ant chest.

- ~~A~~ ~~AP~~

(b)(6)

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

Bed 6

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
DCCF

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

URE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 519 (13)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

NSN 7540-01-165-7294 519-30

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

PCxR

AGE | SEX | SSN (Sponsor) | WARD/CLINIC: ICU #6 | REGISTER NO.

FILM NO.

PREGNANT ☒ YES ☐ NO

REQU (b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

DATE REQUESTED

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

Low SpO², 2 x chest tubes to water seal

DATE OF EXAMINATION *(Month, day, year)* | DATE OF REPORT *(Month, day, year)* | DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

- d/w pneumo pericardium

- multi-lobar pneumonia

- subcut air (L) > Rt chest.

(b)(6)

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE

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

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
CF

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 519 (Rev. 3-93)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

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)

UNKNOWN, UNKNOWN

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 18 JUL 05 — TIME OF ORDER: 0730 HOURS — LIST TIME ORDER NOTED AND SIGN

1. NS 1L Bolus via Cordis now.
2. PCXR – now.

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 18 Jul — TIME OF ORDER: 0745 HOURS

2 amps NaHCO3 now

A Fentanyl 100 to 50mcg IV Q8°

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 18 JUL 05 — TIME OF ORDER: 1012 HOURS

1. Insulin Regular 10 units IV now
2. Calcium Gluconate 10cc of 10% Soln IV now
3. Sodium Bicarbonate 44.6 mEq IV now.
4. ✓ Accucheck in 1°
5. [illegible]
6. BMP Q4 x 3

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

NURSING UNIT	ROOM NO.	BED NO.

18 Jul — 1430 HOURS

Bolus 1000cc NS

(b)(6)

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

DATE OF

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)

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
June 05	0200 HOURS	

Change IV To
D5W @ 3 Amps NaCa @ 125 cc/hr.
Clears Chem 12 CBAY, CBC
at 0430
Calcium Chloride (b)(6)
2 Amps IV Now.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
18 June 05	0200 HOURS	

Serum 2 amps NaCa Now
Vent Severity Changes:
PEEP 18? TV 800 Rate 16
(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
18 June 05	0600 HOURS	

(b)(6)

2 amps Tham 500 mg IV q8"
Flagyl 500 mg IV q6"

UNKNOWN
M O DETAINEE
BCCF

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

24° Chart @ 0500 18 JUN 05

(b)(6)

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
18 JUN 05	0704 HOURS	

(b)(6)

MAGNESIUM SULFATE 4G IVPB 0740
CALCIUM GLUCONATE 10cc of 10% SOLN IV. 07
BMP, ABG ~ Now 0730
(5) (4) TRANSFUSE 4 UNITS of FFP #1 0715 #2 0730 #3 0745

UNKNOWN, UNKNOWN
M O DETAINEE
BCCF

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

(b)(6)

(b)(6)

Chart @ 19 Jun 1200

(b)(6)

49

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

FOR OFFICIAL USE ONLY - Law Enforcement Sensitive

EXHIBIT 3

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

(b)(6)

BCCF M O DETAINEE

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | LIST T ORDE NOTED SIGN

18 June 05 0130 HOURS

Admit ICU GSW (R) Chest / Hip (R)

Cytoxdal

NKDA

NPO

IV: NS @ 125 cc/hr

Vent Settings TV: 700 PEEP 5

FIO2 100% Stress dose steroids has been initiated

DATE OF ORDER | TIME OF ORDER

18 June 05 0130

Meds

Fentanyl 50-100 mcg

Fentanyl 50-100 mcg IV q 1-2 hours

Titrate To effect

Versed 1-5 mg / hour IV

Titrate To effect

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

18 June 05 0130 HOURS

Vecuronium 1 mg / kg / hour

Titrate to TT / IV TOF

Unasyn 3 gm IV q 6°

AM Labs

CBC Bmp Chem 12

(Calcium, PO4, Mag levels)

UNKNOWN, UNKNOWN M O DETAINEE

BCCF

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

18 June 05 0130 HOURS

NG To Suction

OGTs To Suction

Central Line Care

UNKNOWN, UNKNOWN M O DETAINEE

BCCF

NURSING UNIT | ROOM NO. | BED NO.

Chest X 18 June 1/00

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

150

EXHIBIT 3

Baghdad Central Detention Facility Hospital — **LABORATORY RESULTS FORM** (Subject to Privacy Act of 1974)

LAST, FIRST, MI: UNK UNK	X Male / Female	SSN/ISN: (b)(6)	Signs and Symptoms: Respiratory arrest
Physician (b)(6) / Drawn by	Ward: ICU / Bed: 6	X STAT / Routine	Specimen Date and Time: 26 June 0707
Reported by: (b)(6)			Date and Time: 26 June 0707

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

X	TEST	RESULT	REF. RANGE
	ALB	<1.0 L	3.3-5.5 g/dL
	ALP	117	26-184 U/L
	ALT	6 L	10-47 U/L
	AMY	210 (H)	14-110 U/L
	AST	17	11-38 U/L
	Tbil	0.5	0.2-1.6 mg/dL
	BUN	[illegible] (H)	[illegible]
	Ca	7.6 L	8.0-10.3 mg/dL
	Chol	95 L	100-200 mg/dL
	CK	286	M: 39-380 U/L F: 30-190 U/L
	CL	114 (H)	98-109 mmol/L
	TCO2	20	18-33 mmol/L
	Creat	1.8 (H)	0.6-1.3 mg/dL
	GGT	[illegible]	[illegible] U/L
	Glu	157 (H)	73-118 mg/dL
	K	[illegible] (H)	[illegible] mmol/L
	TProtein	4.1 L	6.4-8.1 g/dL
	Na	143	128-145 mmol/L
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5
	Mono	NEG	Negative
	H.pylori IgG	~~NEG~~ POS	Negative
	RPR	NEG	Negative
	HCG (or urine)		Negative
	HIV (Purple Top)		Negative
	Strep A		Negative
	DOA (urine)		Negative
	Chlamydia		Negative
	Flu A&B		Negative
	C. difficile (stool)		Negative
	O&P (stool)		No Ova / Parasite
	OccBld		Negative
	Wet Mount		Negative
	KOH		Negative

X	TEST	RESULT	REF. RANGE
H	WBC	25.0	4.8-10.8 x10(3)/uL
L	RBC	2.87	4.2-6.1 x10(6)/uL
L	Hgb	8.7	12.0-18.0 g/dL
L	Hct	28.0	M: 42.0-52.0% F: 37-47%
	MCV	96.4	80.0-99.0 fl
	MCH		27.0-31.0 pg
L	MCHC	31.2	33.0-37.0 g/dL
	Plt	184	130-400 x10(3)/uL
L	LY%	10.7	20.0-44.0%
	LY#	2.2	0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph: Diff to be Done within 24 hrs.

Plt Abn Morph:

WBC Abn Morph:

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen
Sed Rate		1hr = 0-20 mm
PT	21.7	7.0-14.0 sec
H APTT	66.8	21.0-50.0 sec
INR	2.2	0.5-1.5/therap 2-3
D-Dimer		Negative
H Myoglobin	7500	0-107 ng/mL
CK-MB	1.4	0-4.3 ng/mL
Troponin	0.34	0.0-0.4 ng/mL
Hemoglobin S		Negative

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

Urinalysis

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

Urine Microscopic

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

Other Tests Requested:

Critical! AB <1.0 / LM 7500 / AMY 210 (b)(6)

EXHIBIT 3

Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)

X Male / Female — SSN or ISN: (b)(6)

Physician: (b)(6) — Ward: ICU

Drawn by: — Bed: 6

X Routine / STAT — Specimen Date and Time: 26 June 05 0500

Signs and Symptoms:

Reported by: (b)(6) — Date and Time: 26 Jun 0636

Chemistry

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

Urinalysis

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

Urine Microscopic

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

Other Lab Tests

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	TBil		0.2-1.0 mg/dL
X	BUN	24H	7-22 mg/dL
X	Ca	7.9L	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
X	CL	113H	98-109 mmol/L
	TCO2	37H	18-33 mmol/L
X	Creat	1.6H	0.6-1.3 mg/dL
	GGT		5-85 U/L
X	Glu	152H	73-118 mg/dL
X	K	5.2H	3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
X	Na	151H	128-145 mmol/L
	HDL Chol		30-75 mg/dL
	LDL Chol		50-150 mg/dL
	Triglycerides		50-200 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Other Lab Tests

	Mono		Negative
	H.pylori IgG		Negative
	RPR		Negative
	HCG (or urine)		Negative
	HIV (Purple Top)		Negative
	Strep A S		Negative
	DOA (urine)		Negative
	Chlamydia		Negative
	FluA&B		Negative
	C. difficile (stool)		Negative
	O&P (stool)		No Ova / Parasite
	OccBld		Negative
	Wet Mount		Negative
	KOH		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	29.6H	4.8-10.8 x10(3)/uL
	RBC	3.30 L	4.2-6.1 x10(6)/uL
	Hgb	10.3L	12.0-18.0 g/dL
	Hct	31.9L	M: 42.0-52.0%
			F: 37-47%
	MCV	96.6	80.0-99.0 fl
	MCH	31.3H	27.0-31.0 pg
	MCHC	32.4L	33.0-37.0 g/dL
	Plt	193	130-400 x10(3)/uL
	LY%	5.1 L	20.0-44.0%
	LY#	1.5	0.7-4.3 x10(3)/uL
	Differential		
	Segs(50-70%)	85	Mono(4-10%) 7
	Bands(1-10%)	6	Eos(0-4%)
	Lymph(20-44%)	3	Baso(0-2%)
	Atyp Ly		Immature cells
	RBC Abn Morph:		
	Plt Abn Morph:		
	WBC Abn Morph:		

