DEPARTMENT OF THE ARMY
U.S. ARMY CRIMINAL INVESTIGATION COMMAND
Camp Cropper CID Office, IZ APO AE 09342

24 Nov 2006

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - FINAL/SSI - 0089-2006-CID789-78469 - 5H6

DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 15 MAY 2006, 0001 - 05 JUN 2006, 1005; INTENSIVE CARE UNIT, 21ST COMBAT SUPPORT HOSPITAL, BAGHDAD CENTRAL CONFINEMENT FACILITY, ABU GHRAIB 09342, IRAQ

2. 14 MAY 2006, 1410 - 14 MAY 2006, 1600; SOUTHERN PART OF SOUTH DAM VILLAGE, 500 METERS SOUTH OF HADITHA DAM, IRAQ

DATE/TIME REPORTED: 05 JUN 2006, 1015

INVESTIGATED BY:

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

SA

SUBJECT:

1. UNKNOWN, ; [JUSTIFIABLE HOMICIDE] (NFI)

VICTIM:

1. ISMAIL, IBRAHIM (DECEASED) ; CIV; 1 JAN 1976; IRAQ; MALE; WHITE; INTERNMENT SERIAL NUMBER (ISN) b(6), b(7)(C) XZ ; [JUSTIFIABLE HOMICIDE] (NFI)

INVESTIGATIVE SUMMARY:

"This is an Operation Iraqi Freedom Investigation"

On 5 Jun 06, this office was notified by SSG b(6), b(7)(C), Patient Administration Division (PAD), 21st Combat Support Hospital (CSH), Baghdad Central

Confinement Facility (BCCF), Abu Ghraib, Iraq (AGI) of a detainee death.

Investigation revealed Mr. ISMAIL received his injuries as a result of combat contact with U.S. Forces when he was observed attempting to place an Improvised Explosive Device (IED) at a known IED site with two other individuals and was subsequently engaged by the U.S. Forces according to their Rules of Engagement. On 15 May 06 Mr. ISMAIL was admitted to the Intensive Care Unit, 21st CSH, suffering from a gunshot wound. According to MAJ (DR) b(6), b(7)(C) 21st CSH, AGI, Mr. ISMAIL was treated from 15 May 06 to 5 Jun 06, for a gunshot wound to the abdomen when he began suffering from acute Respiratory Distress Syndrome which lead to multiple organ failure as a result of complications from the gunshot wound. The manner of death is listed as justifiable homicide.

STATUTES:

N/A

EXHIBITS/SUBSTANTIATION:

Attached:

1. Agent's Investigation Report (AIR) of SA b(6), b(7)(C) 7 Jun 06, detailing the initial notification, interview of medical personnel, collection of detainee records of Mr. ISMAIL, and collection of death certificate and medical records.

2. Photographic Packet containing 10 photographs.

a. Packet containing photographs 1-10 (Mr. ISMAIL).

3. Detainee Information Sheet (DIS) pertaining to Mr. ISMAIL, 5 Jun 06.

4. Medical Records and Preliminary Death Certificate pertaining to Mr. ISMAIL, various dates.

5. Capture Paperwork, 14 May 06, pertaining to Mr. ISMAIL.

6. AIR of SA b(6), b(7)(C) 76th Military Police Detachment (CID), Camp Slayer, Iraq APO AE 09342, 10 Jun 06, detailing attending the autopsy.

7. Photographic Packet containing 10 photographs.

a. Packet containing photographs 11-20 (Autopsy).

8. Fingerprints pertaining to Mr. ISMAIL (USACRC copy only).

9. AIR of SA [redacted] 9 Nov 06, detailing the receipt of death certificate and final autopsy report.

10. Death Certificate, 10 Jun 06, pertaining to Mr. ISMAIL.

11. Autopsy Report, #ME06-0490, 16 Aug 06, pertaining to Mr. ISMAIL.

12. Compact Disc 060089.789 containing the photographic images and the originals of Exhibits 2 and 7 (USACRC and file copy only).

13. Compact disc containing the images of the autopsy of Mr. ISMAIL (USACRC and file copies only).

Not Attached:

None.

The original of Exhibits 1, 2, 6 through 9 and 12 are forwarded with the USACRC copy of this report. The original of Exhibits 3 and 5 are retained in the database of Task Force 134, Camp Victory, IZ. The original of Exhibits 10, 11 and 13 are retained in the files of the Armed Forces Institute of Pathology, 1413 Research Blvd., Building 102, Rockville, MD. The original of Exhibit 4 are retained in the files of the Patient Administration Systems and Biostatistics Activity, 1216 Stanley Road, Suite 25, Fort Sam Houston, TX.

STATUS: This is a Final Report.

REPORT PREPARED BY

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

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

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 0089-06-CID789-78469

BASIS FOR INVESTIGATION:

About 1015, 5 Jun 06, this office was notified by SSG b(6), b(7)(C) Non-Commissioned Officer in Charge, Patient Administration Division (PAD), 21st Combat Support Hospital (CSH), Baghdad Central Confinement Facility (BCCF), Abu Ghraib, Iraq (AGI) that detainee Mr. Ibrahim ISMAIL, Internment Serial Number (ISN) b(6), b(7)(C) had died at the hospital.

About 1030, 5 Jun 06, SA b(6), b(7)(C) verified and photographed the body of Mr. ISMAIL. (See Photographic Packet and Compact Disc for details)

About 1045, 5 Jun 06, SA b(6), b(7)(C) interviewed MAJ (DR) b(6), b(7)(C) 21ST CSH, BCCF, AGI who related Mr. ISMAIL was admitted to the 21ST CSH on the 15 May 06 from a gunshot wound to his abdomen. MAJ b(6), b(7)(C) stated from 15 May 06 to 5 Jun 06, Mr. ISMAIL suffered from Acute Respiratory Distress Syndrome (ARDS) which led to multiple organ failure. MAJ b(6), b(7)(C) stated on 5 Jun 06, Mr. ISMAIL stopped breathing on his own and his pupils became fixed and dilated. MAJ b(6), b(7)(C) stated life saving measures initiated by medical personnel were Cardio Pulmonary Resuscitation (CPR), tracheal tube, multiple chest tubes, a central line and being placed on a ventilator. MAJ b(6), b(7)(C) stated Mr. ISMAIL was pronounced dead at 1005 and the preliminary cause of death was Cardio Pulmonary Distress. A review of the medical records verified the information provided by MAJ b(6), b(7)(C) as to the injuries, treatment, life saving measures and preliminary cause of death pertaining to Mr. ISMAIL.

About 1110, 5 Jun 06, SA b(6), b(7)(C) obtained the Detainee Information Sheet (DIS) pertaining to Mr. ISMAIL from the Centralized Operations Police Suite (COPS), Detainee Registration System (DRS). (See DIS for details)

About 1910, 5 Jun 06, SA b(6), b(7)(C) obtained copies of the medical records and preliminary death certificate pertaining to Mr. ISMAIL. (See Medical Records and Death Certificate for details)

About 1125, 7 Jun 06, SA b(6), b(7)(C) coordinated with SSGT b(6), b(7)(C), United States Air Force, Magistrate Cell Paralegal, AGI and obtained the capture paperwork pertaining to Mr. ISMAIL. A review of the Capture Paperwork and Sworn Statements indicated that the Rules of Engagement (ROE) were followed in accordance with making contact with a hostile party with the intent to plant an Improvised Explosive Device (IED) to cause grave or deadly harm to U.S. and Coalition Forces. Enemy combatants were clearly identified and engaged as well as ensuring the area was free of any non combatants to avoid collateral damage. After review of the Capture Paperwork and Sworn Statements, it was deemed that any further pursuit would not be needed as the engagement was IAW both ROE and Law of Armed Conflict (LOAC). (See Capture Paperwork for details)///LAST ITEM///

TYPED NAME, SEQUENCE NUMBER	ORGANIZATION	
SA (b)(6), (b)(7)(C), (b)(7)(F)	76TH MP Det (CID)(FWD)(-), BCCF, AGI, APO AE 09342	
SIGN b(6), b(7)(C)	DATE 7 Jun 06	EXHIBIT 1

CID FORM 94-E
(Automated)

0089-06-CID789-78469

PHOTOGRAPH PACKET

NUMBER	DESCRIPTION OF PHOTOGRAPHS
1	Photograph depicting overhead view of the face.
2	Photograph depicting view of body (feet to head).
3	Photograph depicting view of body (feet to head).
4	Photograph depicting view of left side of torso with wounds and dressings.
5	Photograph depicting abdominal wounds and dressings.
6	Photograph depicting overhead view of torso.
7	Photograph depicting overhead view of abdominal wound and dressings.
8	Photograph depicting right side of body with wounds and dressings.
9	Photograph depicting right side of torso with wounds and dressings.
10	Photograph depicting view of the face, neck and torso.

EXHIBIT 2

0089-06-e20789-78469

Detainee Information Sheet

DATE (YYYYMMDD) 2006/06/05

NAME (Last, First, M) (AKA)
ISMAIL, IBRAHIM

SEQ	ISN NUMBER	HOUSING
189631	US b(6), b(7)(C)	

Left Profile	Left 45	Frontal	Right 45	Right Profile
(b)(3)				

Theater CENTCOM	**Power Served** IRAQ	**Capturing Country** UNITED STATES OF AME		**ICRC**	**Compound** M-MEDICAL
Capture Tag (DD2745) 1779	**Capture Date** 2006/05/14	**Capture By** 3/3 RCT 7, 1MEF	**Circ. of Capture** UNKNOWN		**Grid/Coor** UNK
Physical Consdition GOOD	**Enemy Unit**	**Hard Labor** NO	**Marrital Status**		
Foreign ISN	**MI Number**	**Sex** Male	**Age** 30	**Date of Birth** 1976/01/01	
Race OTHER	**Ethnic Group** UNKNOWN	**Nationality** IRAQ	**Religion** SUNNI-ISLAM	**Hair Color** BLACK	**Eye Color** BROWN
Confinement Type DETAINED	**Military Service** -	**Height** 69	**Weight** 250	**Custody** MIN	
Presence IN FACILITY	**Status** GENERAL POPULATION		**Place of Birth** IRAQ		
Citizenship IRAQ	**Place of Confinement** BAGHDAD CORRECTION FACILITY (BCF) 96TH MP BN BAGHDAD, GV (302) 242-0520		**Arrival Date** 2006/05/30		

Sentence Information:

Current MXRD: **Court Martial Type:**

MRD: **Discharge:**

NO SENTENCE INFORMATION

Offenses:

Offense	Offense Date	Age	Sent. Num	PCO
DIGGING AT KNOWN IED SITE	2006/05/14	30		X

Languages:

Language	Skill Level
ARABIC-IRAQ	3

LAST ITEM

EXHIBIT

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

CERTIFICATE OF DEATH

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

IN[illegible]MENT SERIAL NUMBER

FROM:

TF 21

TO:

(b)(6)

GRADE n/A

SERVICE NUMBER (b)(6)

NATIONALITY

PLACE OF CAPTURE/INTERNMENT AND DATE

PLACE OF BIRTH

DATE OF BIRTH

NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN

FIRST NAME OF FATHER

CAUSE OF DEATH Cardiopulmonary failure

* PLACE OF DEATH Abu Ghraib Hosp

DATE OF DEATH (b)(6) 06

DATE OF BURIAL

PLACE OF BURIAL

IDENTIFICATION OF GRAVE

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

___ RETAINED BY DETAINING POWER

___ FORWARDED WITH DEATH CERTIFICATE TO (Specify)

___ FORWARDED SEPARATELY TO (Specify)

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

Patient sustained gun shot wound to abdomen approximately 3 wks ago. He developed sepsis syndrome, ARDS, & multiorgan system failure. He developed infections with Acenitobacter, E.coli, Enterobacter, & Candida albicans. He had worsening renal failure and ARDS with inability to perform adequate oxygenation, ventilation, or maintenance of reasonable acid/base status. He subsequently developed cardiopulmonary failure.

SIGNATURE OF MED (b)(6)

DO NOT WRITE IN THIS SPACE

CERTIFIED A TRUE COPY

DATE (b)(6) 06

(b)(6)

(b)(6)

(b)(6)

WITNESSES

ADDRESS

SIGNATURE

ADDRESS

SIGNATURE

DA FORM 2669-R, MAY 82

EDITION OF 1 JUL 63 IS OBSOLETE.

APD V1.00

EXHIBIT

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LAW ENFORCEMENT SENSITIVE

- Temp reassessed. Temp 102.7 PRBC still on hold. Will notify (b)(6) Doctor.
- Vent readings: ↑ Resp 35-38, ↓ TV 586. Pt made facial grimaces during cleaning. Gag reflex present, bile suctioned out of oral airway. Pt does not respond to verbal/painful stimuli. Pt repositioned on (L) side, will cont. to monitor. (b)(6)

S F/u from day shift notes: Pt has skin discoloration b/w groin/legs (b)(6) (b)(6) Area. Mycostatin applied on/around area q shift.

340 NG output is dark red drainage. Specimen drawn and will be taken to lab. MD will be notified of the results (b)(6) (b)(6)

may 06 Lab results back on specimen from NG tube. Results pos for. Occult blood. MD will be notified and further tx of pt will be determined (b)(6)

130 Doc (b)(6) consulted in concerns regarding the color of the urine and the NG drainage. Both have been tested for blood and both were positive. Lab results reviewed and ~~no additional plan of care was ord~~ Φ orders/treatments written. Vent alarm is cont. going off due to ↑ resp rate. Pt stated there is also an air leak at the trach site. MD will be notified of all new changes with the pt. (b)(6)

0200 - Pt given 10mg reclomidium x1 IVP per (b)(6) order. Pt has been breathing +10-17 over set vent rate on ID. Will continue to assess and monitor (b)(6)

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LAW ENFORCEMENT SENSITIVE

EXHIBIT

MAY 06 — ORAL CARE performed ON PT. Mouth SUCTIONED AS needed.

0400 Colostomy CARE performed. SITE CLEANED AND BAG changed. STOMA beefy RED color. No signs of INFECTION. LINEN changed, BACK assessed, NO redness or SKIN breakdown noted. Will CONTINUE to monitor the PT. (b)(6)

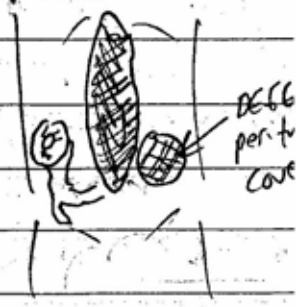
0410 TEMP reASSESSED CURRENT TEMP. IS 101.7. PT. will be given 650 mg SUPP. TYLENOL AND will reASSESS TEMP. @ a later time (b)(6)

0520 lab REPORTED CRITICAL VALUE OF Alb being low. 1.2 g/dL. Mg Results PENDING due to SEND OUT. Will ~~notify~~ ADVISE next shift, to NOTIFY MD. (b)(6)

0600 THROUGHOUT the SHIFT, I NOTICED THAT the PT HAD a decreased OUTPUT b/w 10-30 cc. ~~WHEN THE~~ problem was INVESTIGATED and the PT HAD a ~~LEAK AROUND~~ URINE leak. OLD foley was D/C and PT HAD what appeared to be stones in the URINE and around the tip of the old foley. 16 Fr foley was initiated. PT HAD a large amount of dark brownish URINE in the catheter. ABOUT 500 cc WITHIN the FIRST 15 MINS. will CONTINUE to MONITOR the PT. (b)(6)

EXHIBIT 20

DATE	OP NOTE	NOTES DE[illegible] 06 CID 789 7846
21 MAY 2006	pre-op DX: GSW ABDOMEN S/P Colon resection, ASCENDING COLOSTOMY placement	
1545	SEPSIS	
	Respiratory FAILURE	
	ABDOMINAL WALL FASCIAL DEFECT	
	post-op DX: SAME (L) ART Line placement,	
	procedure: EX-LAP ; ABDOMINAL Re-ENFORCEMENT of COLOSTOMY	
RIJ TLC placement.	ABDOMINAL WASHOUT	
	VAC CHANGE of LLQ ABDOMINAL WALL DEFECT	
	VAC CHANGE of ABDOMINAL WALL /MIDLINE	
	Surgeon: (b)(6)	
	Asst: (b)(6)	
	Anesthesia: (b)(6)	
	EBL: MIN	
	IVF: 250 cc	
	UOP: 100 mL	
	Comp: ✓	
	DISP: TO ICU CRITICAL CONDITION.	
	PLAN TO TAKE TUESDAY MORNING. (b)(6)	



RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) (b)(6)		REGISTER NO.	WARD NO.	

#3

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

PRINTED ON RECYCLED PAPER

509-114

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EXHIBIT

21

0089 06 CID 789 78469

ICU Bed #3

T NAME 1142	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1 May 06 915	Colostomy bag changed. Stoma viable, pouch Nml.
30	
21 May 06 115	Nutrition per NSG - lab notes state pt's blood sample Lipemic checked TKcal intake c correct dyspnea Level 0 ave ~2750 Kcal/day, est needs 1900-2300 If desire, could d/c 20% Lipids & c 27 ml/o dysp. would supply pt c ~2300 kcals/day - appropriate for est needs: (b)(6)
00 21 May 06	Pt to OR via gurney with (b)(6), OR Nurse, & (b)(6) On Monitors & O2. pt safety measures in place. (b)(6)
Note	1200 21 May 06 - 1200 noon assessment completed: Vent changes made AC/PC (PCV) Ri. 14 Fi.O2 100% IP 28 Peep 10. Drew ABG @ 1300 hrs (1° p vent Δ's) Gave calcium Chloride IVP over 10 mins. (b)(6)

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EXHIBIT

STANDARD FORM 509 (REV. 5/[illegible]) BACK

22

0089 06 CID 789 78469

T NA (b)(6)	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
300hrs May06	Obtained blood specimen from pts A-line (R) femoral cath for ABG & labs. Post infusion of NS 0.9% + KCl 80 MEQ. (b)(6) given
354 5May06	Discussed results of pts ABG + lab results c (b)(6) ordered 1 Amp Calcium Chloride + ↑ BPM to 14. ABG to be redone in 1 hour.
May06 215	Respiratory ↑ Vent settings, BPM to 14. - (b)(6) Sent labs for 20May2006, results 2354 hrs.
May06 230	Administered 1 Amp Calcium Chloride IV per physician order (b)(6)
Mar06 200	Pt's axillary temp 102.1, (b)(6) notified & ordered 650mg Tylenol PR Q 6 hrs (b)(6)
Mar06 40	Administered 650mg of tylenol ~~PR~~ PR due to axillary Temp of 102.1. (b)(6) (b)(6)
Mar06 30hrs	↓ Diprivan gtt to 60mcg/Kg/min + ↓ fentanyl to 11mc due to constricted pupils. Will continue to monitor for additional adjustments to medications. (b)(6) (b)(6)
May06 00	Pt Assessment completed see ICU flowsheet. Pt sedated c fentanyl @ 220 mcg/hr (11ml/hr). + propofol @ 20mcg/Kg/hr (13.6ml/Hr). Paralyzed c vecuronium @ 70mcg/min (5ml Ø spontaneous movement or eye opening. Pt vented + intubated @ c AC FiO_2 100%. RR 14 TV 900, spontaneous 640ml, peep 10 PIP 22. Ø signs/SX of pain or anxiety Continuing. Possible plan for Trach Placement 23 (b)(6) will continue to monitor.

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STANDARD FORM 509 (REV. 5/1955) BACK
USAPA V1.00

MEDICAL RECORD — PROGRESS NOTES

DATE — NOTES

See ICU flowsheet for

Mag assessment completed. Vent settings AC RR 14 FiO_2 80
TV = PC Peep 10 PS 5 SaO_2 99%. Inspiratory pressure
↑ to 20 from 16 by RT @ 0730 will draw ABG @ 083
Pt sedated + paralyzed c vecuronium 0.4mcg/kg/hr (3ml/hr
propofol 70mcg/kg/min (47.5 ml/hr), fentanyl 85mcg/hr
(4.3 ml/hr). ∅ signs of pain or facial grimacing.
∅ response to noxious stimuli, ∅ cough/gag reflex
c suctioning. Will continue to monitor.

FiO_2 ↓ .70 from .80 otherwise no changes to prior
vent settings. Assessment completed. D/C vecuronium titrated off.
Pt has positive cough/gag reflex. Will continue to monitor.

ABG results reported to (b)(6). FiO_2 ↑ back up to 80%.

Diamox 60mg IV given per (b)(6).

Assessment completed vent settings TV=PC AC FiO_2 80
RR 14 PS 5 SaO_2 100. Vec remains off fentanyl @ 150m
(7.5ml/hr), propofol ↑ 100 mcg/kg/min (47.8 ml/hr) for
bucking ventilator. BSx4 hypoactive ⊕ stool to colostomy
lungs CTA. ∅ sputum c suctioning. Ca^{2+} CI given
2gm IV per Dr Cen, awaiting ICP 40meq IV. Will
continue to monitor. (b)(6)

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

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

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

ICU Bed #3

(b)(6) (b)(6) No

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PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)

EXHIBIT

0089 06 CID 789 78469

DATE	NOTES
25 May 06	OP NOTE
1310	Pre-op DX: Open Abdomen s/p GSW Abdomen, Diverting Colostomy RUQ / Flank wound Post-op DX: same Procedure: Wound VAC Δ / I&D Surgeon: (b)(6) Asst: (b)(6) Anesthesia: (b)(6) EBL: <50cc IVF: 2000cc UOP: Comp: ø Drains: VAC x2 Disp: to ICU Findings: ALL wound BGOs / small bowel grossly well

(b)(6)

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EXHIBIT

25

0089 06 CID 789 78469

E	FIRST NAME	MIDDLE INITIAL	ID NUMBER

TE	NOTES
1900	Assessment Completed See ICU flowsheet. Vent settings SIMV VT 800 FIO2 .90 RR 10 PS 5 Resp 10 Changed from AC by (b)(6) from AC. Pt sedated c propofol @ (100mcg/kg/min) @ 67ml/hr. to proximal lumen. TPN to distal lumen @ 91ml/hr + NS @ 18ml/hr to distal lumen to (R) IJ. Pt has spontaneous eye movement (+) and (+) cough/gag reflex c suctioning, minimal amount of pink tinged sputum. Pt given 975mg rectal tylenol suppository for HX III. T of 102.7. Will continue to monitor. (b)(6)
2330	Late entry. 0700 Pt RR 35-40s Sat 96%. ABG results back. AST/ALT elevated. Lipids + propofol stopped. 5mg versed IVP + 100mcg fentanyl given IVP. 2nd ABG drawn by (b)(6). (b)(6) notified. (b)(6) (b)(6)
15	ECG performed due to T wave elevation on lead II propaq strip. (b)(6)
1030	Propofol stopped + Dcd. Pt started on versed + fentanyl drip per (b)(6) to proximal lumen versed @ 7mg/hr + fentanyl @ 200mcg/hr. or 7.5ml/hr. (b)(6)
1200	Pt reassessed, see ICU flowsheet, Vent settings "SIMV VT 800, RO2 90, RR 10 PS 10. Pt sedated c versed 2mg Fent 200 mcg to 2u PRBCs per MD order (b)(6)
1300	1st unit PRBCs started see SFS18, will monitor (b)(6)
cont.	Temp 102.4, 122, 110/57 start VS, End VS Temp. 102.4, 110/57, 122, will monitor (b)(6)
1800	2nd unit started, VS taken see list for vitals, Temp. 102.4 Pcd #3 will monitor (b)(6)

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STANDARD FORM 509 (REV. 5/1999) BACK

0017 06 002029

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5-06	ICU Note cont
210	A/p 1) Neuro / ψ / pain - Plan to d/c propofol & start versed gtt. May add Fentanyl as needed.
	2) CV - still febrile so will not transfuse @ this point as we can't monitor for acute transfusion reaction. Once fever down below 101 will transfuse.
	3) Pulm - Overbreathing the vent & sedation as above may have to go back to pressure control.
	4) FEN - Unable to ✓ labs this AM 2° to lipemia. Hold lipids, d/c propofol repeat labs. Cont TPN.
	5) Renal Last creatinine normalized, suspect that he was pre-renal. Cont IVF.
	6) ID - remains febrile, Cx's pending. restarted Amikacin last pm.

(b)(6)

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
MAY 06 530	PT HAS HAD large AMOUNTS OF DRAINAGE VIA his colostomy. MIX DRAINAGE VIA NG tube. URINE/NG samples taken to labs, blood present in both. Please see lab values. All abnormal values to include ABGs and additional labs reported to Night (b)(6) @ 10 cc/hr, TPN @ 91 cc/hr, Lipids @ cc/hr. Total input equals 130 cc/hr total. Propofol Δ to 100 mcg/k/m @ 67.9 cc/hr. Resp rate has been +10, +20 over set rate of 10. TIDAL volume has been reading b/w 500-600. O_2 SATS have been running b/w 94-96 %. PT SUCTIONED PRN. ABD distended VERY Distended. Will CONT to monitor (b)(6)
4AM 06 030	LAB results in PH 7.589, PCO2 39, PO2 78, HCO3 27.7, SO2 97%, BEecf 6. Hgb 10.8, HCT 27.8. CMP results not present due to specimen lipemic. Wound Vac 400 cc output. NG 250cc output. STOOL 1510 cc output. All abnormal findings will reported to next shift (b)(6)
5-06 210	ICU Note: ITO 11 / POD 5 (2 trach/tracheostomy) Overnight patient can't to overbreath the vent, was given dose of vec x 1. This am noted that he can't to have episodes of fever & was not transfused. Exam: 117/68 128 RR32 T=102° Set 96% vent 8/mv/10/850/PEEP 5 F/O 5414/6190 -2854-775 Crew: sedated, NGT, Trach in place - umbilical tape loose around neck Cv tachy @ NSR Lungs - diffuse rhonchi abd - VAC in place @ BS Ext - 2-3 mm edema ABGs: 7.5/34/113/30.3 LABS: lipemic Sample Not performed (cont) (b)(6)

(b)(6)

FOR + CONTINUATION

STANDARD FORM 509 (REV. 5/1999) RACK US/28 V1.00

EXHIBIT

AME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
) 24May06	Gave report to oncoming shift. pt sedated on Diprivan 80 mcg. Fentanyl / vecuronium off. Trach stylet taped Trach @ HOB TPN running @ 91 cc/hr. Continue to provide Care until next shift assumed care (b)(6)
4 May06 1900	I, (b)(6), assumed CARE of PT. Prior shift SHIFT REPORT PT has had good URINE OUTPUT ≈ 100-200 cc/hr. Reported PT still has a temp. Currently temp is 102.8. Propofol ↑ to 110 mcg/k/min @ 74.6 ~~mg/h~~ ml/h. PT has had ↑ resp about 15-25, vent RATE SET AT 10. VENT SETTINGS @ FiO_2 80%, RATE [illegible], Tidal volume [illegible] PSV 5, peep 35, MODE A/C. ABG RESULTS [illegible], PH 7.[illegible], PCO_2 32.7, TCO_2 32, HCO_3 30.6, BE [illegible], [illegible]Normal values will be reported to MD. (b)(6)
[illegible]15	Previous shift's notes and Doctor's orders reviewed. Order to PT give PT 2 V's [illegible] by Doctor [illegible] from any source. No Doctor's order to treat DRBC [illegible]. Will consult if Night MD about further actions. (b)(6) during the cares where previous order for fluids to maintain: IV, TPN, and [illegible] ml/hr. TPN @ 91 cc/hr, Lipids @ 21 cc/hr, Potassium will be infused @ 10 cc/hr after to give PT Tylenol 975 mg Sup to [illegible] temp and continue to monitor. IF temp [illegible] (b)(6)
1115	ABG results back. PH 7.584, PCO2 32.3, PO2 64, HCO3 30.5, AND BE ecf 9. (b)(6)
1110	Propofol increased to 115 mcg/k/min @ 78.0 ml/k. Vent RR reading @ b/w 20-24. (b)(6) notified about ABG results. No new orders written. Will continue to monitor pt. (b)(6)
	(b)(6)

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EXHIBIT

STANDARD FORM 509 (REV. 5/1999) 29 BACK
USAra v1.00

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
4 May 06 0000	ICU Note cont A/p 1) Neuro/Ψ/pain - Intubated & sedated. 2) Pulm - acute episode of desat & continued 100% FiO2 requirements. CXR not c/w severe ARD - ARDS or pulm edema. Will cont to tx for Presumed PE even though (B) LE bedside US was unrevealing for DVT. We have no ability to do V/Q scan & limited CT ability. Will cont aggressive suction, vent management. 3) CV - Hemodynamically stable; he did have a decrease in his HCT but minimal operative blood loss. Will follow & if needed will transfuse. 4) FEN - Replace Co, Mag, K+ today. Cont TPN 5) Renal: ARF - his IVF had been held given the volume he was getting from TPN & other. We will restart today, suspect pre-renal. Lab unable to obtain urine lytes. Will follow. 6) ID: Zosyn D8 - Sputum Gram stain (+), culture pending. Cont Zosyn for (+) drive cx for 10 days total.
0700 5 May 06	pt FSBS' 284 covered c 6 units Regular insulin per sliding scale. pt temp 101.9 gave 650 mg Tylenol suppository. 1200 meds given. 200 cc NG output brown/green secretions. Continues care & monitoring given

(b)(6)

(b)(6)

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EXHIBIT

(b)(6)

STANDARD FORM 503 (REV. 8/1998)

(b)(6)

0089 06 CID 789 78469

AME	RST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5 24May06	Δ'd Colostomy bag on pt. Colostomy site pink / beefy red. cleaned and secured site with new bag. No Δ from morning assessment. Suctioned patient, pink / grey secretions suctioned. tracheostomy site draining serosa fluids. cleaned around trach with strile 2X2. Continues care & monitoring given to patient (b)(6)
0 24May06	(b)(6) @ bedside with (b)(6) Vent Δ'd from 100% FiO2 → 90% FiO2. (b)(6) will Draw ABG @ 1400 hrs.
24 May 06	ABG drawn for 1300 Vent change. pt VS: Bpm 115, BP 130/73, RR. SpO2 100. Vecuronium & Fentanyl drip turned off. Type & cross for 2 units PRBC's. CMP sent to Lab. Continues Care & monitoring given
24May06	Gave Diamox 60 mg IVP per Dr order over 5 mins pt tolerated well. (b)(6)
0 24May06	started NS 500 cc bolus over 1 hr as ordered. Provided oral care and suctioned lungs via trach. trace pink / grey sputum. TPN complete. lab results posted in chart will notify MD. Continues care & monitoring given (b)(6)
24May06	pt spiked Fever 103.5 Axillary. Placed Ice packs in axillaries & back of neck. Dr. notified of lab results & TMax for shift. (b)(6)
	@ bedside Continue to monitor temp now 102.6 oral (b)(6)
24May06	Drew BC x 3 (central, arterial line, & peripheral stick). Urine C&S sent. Vent changed to FiO2 80%. (b)(6)
0 24May06	ABG Sent. Temp down to 102.2 IV maintenance @ 125 cc/hr Amikacin 1gm restarted / running. (b)(6)
0 24May06	Order to infuse 2 units PRBC's on hold due to temp. not able to give tylenol due to increase liver enzymes.
24May06	FSBS 153, gave 2U Regular (b)(6) made aware assessment completed.
(b)(6)	Lungs Fine Rhonchi. Febrile temp 102.6 no other changes

EVIDENCE

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STANDARD FORM 509 (REV. 5/19) 31 BACK
USAPA V1.00

AME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE

NOTES

May 6

ICU Note HD 10 POD 4 / 1 (trach).

s/p Trach & abd wash-out yesterday. Upon return had desat down to mid 90's. He underwent Switch, bedside expedient branch c suction and no significant change all on 100% FiO2. Stat CXR was essentially unchanged x pass. LLL airspace dz. Given concern for PE he was started on full dose LMW heparin. His vent was also changed out and mode of ventilation was changed to A/c volume control. He stabilized but still required 100% FiO2.