Other Lab Tests

	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen
	Sed Rate		1hr = 0-20 mm
	PT	17.3	7.0-14.0 sec
	APTT	84.7	21.0-50.0 sec
	INR	1.7	0.5-1.5/therap 2-3
	D Dimer		Negative
	Myoglobin		0-107 ng/mL
	CK-MB		0-4.3 ng/mL
	Troponin-I		0.0-0.4 ng/mL
	Hemoglobin S		Negative

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis test (CS

Critical Results given to (b)(6)

NSN 7540-01-165-7294

519-3

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

NON CONTRAST
CT SCAN OF CHEST

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

WARD/CLINIC: ICU

REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☑ NO

REQUESTED BY (Print) (b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

DATE REQUESTED: 21 JUN 05

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

R/O PULMONARY PERICARDIUM

DATE OF EXAMINATION (Month, day, year) | DATE OF REPORT (Month, day, year) | DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

- c/w pneumo pericardium.
- multilobar pneumonia.
- prox post ⓛ pl drain in lat chest soft tissue.

(b)(6)

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

(b)(6)

UNKNOWN
M O DETAINEE
PCCF

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 519 (83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

EXHIBIT 2

NSN 7540-01-165-7294 519-30

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED: CXR

AGE | SEX | SSN (Sponsor) (b)(6) | WARD/CLINIC: ICU | REGISTER NO.

FILM NO.

PREGNANT: ☐ YES ☒ NO

REQUESTED BY (Print): (b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR: (b)(6)

DATE REQUESTED: 20 JUN @ 200[illegible]

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

DATE OF EXAMINATION (Month, day, year) | DATE OF REPORT (Month, day, year) | DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

multilobar pneumonia (ant.

(L) cat chest not well seen.

(b)(6)

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

Bed 4

(b)(6)

UNKNOWN, UNKNOWN
N O DETAINEE
ICCF

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 519 (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

NSN 7540-01-165-7294 519-30

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

KUB

AGE | SEX | SSN *(Sponsor)* | WARD/CLINIC | REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY *(Print)* (b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR (b)(6)

DATE REQUESTED 2 15 ch

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

Had intra-abdominal packs
Make sure none are left behind

DATE OF EXAMINATION *(Month, day, year)* | DATE OF REPORT *(Month, day, year)* | DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

? Drain in pelvis.

- Shrapnel in lateral abdomen.

(b)(6)

PATIENT'S IDENTIFICATION
Name (b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
CCF

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 519 (-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

NSN 7540-01-165-7294

519-

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED: CXR

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

WARD/CLINIC: ICU

REGISTER NO.:

FILM NO.:

PREGNANT: ☐ YES ☒ NO

REQUESTED BY (Print): (b)(6)

TELEPHONE/PAGE NO.:

SIGNATURE OF REQUESTOR:

DATE REQUESTED: 21JUN05 @ 060

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

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

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

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

RADIOLOGIC REPORT

(L) thorax not fully imaged - 2 pl drain

- c/w ARDS, multifocal pneumonia

(b)(6)

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

(b)(6)

UNKNOWN, UNKNOWN
N O DETAINEE
RCCF

#6

LOCATION OF MEDICAL RECORDS:

LOCATION OF RADIOLOGIC FACILITY:

SIGNATURE:

RADIOLOGIC CONSULTATION REQUEST/REPORT
2-7 PHYSICIAN

STANDARD FORM 519 (Rev. 7-83)
Prescribed by GSA/ICMR
CFR) 41 CFR) 101-11.806-8

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

PCxR

WARD/CLINIC: ICU # 1

REGISTER NO.

FILM NO.

PREGNANT ☒ YES ☐ NO

REQUESTED BY (Print): (b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

DATE REQUESTED: 21 June

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

S/p (R) Chest tube

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

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

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

RADIOLOGIC REPORT

- (R) pl drain, B/L basilar atx/ cubeltate

- No PTX.

(b)(6)

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

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
DCCF

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 511 (157-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

NSN 7540-01-165-7294 519-30

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
[redacted]				[redacted]	
CXR	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY (b)(6)				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED 20JUN05 0600

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

[redacted] intubated

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

RADIOLOGIC REPORT

[redacted] – B/L atx us pl eff

– NGT tip @ well seen [redacted]

reject.

3 = PHYSICIAN [redacted]

(b)(6)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
(b)(6)	LOCATION OF RADIOLOGIC FACILITY
UNKNOWN, UNKNOWN M O DETAINEE CCF	SIGNATURE

#6

RADIOLOGIC CONSULTATION REQUEST/REPORT 2 APR 2003

STANDARD FORM 519-B (8-83) Prescribed by GSA/ICMR (41 CFR) 101-11.806-8

158

ACLU-RDI 5500 p.158

FOR OFFICIAL USE ONLY – Law Enforcement Sensitive

10-L-0126/ACLU CID ROI 7006

EXHIBIT 3

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED: CXR

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

WARD/CLINIC: ICU

REGISTER NO.

FILM NO.

PREGNANT: ☐ YES ☒ NO

REQUESTED BY (Print): (b)(6)

TELEPHONE/PAGE NO.

DATE REQUESTED: 19 JUN 04 AM

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

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

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

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

RADIOLOGIC REPORT

- New pl drain on (R), Bibasilar atx.

- Tubes / lines unremarkable.

(b)(6)

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

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
CCF
Bed 6

LOCATION OF MEDICAL RECORDS

TION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 516 (Rev. 5-83) Prescribed by GSA/ICMR (41 CFR) 101-11.806-8

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: Unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 19 Jun 05

DATE AND HOUR REQUIRED: 19 Jun [illegible]1000

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN *(Print)*: (b)(6)

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P GSW to back

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)

DATE VERIFIED: 19 Jun 05

TIME VERIFIED: [illegible]

(b)(6)

SECTION II – PRE-TRANSFUSION TESTING

(b)(6) TRANSFUSION NO. 2

Exp. 22 Jun 2005

(b)(6)

DONOR	RECIPIENT
ABO: B	ABO: B
Rh: POS	Rh: POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: PA

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 19 Jun 05

REMARKS: No antibody screen performed

Immediate Spin Crossmatch Only

(b)(6)

SECTION III – RECORD OF TRANSFUSION

(b)(6)

AMOUNT GIVEN: 330 ML

TIME/DATE COMPLETED/INTERRUPTED: 20 June at 1220

AT (Hour): 1020 ON (Date): 20 Jun 05

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100.8	140	120/66

IDENTIFICATION

I have examined the Blood Component container label and this form and have compared the information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

1st VERIFIER: (b)(6)

2nd VERIFIER: (b)(6)

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

PRE-TRANSFUSION

TEMP.	PULSE	BP
101.3	130	160/60

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)*

DATE OF TRANSFUSION: 20 June 05

TIME STARTED: 1030

SIGNATURE: (b)(6)

PATIENT IDENTIFICATION—USE EMBOSSER (For hand printing—Last, first, middle; grade; rank;

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
PCCF

SEX: M

WARD: ICU #6

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

SF/DA/AD FORM 518 (REV. 6-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

160

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I - REQUISITION

COMPONENT REQUESTED (Check one)

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) _____

VOLUME REQUESTED (If applicable): 1 unit _____ ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 19 JUN

DATE AND HOUR REQUIRED: [illegible]

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN (Print): (b)(6)

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P GSW to Back

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)

DATE VERIFIED: 19JUN05

TIME VERIFIED: 0850

SECTION II - PRE-TRANSFUSION TESTING

UNIT NO.: # (b)(6)

PATIENT NO.: (b)(6)

TRANSFUSION NO.: 1

Exp 22 Jun 2005

DONOR	RECIPIENT
ABO: B	ABO: B
Rh: POS	Rh: POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: PA

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 19 Jun 05

REMARKS: No antibody screen performed Immediate Spin crossmatch only

SECTION III - RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY: (b)(6)

AT (Hour): 0820 ON (Date): 20 Jun 05

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

VERIFIED BY: (b)(6)

2nd VERIFIER (Signature): (b)(6)

PRE-TRANSFUSION: TEMP. 100.3 | PULSE 130 | BP 147/78

DATE OF TRANSFUSION: 0830 20 JUNE | TIME STARTED: 0830

AMOUNT GIVEN: 320 ML

TIME/DATE COMPLETED/INTERRUPTED: 1015 20 July 05

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
101.4	112	99/60

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [X] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)

- [X] NO
- [ ] YES (Specify)

SIGNATURE: (b)(6)

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: Name - Last, first, middle; grade; rank;

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
DCCF

SEX: M

WARD: ICU #16

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* (Units) ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested)*
- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 18 Jun 05

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION(S)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* (b)(6)

DIAGNOSIS OR OPERATIVE PROCEDURE S/P GSW Abd

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER (b)(6)

DATE VERIFIED 18 Jun 05

TIME VERIFIED 0240

(b)(6)

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)

TRANSFUSION NO. 5

PATIENT NO. (b)(6)

EXP: 22 Jun 05

DONOR
ABO B
Rh pos

RECIPIENT
ABO B
Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

(b)(6)

DATE 18 Jun 05

REMARKS: No antibody screen performed
Immediate Spin crossmatch only

SECTION III – RECORD OF TRANSFUSION

(b)(6)

PRE-TRANSFUSION DATA

(b)(6)

AT (Hour) 1500 ON (Date) 19 Jun 05

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature) (b)(6)

2nd VERIFIER (Signature) (b)(6)

PRE-TRANSFUSION
TEMP. 37.6 PULSE 126 BP 119/47

DATE OF TRANSFUSION 19 JUN 05 TIME STARTED 1530

POST-TRANSFUSION DATA

AMOUNT GIVEN ALL ML

TIME/DATE COMPLETED/INTERRUPTED 19 JUN 05 1610

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
37.2	115	124/64

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON ACTING ABOVE (b)(6)

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)

UNKNOWN, UNKNOWN
NO DETAINEE
CCF

SEX M WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 162 202-1

Medical Record Copy

ANESTHESIA RECORD

Procedure: Abd wound exploration / colostomy / [illegible] transverse colon resect.