Exam: 153/72 100 P=14 101² vent AC/14/850/10/55
I/o: 3820/3315 ABG 7.49/44/95/33.9 iCa=0.98

Gen Sedated & Intubated, Trach, NGT in place
HEENT IJ TL
CV - mild tachy, o/w NSR s m/g/r
Lungs - Diffuse rhonchi, coarse
Abd - vac in place, PEG tube output into colostomy
GU: Foley in place
ext: 3-4mm LE cellulitis.

CXR
No Δ - LLL mild ASD
trach/NGT in place.

LABS
[illegible] 155 14 [illegible]
Alb=1.2 AG=56 ALT=115 TB=1.4
Ca=6.9 TP=4.5 AST=234

(b)(6)

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(b)(6)

STANDARD FORM 509 (REV. 5/1999)

USAPA V1.00

	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES
24May06	recieved pt report from night shift. am cares, assessment, safety checks performed. Pt on Sedation Fentanyl drip 100 mcg hr Propofol 80 mcg/k/m vecuronium .8 mcg/k/min. TPN infusing 91 cc/hr. Vent settings (on vent AC/VC 850, 14 R, PEEP 10, PSV 5, FiO_2 100%. Pt has some breakdown on thigh between scrotum & thigh. Washed, ~~dried~~ pat dried site and administered Mycostatin powder to site. Pt (L) radial/art flushed, Patent, Secured via sutures. (R) IJ triple lumen. 23cm @ skin Flushed, blood able to be drawn, patent. Secured via sutures. site dressed 24 May 06 during night shift. 16 F Foly placed / replaced. am Foley Cares performed. Continues care & monitory given (b)(6)

EXHIBIT 4

T NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 May 06	Pt back from OR. O_2 via ~~BiPAP~~ BVM. Pt SpO_2 low 90's to mid 80's @ 100%. Pt back from tracheostomy size 8 tube stylet taped @ hob. Pt desating placed on Ventilator, pt has coarse rhonchi, suctioned with some bloody / pink sputum / secretions suctioned patient back to BVM. Gave 40 mg lasix @ 1730. CXR @ bedside. ABG, labs sent to Lab. ABG 7.335/59.7/64/31.8/ FSBS 150 no coverage needed, pt back on sedation pt recieved total of 5 doses of vecuronium (3 in OR & 2 @ bedside), started vecuronium @ 5cc/hr (5mg/hr .7mcg/min per kg). (b)(6) (b)(6) @ bedside. (b)(6) (b)(6) performed bronchoscopy @ bedside. Pt recieved respirations via BVM during procedure. (b)(6) performed ultrasound @ bedside. 6500 Unit heparin bolus given via IVP, IJ. Pt back on ventilator 1830 via tracheostomy. Settings: AC volume control 850, R14, PEEP 1 PSV 5, F_iO_2 100%. ABG Sent. to lab. VS posted on chart for reference during 1630 → 1900 time frame. (Temp @ 1630 97.7 placed warming blanket on pt.) Pt temp now 99.6 @ 1900 hrs. Pt [illegible] $\bar{x}$ BPM 125, RR 14, BP 117/67, SpO_2 93%. Via [illegible]. Gave report to oncoming shift. Total urine [illegible] 50cc, NG output 300cc, Wandvac 35. Patient [illegible] monitoring & care (b)(6)

17:46	129	91	139 / 78	91	28		
17:44	126	93	162 / 78	103	17		
17:42	125	95	182 / 85	113	16		
17:40	123	96	195 / 90	120	OFF		
17:38	128	96	193 / 92	120	OFF		
17:36	128	96	171 / 85	110	OFF		
17:34	123	94	151 / 80	102	OFF		
17:32	124	91	115 / 61	80	OFF		
17:30	124	91	118 / 58	74	OFF		
17:28	129	91	149 / 71	96	OFF		
17:26	127	91	134 / 69	91	OFF		
17:24	126	96	181 / 86	112	OFF		
17:22	[illegible]	86	145 / 69	93	OFF		
17:20	[illegible]	92	163 / 77	106	OFF		
17:18	[illegible]	94	127 / 69	87	OFF		
17:14	[illegible]	89	124 / 65	86	OFF		
17:12	[illegible]	91	147 / 73	95	OFF		
17:10	[illegible]	90	NOT ZEROED		16		
17:08	[illegible]	89	NOT ZEROED		15		

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EXHIBIT 34

0089 06 CID 789 7846

	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Surgery
23 MAY 2006	OP NOTE
650	PRE-OP DX: GSW ABDOMEN
	Respiratory Failure
	POST-OP DX: SAME
	PROCEDURE: TRACHEOSTOMY
	ABDOMINAL WALL VICRYL/MESH PLACEMENT
	WOUND VAC PLACEMENT ABDOMINAL WALL
	WOUND VAC PLACEMENT LUQ/FLANK SOFT TISSUE DEFECT
	SURGEON: (b)(6)
	ASST: (b)(6)
	ANESTHESIA: (b)(6)
	EBL: MINIMAL
	IVF: 1 LR
	UOP: FOLEY
	COMP: ✓
	DRAINS: VAC x2
	#8 CUFFED NON-FENESTRATED SILICONE TRACH PLACED
	12" x 12" VICRYL MESH SUTURED TO ABDOMINAL WALL
	BLACK VAC SPONGE PLACED OVER.
	STAT (P) CXR (b)(6) (b)(6)

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EXHIBIT 4

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
May 06	ICU Note HD 9 POD 3
1100	No events overnight. Remains intubated & sedated.
	Exam T^m 101^7 TC 101^2 141/71 95 15 100% PCV 14 IP 16 PEEP 10
ds	I/O = 1819/2278 -459 ABG 7.45/42.4/87/29.7 ; Ca = 1.2
	Gen ETT secure / NGT in place. LABS
cam 1g	Neck (R) IJ TL cx's - ∅ growth x7
3375 q6	CV RRR s̄ m/g/r (R) art line - ∅ growth x7
ta 1500	Lungs CTA (B) faint rhonchi Bld cx's - ∅ growth x7
10x 30 BID	Abd Vac in place midline & (L) abd wall Chem 7 - Lipemic
yl GTT	GU - Foley in place 140 | 21 | ...
un q#	ext - (R) radial art line, (B) LE edema w 5mm 3.0 | 29 | 71 | 1.2
tin powder	Urine Cx: Enterobacter cloacae sensitive 13^3 | 11^4 | 389 | 32'
S	CXR ETT stable ∅ PTX, mild ATX
@ 9 cc/hr	
ls TIW	A/P 1) Neuro/Ψ/Pain - stable
(b)(6)	2) Pulm - stable, but still requiring a high FiO2
	plan for trach today.
	3) CV - stable, HCT 32' down from 39. Repeat
	HCT @ 1600.
	4) FEN - low K+ again, Mg 2g, KCl 60 meq.
	Cont TPN & IVF.
	5) ID: (+) Urine Cx, neg Bld, x3 sites.
	- Sens. to both Antibx's. D/C Amikacin,
	Zosyn Day 7 (b)(6)

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EXHIBIT

STANDARD FORM 509 (REV. 5/1999) BACK

NAME	FIRST NAME	MIDDLE INITIAL	(b)(6)

DATE	NOTES
May 06	
0330	pt stable VSS $\frac{127}{85}$ (81) 94 14 100° 99%. 170 cc URINE output. 100 cc loose stool output. AM Care complete pt repositioned to (R) side. Will cont to monitor (b)(6)
510	AM CXR done, AM LASS, CBC, CMP, POY + ABG sent. Pt repositioned to (L) side. VSS $\frac{118}{66}$ (78) 96 14 100%. 101° NO change in lung sounds, clear throught c̄ diminished posterior lower lobes. Ø BS w/v intact c̄ approx 200 cc serous drainage thru entire shift. Approx 300 cc loose stool from colostomy. Adequate amber/green urine from foley. Green color due to propofol drip. minimal oral secreation from suctioning.
0630	CMP coming BACK inconclusive due to lipidemia. Lipids currently on hold to redraw CMP. BS 296 – low regular insulin administered. VSS 140/70 95 16 98%. 100.7. iCa 8.1 2 amp CaCl IV x1 per Md order.
23May06	assumed care of pt. recieved report from (b)(6). Pt sedated on fentanyl 7.5 ml/hr (150mcg) and propofol 67.8 ml/hr (100mcg/min). TPN @ 91cc/hr, Lipids on hold due to erroneous lab results. Hold for redraw in 1 hrs. Vent settings AC/PC RR 14, TV 1000 (937 pt) IP 28, FiO2 80%, PEEP 10, PSV 5. ETT # 7.5 24cm @ lip. petroleum Jelly placed on lips due to some skin breakdown repositioned tube to left side of mouth. Tube secured via tape, lungs CTA ↓ bases, S1-S2 SR inverted T wave. good capillary refill / peripheral pulses. Ø BS noted. trace amount from colostomy, site beefy red. Wound Vac x 2 in place draining to suction. ~~(R) radial arterial~~ line flushed good waveform. 16 Fr foley draining to gravity concentrated urine quantity sufficient. TJ 23 cm @ skin site dressed 0023

DATE	NOTES
28 May 06 1900	Assumed care of pt from day shift. Pt sedated minimal movement noted. Pupils 1mm ; PERRL. Pt on vent : AC/PC FiO_2:80, Peep:10, P(insp):2 PSV: 5 RR 14 SaTS: 100%. Pt has ~~propofol~~ over propofol @ 100 mcg/kg/min & Fent @ 150 mcg/h via red port. KCL @ 125 ml/h via white port ; TPN @ 41ml/hr ; Lipids @ 42 through blue port. All lumen on (R) IJ are flushed, patent & draws back blood. w/v to abdomen c intact suction & draining serosanguinous fluid @ 125 ml/hr. Ostomy to RLQ draining liquid stool. Bruising noted to bitten lip, bacitracin applied PRN. No other skin breakdown noted. (B) LE elevated due to +3 pitting edema. Cap refill <3 sec, pulses +2, warm & dry to touch. Scars noted to (R) inner thighs. Arterial line to (L) Radial, line zeroed and flushed @ beginning of shift. Pt HOB @ 30°. Pt repositioned to supine. Will cont to monitor — (b)(6)
2000	Temp taken auxillary — 100.0. Will cont to monitor — (b)(6)
2200	Pt stable, VSS T 100.3 P 92 BP 134/65 RR 14 SaO2 95% NO change in lung sounds, rubbing anteriorly, diminished posterior lower lungs. 200 cc loose stool from colostomy. 90 cc urine noted. oral care done. zantac hung, lavenox 30mg given. Sub Q A (b)(6) — Will cont to monitor —
0040	ZOSYN HUNG, PT STABLE. VSS ~~135/61 (91) 92 14 room air~~ 125/61 (78) 98 14 98%. RA. NO change in lung sounds. Will cont to monitor — (b)(6)
0050	PS 269 bu regular insulin given —

EXHIBIT

0089 06 CID789 7846

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Surgery HD #8 POD #1
May 2006	Intubated, sedated, paralyzed. ITime 1.6
2945	Tmax 103.8 P128 BP 110/66 SpO2 99% PCV R14 IP20 PEEP 10
	3006 / 5480 → -2.4 L ostomy 130 wound vac 1200 UOP 2350 Trace @ NGT
166.5/15/36/34.2/94 +4	PE - NEGNT - NGT / ETT secure
7 Zantac cefo	CV - Tachycardic
	Lung - Clear
33 / 35	Abd - open, vac in place ; (L) Abd wall well vac in place
50.2/107/35/35.7/58/10	Ext - 1+ BLE pedal edema / 2+ pedal pulses
12.8 / 325 / 35.1	CXR - pending
	A/P s/p GSW Abdomen / colon resection / diverting colostomy
104/18 / 35/1.0 / 100	Neuro / ↓/pain - cont VEC / prop. / Fentanyl.
	pulm - Respiratory Acidosis
1.2	Currently on PCV / paralyzed ō difficulty oxygenating / ventilating
1.6	c/w ARDS ; Trach as soon as surgically allows.
- 93	
- 2.12	HD - STABLE
	FGN - Lytes WNL ; I&O s/p diuresis ygstrasm.
Kcl?	Cont TPN
	ID - Cont Amikacin / Zosyn for peritonitis / open Abdomen
	↑↑ Temp / ↑WBC → Blood cxs urine, all lines new
	To OR in AM for Trach (b)(6)

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EXHIBIT 39

STANDARD FORM 509 (REV. 5/1999) BACK

DATE	NOTES (b)(6)
1 May 06	
1900	Assumed care of pt from day shift. Assessment complete. VSS $\frac{104}{61}$ 107 14 100% 101³, ~~HV intact~~ ... Lungs c̄ diminished bases c̄ rhonci throughout pt on vent: AC FiO2 - 100 PEEP 12 PSV 5 Insp pressure 28. Tidal volume 850. ETT secure reading 26cm at ~~pt~~ teeth. (R) IJ patent c intact, Triple lumen c̄ Fent @ 38ml/hr - 75 mcg Diprivan @ 40⁷ ml/hr - 60 mcg/k/min, TPN @ 91ml/hr. KCl held due to K⁺ value of 5.8. Vecuronium on hold. w/V intact on cont suction at 200 mmHg (up from 125 prior to OR transfer). NGT to LIWS, small amt bowel colored drainage noted in canister. Foley patent - draining clear yellow urine - (b)(6) —
1930	NEW Diprivan hung running @ 40⁷ ml/hr - (b)(6)
2000	Diprivan increased to ~~65 mcg/k/min~~ ... 70 mcg/k/min 47⁵ ml/hr, Fent increased to 85.0 mcg/h x³ ml/hr. will cont to monitor — (b)(6)
2001	increase of Diprivan & Fentanyl due to pt fighting the vent — (b)(6)
2100	pt fighting vent less. HR 124 BP 108/71 T 102.4 (A) - Given acetaminophen 1300mg tylenol given rectally. Diprivan increased to 80mcg/k/min. pt repositioned — (b)(6)
2130	Diprivan increased 80mcg/k/min (54³ ml/hr) due to pt fighting. Will cont to monitor — (b)(6)
2132	New diprivan hung, pt received 80 mcg bolus via charge nurse. Will cont to monitor — (b)(6)

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EXHIBIT 40

0089 06 CID789 7846

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
D#7 POD#3			

DATE	NOTES
	Surgery/Megaging
MAY 2004	Paralyzed/Sedated/Intubated.
22	No major events overnight
	~1200 ETT cuff leak noted c ↓TV → cuff re-inflated,
	Improved ventilation. per R14
	Tm 101 Tc 100 BP 130/69 P102 RR 14 FiO2 100% IP 28
	PEEP 10
	I/O: UOP last 40 200, 150, 160, 90;
	Lastly I/O 6607/3550 + 3052 I>>O + 5L last 48°
	PE - ETT/NGT secure
	CV - RRR
	Lungs - Coarse
	ABD - soft, VAC in place. Ostomy edematous but functioning well (+) bilious output
	EXD 2+ edema BLE
	(L) ABD wall wound VAC (R) base ↑ density
	CXR - Tubes/lines stable; Mild opacification (B) CP angles
	LAB - UAG; 13.5 11.6 25.8 253; 134 106 11 4.6 28 0.2 <162; ALB (1.6); AP 52
	A/P S/P GSW abdomen (P) colon resection TBil.2
	Neuro/Ψ/Pain - Cont. sedation/Analgesia "protocol" ALT 63 ~~6.5~~ AST 146
	Pulm - Trach in next 48°; ETT cuff leak → will Prot 2.4
	Exchange in OR. will diurese. TP 4.8
	HD - stable/Hb/Hct stable (TG 1.04)
	FEN - TPN increased; Ca → replete. ; (↓ ILF) / Diurese ⇒ Aneluria
	ID - Cont Amikacin/Zosyn for pseudomonas/pneumonia / open abdomen.
	Plan
	- To OR Tuesday for Ex-lap/VAC Δ; washout.
	- TD on 1D 4J-720 for tracheostomy.