	START	STOP
Anesthesia	1414	1730
Procedure	1433	1708
Room Time IN:		OUT:

Date 19 Jun 05 | OR # 1 | Page 1 of 1 | Surg (b)(6)

PRE-PROCEDURE

- ☐ Pt identified ☒ ID Band ☐ Questioned ☐ Guardian
- ☒ Chart reviewed ☐ Permit signed
- ☒ NPO since MN ☐ Full stomach
- ☐ Patient reassessed prior to anesthesia &
- ☒ Peri-operative pain management discussed with patient / guardian, plan of care completed
- Pre-Anesthetic state: ☐ Awake ☐ Anxious ☐ Uncooperative ☐ Calm ☐ Lethargic ☒ Unresponsive

PATIENT SAFETY

- ☒ Anesthesia machine # 500 checked
- ☒ Critical clinical alarms checked & activated
- ☐ Secured with safety belt ☐ Axillary roll
- ☒ Arm(s) secured on armboards L R
- ☐ Arm(s) tucked: L R ☒ Arms < 90°
- ☐ Pressure points checked, padded, monitored
- ☒ Eye Care ☒ Taped closed ☐ Ointment ☐ By surgeon ☐ Saline ☐ Goggles
- ☐ Prone - no pressure on orbits/nose/ears/genitals

MONITORS AND EQUIPMENT

- Steth: ☐ Esophageal ☐ Precordial ☐ Suprasternal
- ☒ Non-Invasive B/P ☐ V lead ECG
- ☒ Continuous ECG ☐ ST / Dysrhy analysis
- ☒ Pulse oximeter ☐ Nerve stimulator
- ☐ Facial
- ☒ Oxygen monitor
- ☐ ET agent analyzer ☐ Fluid / Blood warmer
- ☒ Temp nasopharyngeal ☐ Cell Saver ☐ BIS
- ☐ Body warmer ☐ TEE ☐ ICP
- ☒ Airway humidifier ☐ CPB ☐ EEG
- ☐ Evoked potential
- ☒ NG / OG tube
- Foley ☐ OR ☒ Ward ☐ Doppler
- ☒ Arterial line ® radial
- ☒ C-line/CVP ® SCV TLC
- ☐ PA line
- ☒ IV(s) ® PIV, chest tubes x 2

ANESTHETIC TECHNIQUE

- GA Induction: ☒ Intravenous ☒ Pre-O₂ ☐ RSI
- ☐ Cricoid pressure ☐ Inhalation ☐ IM ☐ PR
- GA Maintenance: ☒ Inhalation ☐ Inhalation / IV
- ☐ GA / Regional combination ☐ TIVA
- Regional: Epidural - ☐ Thoracic ☐ Lumbar ☐ Caudal
- ☐ SAB ☐ Ankle ☐ Femoral ☐ Axillary ☐ Interscalene
- ☐ CSE ☐ Bier ☐ Continuous Spinal ☐ Cervical Plexus
- ☐ Other:
- Regional Technique: ☐ See remarks ☐ Local ☐ Needle ☐ LA ☐ Narcotic ☐ Additive ☐ Test dose Rx ☐ Attempts x ☐ Level ☐ Catheter ☐ Test dose response: + − L.O.R. cm Skin cm ☐ Secured
- ☐ Position ☐ Prep ☐ Site ☐ Introducer

AIRWAY MANAGEMENT

- ☒ Oral ETT ☐ RAE ☐ LTA ☐ Magill forceps
- ☐ Nasal ETT ☐ LMA #
- ☐ Stylet ☐ LMA Fastrach #
- ☐ DL ☐ LMA ProSeal #
- Tube size 7.5 ☐ FOI ☐ Awake
- ☐ Blade: in situ ☐ Laser ETT ☐ LIS
- ☐ Attempts x ☐ EMG ETT ☐ Bougie
- ☐ Grade I II III IV blind ☐ Armored ETT ☐ TTJV
- ☐ Atraumatic intubation/LMA ☐ DLT
- ☒ Secured at 24 cm ☐ Bronchial blocker system
- ☐ ET CO₂ present
- ☐ Breath sounds = bilateral ☐ Rigid FO laryngoscope
- ☐ Cuffed - min occ pressure
- ☐ Uncuffed ETT - leaks at cm H₂O ☐ Nerve blocks / Topical / Nebulizer - See Remarks
- ☐ Oral airway ☐ Nasal airway ☐ Bite block
- Mask vent. ☐ Easy ☐ Head-tilt ☐ Max jaw-thrust ☐ Cannot Ventilate
- Circuit ☐ Circle system ☒ NRB ☐ Bain
- ☐ Mask case ☐ Via tracheotomy / stoma
- ☐ Nasal cannula ☐ Simple O₂ mask ☐

AGENTS

Time: 1415 ... 1430 ... 1500 ...

Agent													TOTAL
☐ Des ☒ Iso ☐ Sev ☐ Hal (ET%)	1.6	1.0	0.8	1.5	1.5	1.5	1.0	1.0	1.0	0.8	0.6	0.6	
☐ N₂O ☐ Air (L/min)													
Oxygen (L/min)	4	1	1	1	1	1	1	1	1	1	1	1	
Versed (mg)	5												5 mg
Vecuronium (mg)	10												
Fentanyl (mcg)	250	250				150 / 50		150	> 50	100			1000 mcg
Calc. (mg)	100	100	100	100	100	100	100	100	100				

FLUIDS

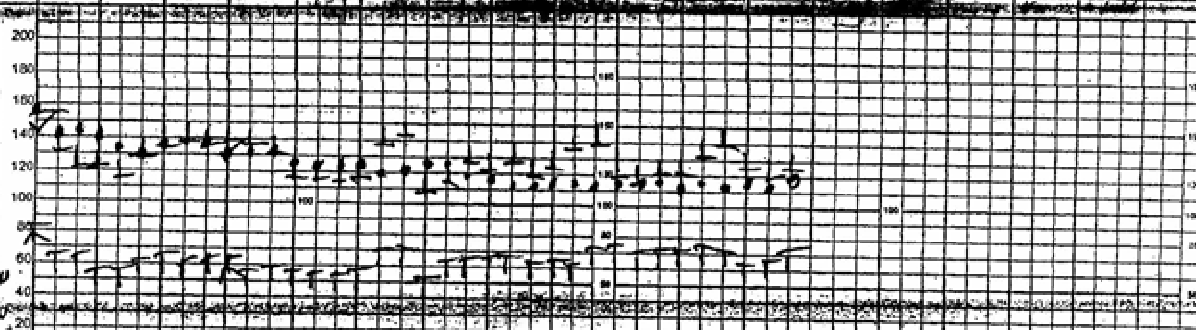
Fluid		TOTAL
NS / 5% ALB	500 / 500	1000 NS /
Prednisolone? / [illegible]	150 ... 410 ... 150 ... 125	
PRBC		1 unit PRBC

OUTPUT

Output (ml)		TOTAL
Urine - Foley	100 ... 250 ... 350	450
EBL	150 ... 250 ... 300	350
Gastric - NG	scant ... 15	50

MONITORS

ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST
% Oxygen Inspired (FiO₂)	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
O₂ Saturation (SaO₂)	94	96	98	98	98	98	99	99	100	100	100	100
End Tidal CO₂	38	31	32	31	31	31	31	31	31	32	31	31
Temp ☒ C ☐ F	38.4	38.2	38	37.9	37.7	37.5	37.4	37.4	37.2	37.1	37	36.8
TOF	4/4									4/4		



Symbols: ∨ ∧ B/P cuff pressure; ↓ ↑ arterial line; X mean arterial pressure; • pulse. Ventilation: O / SV spontaneous; Ø / AV assisted; ⊠ / CV controlled. Tourniquet. Sedation.