(b)(6)

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AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25 may 06 2000	I, (b)(6), Assumed Care of PT @ 1900. PT STAT POST wound CLEAN. PT converted back to ICU STAT @ 1930. VENT SETTINGS change to: MODE - SIMV, TIDAL 800, PS 10, PEEP 10 FiO2 80%. NGo to D/C due to clot. OG tube in place. MD CCU gave VO to reinsert NGo tube. T-MAX 103 given 1gm Tylenol PR by day shift. 2U PRBC infused during day shift. Fluids: Versed @ 2 ml/h, NS ē KCl @ 125 ml/h, Vecuronium 1 mcg/K/MN @ 6.8 ml/h, Fent @ 10 ml/h. Vecuronium to be d/c @ 0500 per order of (b)(6). Will cont. to monitor (b)(6)
2115	RT & MD CARE ↑ resp rate ON VENT SETTINGS to 14. ILT PFE/ changed A-line. CDI / PATENT. NG Tube Flushed. Doctor order IVF 500 cc NS Bolus done. ABG / CBC labs drawn. Ab Normal Results will be reported. 0030 GASTRIC lavage done by ILT PFE/ flushed ē 3000cc NS. Drainage: dark reddish brown (b)(6)
2345	SKIN breakdown b/w legs AND ON buttocks. Breakdown area around buttocks was cleaned AND Dsg Δ. PT repositioned. (b)(6)
26 may 06 0130	@ 2315 PT given 1000 cc bolus of NS per ~~MD~~ orders of (b)(6) 1000 cc bolus running NOW prior to administration of PRBC
0300	PT given 975 mg Tylenol PR. PT is to receive 2U PRBC followed by A CBC. Abnormal findings or Any Adverse reaction will be reported to the MD. Will reassess temp. (b)(6)
*	LATE NOTE AROUND 2100 ILT PFE/ placed NG tube R NARE. RAD confirmed placement. (b)(6)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
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.)* (b)(6)

REGISTER NO.

WARD NO.

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

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EXHIBIT 4
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
26 MAY 06	BEGAN INFUSION OF 1ST U PRBC VSS: Temp 101.5, HR 136, BP
0305	140/78. VS REASSESSED IN 15 MINS. Adverse REACTIONS will report to
	NIGHT MD. (b)(6)
0415	~~1st U~~ 1st U PRBC finished infusing. NO ADVERSE REACTION noted.
	VS remained stable. BP- 147/74, HR 131, Temp 100.5. PT has bloody
	mucus draining from TRACH SITE, MD will be advised. ROM exercises
	performed. AM. CARE DONE. Pepping line for next blood transfusion,
	will cont to monitor. (b)(6)
0445	2nd U PRBC infusing. VS: Temp 101.4, pulse 129, BP 140/75. Infusing
	RATE 50 ml/h for first 15 mins. 0415 VS BP 134/69, Temp 101.6,
	HR 128. ↑ INFUSION RATE TO 200 cc/hr. will cont to monitor
	for adverse reactions (b)(6)
0630	2nd U PRBC infusion completed. Temp. 100.2, BP 162/82, HR 125. OUTPUTS:
	COLOSTOMY 700cc, NG 400cc, Wound VAC 500 cc. (b)(6) notified
	by (b)(6) about drainage from TRACH site. VERSED @ 3 ml/h.
	Fent 75.0 mcg/h @ 3.8 ml/hr. TPN @ 91 ml/h. LAB RESULTS still
	PENDING. (b)(6)
26 MAY 06 0800	Assessment Completed, see IC flowsheet. Awaiting 0730 labs. Pt vented SIMV RR 14 FiO_2 80 Peep 10 PS 10 TV 800 SaO_2 100. Pt sedated c fentanyl + versed to ⓒ IJ ~~75~~ 50 mcg/hr (2.5ml) + 2mg (2ml/hr) to proximal lumen along c NS 20 meq K @ 125ml/hr, TPN 91 ml/hr to medial lumen. Ø signs of pain or facial grimacing noted. Will continue to monitor
1200	assessment Completed. Currently Ø Changes. Pt continues on vent settings + sedation (fentanyl + versed). TPN Dcd. TF started at 20ml/hr to NGT c optimental.

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EXHIBIT 43 4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5-26-06	FCV Notes:
0900	Overnight he can't to leave low grade fevers, & bloody NGT aspirate, Lovenox held, & he was transfused additional
meds	2u of prbc's for a total of 4u yesterday.
Fentanyl gtt	
Zosyn 3.375 D10 Q6	Gen: 175/85 129 RR 17 100% 100% vent SIMV/14/850/Peep 10/PS 10/
Zantac 50 BID	I/O = 8706/8910 ABG 7.36/45/71/28/26 iCa = 0.81
Nistatin powder	Gen sedated, trach, NGT, (R) IJ intact
ISS	NGT & bloody aspirate
TPN	CV tachy & @/Rr
Amikacin 1gm QD	Lungs CBS bases - diffuse rhonchi
Versed gtt	Abd - Vac in place, faint BS
IVF NS @20cc/hr	Ext + Diffuse 3mm pitting edema
Tylenol prn	Skin = 2 sacral grade 2 decubs. (R) gluteal ~ 7cm x 4
	(E) gluteal 3cm x 2cm, partial skin break down
	@ areas of scrotal contact to legs.
	LABS: 129 / 109 / 9.5 / 27 / 1.0 (187) Alb = 1.3 AST = 390 TP = 5.6 Ab = 5.7 TB = 1.2 ALT = 121 Ca = 6.7 (25) 10^8 / 325 (3.5
	A/P 1) Neuro/↓/pain: maintain light sedation
	2) Pulm: still requiring high FiO2, rev venous (b)(6)
	Given hrs transfused. OVER// (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) FCU Bed 3

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EXHIBIT 44

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	ICU Cont CX: Injured HCT, remains tachy FEN: ↓ maintenance IVF to 75cc/hr, Cont TPN & resume lipids until we can place a dophoff and start enteral feeds. GI: UGI bleed, plan to add sucralfate, pull NGT as he has good output in the colostomy bag. Will use enteral nutrition. If LFT's cont to rise will have TPN being held. Start Optimental @ 20cc/hr ✓ residuals after 4 hours. Cgive per NGT for now). ID: Cont current Antibx's. Acenetobacter per BAL, sensitive to current Antibx's. (b)(6)
26May08 1600	Procedure Note: (R) Radial Art line / (R) subclavian TL Operator - Carr Anesthesia - 1% Lidocaine 5cc EBL - 2cc Procedure - both done using seldinger technique & complication. CXR pending. (b)(6)
1600	(b)(6) at BS. new A-line placed to (R) radial me + (R) SCTh. (R) is removed + tip sent for CX. Chest X-ray completed + confirmed by (b)(6) assessment completed. PA placed back on FIO .90 from .85 by (b)(6). 2gm Cefd IV

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1750/1630 26 May 06	Pt given 60mg lasix IV per (b)(6) Over 1L ml out in foley. 975mg tylenol per rectal for temp 102.1 IV parks placed. Will continue to monitor. (b)(6)
26 May 06 1815	Pt had one episode of desaturation to 89%. Pt suctioned + bagged, ↑ RR 40s. RT at BS. Moderate amt of tan bl. tinged sputum out. (b)(6)
26 MAY 06 1930	I, (b)(6), Assumed care of pt. Vent settings: RR-17, TV 850, FiO2 50%, PSV 10, SIMV mode. Pt has NS @ 20 mEq KCl @ 75 cc/hr. Versed @ 9 ml/h, Fent 150 mcg/h @ 7.5 ml/h, Lipids @ 42 ml/h and optimental per NG @ 20 ml/hr. Reported Dayshift reported, the Development of skin breakdown on the heels. WSS will cont. to monitor. (b)(6)
	* Versed rate ↑ 11 ml/h (b)(6)
2100	Residual checked on NG tube. Had 240 cc residual. (b)(6) Notified. Residual replaced. Optimental held for 4 hrs. Will recheck residual and cont. tube feeding. Versed @ 12 ml/h, Fent 250 mcg/h @ 12.5 ml/h. (b)(6) Pt has ↑ RR of 20, vent settings 17. Will cont. to monitor
2830 27 MAY 0220	Temp rechecked, pt remains febrile c a temp of 103.3. (b)(6) Residual checked on NG, 250 cc residual, optimental still on hold. 400 cc output wound vac. Pt bathed and repositioned. FS D/C By MD PEASE due to ↓ TPN infusing. Versed @ 14 ml/h. Fent @ 15 ml/h NS c 20 mEq KCl @ 75 ml/hr. (b)(6)

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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)

REGISTER NO. | WARD NO.

ICU Bed #3

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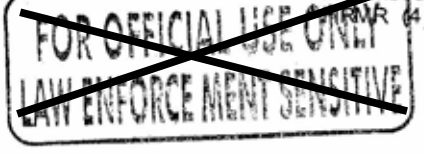

EXHIBIT 46

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27 MAY	Residuals checked on NG. Pt has 400 cc residual. (b)(6)
0500	Consulted ē (b)(6) VO place pt back on LIWS. Green drainage from tube. Doesn't appear to have any blood in Drainage. (b)(6)
0520	LAB Results Returned. ABG P_{CO_2} 47.5, HCO_3 32.9, HCT 31, Hgb 10.5. CMP: AIB 1.5, Glu 121, CoAG: 19.4 PT, INR 1.9. MD will be Notified of Abnormal values (b)(6)
0530	MD Please notified of abnormal values, no further plan of Care no new orders written (b)(6)
0620	NG tube ē green drainage. LIWS. Optimental on hold due to high AMTS of residual. T max 103.8. NS ē KCl @ 75 ml/h. Versed 11 ml/h. Fent 150 mcg/h @ 7.5 ml/hr. Vent settings RATE 17, TV 850, F_iO_2 90%, PS 10, Peep 10, mode SIMV. Stool drainage 800 cc. Stool wound VAC 900 cc. All Abd values Report to night MD. (b)(6)
27 May 2006 0830	Pt assessed, see ICU flowsheet, pt vented R 17, VT 850, FiO_2 90%, PS 10, Peep 10. Pt sedated ē 11mg Versed & 150mg Fentanyl ó Banana bag, pt localizes to noxious stimuli thick grimacing, lungs diffuse ronchi. will monitor (b)(6)
0850	Tube feeds started per NST, check residuals minimal will check residuals in 2 hours, will monitor (b)(6)

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5-27-06	ICU Note: HD: 13
1005	Overnight TF held as there was 400cc residual, also given tylenol. Also cont to have fevers T max = 103.8
meals	New (R) radial artline & (R) subclavian TL placed yest
Zocyn 3.375 gm IVPB	Exam: 114/57 129 29 101.9 100% SIMV 17/850/FiO2 90/PEEP 10/PS1
Amikacin 1gm QD	I/O = 4627.5/9095 -4467 ABGs: 7.45/47.5/82/34/82.9
Fentanyl gtt	CVP = 7 iCa = 1.07
Zantac 50 BID	Gren sedated, Trached, NGT in place
Nystatin powder	ex- tachy @ 6g/hr
Sucralfate 1gm TID	lungs - Diffuse Rhonchi - worse LLL
Benzonatate QD	abd - @ BS, @ distension, Voc in place
Versed gtt	Ext: 2-3 min (B) LE edema.
Optimal TF	145 / 4.6 / 111 / 29 / 1.0 / 121 Alb = 1.5 Aφ = 6.9 ALT = 191 AST = 690
9 / 17 / 10^2 / 30^5 / 419	Ca = 8.5 TP = 6.1 TB = 1.4
	CXR: worsening LLL infiltrate, ↓ pulm edema, R exc ok

Lines
(R) Radial - D2
(R) SC - D2

ABS
CLBkl & (+) Acinetobacter
S - imipenem
urine LSC - candida

A/P 1) Neuro/Ψ Pain - Cont Fentanyl & Versed for tube tolerance & pain control.

2) Pulm: Physiology c/w ARDS, cont to require ↑ FiO_2 despite attempts to wean. Reasonable oxygenation/ventilation now. CXR c cont/progressive infiltrate (Can't) ∧

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	(b)(6)
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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EXHIBIT Y
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5-27-06	ICU - cont (pulm cont) in LLL, & cont to have high PIP. Significant diuresis yesterday, ↓ pulm edema. Will follow. 3) CV - persistent tachycardia, likely multifactorial: Sepsis, ARDS, hypermetabolic state. HCT stable. however will transfuse 2u prbc's again today in attempt to max O_2 carrying capacity. Pt will give lasix 20mg IVP if CVP > 12 cm. 4) FEN: Follow CVP as above. Will re-attempt TF's hold for residuals. Give Cal today. 5) ID: Acinetobacter growing from previous TL site. That has been changed, will D/C Zosyn in favor of Imipenem. Also low growth of Candida in urine. Given persistent fevers will tx c diflucan 400mg IVP. 6) GI: Transaminases cont to rise. Will ✓ RUQ US. Suspect related to prolonged ~~TPN~~ TPN, lipids, propofol use. Will follow. (b)(6)
1200 CP	Report given by (b)(6), Assumed pt care. Assessment Completed, see ICU flowsheet for vitals. Vent settings changed by (b)(6) to SIMV c PC - IV 850 RR 18 FIO2 90 Keep 10 PS 10 SaO2 100%. ABG sent prn to vent changes. Will repeat ABG in 1 hr. Pt continues on sedation c fentanyl at 150 mcg/hr (7.5ml/hr) + versed at 11mg/hr (11ml/hr) to proximal lumen + Banana bag at 125ml/hr. Pt has CVP monitor to distal lumen 3-8. A-line to (R) radial CDI Ø S/Sx of ↓ CAP refill. Pt has 3+ pitting edema to (B)U + (B)LE
stylet aborted	to trach 8.0 non fenestrated cuffed shiley
	(b)(6)

ICU Bed #3

EXHIBIT 49

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
27May06 1220	Pt has ~~Abona~~ phonchi to (B)UL, wheezes to (R)LL + Crackles (L)LL upon auscultation. RT at BS giving atrovent + suctioning. Scant amt of tan/bl. tinged. WV to mid abdomen (P) (L) axillary at 125mmHg. BS X4 hyperactive. NG to (R) nare c optimental TF @ 20ml/hr, residual ≈ 10 Tylenol 975mg per rectum for T 101.7 (A). Pt has 2 Stage II ulcers to (B) buttocks + stage I to (R) heel + (R) lateral thigh. Pt on (L) side c feet elevated. Will Contin to monitor. (b)(6)
1540	Blood transfusion started. (b)(6) notified of T 102.1 (O)
T	102.1 (O) RR 18 HR 134 BP 122/62 100 SaO_2
	102.1 20 134 119/57 99
	102.2 20 134 118/58 99
1555	102.1 20 132 129/58 99
1600	101.9 23 131 122/56 100
1630	100.4 (O) 22 128 93/60 100
	Assessment completed. Ø Changes except vent setting SIMV c PC see ICU flowsheet other settings. TF held for residual 75ml (b)(6) notified ordered to hold for 2 hrs + recheck. Will Continue to Monitor.
1815	1u PRBC Complete see transfusion sheet for vitals Ø adverse reaction noted. (b)(6)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	
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(b)(6)

ICU Bed #3

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1820	2u PRBC started @ 30ml/hr see transfusion sheet for previtals.
	100.7 @ 28 129 142/57 100%
	100.4 30 128 143/60 100%
	100.7 32 126 143/60 100
	100.7 32 126 145/62 100
1900	Residuals checked while TF held 190ml. Secondary held until [redacted] notified.
1900	Report given to [redacted]
1900 27 Mayo6	Assumed Care of Pt. Pt with FIO2 of 80%. Pt currently on PRBC infusing @ 130ml/Hr. Pts V/S BP 142/60, Pulse 125, Resp 32, Temp 100.7 POx 100% on FIO2 80%
1930 27 Mayo6	Pts V/S = 2nd unit PRBC's infusing. BP 149/65 Pulse 125 Resp 36, POx 100% Temp 101.7 Axillary. →
2000hrs 27 Mayo6	Pts V/S @ 30 minutes into blood administration. BP 12[illegible] 6[illegible]
2000 27 Mayo6	Pulse 129, Resp 36, Temp 101.7, POx 100%.
	Pts NG tube residuals 195 cc. Pt tube feeds Continue to be held. Pt [illegible] Atrovastatin Per NG tube. -
2025 27 Mayo6	Secretions. [redacted] Contacted in reference to ABG results from [redacted] reviewed results
	Pts @ 1915 hrs Blood Drawn. [redacted] + stated no further changes. [redacted]
2135 27 Mayo6	Pts 2nd blood infusion complete. Post infusion V/S = BP Pulse 128, Resp 36, Temp 102, POx 100%. ABG + CBC to be drawn @ 2235 hrs.
2300 hrs. 27 Mayo6	Pts 2235 hr lab results were shown to [redacted] No further chg. given. - [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5-28-06	ICU Note: HD 14
1138	Overnight head Lin CVP's was given 500cc IVF bolus. TF held 2° residu
meds	Exam: 143/60 116 29 101° 100% vent SIMC PC 18/850/Peep 10/FS 10/PIP set 2
Imipenem 1g Q8° D2	I/O = 5,271 / 6974 ↓1700 ABG 7.37/53/77/31 PIP 31
Lovenox 30 BID	Green sealed trach, NGT in place. Lines
Fentanyl gtt	CV tachy @ RR/gtr R SCTL
Zantac 50 Q8	lungs diffuse rhonchi, ↓BS (L) lung R Radial art
Nostatin powder	Abd- vac in place, (+) colostomy output
Sucralfate	ext- 2-3mm (B) LE edema.
Banana Bag	skin- Rash over chest/abd wall beneath
Diflucan 400 QD D2	adhesive tape for vac - some
Amikacin 1g QD	extravasation on (R) chest out of
NS @ 20cc/hr	taped area. present nurse today - noticed first yesterday
Versed gtt	Sacral decubs - stage 1-2 10cm @ greatest diameter.
	CXR: - Progressive (L) lung infiltrate
	LABS: 133/4.8 119/26 40/0.7 113 Alb = 1.4 Ab = 72 ALT=145 AST=493 TB=0.9 TP=5.7 Ca=8.7 ϕ=4.1 15 9 / 84 4 36
	A/p 1) Neuro/P/pain - stable
	2) Pulm - adequate oxygenation on toxic O2 levels, can't PC vent. allow permissive hypercapnia for ARDS.
	3) CV - Stable, appr. response p Zyprexa, Gl bleed resolved.
	4) FEN - Hypovolemic IVF to 125c/hr, 500cc bolus, will run banana bag over (can't to try & TF. Hold TPN until LFT's improve more
	5) Rash - Started prior to 1st dose of Imipenem - Maybe 2° to Zosyn will follow. Looks like drug rash. (b)(6)
	6) ID - cont current antibiotics.

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(b)(6)

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EXHIBIT

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0230hrs 28May06	Pt administered 1gm tylenol P.R @ 0200 hrs for axillary temp of 102.°. Pt turned to (L) side, am A.M. Care done and Stage II Decubitus ulcers to Pts Bilateral Buttocks were cleaned & dressed c Comfeel.
0300hrs 28May06	Pts CVP ↓ 2, ~~attempts~~ attempts were made to zero CVP line by flushing + repositioning. (b)(6) Was notified & ordered 500 ml Bolus of NS - (b)(6) (b)(6)
0500hrs 28May06	Pts CVP ↑ 11 @ 500 ml bolus of NS. (b)(6) notified of results.- (b)(6)
0600hrs 28May06	Pts lab result reviewed c (b)(6) No further ons. Given.- (b)(6)
0630hrs 28May06	Pts Abdominal residuals remained elevated @ 04hrs, >190ml Pts 0600 residual 90 ml, (b)(6) notified & ordered tube feeds held until further notice.- (b)(6)
0800	Assessment Completed, see ICU flowsheet. Pt vented @ SIMV/PC RR 18 FiO_2 80 TV 850 PS10 Peep 10 SaO_2 100%. Pt sedated c fentanyl 150mcg/hr (7.5 ml/hr) + versed (9mg/hr) 9ml/hr. @ signs of facial grimacing noted. TF restarted at 20ml/hr residual 10ml/hr. Pt. noted rash on chest + trunk. Will continue to monitor. (b)(6)

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
28 May 06 1200	Assessment completed. See ICU flowsheet for vitals. TF residual to NGT 10ml, TF resumed @ 20ml per hr. (b)(6) into SICU stage II to buttocks. Pt turned to (L) side + colostomy bag changed along c (R) SCTL + (R) aline. Will continue to monitor. (b)(6)
1600	Assessment completed. See ICU flowsheet for vitals. Pt given 50mg IV benadryl IV for rash to trunk + arms. Diflucan D/c'd. CVP obtained c pt lying flat = 14-15. Cx sent pt urine, sputum + (R) SCTL per (b)(6). Pt repositioned to (L) side. FS 130. TF residual 70ml ordered to keep feeding going. T 102.9 tylenol prn given. Pt given 975mg tylenol per rectum at 1530. Will continue to monitor.
28 May 06	Assumed care of pt at 1900. Pt on vent c settings SIMV c P/C. FiO_2 80 PSV 10 Peep 10 P(insp) 24 Tidal volume 550 sats 98% RR 32. Pt has versed a 9ml/hr, fent @ 200 mcg/hr & NS @ 125 ml/hr to (R) subclavian TH lumen c cm patent, flushes and draws back blood. (R) CVP monitoring. Pt has (L) radial a line which is patent, flushes + draws blood back.

—over—

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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(b)(6)		

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EXHIBIT 54

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
28 May 06 1900 (cont)	Pupils approx 4mm, PERRL, lungs: rubbing ~ rhonci noted to (B) upper lobes, diminished ~ congestion to (B) lower lobe lobes. + BS present. abdomen soft but distended. Foley to gravity draining dk yellow urine ~ white sediment, sufficient amounts. +2 edema ~ pitting to all extremities. +2 pulses x 4 extremities. acewraps + elevation to (B) lower extremities. Stage II sacral decubitus to buttocks area, comfeel in place. Stage on ~ blood formation noted to LLE / heel. Rash ~ stuffiness noted to chest ~ groin area due to possible antibiotic reaction. NCT to LUQ draining bile colored drainage. ~ residual check and flush per MD orders. Optimental tube feeding @ 20 ml/hr. Will cont. to monitor. —(b)(6)
2200	25 mg benadryl given IVP temp 102.9 next tylenol due at 2200. ABG sent per (b)(6) order. Awaiting results —(b)(6)
2200	Zantac 50mg, 30mg Lovenox given SQ. Erythromycin applied to both eyes. 950 mg tylenol given per rectum. temp 102.9. —(b)(6)
May 29 06 0001	Pt repositioned to @ side, trach care provided. 25 mg benadryl given IV. 0 residual, noted at this time —(b)(6)

EXHIBIT 55

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29 May 06 0215	Pt repositioned to supine position. Pt RR 28 temp 102°. Next tylenol due 0400. Will cont. to monitor (b)(6)
0400	Am labs drawn, Am care done. 25 mg benadryl given. pt repositioned to (R) side (b)(6)
0600	FS 105, no coverage needed. pt tmp 101.9 axil 103 A line pressure 110/57 (b)(6)
29 May 06 1009	ICU Note: HD 15 Overnight there were no events Exam: 105/36 97 20 100% vent SIMV Pc 80%/TV 850/18/PEEP 10 PS 10 I/O = 5143/5310 Gen sedated, NGT/trach stable CV RRR & NL S1 S2 Lungs & BS entire (L) lung, diffuse rhonchi Abd soft in place, (+) colostomy output. ext - ACE wraps - Exp refill x 2 sec. Skin - Rash is now scaly, & less erythema & progression. Labs 7.33/54/99/28 iCa=1.09 14' 9.8 30 369 ?repeat 157 124 46 105 4.6 27 1.3 Alb=1.4 Alk Φ=6 ALT=224 AST=56 TB=0.6 Φ=4.0 CXR: progressive (L) lung infiltrate (R) basilar infiltrate (OVER) (b)(6) Lines (R) SC TL (R) Radial Foley Vac

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SE	RECORDS MAINTAINED AT
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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)

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EXHIB 56 4

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29 May 06 1009	ECV Cont'd A/P 1) Neuro / ↓ / pain - will wean today to check MS. 2) Pulm - Cont to have GNR in sputum from sample yest. Cont current vent settings & allow permissive hypercapnia c his ARDS PIPS still ~30's 3) CV - stable, CVP ~ 10, will follow CVP & IVF bolus keep CVP ~ 10-15 4) FEN - Repeat chem 7, Δ IVF to D5 ½ NS, Advance Tube feeds as he currently has no residuals. 5) ID - Have held Antibx's since yesterday given Rash. Sputum GS still ⊕, likely Acenitobacter. Consider test dose of Imipenem tomorrow. 6) Renal - ARF, suspect pre-renal, fluid bolus, have D/c Amikacin 7) Derm - Derm & ID consult done via email yesterday c initial impressions this is drug rash, but not a exfoliative process. Will follow p test dose of Imipenem tomorrow. (b)(6)
29 May '06 1230	- Versed gtt stopped per (b)(6) Continue to evaluate (b)(6)

ICU Bed #3

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1436 29May06	Day note: pt stable. BP's this am were in 110's et CVP in 7-9's. Pt received 1L bolus banana bag in 1hour et 500ml hetastarch. Pt current BP is 154/63 et CVP = 15. Pt still has decubiti on bilat heels et bilat buttox. Duoderm intact on buttox et pt being turned q2hrs. Feet elevated et padded to ↓ pressure on those areas. Bilat hands 3+ pitting edema; hands elevated. NGT D/C'd this afternoon c ↓d/min residuals. NGT replaced o DHT, xray done et verified for proper usage of DHT in stomach. TF ↑'d to 40ml/h Continue to monitor. (b)(6)
1900 29May06	Pt sats 93% on 100% FiO2. See nurse resp. decomp. note for details Pt sats ↓d @ 1730 again. Pt bagged o 100% BVM et suctioned for 15 mins. Sats ↑'d to 93% et stayed @ present. ABG results in chart for

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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)

REGISTER NO.	WARD NO.

ICU
Bed #3

EXHIBIT 58 4

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	current vent settings. Report given to night shift. Lungs both have symmetrical rise/fall equal L & R. lungs coarse throughout. 3 CT's @ present. (L) CT to 20cm H2O suction, (R) anterior CT to 20cm H2O suction, (R) post. CT to H2O seal. Ø sub q emphysema noted. previous orders resumed. CXR pending. Continue to monitor et al with night (b)(6) nurse to resume care. —

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

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

29 May 2006

1500 - Called to bedside by (b)(6), Dr. (b)(6) arrived VS: 136, (O_2 sats 72%)

1505 - O_2 sats continue to ↓ into 70's and improve to 96-9[illegible] after pt ventilated @ 100% FiO_2 via Bag/Valve mask.

1510 - P-141, sats 72% continues to ventilate 100% BVM.

1512 - Dopamine started @ 10mg/kg/min → B/P 80/60's

1520 - Chest tubes placed to (R) and (L) chest walls attached to 20 cm of H_2O suction - (Chest tube) placed by (b)(6)

1 Liter bolus LR infused

(b)(6) VS: 136, (93% SpO_2)

1522 - (b)(6) attempting to visualize obstruction via Bronchoscopy @ suction. VS: 137, (94% SpO_2)

1525 - Continue to ventilate @ 100% BVM. VS: 136 (89% SpO_2)

1528 - SpO_2 45% on 100% FiO_2 - continue to suction and ventilate.

1530 - SpO_2 47%, (55 HR)

1535 - Continue to Ventilate 100% NRB

1540 - Portable Chest X-Ray done.

1545 - Continue to Ventilate, 100% NRB

1550 - SpO_2 67%, HR 125, Continue to ventilate + Suction, Albuterol 1[illegible]

1600 - SpO_2 72%, continue to ventilate, Suction (Vecuronium 10mg) administered

1608 - 3 ml's Mucinyst administered via trach → (Cont'd)

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(b)(6)

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160 Bed #2

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EXHIBIT 60

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1618	- 3rd chest tube placed to (R) chest wall - attached to 20 cm of H_2O suction
1619	- Dopamine ↓'ed to 15 mg/kg/min (B/P 78/40) (-3rd Mucomyst per trach)
1620	- (b)(6) continues to suction - sat's 67%
1622	- Dopamine ↓'ed to 12.5 mg/kg/min (B/P 102/49)
1630	- Mucomyst 3 ml given per trach - ventilate & suction
1632	- Dopamine ↓ to 7.5 mg/kg/min (B/P 101/45)
1642	- (b)(6) suctions a large mucous plug via bronchoscopy sat's ↑ing from 70's to 100%.
1645	Dopamine ↓'ed to 5 mcg/kg/min. O_2 sat's 95%
1646	- Dopamine stopped - continue to ventilate.
1648	- Placed on ventilator @ 100% FiO2 SIMV-20 TV-[illegible] (b)(6)
	→ O_2 sats 98-100% continue to
1730	- hypoxic episode, sats 80's, BP 84/40
1734	- Dopamine started @ 8mcg
pt 1737	- MAP 57 90/30
bagged 1742	- Dopamine ↓'d to 5mcg BP 108/49
ō 100% 1746	- PEEP ↑'d 15
BVM 1747	- Dopamine off, sats 93% on 100% FiO2
et frequent 1800	- ABG drawn, see results BP Stable
suction 1830	- PIP ↑'d to 24
1900	- ABG drawn, see results (b)(6)

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EXHIBIT 61

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5-24-06 1710	ICU Resp. Arrest Note: See Nursing code note for details. In summary; pt had acute desaturation c lowest sats in the 30's. In addition he became hypotensive c SBP's in the 70's-80's. Initially removed from vent & manually bagged c improvement in sats. After aggressive suction still no improvement. Emergent (R) chest tubes were placed c the operators being (b)(6) Dopamine gtt was started c good response - max dose 15 mcg. Emergent Bronchoscopy revealed large mucous plug; mucus pt was lavaged into plug. After aggressive suction his saturations recovered. ABG during the acute event was 7.24/65.8/37/28 (PO_2 / Bicarb). CXR revealed apical (L) CT but posterior (R) CT c a pneumothorax on (R). Therefore a 2nd (R) CT was placed. CXR & repeat ABG are pending. He is back on vent SIMC c PC/Tv 850/RR 10/FiO_2 100% PEEP 10/PS 10. Plan scheduled mucous pt nebs, wean O_2 as tolerated, & resume previous care. There is concern for anoxic brain injury given prolonged period of hypoxia. (b)(6)

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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.
ICU #3 (b)(6)		

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EXHIBIT
62

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29 May 06 @1950	Notified by DCCS of Ethics Committee ~~from~~ (b)(regarding decision of in consultation c 30th med Bde commander to withold chest compressions, defibrillation + ACLS meds in the event of cardiac arrest. Orders written to reflect this decision (b)(6)
29 MAY 06 2140	After review of (b)(6) medical summary, consideration of Abn Hospital Ethics Committee recommendation for DNR order and discussion with (b)(6), (b)(6) and (b)(6) (b)(6) I concur with DNR order. I have informed (b)(6) TF-134 CDR, of my decision. We will continue all efforts short of chest compressions, defib. and ACLS medication (b)(6)

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1900 29 May 06	received report from day shift. Pt stable. ICU monitors & safety protocols in place. pt SpO_2 92%, suctioned aggressively, large amount plug retrieved and cle from trach, trach cares performed, pt SpO_2 up to 100%. Cont 1L LR bolus for hypotension. pt VSS $\bar{x}$ ST, febrile temp 103.2 Ice packs placed on neck & groin. (R) subclavian triple lumen 19 cm @ skin. (L) nare Dophoff in place clamped. CT x 3 (1 x L midaxil 2x R midaxillary). Wound vac to mid abdomen & mid (L) axilla. 16 F Foley draining cloudy, yellow concentrated urine with sediments, >30 (b)(6) Continuous care & monitoring given
2330 29 May 06	Pt placed on Levophed drip to maintain Systolic pressure >90. (b)(6) titrate for effect. Continuous care & monitoring given
0200 30 May 06	gave patient bed bath, shave, oral cares, trach care, Foley cares. Redress decubiti wounds on buttocks. changed linen. Δ'd CT dressings (b)(6) continuous care & monitoring given to patient
0400 30 May 06	pt sedated lying on back. VSS $\bar{x}$ ST febrile 102.9. No Δs in (b)(6) pt status - will continue to monitor and provide care
0500 30 May 06	↓ F_iO_2 to 50%. am ABG: 7.44/38.7/227/28/26.5/100½. Redra @ 0530. Am assessment performed. NO Δ to last assessment $\bar{x}$ fine Rhonc throughout bilateral. Continuous care & monitoring given (b)(6)
0530 30 May 06	pt responds to pain and shows purposeful movements. GCS 10 (b)(6)
0600 30 May 06	am labs drawn 950 mg Tylenol given PR for temp 101.5. Levophed titrated do to 1 mcg/min will attempt to titrate to off (b)(6)