Preoperative Vital Signs: Pulse 158 | Resp | BP 135/82 | Temp | Sat 93-95

VENT

Tidal Volume (ml)	790	790	780	790	810	770	790	810	780	750	760	780
Respiratory Rate	15	15	15	15	15	15	15	15	15	15	15	15
Peak Pressure (cm H₂O)	32	32	32	32	32	33	32	32	32	32	33	34
☒ PEEP ☐ CPAP (cm H₂O)	5	5	5	5	5	5	5	5	5	5	5	5

Symbols for Remarks

Position

PROVIDER (b)(6)

Patient Identification (Addressograph Card)

(b)(6)

Remarks:
OR - AA via ETT, monitors, VS / APRBC per surg request. Surg aware of H/H. To ICU ventilated c 100% O₂ monitored

10 66383

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FOR OFFICIAL USE ONLY / Law Enforcement Sensitive

10-L-0126 ACLU CID ROI 7011

EXHIBIT 3

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA stretcher BY (b)(6)

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)

3. DATE 19 JUN 05 TIME PATIENT ARRIVED IN SUITE 1415

4. PATIENT IN ROOM TIME 1415 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☒ OTHER (Specify) Intubated

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)	RELIEF SCRUB	
ASSIGNED CIRCULATOR	(b)(6)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: safety strap over thighs, pillow under knees

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO

DONE BY: ☒ OR (b)(6) ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: ABDomen, no nicks or cuts noted

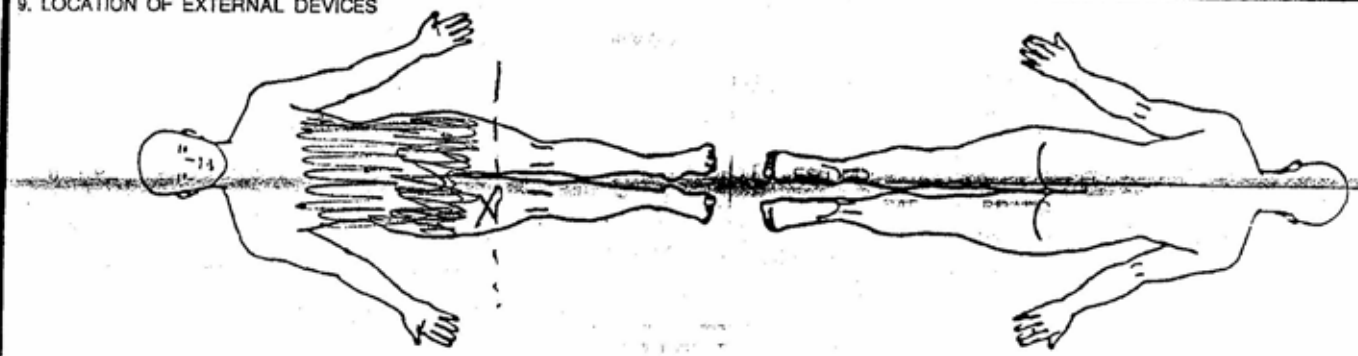
PREP SOLUTION (Specify) Betadine

SITE: ABDomen

BY WHOM: (b)(6)

COMMENTS: No pooling of solutions

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap ═══ Tourniquet

C = Correct I = Incorrect

10. COUNTS	Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge ☐ Yes ☐ No	C	C	C	(b)(6)	(b)(6)
Needle Sharp ☐ Yes ☐ No	C	C	C		
Instrument ☐ Yes ☐ No	C	C	C		
Other ☐ Yes ☐ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

(b)(6)

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☐ ESU NO: (b)(6)

GROUND PAD: BRAND Valley Lab

LOT NO: (b)(6)

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE.

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) _____

VOLUME REQUESTED (If applicable): 1 unit ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 18 JUN 05

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN (Print): (b)(6)

DIAGNOSIS OR OPERATIVE PROCEDURE: SP GSW Abd

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)

DATE VERIFIED: 18 JUN

TIME VERIFIED: 0740

(b)(6)

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6) EXP: 22JUN05

TRANSFUSION NO.

PATIENT NO. (b)(6)

DONOR ABO: B Rh: POS

RECIPIENT ABO: B Rh: POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	COMP

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD (b)(6)

DATE 18JUN05

REMARKS: No antibody screen performed Immediate spin crossmatch only

(b)(6)

SECTION III – RECORD OF TRANSFUSION

(b)(6)

DATA

18 JUN 05

label and this form and I find all ded recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature) (b)(6)

2nd VERIFIER (Signature) (b)(6)

PRE-TRANSFUSION
TEMP. 101 | PULSE 144 | BP 91/64

DATE OF TRANSFUSION: 19JUN05 | TIME STARTED: 0910

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; (b)(6)

UNKNOWN UNKNOWN
NO DETAINEE
RCCF

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED: 19JUN05 1100

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	99	118	92/64

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
[ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
[X] NO [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)

SEX: M | WARD: ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy 165

NSN 7540-01-165-7294 519-3

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
PCXR				ICU #6	
	FILM NO.				PREGNANT ☒ YES ☐ NO
	REQUESTED BY (Print) (b)(6)				TELEPHONE/PAGE NO
	SIGNATURE OF REQUESTOR				DATE REQUESTED

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

Line Placement

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)

RADIOLOGIC REPORT

- Tube / line in good position.

- Swan-Ganz [illegible] at possibly inside chest cavity (L) mid lung region & (R) supraclav region.

(b)(6)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
(b)(6)	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

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RADIOLOGIC CONSULTATION REQUEST/REPORT 2 PHYSICIAN

STANDARD FORM 519-B (8-83) Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.806-8

EXHIBIT 3

NSN 7540-01-165-7284

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

CXR - Portable Pelvis - AP

KUB

AGE | SEX | SSN (Consrd) (b)(6) | WARD/CLINIC ER-I

FILM NO.

PREGNANT ☐ YES ☐

REQUESTED BY (Print) (b)(6)

TELEPHONE/PAGE NO.

DATE REQUESTED 18 JUN 05

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

Csw Chest / Pelvis

DATE OF EXAMINATION (Month, day, year)

DATE OF REPORT (Month, day, year)

DATE OF TRANSACTION (Month, day, year)

RADIOLOGIC REPORT

CXR: Tubes / lines unremarkable. pelvic contusion / hemorrhage (L) lung. Likely intrathoracic stomach (L); subcut air (L) chest

(b)(6)

KUB: possible retained sponge (L) hemi abdomen. Likely intra-abd stomach

Old healed fx (L) pubic / ischial rami

w/ angulation.

(b)(6)

PATIENT'S IDENTIFICATION (For typed or written entries give. Name - last, first, middle, Medical Facility)

(b)(6)

UNKNOWN K 0 DETAINEE

CCF

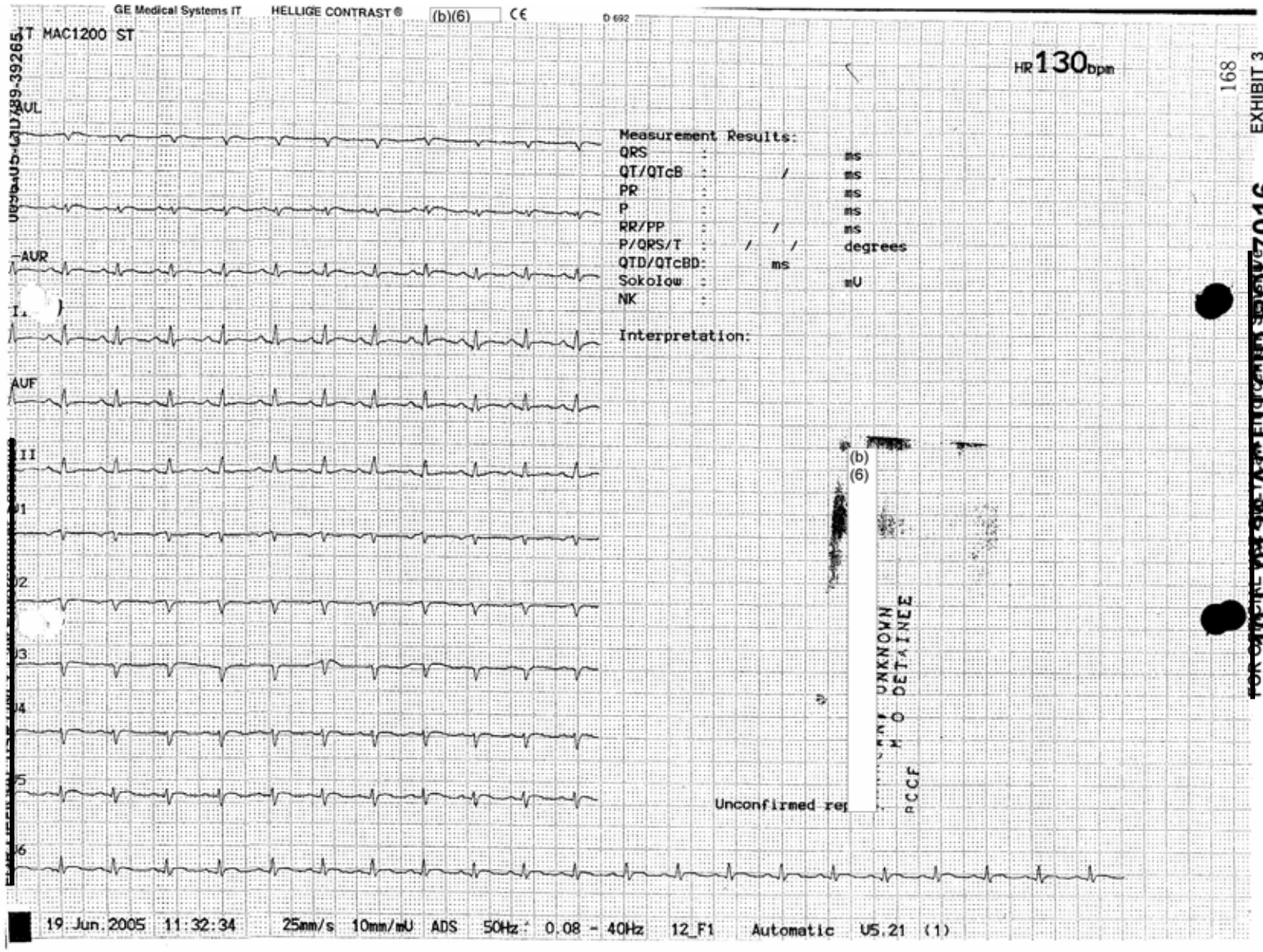
LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 5...


GE Medical Systems IT
HELLIGE CONTRAST®
(b)(6)
CE
D 692
IT MAC1200 ST
HR 130bpm
168
EXHIBIT 3
10-L-0126 ACLU CID ROI 7016
Measurement Results:
QRS : ms
QT/QTcB : / ms
PR : ms
P : ms
RR/PP : / ms
P/QRS/T : / / degrees
QTD/QTcBD: ms
Sokolow : mU
NK :
Interpretation:
(b)
(6)
UNKNOWN
DETAINEE
ACCF
Unconfirmed rep
19 Jun 2005 11:32:34 25mm/s 10mm/mU ADS 50Hz 0.08 - 40Hz 12_F1 Automatic V5.21 (1)

DETAINEE PERSONNEL REPORT

For use of this form, see AR 190-8; the proponent agency is OD[illegible]OPS

PART I - TO BE COMPLETED AT TIME OF PROCESSING

CARD I	1. INTERMERNT SERIAL NO. (1-13) (b)(6)	2. NAME (Last, first, middle (14-34) UNKNOWN,UNKNOWN UNKNOWN	3. RANK (35-37)

4. ENEMY SVC NO (38-46) (b)(6)	5. TYPE (47)	6. DATE OF CAPTURE (48-53) 2005(b)(6	7. DATE OF BIRTH (54-59) 2005/(b)(6

8. NATIONALITY (60-61) IZ-Iraq	9. EDUCATION (62)	10. RELIGION (63-64)	11. MARSTA (65)	12. PW CAMP UIC WYTNAA	13. PW PROCESS DT 2005/(b)(

CARD II (Keypuncher will pick up item 1 above)	14. SEX (14) M	15. LANGUAGE I (15-16)	16. LANGUAGE II (17-18)

17. PHYSICAL CONDITION (19) G-GOOD	18. PW CAMP LOCATION (20-22)	19. ENEMY UNIT (23-24)

20. ARM OF SVC (35)	21. MOSC (36-39)	22. CIVILLIAN OCCUPATION (40-45)	23. UIC-CAPTURE UNIT (46-51) UNKNOWN

24. CORPS AREA OF CAPTURE	25. PLACE OF CAPTURE UNKNOWN	26. POWER SERVED IZ-Iraq	27. PLACE OF BIRTH

28. ADDRESS TO WHICH MAIL FOR PW MAY BE SENT (b)(6)	29. FATHER/STEPFATHER ,
	30. MOTHER'S MAIDEN NAME ,
31. PERMANENT HOME ADDRESS OF PW	32. NAME, ADDRESS, AND RELATIONSHIP OF PERSON TO BE INFORMED OF CAPTURE
33. OTHER PARTICULARS FROM ID CARD 44336NP	34. DISTINGUISHING MARKS

35. IMPOUNDED PERSONAL EFFECTS AND MONEY (IAW AR 37-36)

THE ABOVE LIST OF IMPOUNDED ITEMS IS CORRECT _____

(Signature of Detainee)

36. REMARKS NO PAPERWORK, PROCESSED AS PER TF 134	37. PHOTO (b)(6)
38. PREPARED BY (Individual and unit) (b)(6)	39. SIGNATURE _____

40. DATE PREPARED 2005(b)(6	41. PLACE APO AE 09342

DETAINEE PERSONNEL REPORT

For use of this form, see AR 190-8; the proponent agency is OD[illegible]OPS

PART II - TO BE MAINTAINED BY UNIT HAVING CUSTODY

42a. LAST NAME	b. FIRST NAME
UNKNOWN	UNKNOWN

43. INTERNMENT SERIAL NUMBER

(b)(6)

44. MEDICAL RECORD

a. IMMUNIZATION (Vaccinations and Innoculations with Dates)

b. MAJOR ILLNESSES AND PHYSICAL DEFECTS (With Dates)	c. Blood Group

45. INTERNMENT EMPLOYMENT QUALIFICATIONS

46. SERIOUS OFFENSES PUNISHMENTS AND ESCAPES (With Dates)

47. TRANSFERS

FROM (Location)	TO (Location)	DATE

48. REMARKS

49. FINANCIAL STATUS AT TIME OF FIRST INTERNATIONAL TRANSFER

a. CERTIFICATE OF CREDIT BALANCE ISSUED TO EPW (Amount in words)	b. AMT IN FIGURES
c. LOCATION	d. DATE

50. FINANCIAL STATUS AT TIME OF SECOND INTERNATIONAL TRANSFER

a. CERTIFICATE OF CREDIT BALANCE ISSUED TO EPW (Amount in words)	b. AMT IN FIGURES
c. LOCATION	d. DATE

51. REPATRIATION

a. Reason

b. MODE	c. DATE

52. FINANCIAL STATUS AT TIME OF REPATRIATION

a. CERTIFICATE OF CREDIT BALANCE ISSUED TO EPW (Amount in words)	b. AMT IN FIGURES
c. LOCATION	d. DATE

Fluid: 3 L N/S or LR time unknown
1 L N/S or LR time 2200
1 L N/S or LR time

Fluid: 500 cc Hetastarch time
500 cc Hetastarch time
500 cc Hetastarchtime

MEDICATIONS	Dosage	Route	Time
Morphine			
Morphine			
Morphine			
Fentanyl		IV	
Fentanyl		IV	
Cefazolin/ Ancef	1 gm	IV	
Invanz/ Ertapenem	1 gm	IV	
Clindamycin	900 mg	IV	
Levaquin	500 mg	IV	
Tetanus Toxoid	0.5 cc	IM	2127
Succinylchloine	200mg	IV	2141
Etomidate		IV	
Vecuronium	10 mg	IV	2146
Vecuronium		IV	
Versed		IV	
Versed		IV	
Ketamine		IV	
Ketamine		IV	
Robinul		IV	
Reglan	10 mg	IV	2137
Amidate	20mg	IV	2140
Versed	2mg	IV	2149

Vitals Time	Pulse	B/P	RR	02 @ L/min RA FM BVM ET
2133	104	131/44	18	18 NRB
2137	130	90/60	39	85%
2140	125	90/60	37	96%
2144	148	100/100	19	78%
2147	148	135/90	17	98%
2150		90 systolic		

Blood: Yes or No O- / O- Unit 1 time ____ Unit 2 time ____

Wound location: ____ Washout- 1 L N/S time ____ 1 L N/S time ____ 1 L N/S time ____
Wound location: ____ Washout- 1 L N/S time ____ 1 L N/S time ____ 1 L N/S time ____
Wound location: ____ Washout- 1 L N/S time ____ 1 L N/S time ____ 1 L N/S time ____

EPW

Providers Notes:
GSW to Back and (R) hip. GCS 10 [illegible] Seen @ local hospital first had blood NS then Chest tube c 2,500 cc blood return. Intubated at Charlie Med c (+) capnometry. (+) Tender BD

A) GSW to Back c hemopneumo
(R) hip GSW
(P) Transport to IQ for Surgical eval

(b)(6)

VE Category: Urgent Surgical Urgent Medical Priority Routine RTD
VE Destination: (b)(6)

Standard Form 517

TQ SURGICAL CLINICAL RECORD

ANESTHESIA

ANESTHETIC(S)

ET ISO

O2 FLOW

FIO2

O2 SAT

ETCO2

EKG

TEMP

CODE
- ● PULSE
- ○ RESP.
- V ^ B. P.
- X ANES.
- ⓞ OPER.
- T TOURN.

FLUIDS
- B BLOOD
- N SALINE
- G 5% G/W
- DX EXPAND.

NUMBERS FOR REMARKS

IV FLUIDS

TIDAL VOL
RESP RATE
PEAK PRESSURE

AGENTS AND TECHNICS

REMARKS

ENDOTRACHEAL: SIZE 7.5 BLADE ..... ORO ..... NASO ..... CUFF ..... PACK .....

REMARKS: Arrived c ETT in place - placement confirmed

OPERATION PERFORMED

Exp Lap
Chest tube

TOTAL FLUIDS

NAME(S) OF SURGEON(S)

(b)(6)

RECOVERY

TIME:
HR:
BP:
RR:
T:
%SAT:

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

(b)(6)

REGISTER NO.

WARD NO. 2

DATE 6/17/05

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL REC
FPMR 101-11.806-6
OCTOBER 1975

172

- the p suffure from bullet & multiple shell ing of the back of the chest (severe inj.) & he was severly dyspneic & hypotensive (50/20). & received 3 pint of normal saline & one pint of Blood (B+).

- We put chest tube for him & drain 2500 cc of blood, also he is unconcious
- he need urgent thoracotomy.
- semiconcious.