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(b)(6)

ICU Bed #2

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EXHIBIT 64

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 May 04	Surgery
2304	Events of today summarized well per (b)(6) [redacted]
	Now DNR no CPR / ACLS meds / cardioversion / shock.
	Currently hypotensive requiring fluid boluses. May
	need pressors soon as SBP ~ 70-90mm Hg.
	Suspect profound septic shock / ARDS / multiorgan
	failure.
	Continue all other care & aggressive pulmonary toilet /
	Breath prn.
	Surgery / will Δ NGen indefinitely until pt less labile
	If ∅ improvement will Δ VAC @ bedside
	tomorrow. (b)(6) [redacted]
30 May	RT assess, pt given Mucomyst - 3.2 ml
0130	via neb @ 6lpm inline. HR 106 Sat 100
	changed circuit. (b)(6) [redacted]

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EXHIBIT 65

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
0700 30May06.	gave report to oncoming shift. Continue care & monitoring given — (b)(6)
30May06	Pt assessment completed, see ICU flowsheet. Pt ventilated
0800	via trach c SIMV/PC TV850 FiO2 60 RR20 Peep15 PS
	SaO2 100%. Pt sedated c fentanyl 200mcg/hr (10ml/hr)
	versed 6mg/hr (6ml/hr) to proximal Ⓡ SC, levophed to
	medial @ 1mcg/min (75ml/hr) + maintenance @ 125ml/h
	D5 1/2NS to proximal lumen. Pt has ⓟ corneal reflex, ⊕ g
	cough reflex c suctioning. Will continue to monitor. — (b)(6)
5-30-06	ICU Note: HD16
0845	Overnight after respiratory event, mucomyst nebs were
	started & aggressive suction was utilized. Low dose
	levophed was also started. No further events, and FiO2
	was weaned down to 60%.
	Exam: 121/43. 110 20 102^6 100% SIMV PC 20 TV850/PEEP15/PS10 / I:2
	I/O: 4682/4836 Note IVF Bolus ~2L not recorded ∴ ~6500/4836
	Gen Sedated — Lines & tubes
	c mild tachy s @/glr — Dophoff Ⓛ
	Lungs ↓ rhonchi but still present — trach
	Abd vac in place, BS, ⊕ colostomy — Ⓡ SC TL
	ext ↓ LE edema c ACE wraps. — Ⓡ CT x 2, Ⓛ CT x T
	Ⓡ rad. art line
	(b)(6) — Foley
	(Continue) — Continue —

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EXHIBIT 66 4

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
6-30-06	ICU Note Cont
0845	LABS
	ABG 7.43/40/83/27/96% $16^{6} \rangle \frac{8^{9}}{27^{7}} \langle 323$ $\frac{136}{9.2} \mid \frac{125}{23} \mid \frac{55}{1.9} \rangle 166$
Needs	CXR: (B) CT's, ARDS Alb=1.4 Alk=77 Amy=140
Banana Bag	PT/INR = $\frac{9.4}{0.9}$ AST=398 ALT=197 TB=6.6
D5 1/2 NS 125cc/hr	TG=412
Mucomyst nebs QID	Cultures: ∅ Growth in Blood
-levophed gtt	Sputum: Enterobacter - Sensitive to multiple Antibx
-ofenux 30 BID	E. coli - Sensitive to multiple Antibx
ISS	A/p 1) Neuro/Ψ/Pain: cont needs.
Imuyer eye	2) Pulm: Greatly improved this am. Cont to wean F_iO_2 as
Fentanyl gtt	much as poss. Pulm toilet, mucomyst nebs.
Versed gtt	3) CV: Guarded, levophed is down to 0.5mcg this am
Zantac 50 BID	and we will cont to wean as long as SBP
incr cloths TID	is maintained.
Nystatin powder	4) Gel: Attempt to resume TF via DHT as tolerated.
	Transaminase are a little lower.
	5) FEN: ↑Na+, suspect poss. DI but unable to √urine Osm
	Will cont @ D5 1/2 NS @ 125cc/hr as maintenance &
	follow.
	6) ID: Cultures back & NO acenitobacter in sputum, ∅ growth
	in blood. (+) Enterobacter, (+) E. coli. Sensitive to
	several drugs. Start Levoquin 750mg IV QD, will
	follow renal function & if no improvement will √done
	to 500mg QD. Add Diflucan 400 QD.
	7) Skin: Rash is improving, no need for Imipenem now.
	If needed in future will test dose first. Cont decub
	care.

(b)(6)

(b)(6)

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ICU Note

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
30May06 1200	Pt assessment completed, see ICU flowsheet for vitals. Cur Ø Changes.
1307	(b)(6) at BS change wound vac to midline abd + (L) axillary. Pt premedicated by (b)(6) c prop ketamine, fintanyl, + vecuronium. Pt remains on vesicul + fentanyl drip. Pt tolerated procedure well. Sl changed + mouth care performed at 1407 after pr TF restarted at 20ml/hr + pt given 100ml Albumin ~~NOT~~ clothing. Will continue to monitor. (b)(6)
1600	assessment completed, see ICU flowsheets. FiO_2 ↑ back up to .55 from .50. SaO_2 100's, otherwise Ø Changes. Will continue to monitor. (b)(6)
30may06@1915	Assumed care of pt per (b)(6) report. Pt stable in NAD. Vent settings SIMV Rate 20, TV 900 PIP 20, PEEP 15, FiO_2 55%. Pt opens eyes spontaneously. Optimental feeds @ 20mL/hr through (L) nare dobhoff. Fentanyl gtt infusing @ 200mcg/hr (40mL/hr) and v gtt infusing @ 5mg/hr. D5 ½NS infusing 125 mL/hr. Pt placed r (R) side. CT x2 to (R) and CT x1 to (L) draining c wall suction. Pt appea to be resting. All care complete @ this time. Will continue to assess and monitor (b)(6)
30May06@2080	All lines flushed and new foley catheter placed. Pt opens eyes spontaneously and has purposeful movmt. Will continue to m

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(b)(6)

EXHIBIT
68

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
30May 2100	RT ASSESS. RT Delivers 3 mL Mucomyst TO PT VIA in line NEB. HR 99 SAT 100 RR 20 NO SIDE EFFECTS (b)(6)
30May06@ 2330	Assessment completed. Pt has drained some kidney stones through new catheter that was placed. Pt arouses to spontaneous. Pt moves fingers. Temp 101.9. Pt has ice packs to underarms. Pt laying on (L) side @ present c HOB elevated. Lungs still rhonchorous in upper lobes, diminished CT x3 draining serosanguinous drainage. Suctioned. Pt resting in bed Continue to assess and monitor (b)(6)
31May06@0330	Assessment completed, AM care completed. Pt bathed, hair washed, oral care complete. Ace Wraps taken off for 1°, placed back on feet. Pt arouses during bath. Lungs still rhonchorous, trach care done again. Suction x4 - brought up large amounts of bloody thick secretions. Pt in and out of sedation @ times will have purposeful gaze, movement, to response. Will continue to assess and monitor (b)(6)
31May 0430	RT assess. RT deliver 3mL Mucomyst to RT via in line neb (b)(6) HR 110 RR 20 Sat 100. No side effects.
31May06@0630	AM care, AM CXR, am labs complete. Showed (b)(6) ABG pH 7.326, pCO_2 45.7, PO_2 79, HCO_3 23.8, BE -2, SO_2 95% pt slightly acidotic, but (b)(6) stated to leave vent settings as is to see if pt improves himself. Pt arouseable @ times. fent ↓ 175mcg/hr, versed ↓ 5mg/hr. Will continue to assess and monitor (b)(6)

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EXHIBIT 69

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5-31-06	ICU Notes!
0830	No events overnight.
	Exam 114/50 110 20 100² 97% vent SIMV RR 20/600/15 Peep/PS 10/50%.
Med	CVP=15. I/O=6030/5903
Banana Bag	Coen Sedated but makes purposeful movements.
Mucomyst	Neuro old IP sites clean
IS's	Lungs + Rhonchi, few faint wheezes
E-mycin oint	CV RRR + prominently splint S2 @ R/LUE
Dext gtt	Abd (+) colostomy output
Versed gtt	ext ↓ BLE edema
Zantac 50 BID	
Nystatin powder	LABS
Levaquin 750 QD D2	ABG 7.33/45.7/29/25°/95% iCa 1.2
Diflucan 400 QD D2	153 (4.1) 124 (26) 59 (2.0) 132 ADD=1.2 AP=73 TB=0.6 Φ=5.2
TFR 20cc	ALT=162 AST=247 Ca=8.6 TP=5.6
100cc water TF TID	18 26 8.5 297
Sucralfate TID	

LINES
(R) SC TL
(R) CT X2
(L) CT X T
(L) DH Foley
(R) radial art line

A/P
1) Neuro/P/Pain: stable making purposeful movement
2) Pulm: stable on FiO_2 50%; cont therapy
3) CV: Stable, IF ↓HCT over past several days will transfuse 2 prbcs, also ✓ BNP.
4) GI: cont to home colostomy output, had resistant yeast.
5) FEN: ↑ Na+, will gently replace free water advance TF to 40cc, keep HOB elevated
6) Renal: slowly improving
7) ID: ↑ WBC, low grade fever, cont levaquin ↓ 500 QD for Renal dose. Cont Diflucan — Candida -

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(b)(6)

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EXHIBIT 70 4

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5-31-06 1430	ICU Note: addendum Patient O_2 sat ↓ down to 90% after 2nd unit RBC's. Exam c/w pulmonary edema. CVP was w 12; → Rezeroed and 20-24. Plan diuresis ī 20mg IV Lasix. In the future when blood is needed will give Lasix between units. Plan to wait to titrate O_2 back down to 50% if possible, & keep HOB elevated. Procedure Note (L) Radial arterial line Operators - (b)(6) Placed over wire ē EBL ~ 5cc Complications None: (b)(6)
31 May 06 1320	Assessment completed, see ICU flowsheet. Pt Stable, T.Max 100.2 Axillary. KUB done to confirm DHT placement. DHT in stomach et TF ↑'d from 20ml/hr to 40ml/hr. Pt tolerating ↑ TF. Pt to I. vent settings @ 50% FiO_2 & Sats of 100%. Continue to monitor. (b)(6)
31 May 06 back note	1445 - pt sats 90% On 50% FiO2. Frequent suctioning required. Large amounts thick bloody sputum suctioned et then turned into pink frothy sputum to reveal pulm. edema. Continuous suctioning done per RT, D5½NS turned to 10ml/hr, et 20mg IV push lasix given. (b)(6)

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EXHIBIT 71

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
FiO2 set @ 100%. ↓ FiO2 when pt tol sats ≥98%. Do ABGs to check IF pt tol.	bedside during the initial presentation of pulm edema. Pt turned on backside c HOB elevated, CVP reading = 19. Hold DS½NS @ 10ml/hr until further orders. Continue to monitor pulm. status c frequent/aggressive pulm. toileting. — (b)(6)
Blood transfusion note 31 May. 1618	Pt Hct this am was 26.3. Orders written for 2u PRBCs to be transfused. Blood transfusion started @ 1112 et ended @ 1605. No reactions to blood or during transfusion @ present. See Form 518 for vitals. Strip from propack included c continuous vitals during transfusion. Post CB to bedr @ 17(pt current temp = 100.3 — (b)(6)
31May06 1645.	ABGs done @ 1600, c FiO2 @ 80%. Sats are 99%. Sputum suctioned os more yellow/tan e occassional bloody mucus. RR 22, NAD noted. See ABGs for results. Continue to monitor et check ABGs. — (b)(6)

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EXHIBIT 72 4

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
31 May 01 1930	Assumed care of pt from day shift. Pt stable VSS. 134/70 111 20 100% CVP 10. Vent settings F_iO_2 80% SIMV/PC R 20 TV 900 PEEP 15 PSV 10. Pt does have facial grimace to stimulation light or pain. Lungs Rhonci (B) & slight diminished sounds (B) ∅ BS +2 pulses to radial, +1 to LUE faint +1 to RLE. +3 pitting edema to (B) UE + LE, cap refil <3sec, slightly cool to touch. Pt currently on (L) side. No restraints. CT to (R) side x2 anterior & posterior. 7cc drainage from 1800 - 1930 Foley drainage in tube currently at 32 ml / posterior 30 cc drainage from 1800 - 1930 due to drainage noted in tubing, currently q 1hr. CT x1 to (L) side ∅ drainage noted from 1600 to 1930 @ 120 ml, all CT @ 20cm H_2O seal. (R) subclavian III lumen patent, flushed & draws blood back, cvp monitoring to red port, Fent @ 8.5 ml/hr / 175 mcg/h, Versed 5.0 ml/hr / 5.0 mcg/hr D5 .45 NS @ 10ml/hr all running to white port, blue port HL. Aline to (L) wrist placed 31 May 01 @ 1700, patent. No drainage noted in colostomy. Black oval shaped necrotic like tissue & red ring noted below first layer of skin on (L) heel. Will cont to monitor (b)(6)
2000	F_iO_2 decreased per (b)(6) to 70%. 2 amp calcium chloride given IVP. Will monitor and draw ABG to monitor changes (b)(6)
2100	STAT ABG & CVP DRAWN DR (b)(6) TO EVALUATE LIGHT CHANGES & RENAL FUNCTION (b)(6)

(b)(6)

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EXHIBIT

Y 73

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31May06 2230	Lab results back PO_2 118, (b)(6) ordered F_iO_2 to 60% and elevated @ 71. Pt metabolically and respiratory acidotic. Will cont to monitor ——— (b)(6)
31May06 2330	RT Asses. RT Delivered 3mL Mucomyst 2.5 mg ABS in 3 NSS to PT via in Line Neb @ 8 LPM. HR 115 RR 28 SAT 99 (b)(6)
1Jun06 0000	Pt stable, facial grimacing noted. VSS. 107/66 HR 21, 99. 100.7 (A) — Will cont to monitor ——— (b)(6)
0230	Pt stable, pt moved to (R) side. spontaneous eye opening noted, apils responsive. VSS. 110/60 104 100%. CVP 8. ——— (b)(6)
0500	AM CARE DONE, AM LABS DONE, AM CXR DONE. PT INCREASED TO 30 RR, 100 cc H_2O PUSHED THROUGH BOVIAFF. PEEP DECREASED TO 7.5 & VERSED ↓ TO 4. PT TEMP 101.1, WILL MONITOR AFTER PT CALMS DOWN ——— (b)(6)
0630	T 101.3 RR 20. BP 146/78. CVP 10 HR 128 SATS 94%. PT ON (R) SIDE. OSTOMY BAG CHANGED CT DRESSINGS CHANGED ——— (b)(6)
1Jun06 0800	Assessment completed, see ICU flowsheet. Pt is ventilated per trach SIMV/PC TV 950 FIO_2 60 RR 20 PEEP 15 PS 10

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.

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	SaO_2 99%. Pt is sedated & fentanyl at 7.5 ml/hr (150mcg + Haldol @ 4mg/hr (4ml/hr). Pt has spontaneous eye openi + responds to noxious stimuli by facial grimacing. PT ~~spontaneous~~ ⊕ Cough / gag reflex & suctioning. Pt curr receiving 500ml NS Bolus via ⓟ TLSC to medial port + CVP reading to distal port. Will continue to monitor — (b)(6)
6-1-06 0855	ICU Note:
Meds	No events overnight. Titrated F_iO_2 down to 50%
Atb. meds	Exam 111/64 133 20 99%. vent SIMV PC Tv 900/20/FiO2 50/PEEP 15/PS 10 pvc Tv 4-600
Mucomyst	I/O: 3861/5404
Lovenox	Gen sedated, trach in place ABG 7.35/41/117/22.7
ESS	Lungs Diffuse rhonchi crackles.
Zmycin	abd vac in place Fecal BS
Fentanyl gtt	ext 1-2mm ⓑ LE edema
Versed gtt	CV tachy S @ 1/lr
Zantac	
Nystatin	
Levaquin 500	
Diflucan	
IVF @ 40ml/hr	
Sucralfate TID	
200 H_2O TID via PT	

17 | 10 | 238 / 30
153 | 127 | 77 / 4.5 | 23 | 20 | 124

Alb = 1.4
Alk = 91
ALT = 147
AST = 162
TB = 0.7
Cu = 8.0

CXR - Diffuse patchy
ASP - no Δ

Asp: Neuro/Y/pain - stable

2) Pulm - Developed Pulm edema ⊕ IVF & Blood yesterday Give 4 BNP suspect LV Dysfunction. Will have to give very gentle fluids. Titrate F_iO_2 as poss.