Report

ATTACH TO PW

DATE OF CAPTURE [ ] 17 JUN05
NAME [ ]
SERIAL NUMBER [ ]
RANK [ ]
DATE OF BIRTH [ ]
UNIT [ ]
LOCATION OF CAPTURE [AR RAMADI]
CAPTURING UNIT [ ]
SPECIAL CIRCUMSTANCES OF CAPTURE [ ]

173

8CR-05-0678 292

Theater Medical Registry Record

MTF Designation:	Location:	Facility Type: ☒ Base-X ☐ GP ☐ CBPS ☐ Hard Bldg	Casualty Name (Last, First MI):	Casualty SSN:
	BSTB		EPW	- -

MTF Casualty Received From:	Rank:	Date of Birth:	Gender: ☒ Male ☐ Female	Unit:

Date/Time of Injury:	Date/Time Arrived:
DDMMMYY/TIME	DDMMMYY/TIME

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

Transit Duration Time _____

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

Category:
- ☐ Civilian
- ☐ Combatant
- ☐ Contractor
- ☐ USA
- ☐ USN
- ☐ USMC
- ☐ USAF
- ☐ SOF
- ☐ NGO (_____)
- ☐ Other (EPW)

Protection:

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

Triage Category:
- ☐ Immediate
- ☐ Expectant
- ☐ Delayed
- ☐ Minimal

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

Glasgow Coma Scale

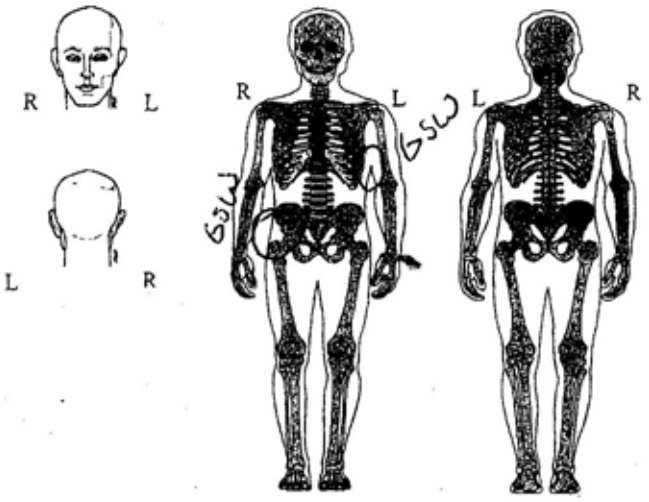
Eye Opening	Verbal Responsiveness	Motor Response
1-None	1- None	1-None
2-To pain	2-Incomp sounds	2-Extend pain
3-To command	3-Inapprop words	3-Flex to pain
4-Spont.	4-Confused	4-Withdraws
	5-Oriented	5-Localize pain
		6-Obeys

Glasgow Score_____ (Enter total number)

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

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

2230 CXR
received 2 pints of Wood 2235



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

Vitals:

Time	1915	2230	
Pulse	133	129	
Temp			
B/P	157 / 162	169 / 84	/
Resp		20	
SpO2	%	100 %	%

Tx & Procedures:

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

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

Provider: (b)(6) | Specialty: GEN. SURG. | Date: DDMMMYY

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

MEDCOM Test Form 1381, JAN 2004/Naval Health Research Center (Rev. 8/17 AUG 2004)

Treatment: DNVT 302-520
TOC: DNVT 302-521-13
Timothy.[illegible]@us.army.mil

(b)(6)

Date: 17 June 05
Time Injured: 1920
Time Arrived: 2121

MOI: GSW @ hip SI. GSW to Back
HPI:
PMH:
PSH:

Field Treatment:

MEDS:
Allergies:

Physical Exam:
Initial VS- Pulse 68 BP 80/60 RR 22 %O2 99 RA/FM/BVM@ 12 L/min NRB

Primary Survey:

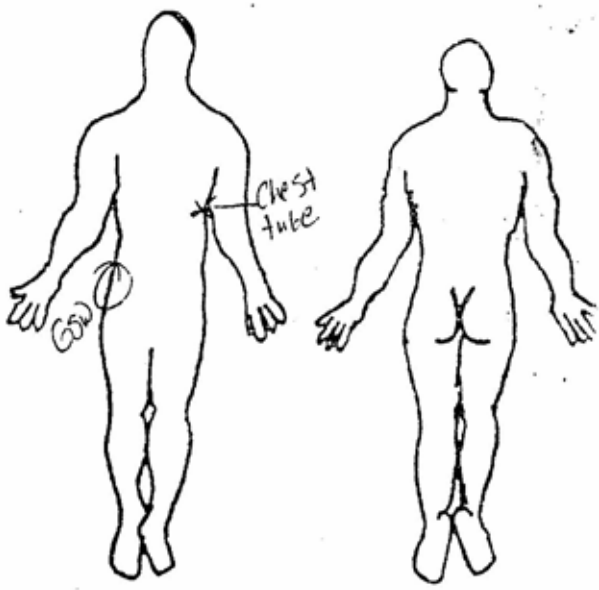
Last oral intake: (L) hand
1st IV Site (R) AC
2nd IV Site (R) AC
3rd IV Site

Airway: Patent / Mechanically supported by
Breathing: Spontaneous / Supported by
Circulation: Pulse + Carotid/ + Femoral/ + Radial/ + Dorsalis Pedis
CPR Start time: hrs.
Tourniquet Start time: hrs.

Secondary Survey:

Foley:
Yes or No
Blood: Yes or No
Urine Output: cc
Chest Tube:
Yes or No
Site: (L) Chest
Output: 2500 cc
Central Line:
Yes or No
Site: (L) Chest
Cut down:
Yes or No
Site:

Head
Neck
Chest
Back
Lungs
Heart
ABD
Pelvis
Rectal heme + or -
Extremity
Neuro



Name:
SSN:
Unit:

X-Rays:

(b)(6)

Casualty Name (Last, First MI):			Casualty SSN: - -
Medications:	Labs:	X-Rays: Chest	PMHx: Allergies: Unknown

☐ SOAP Note

Recieved "3 pint of normal Saline" 1 pint of Blood (B+)
pt recieved Chest tube + drain 2500cc of Blood

Shot when trying to evade USMC. Taken initially to Ramadi General. Per paperwork had a pressure of 50/20, (L) chest tube drained 2500cc. Given 10 PRBC, transferred to Ramadi Med. Given 20 PRBC, in total, given 2 additional units PRBC. To us via helo - taken urgently to OR. 2nd chest tube placed. Stable throughout case - SBP 130, HR 130. ? wide complex on EKG. Exp lap - Colon lac,

Region	☐ Discharge Summary Information (Diagnosis, Procedures and Complications)
Head & Neck (incl. C-Spine)	(L) renal lac. Colon resected NOT Anastomosed,
Chest (incl. T-Spine)	renal lac packed x 1 laps. Temp. abd closure.
Abdomen (incl. L-Spine)	Has hole in center of back that is juxtaspinal.
Upper Extremities	RECOMMEND CT OF CHEST
Pelvis	[redacted] last intact pedal pulses.
Lower Extremities	
Skin	

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

DNBI Category:

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

Disposition Date/Time: DDMMMYY/TIME

☑ Evacuated to BG MC CSH ☐ Light duty x ____ days
☐ RTD ☐ SIQ x ____ days
☐ Deceased - ☐ DOA ☐ DOW (see below)

Evacuation Priority: ☐ Routine ☐ Urgent Surgical ☐ Priority ☐ Convenience ☑ Urgent

Date/Time of Death: _____ DDMMMYY/TIME

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

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

Comments:

(b)(6)

ed name)

TQ SURGICAL OPERATION REPORT

(b)(6)

Primary Surgeon	1st Assistant	2nd Assistant/3rd Assistant
(b)(6)	(b)(6)	(b)(6)

Anesthesiologist/Anesthetist	Anesthesia	OR In: 2217	Start: 2231
(b)(6)	(b)(6)	OR Out:	Stop: 2330

Scrub Technician	Circulating RN	Counts: Sharps / Sponge
(b)(6)	(b)(6)	Aborted Deferred Correct
		ature:

Mechanism of Injury	Drains, Tubes, Other
GSW	foley - bladder > in place from field 36fr chest tube 36fr chest tube - (L)

Preop Diagnosis: GSW abdomen + chest

Postop Diagnosis: Same,

Procedure: (1) insertion (2) chest tube
(2) Ex lap, segmental colon resection
(3) Packing (L) kidney laceration

Complications: none

Findings: (1) perforation proximal descending colon
(2) capsular laceration (L) kidney
(3) left hemopneumothorax
(4) Frags near shoulder (R) on CXR

IVF	Blood Products	EBL	UOP
8000 CCLR	PRBC 7U PRBC	1500 cc	500 cc

Surgeon Signature	Date
(b)(6)	17 Jun 05

P SSN:

177

(b)(6)

Certificate Of Death

For use of this form, see AR 180-8, the Proponent agency is DCSOPS

Internment Serial Number

(b)(6)

To:

From:

WYTNAAAPO AE 09342

ABU GHRAIB

BAGHDAD

Name(Last, First, MI) Grade

UNKNOWN,UNKNOWN UNKNOWN

Service Number

(b)(6)