3) CV - May consider low dose ACEI in the future if renal Fxn returns. Can't current management now.

4) Renal: ↓ Creatine, ↑ BUN: concerned for worsening uremia. Fluid status very tenuous; suspect he may be overall Fluid up; but IV Fluid down. Small bolus

5) ID: Stable, ↓ WBC; cont antibiotics.

(b)(6)

(b)(6)

CV Back

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EXHIBIT 75 4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6-1-06 1138	ICU Addendum! After 500cc NS bolus this am pt had desat down to 85%. ↑ F_iO_2 to 100% & performed aggressive suction, CV. Repeat ABG reveals adequate ~~PO_2~~ ww 94, however he cont to develope progressive hypercapnia c most recent ABG 7.12 | 73.8 (PCO_2) | 94 (PO_2) | 24.4 (HCO_3) | 94% on 100% F_iO_2 Attempted to ↑ rate but can't to pull low Tv ~300–400 c peak pressures ~40. Change vent back to Vol. control Simv Rate=20 | Tv=800 | F_iO_2=100% | PEEP=5, & were restarted vec ylt. c that change he now has Tv in the 750–800 range. Also chem 7 revealed BUN=80, K^+=5.6. EKG revealed ⊗Δ's associated c Hyperkalemia. Plan repeat ABG & chem 7. Will change vent based on results. If K^+ still elevated c & EKG changes, will consider Kexalate. (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) ICU #3.		

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EXHIBIT 76

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

EXHIBIT 77

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1Jun06	500ml NS Bolus Complete. HR ↑ 149, sat ↓ 87%. (b)(6)
0930	at BS. FiO_2 ↑ to 100% from .50. Pt suctioned appro
	ABG drawn. BP 100s/50s (70s) map.
0945	ABG results given to (b)(6). Pt remains on FiO_2 100%
	P(insp) pressure ↑ 24 from 20. HR 148 BP 100s/50s (70
	SaO_2 96%. Ordered to draw ABG 1030. Will continue to
	monitor. (b)(6)
1030	ABG ~~repeated~~ repeated. Results given to (b)(6) ECG done
	per (b)(6) + Vent settings changed to SIMV IV.
	FiO_2 remains at 100%, TV Δ to 800 from 95
	Will repeat ABG in 30 minutes SaO_2 ↑ 99%. Will
	Continue to monitor (b)(6)
1045	Pt given 20 mg IVP Vecuronium + started on Vecuro
	drip per (b)(6). 1mcg/kg/min (6.3 ml/hr).
1200	Assessment Completed. See ICU flowsheet for vitals. Pt
	remains on Vecuronium drip at 1mcg/kg/min (6.6ml/h
	+ Sedation fentanyl @ 125mcg/hr + Versed 2mg/hr. Vent
	Settings SIMV volume control RR 25 TV 800 Peep 15 PS
	SaO_2 100%. ABG due @ 1315. Will continue to monitor.
1600	Pt assessment Completed. Vecuronium drip turned off
	per (b)(6) Vent settings changed to SIMV/PC RR 2
	TV 850 Peep 15 PS10 FiO_2 .90 SaO_2 100%. ABG +

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)		

ICU Bed #3

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EXHIBIT 78

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Chemistry drawn. Pt turned to (L) side. Will continue to monitor.
1715	FiO_2 ↓ to .80 ᾱ ABG results reported to (b)(6) tylenol per rectum 975mg given for T 102.7 (R) (b)(6) CT x3 changed to water seal.
1900 1 Jun 06	assumed care of pt from day shift. report received, pt stable VSI, DN (CODE STATUS III). ICU monitors & safety measures in place. Evening assessment complete. See assessment sheet. All changes from assessment (evening) will be noted on progress notes. (R) subclavian triple lumen 19cm @ skin (L) radial art-line zeroed patent. CVP zeroed. all ports on triple lumen flushed 16 F Foley draining clear yellow urine with some sediment. CT x 3 to (b)(6) H_2O seal. pt lying on (R) side. continuous care & monitoring given
2000 1 Jun 06	drew labs sent specimen to lab results pending. (b)(6)
2200 1 Jun 06	gave 975 mg Tylenol PR for temp 102.3 oral tolerated well continue to monitor & give care to pt (b)(6)
2200 1 Jun 06	RT ASSESS. RT DELIVERS 3 mL Mucomyst And 2.5 mg alb in 3 NSS to PT via in line neb (b)(6) @ 6 LPM.
2240 1 Jun 06	pt ventilator High pressure alarm on. pt SpO_2 ↓ 86% 100 FiO_2 suctioned with inline suction met resistance. used 16 F Trach suction x3 times. suctioned copious amounts of tan → dark bloody secretions (b)(6) pt SpO_2 back to 97% 70% FiO_2 continuous care & monitoring given
2320 1 Jun 06	increased FiO_2 80% from 70% pt sats continued to drop. repositioned (b)(6) SpO_2 meter x3 good wave form. SpO_2 93% FiO_2 80%. (b)(6) @ bedside with verbal order
1 Jun 06 @ 0030	RT changed I:E ration 2:1, Rate 20, labs not seen yet by this nurse MD has not told nursing staff of orders. Will talk to nurse who is in care of this pt (b)(6)

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6-2-06 1800	ICU addendum: Patient had acute desaturation down into 80's. ↑ FiO_2 to 10. ↓ response, bagged manually and performed aggressive suction. Obtained CXR, held TF, and sats increased to low 90's. Pt then dropped SBP down to low 80's; → Given 500cc NS bolus, 250cc IV Albumin and Dopamine up to 10 mcg/kg/min ↑ Recovery of SBP. Currently on previous vent settings ↓ FiO_2 set @ 100%. Dopamine @ 2. (R) CT's put back on suction as CXR revealed small apical PTX. Also CXR revealed New RUL infiltrate. Plan to repeat ABG in 30 min as ABG during event is as follows: 7.15 | 68.5 (PCO_2) | 65 (PO_2) | 24.3 (HCO_3). (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.

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EXHIBIT
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0200 2 Jun 06	Pt vent Δ made. ABG results pending. Pt stable afebrile. aggressive suctioning performed grey to dark brown bloody sputum noted. Weaned sedation to: versed 1mg/hr Fentanyl 50mcg/hr. Performed am cares / bed bath, foley cares, oral cares, redressed CT site Ⓛ mid axillary. redressed Ⓑ buttocks with duoderm. Changed all linen & IV tubing. performed Ⓛ radial artline dressing change. Continuous care & monitoring given — (b)(6)
0400 2 Jun 06	am assessment completed; Ⓡ lung fine Rhonchi Ⓛ lung coarse Rhonchi. BS active x 4. Vent change / settings. SIMV PC, Rate 25, Vt 850 PEEP 15, PSV 10 Pi 24, FiO2 80%. SpO2 100%. Continuous care & monitoring given will note any changes. am labs drawn and posted — (b)(6)
0700 2 Jun 06	gave report to oncoming shift. Pt resting / sedated — (b)(6)
6-2-06 1015	ICU Note: HD20
meds:	No events overnight. Unable to titrate FiO2 below 80%.
tb nebs QID	Exam 122/60 109 29 100³ vent: SIMV PC R=25 / TV850 / PEEP15 / PS10. CVP = 16.
mucomyst	LABS ABG: 7.31/426/75/21.8
lovenox	Gen sedated
SSI	CV: mild tachy, ⊘Rub, ⊘M, ⊘S3
Fent gtt	lungs: diffuse rhonchi / crackles.
Versed gtt	Abd: ⊕ BS, NT/ND, good ostomy output
Zantac 50 BID	ext: 1-2mm LE edema
Nystatin	154 / 125 / 87 / 151 ; 4.4 / 20 / 2.7 ; ALT = 203 ; AST = 271 ; 19 > 9.4 / 28.5 < 269 ; PT/INR = 14 / 1.4 ; BNP = 153 ; CXR: ? pulm edema ; f/u no Δ. ⊘PTX
A/p	1) Neuro / P / pain - cont
levofloxacin 500	2) Pulm: ? edema, Lasix 10mg IV
Diflucan 400	3) CV: Suspect vol. overload despite I/O measurements. Will gently diurese & follow lytes.
sucralfate TID.	4) ID: Cont current antibx.
	5) FEN: Cont current TPN TF & IVF — (b)(6)

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EXHIBIT 81

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

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

03 June 06 0700 Received pt from previous shift. Assessment completed and noted on ICU flowsheet. 1000 (b)(6) ordered a chem 7 to verify sodium levels reported earlier. Results pending. 1400 Dobhoff tube flushed w 200 ml free water. 1500 Tube feeds changed from Optimental to Nepro @ 50ml/hr as ordered by (b)(6) 1700 O2 sats ↓ to 93%, suctioning by RT followed treatment (Chest PT) produced small amount blood tinged mucus. CVP was zeroed, results 2, BP 113/53 (74). Tube feeding stopped per (b)(6) Lasix 20mg IV push given per (b)(6) orders. Stat CXray completed. ABG drawn and sent for results. 1730 (b)(6) @ bedside, O2 Sats ↓ 88%. BP- 79/37 (50's). All sedation (Fentanyl/Versed) stopped. (R) chest tubes connected to suction per (b)(6) RT began bagging PT & BVM. CXray revealed aspiration and pneumothorax. NS bolus of 500cc, Albumin 5%. 250ml started, Dopamine 5mcg/kg started per Dr. (b)(6) RT began responding to current treatment regimen, BP-110/50 (70), Sa O2 100% on ventilator, FiO2 ↑ to 100%. per (b)(6) during ~~this~~ episode. 1800 BP-132/65 (87) Sa O2 99% NS reduced to 75cc/hr after bolus. Albumin completed. Some blood noted in urine. Dopamine titrated down and turned off. 1835 Repeat CXray completed and ABG redrawn. (b)(6)

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPAR

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)

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EXHIBIT

0089 06 CID789 78469

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2 June 06	I, (b)(6), assumed care of pt. ~~Hen~~ DP current vent
1920	settings: RATE 25, TV 850, PSV 10, peep 15, FiO2 100, mode
	SIMV. ~~set~~ settings do not match orders of Doctor, will
	Notify MD. Versed 4.0 mg/h @ 4.0 ml/h. Fent 150 mcg/h
	@ 7.5 ml/h, NaCl @ 75 ml/hr. Pt has NaCl Running (b)(6)
	orders are for D5 ½ NS, will notify MD.
2000	Tube feeding put on hold on previous shift per verbal order (b)(6)
	(b)(6)
2040	MD CARE NOTIFIED About vent/Fluid orders not matching.
	orders corrected as need. D5 @ 75 cc/hr maint fluids per
	orders of (b)(6). Dobhoff flush 100 cc QID. TF still (b)(6)
	on hold, will cont. to monitor
2 June 2200	PT ASSESS – PT delivered 3mL mucomyst and
	unit dose albuterol 2.5 mg/3 NSS solution via neb in line (b)(6)
	@ 6LPM. PT received CPT 10 MIN.
2300	Pt positioned on his (L) side. Trach care performed. SpO2 98%
	Pt. has ~~set~~ skin tear @ Trach site from sutures pulling @ (b)(6)
	skin. site covered c̄ bacitracin. MD will be notified
June 0400	RT Assess – PT delivered 3mL mucomyst and unit dose
	albuterol 2.5 mg/3 NSS solution via neb in line @ 6 lpm.
	PT received CPT 10 min (b)(6)
3 June 0425	AM CARE given. pt cleaned and linen changed. Drsg Δ
	to both chest tube sites and ART line. Oral care given to (b)(6)
	pt. 1/SS will cont. to monitor.
0630	LABS RESULT returned, ABG values will be reported to MD,
	CXR per orders. Fluids D5 @ 75 cc/hr. Dobhoff flush
	100 cc QID. PH 7.178, PCO2 60.6 Resp acid, will report to
	MD/ Next shift. Drsg Δ to both Chest tube sites and Art line

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EXHIBIT 4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 June 04 0630	15cc output from the chest tube. Min drain wound ... (b)(6) [redacted]
	Total 3686 input, 4629 output, —
3-6-04 0830	ICU Note: HD21
	Called to bedside by nurses as pt dropped sats to 88% & SBP dropped to low 90s c MAPS ~65. CVP ~14, suction yielded ~200cc of bloody sputum & manual Bagging c 100% FiO2 returned sats to 98% on 100% FiO2. Otherwise no events reported. However a Tm = 102.9 was noted.
	Exam: T = 102.9, Tc = 101.8, 104/49, 130, 25, vent SIMV PC R25/Fi 80%/PE 15/PS 10
	I/O = 3689/4629 ABG: 7.17/PCO2 60.6/PO2 101/22.5
	Gen: sedated, trach suture skin breakdown. Pupils reactive
	cv: tachy, grub appreciated
	Lungs: diffuse coarse rhonchi
	abd: ⊘BS, ↓stool (200cc)
	ext: [illegible] LE edema
	LABS 0840 draw: 20.1 > 8.6/27.5 < 256; 156 / 126 / 88 < 119; 4.7 / 21 / 3.1
	APP = 116 ALT = 150 AST = 150 TB = 0.7
	Alb = 1.5 TP = 6.2 Gram stain sputum: Many GNR.
	[illegible] INR/PT = 1.8/17.9
	[illegible] Bloody

84

ACLU-RDI 5531 p.74

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Jun 06	lab results posted (b)(6) @ bedside reading results. No orders or Δ's made to chart. Continuous care & monitoring given to patient (b)(6)
3 June 06	RT assess. (b)(6) 3 ml Mucomyst and 2.5 mg Alb in 3 ml via neb in in line neb (b)(6) @ 6 LPM. (b)(6) for 10 min Given Tx (b)(6) (b)(6)
3 Jun 06	evening Medications given. pt suctioned x3 in line with moderate bloody secretions tan colored with clots. pt tolerated well SpO2 99% @ 80% FiO2. Trach cares, oral cares, foley cares performed. All lines flushed, blood pulled, Ports patent. CT x2 Ⓡ to wall suction minimal output. Foley draining to gravity clear yellow with some sediment / cloudy areas. UOP quantity sufficient. Central line 18cm skin. Dophoff to Ⓛ nare. clamped / flushed with 100 cc H_2O (sterile) pt position changed every 2 hrs to prevent further skin breakdown. Continuous care & monitoring given patient stable (b)(6)
4 Jun 06	2400 FSBS 125 Ø coverage [illegible] sliding scale needed. patient placed [illegible] 100% 80% FiO2 continues [illegible] (b)(6) [illegible]

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
June	O_2 sat ↓ 92%. HR 114 A-line 113/52 (73) RR 35. Pt suctio
0735	x 2 ∅ sputum. FiO_2 on vent 100%.
0745	O_2 sat 85%. RT - (b)(6) at BS bagging pt c BVM 100%. 108/52 HR 112 RR 35-40. O_2 ↑ 92% c
0750	(b)(6) at BS ordered 2mg bumex IVP given by (b)(6)
756	BVM Sat 92%. HR 104 94/46 cuff, Art line 82/41(5 Fentanyl + Versed gtts stopped. Levophed ↑ to 3mcg/mi 5% albumin started bolus 250ml. Pt suctioned by RT, moderate amount of tan / bloody secretions. (L) CT on H_2O seal placed back on 20cm suction.
800	O_2 ↑ 100% c BVM, A-line 96/45 HR 106
810	↓ sat 83% after placing pt back on vent. D/C vent, b to BVM.
815	BVM SaO_2 100%. Aline 112/52, (MAP - Cuff 110/50 HR 109
820	25%. Albumin bolus SaO_2 93% c BVM HR 111, A-lin 112/53
830	2mg [redacted] IVP per (b)(6). UO since 0800 80m O_2 Sat c BVM 84%

AL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
400 4 Jun 05	Performed am cares, bed bath, Poly, trach, tube, cares oral cares, am assessment complete am labs and CXR obtained results pending: change linen and repositioned patient. continue care & monitoring given (b)(6)
4 Jun 05 0745	Pt assessed, see ICU flowsheet, pt vent settings thru Trach R 25, VT 850, FiO2 80%, PS 10, Peep 15, Versed 4mg, Fent 150 mcg pt resting, mild monitor (b)(6)
6-4-05 0900	ICU Note: HD 22 No events overnight. Exams. 134/66 99 RR25 98% 100% SIMV PS/TV850/FiO280/RR25 I/O= 3178/4817 -1638 PEEP PS 10 Gen Periorbital edema diffusely. ABG 7.29/41.8/107/20.5 Neck: skin breakdown around trach. CV RRR @ sub Lungs Diffuse Rhonchi abd vac in place ext 2-3mm edema. A/P 1) Neuro/Pain = cont, wean sedation for short period task 2) Pulm: ↓ FiO2 to 70, repeat ABGs in 1° 3) CV: Stable, failure ↑ BNP. Cont lasix 4) FEN: still ↑ Na+, can't give free water replacement ↑ D5. Resume TF @ low rate [OVER]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECOR (b)(6)
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)		

ICU Bed #3

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EXHIBIT 87

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

PART I

ICU Note cont

5) Renal: Progressive Uremia, maintains high volume of urine output. Cont to have acidemia 2° to ↑BUN - Awaiting CRRT

6) ID: ↓WBC, cont IV Levo.