Nationality

IZ-Iraq

Power Served

IZ-Iraq

Place of Capture/Internment and Date

UNKNOWN 2005/(b)(6)

Name, Relationship, Address of Next of Kin

,APO AE 09342

ABU GHRAIB

BAGHDAD

Father's First Name

Place Of Birth:

Date Of Birth:

2005/(b)(6)

Place of Death

ABU GHRAIB,

Date Of Death

2005/(b)(6)

Cause Of Death

GUNSHOT WOUND

Place Of Burial

,

Date Of Burial

2005/(b)(6)

Identification Of Grave

Personal Effects: Please See Attached Page

Brief Details Of Death And Burial: Please See Attached Page

Do Not Write In This Space

Date

2005/(b)(6)

(b)(6)

(Seal of the Office of The Provost Marshal General)APO AE 09342

ABU GHRAIB

BAGHDAD

Signature o

Witnesse (b)(6)

Signatur ddress

Signature Address

Personal Effects And Money

Internment Serial Number (b)(6)

Property Tag	Description	Qty	Dispostition

The Above List Of Items Is Correct _____

Signature Of Detainee

Brief Details Of Death/Burial By Person Who Cared For The DeceasedDuring Illness Or During Last Moments (Doctor, Nurse, Minister of Religion, Fellow Internee). Death/Cremation Details. GUNSHOT WOUND TO LEFT THORAX AND ABDOMEN. OTHER SIGNIFICANT CONDITIONS: PNEUMOPERICARDIUM AND PNEUMOTHORAX. PRONOUNCED DEAD ON 26 JUN 05 AT 0715 HOURS.

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

ARRIVAL OF UNDOCUMENTED DETAINEE WORKSHEET

(Return this form to 306th MP BN TOC Immediately)

0046

The following detainee arrived at the BCCF at 200506 18 (DTG).

Flight Info: (At a minimum)

Flight Origin (Unit/Hospital, etc): TQ

OIC: CPT (b)(6), (b)(7)(C) POC Phone#: _____

Pilot's Name: CW2 (b)(6), (b)(7)(C) Call-Sign: (b)(6), (b)(7)(C)

Flight Tail# (if no flight info can be obtained): (b)(6), (b)(7)(C)

Flight Authorized by: TQ airboss

Detainee info:

Name: _____

ISN# (If Known): (b)(6), (b)(7)(C) DOB: _____ Age: _____

Description of Detainee: Overweight, gunshots wounds, unconcious, ventilator, chest tu

Date of Capture: 17JUN05 Capture Unit: USMC

Capture Tag#: [redacted] Hospital # 13561

POC Phone#: _____

Capture Location: Ramadi

Capture Grid: _____

Any other pertinent information that may help to identify the detainee and his capture unit: _____

(Return this form to 306th MP BN TOC Immediately)

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LAW ENFORCEMENT SENSITIVE

Document 4

EXHIBIT 181 4

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

FINAL AUTOPSY EXAMINATION REPORT

Name: Unknown
Detainee No.: (b)(6)
Date of Birth: Unknown
Date of Death: (b)(6) 2005
Date of Autopsy: 3 JUL 2005
Date of Report: 7 SEP 2005

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

Circumstances of Death: This unknown Iraqi male died in the medical treatment facility at Abu Ghraib where he was being treated for multiple gunshot wounds sustained during a hostile encounter with coalition forces.

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

Identification: No positive means of identification is available. The detainee number (b)(6) appears on paperwork and on an ID band on the left wrist of the decedent.

CAUSE OF DEATH: Gunshot Wounds of the Chest and Abdomen, with Complications

MANNER OF DEATH: Homicide

EXHIBIT 1825

FINAL AUTOPSY DIAGNOSES:

I. **Multiple Gunshot Wounds**

A. **Perforating Gunshot Wound of the Torso**
1. **Entrance: Lower left chest (24 ¼-inches below the top of the head and 3 ½-inches left of the anterior midline), ¼-inch ovoid wound with minimal marginal abrasion between 6 and 9 o'clock; no soot deposition or gunpowder stippling on the surrounding skin**
2. **Wound Path: Skin, subcutaneous tissue and muscle of the lower left chest/upper abdomen, descending colon, stomach, left kidney, lateral left 12th rib (with fracture); muscle, subcutaneous tissue, and skin of the lower left back**
3. **Exit: Lower left back (25-inches below the top of the head and 5 ½-inches left of the posterior midline), 1 ½ x 1-inch irregular, gaping defect; no bullet or bullet fragments recovered**
4. **Wound Direction: Right to left, front to back, and slightly downward**

B. **Perforating Gunshot Wound to the Lateral Right Abdomen**
1. **Entrance: Right side of the abdomen (37-inches below the top of the head and 9-inches right of the anterior midline), 3/16-inch ovoid wound with a 1/16-inch marginal abrasion between 6 and 9 o'clock; no soot deposition or gunpowder stippling on the surrounding skin**
2. **Wound Path: Skin, subcutaneous tissue, and muscle of the abdomen, small bowel and mesentery, 8th thoracic vertebra (fractured, with cord injury); muscle, subcutaneous tissue, and skin of the back**
3. **Exit: Mid back (17 ½-inches below the top of the head and ½-inch left of the posterior midline), ¾ x ½-inch defect; no bullet or bullet fragments recovered**
4. **Wound Direction: Right to left, front to back, and upward**

C. **Penetrating Gunshot Wound of the Left Shoulder**
1. **Entrance: Left shoulder (11 ½-inches below the top of the head and 9 ½-inches left of the posterior midline), 3/16-inch ovoid wound with 1/8-inch abrasion between 12 and 4 o'clock**
2. **Wound Path: Skin, subcutaneous tissue, and muscle of the left shoulder, fragmentation of the projectile with perforation of the upper lobe of the left lung, soft tissue of the left chest**
3. **Recovered: Fragments present in the left lung and along the wound path on imaging and a deformed copper colored jacket recovered from the soft tissue of the left chest wall**
4. **Wound Direction: Left to right, back to front, and downward**

5. Associated Injuries: Left hemothorax (50-milliliters)

D. Multiple Penetrating Gunshot Wounds of the Right Hip
1. Gunshot wound of the right hip that goes through skin and soft tissue (situated 31-inches below the top of the head and 10 ½-inches right of the anterior midline), ¾-inch irregular, ovoid defect; no associated exit wound, but multiple small metallic fragments present on imaging
2. Gunshot wound of the right hip that goes through skin and soft tissue (situated 34-inches below the top of the head and 11-inches right of the anterior midline), ½-inch irregular, ovoid defect; no associated exit wound, but multiple small metallic fragments present on imaging and one core fragment recovered from the right buttock
3. Gunshot wound of the right hip that goes through skin and soft tissue (situated 37-inches below the top of the head and 9-inches right of the anterior midline), ½-inch irregular, ovoid defect; no associated exit wound, but multiple small metallic fragments present on imaging

II. Other Injuries
A. Contusion of the left ventricle of the heart
B. Abrasion (1 ¾ x 1-inch) of the left side of the back
C. Laceration (1/4-inch) of the lateral aspect of the right knee

III. Diffuse alveolar damage and pulmonary edema; clinical history of multiple organ system failure

IV. Mild atherosclerotic cardiovascular disease; early cirrhotic changes of the liver

V. Early decomposition changes, including green-brown discoloration and marbling of soft tissue and skin slippage

VI. Remote gunshot wounds of the right shoulder and the left side of the face

VII. Toxicology is negative for ethanol and screened drugs of abuse. The therapeutic agent midazolam is present in liver tissue at a concentration of 0.85 mg/L. Cyanide is not detected in the blood.

EXTERNAL EXAMINATION

The remains are received nude and without any accompanying clothing. They consist of a well-developed, well-nourished, male. Early to moderate decomposition changes include green discoloration over the abdomen, marbling of the vasculature, fly eggs in the corners of the eyes, and skin slippage over the upper extremities. Rigor is present but passing. The body temperature is that of the refrigeration unit.

The scalp is covered with short, black hair in a normal distribution. The corneae are cloudy, with abundant mucous in the eyes. The sclerae are unremarkable. The irides are brown and the pupils are round and equal in diameter. The teeth are natural and in poor condition, with many upper teeth absent. Facial hair consists of a short cropped beard and mustache. A 1 ¼ x ¼-inch scar is on the left side of the face, over the mandible. Two ½-inch, round scars and a ¼-inch scar are on the anterior right shoulder.

The neck is mobile and the trachea is midline. Injuries of the torso will be described. The external genitalia are those of a normal adult, circumcised, male. The testes are descended and free of masses. Pubic hair is present in a normal distribution. The buttocks and anus are remarkable only for two scars on the posterior left buttock. The upper and lower extremities are symmetric and without clubbing or edema. The fingernails are intact. A 2 ¼-inch linear scar is on the posterior left forearm. Multiple small scars are on the posterior aspect of the right upper extremity.

MEDICAL INTERVENTION

There is a closed, midline, abdominal surgical incision (16-inches) and a colostomy in place on the right side of the abdomen. Venipuncture sites are noted on the left subclavian area, the right antecubital fossa, and right femoral areas. Two small, sutured incisions, ½-inch and ¾-inch, are on the left anterior-lateral chest. A 1-inch sutured incision is on the right anterior-lateral chest. These are consistent with prior thoracostomy tube locations and correspond to a perforation of the right chest wall below the 5th rib and two perforations of the left chest wall below the 4th rib. A surgical drain is in place, associated with the abdominal incision. A defect of the stomach has been sutured closed and a portion of the descending colon has been surgically resected.

RADIOGRAPHS

A complete set of postmortem radiographs is obtained and demonstrates the injuries as described and an absence of recoverable metallic foreign material.

EVIDENCE OF INJURY

I. Multiple Gunshot Wounds

A. Perforating Gunshot Wound of the Torso-there is an entrance gunshot wound on the left chest, situated 24 ¼-inches below the top of the head and 3 ½-inches left of the anterior midline. The ¼-inch wound has a minimal 1/16-inch abrasion between 6 and 9 o'clock. No soot deposition or gunpowder stippling is present on the surrounding skin. The wound path goes through the skin, subcutaneous tissue, and muscle of the chest and upper abdomen, the descending colon, stomach, left kidney, the lateral aspect of the left 12th rib (fractured), and the muscle, subcutaneous tissue, and skin of the lower left back.

No bullet or bullet fragments are recovered, though multiple, small metallic fragments are seen on radiographic imaging. The exit wound consists of a 1 ½ x 1-inch, irregular skin defect on the lower left back, situated 25-inches below the top of the head and 5 ½-inches left of the posterior midline. The direction of the wound path is right to left, front to back, and slightly downward.

B. Perforating Gunshot Wound to the Lateral Right Abdomen-there is an entrance gunshot wound on the lateral right abdomen, situated 32 ½-inches below the top of the head and 4-inches right of the anterior midline. The 3/16-inch ovoid wound has a 1/16-inch marginal abrasion between 6 and 9 o'clock. No soot deposition or gunpowder stippling is present on the surrounding skin. The wound path goes through the skin, subcutaneous tissue, and muscle of the abdomen, the small bowel and associated mesentery, the 8th thoracic vertebra (fractured), and the muscle, subcutaneous tissue, and skin of the back. No bullet or bullet fragments are recovered along the wound path. The exit wound consists of a ¾ x ¼-inch skin defect on the mid back, situated 17 ½-inches below the top of the head and ½-inch left of the posterior midline. The direction of the wound path is right to left, front to back, and upward.

C. Penetrating Gunshot Wound of the Left Shoulder-there is an entrance gunshot wound on the left shoulder, situated 11 ½-inches below the top of the head and 9 ½-inches left of the posterior midline. The 3/16-inch ovoid wound has a 1/8-inch marginal abrasion between 12 and 4 o'clock. No soot deposition or gunpowder stippling is present on the surrounding skin. The wound path is through skin, subcutaneous tissue, and muscle of the left shoulder, with fragmentation of the projectile and some fragments penetrating the upper lobe of the left lung. Small metallic fragments are seen on imaging and a deformed, copper colored jacket is recovered from the soft tissue of the left chest wall, within a 5 x 5-inch area of soft tissue hemorrhage. The wound path is directed left to right, back to front, and downward. There is an associated 50-milliliters of blood in the left pleural cavity, though medical intervention would have altered this from the time of the original injury.

D. Multiple Penetrating (3) Gunshot Wounds of the Right Hip-there are three entrance gunshot wounds on the right hip. The most superior is situated 31-inches below the top of the head and 10 ½-inches right of the anterior midline. The wound is a ¾-inch, irregular, ovoid defect with the wound path going through skin and soft tissue. No soot deposition or gunpowder stippling is present on the surrounding skin. The next most superior is situated 34-inches below the top of the head and 11-inches right of the anterior midline. The wound is a ½-inch, irregular, ovoid defect with the wound path going through skin and soft tissue. No soot deposition or gunpowder stippling is present on the surrounding skin. The most inferior is situated 37-inches below the top of the head and 9-inches right of the anterior midline. The wound is a ½-inch, irregular, ovoid defect with the wound path going through skin and soft tissue. No soot deposition or gunpowder stippling is present on the surrounding skin. The wound paths co-mingle through the soft tissue of the right hip and right buttock. One bullet core fragment is recovered from the soft tissue of the right buttock and there are small metallic fragments seen in the right hip and pelvis on radiographic imaging.

II. Other Injuries- A ¾ x ¼-inch contusion involves the free wall of the left ventricle of the heart. A 1 ¾ x 1-inch abrasion is on the left side of the back. There is a ¼-inch laceration on the lateral aspect of the right knee.

III. Remote Injuries-Cutaneous scars and radiographic imaging demonstrate evidence of remote gunshot wounds to the right shoulder and the left side of the face. One small metal fragment is recovered from the soft tissue adjacent to the proximal right humerus.

INTERNAL EXAMINATION

HEAD:
The scalp, skull, and brain have no evidence of acute injury. There is some softening of the brain present, due to decomposition. The brain weighs 1480-grams and sectioning reveals no parenchymal injuries and no evidence of significant natural disease processes.

NECK:
The strap muscles of the anterior neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid bone are without injury. The tongue is unremarkable. The larynx is lined by intact white mucosa. The thyroid gland is symmetric and red-brown, without cystic or nodular change.

BODY CAVITIES:
The ribs, sternum, and vertebral bodies are visibly and palpably intact. The left pleural cavity contains 50-milliliters of blood. There is no excess accumulation of fluid in the right pleural cavity or the peritoneal cavity. There are 20-milliliters of serous fluid in the pericardial sac. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 1530 and 1220-grams, respectively, and are markedly congested and firm. The external surfaces are smooth and red-purple, with injuries to the left lung as previously described. The pulmonary parenchyma is diffusely congested and exudes copious fluid upon sectioning. No mass lesions or areas of consolidation are present. The pulmonary arteries are unremarkable.

CARDIOVASCULAR SYSTEM:
The 510-gram heart is contained in an intact pericardial sac. The epicardial surface has minimal fat investment and the heart is slightly soft due to decomposition. The coronary arteries have a normal appearance and branch in a right-dominant distribution. The proximal left anterior descending coronary artery has 30 percent luminal narrowing by atherosclerosis. The thicknesses of the left ventricle, septum, and right ventricle are 1.5, 1.7, and 0.5 centimeters, respectively. The myocardium is remarkable only for the previously described contusion. The cardiac chambers and valves are grossly normal. The aorta gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 2580-gram liver has an intact capsule and a sharp anterior border. The parenchyma is tan-brown and congested with a somewhat nodular architecture. No mass lesions or other abnormalities are noted. The gallbladder contains 15-milliliters of green-black bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 430-gram spleen has a smooth, intact, red-purple capsule. The parenchyma is maroon, soft, congested, and exhibits early decomposition changes.

PANCREAS:
The pancreas is soft and exhibits changes of decomposition. The usual lobular architecture is present. No mass lesions or other abnormalities are seen.

ADRENAL GLANDS:
The right and left adrenal glands are symmetric, with yellow cortices and gray medullae. Decomposition changes are prominent. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 210 and 250-grams, respectively. The external surfaces are intact and smooth, except for the previously described injury to the left kidney. The cut surfaces are red-tan and congested, with uniformly thick cortices and distinct corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The urinary bladder is empty. The prostate gland is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, gray-white mucosa. The gastric wall has a defect that has been surgically repaired. The stomach contains 20-milliliters of light tan viscous material. The duodenum, loops of small bowel, and colon are remarkable for a previously resected descending colon and the presence of a colostomy. The appendix is present.

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

MICROSCOPIC EXAMINATION

Select portions of major organs are retained in formalin, without preparation of microscopic slides.

ADDITIONAL PROCEDURES/REMARKS

- Documentary photographs are taken by OAFME staff photographers
- Specimens retained for toxicologic testing and/or DNA identification are: heart blood, vitreous fluid, spleen, liver, lung, brain, bile, kidney, adipose tissue, and psoas muscle
- Full body radiographs are obtained and demonstrate the injuries as described
- The dissected organs are forwarded with the body
- Recovered evidence is retained to be transferred to the appropriate investigative agency
- Personal effects are released to the mortuary affairs representatives

OPINION

This male Iraqi detainee died as a result of multiple gunshot wounds with medical complications. The gunshot wounds caused injuries to the left lung, stomach, colon, left kidney, and small intestine. There was no evidence of close range discharge of a firearm associated with any of the entrance wounds, though the deceased had received extensive medical treatment and no clothing was available for examination. Projectile fragments were recovered and retained. Toxicology was positive only for a therapeutic medication. The manner of death is homicide.

(b)(6)

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

AGENT'S INVESTIGATIVE REPORT

CID Regulation 195-1

ROI NUMBER 0096-05-CID789-39265

DETAILS:

About 1100, 3 Jan 06, SA (b)(6), (b)(7)(C) received a compact disc containing autopsy photographs from the Office of the Armed Forces Medical Examiner, Armed Forces Institute of Pathology, 1413 Research Blvd, Building 102, Rockville, MD 20850. (See compact disc for details) ///Last Entry///

TYPED NAME, SEQUENCE NUMBER
SA (b)(6), (b)(7)(C), (b)(7)(F)

ORGANIZATION
76th MP Det (CID)(FWD)(-), BCCF, AGI, APO AE 09342

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

DATE
3 Jan 06

EXHIBIT

CID FORM 94-E
(Automated)

PROTECTIVE MARKING IS EXCLUDED FROM AUTOMATIC TERMINATION (Para 13, AR 34-16)

EXHIBIT 190 6

0096-05-CID789-
39265-5