(b)(6)

4 Jun 06

0945 (L) Blister on (R) ear, MD notified, pt turned prn, will monitor

0946 Pt suctioned on line, noted thick white mucous. Pt tolerated well, will monitor

(b)(6)

1038 ABG results received, MD notified, RR 28, FiO2 @ 60%. will monitor

(b)(6)

1200 Pt reassessed, no significant Δ's, vent RR 28, VT 850, FiO2 65%, PEEP 10, PEEP 15. NO other Δ's, will monitor

(b)(6)

4 Jun 06 1435 Pt turned on (R) side, sats ↓ 68%, RT @ bedside and started ventilation via BVM for five minutes. Sats ↑ to 97%. Will notify MD. Will continue to monitor.

(b)(6)

1505 Pt c (R) LL rhonchi & crackles, Lasix 20mg IV given per MD, SpO2 @ 95%, will monitor

(b)(6)

1615 1st CRRT PROC started Temp 99.9, 120, 120/62, Temp @ 0620 99.9 oral, 99.8, sec sign, will monitor

(b)(6)

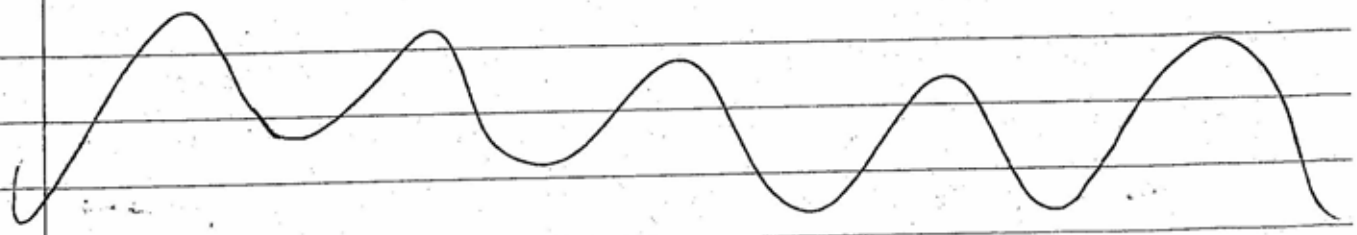

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EXHIBIT 88 4

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4 June 06 1900	I, (b)(6) ASSUMED CARE OF THE PT. VS WNL HR - 131, BP 116/64, SpO2 96%. DAY SHIFT REPORTED GRADUAL DECREASE IN O2 SAT. VENT SETTINGS: RATE 33, TV 880, PS 10, PEEP 5, FiO2 80% MODE SIMV/PC. Fluids: Versed 6 mg/h @ 6 ml/h, Fent 175 mcg/h @ 8.8 ml/h. D5 on hold. PRBC @ 125 cc/hr hung @ 1845 by previous shift. Dobhoff @ nare, E suplena @ 30cc/hr. Reported by (b)(6) pt is to begin TX of imipenem cilastatin to bacterial presence. VS AND pt integrity will be closed monitored. (b)(6)
2000	GRADUAL ↑ IN temp since infusing of PRBC. Initial temp 99.9. @ 1930 - 100.8, @ 1945 = 101.3. Cold packs placed b/lat atm p.t AND GROIN AREA. MD will be advised of findings (b)(6)
2120	1st u PRBC infusion completed, no adverse effects noted. 2nd u PRBC infusion started. 18g IV initiated @ upper arm. Versed being infused via peripheral line. (b)(6)
2200	RT ASSESS RT DEVICE 3 ML MUCOMYST AND UNIT DOSE 2.5 MG ALB IN 3 ML NSS VIA IN-LINE NEB PER LDM. (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)

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

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EXHIBIT 4

ICU BED #3

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4 JUNE	THIS IS the flow sheet for vitals/monitoring of the drug INFUSING DESENSITIZATION process, MEDICATION imipenem.
2145	1st Bag (1A) Imipenem infused HR 130, BP 118/57, RR 13, SpO2 95%, Temp 100.6 Ø RASH, Ø REACTION present
2200	HR 129, BP 118/59, RR, 33, SpO2 96%, Temp 100.5 Ø RASH, Ø REACTION present
2215	HR 130, BP 114/59, RR 33, SpO2 95%, Temp 100.6 Ø REACTION, Ø RASH
2230	HR 131, BP 98/57, RR 33 SpO2 93%, Temp 100.6 Ø RASH, Δ IS VS (BP SpO2)
	(b)(6) NOTIFIED ABOUT changes IN VS. Verbalized limits of VS to take further actions.
2245	HR 128, BP 95/56, RR 33, SpO2 95%, Temp 100.4 Ø RASH
2300	ART BP 91/52, NIBP 103/53 HR 127, BP 89/51, RR 33, SpO2 94%, Temp 99.9 Ø RASH
	(b)(6) NOTIFIED of CHANGES & VS. Written order to ↑ FIO2 to 100% and to obtain ABG. All actions taken per MD's orders
2315	HR 126, BP 89/51, RR 33, SpO2 97%, Temp 99.8 Ø RASH MD CARE @ bedside. (b)(6)

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE

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)

ICU BED #3

EXHIBIT 90

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4 June 2330	BP 92/52 HR 125 RR 33, SpO2 98%, Temp 99.5 Ø RASH
2330 0345	NIBP 100/55, BP 93/53, HR 124, SpO2 98%, Temp. 99.5 Ø RASH
5 June 0400	NIBP 93/53, ART 90/51, HR 123, SpO2 99%, Temp 99.6 Ø RASH
0015	NIBP 96/54, ART 90/50, HR 123, SpO2 99%, Temp 99.8 Ø RASH
0030	NIBP 99/51, ART 93/52, HR 123, SpO2 99%, Temp 99.4 Ø RASH
0045	NIBP 98/51, ART 91/50, HR 122, SpO2 99%, Temp 99.2 Ø RASH
0100	NIBP 101/53, ART 103/56, HR 121, SpO2 99%, Temp 99.3 Ø RASH
0105	Imipenam TX finished. PT is now ON cont dose @ 25 cc/hr. NO ADVERSE REACTIONS noticed during the time. PT has bumps on chest/shoulders may be related to general dermatitis issues. Will be reported to MD. PT has had a gradual decrease in HR and SpO2. FiO2 on vent ↑ to 100%. Currently PT is receiving levophed 2.5 mcg/mn @ 4.7 ml/h. MED drip was hung by (b)(6) PT's current VS are as follows: ART 97/51, NIBP 101/51, HR 119 sinus 96%, Temp. 99.2. Will cont to monitor (b)(6)

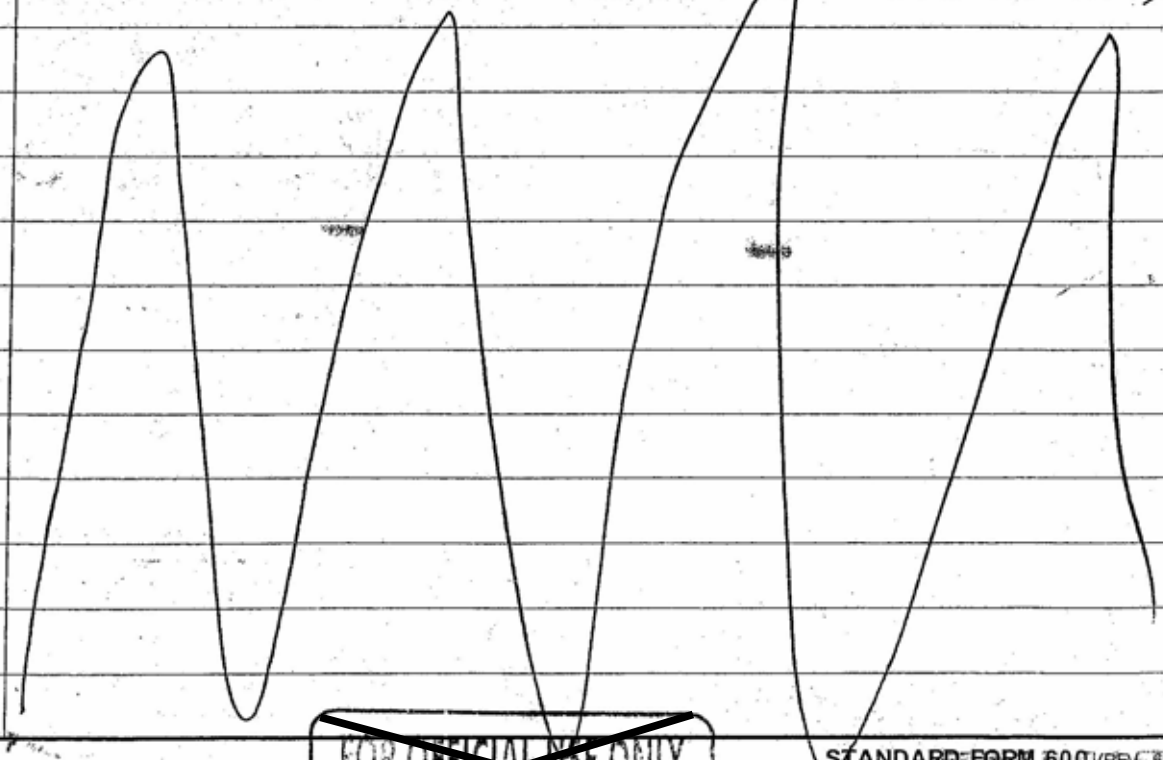

EXHIBIT 4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4 JUNE	This is the flow sheet for vitals/monitoring of the drug INFUSING ~~ADMINISTRATION~~ process, MEDICATION Imipenem.
2145	1st Bag (IA) Imipenem infused HR 130, BP 118/57, RR 13, SpO2 95%, Temp 100.6 Ø RASH, Ø REACTION present
2200	HR 129, BP 118/59, RR, 33, SpO2 96%, Temp 100.5 Ø RASH, Ø REACTION present
2215	HR 130, BP 114/59, RR 33, SpO2 95%, Temp 100.6 Ø REACTION, Ø RASH
2230	HR 131, BP 98/57, RR 33 SpO2 93%, Temp 100.6 Ø RASH, Δ IS VS (BP SpO2)
	(b)(6) NOTIFIED ABOUT changes IN VS, Verbalized ~~PARAMETER~~ limits of VS to take further actions.
2245	HR 128, BP 95/56, RR 33, SpO2 95%, Temp 100.4 Ø RASH
2300	ART BP 91/52, NIBP 103/53 HR 127, BP 89/51, RR 33, SpO2 94%, Temp 99.9 Ø RASH
	(b)(6) NOTIFIED of CHANGES & VS. Written order to ↑ FiO2 to 100% and to obtain ABG. All actions taken per MD's orders
2315	HR 126, BP 89/51, RR 33, SpO2 97%, Temp 99.8 Ø RASH MD CARE @ Bedside. (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)

ICU BED #3

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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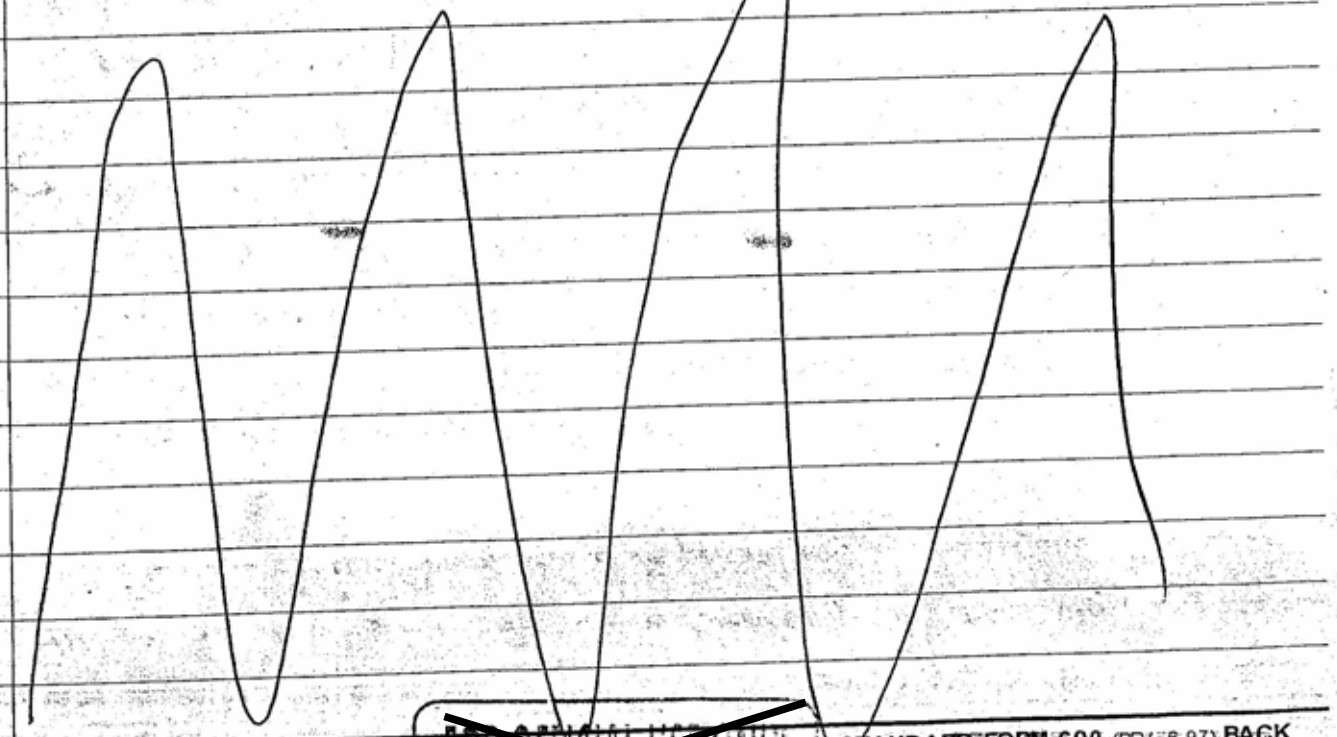
EXHIBIT 92

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4 June 2330	BP 92/52 HR 125 RR 33, SpO2 98%, Temp 99.5 Ø RASH
~~2330~~ 2345	NIBP 100/55, BP 93/53, HR 124, SpO2 98%, Temp. 99.5 Ø RASH
5 June 2400	NIBP 93/53, ART 90/51, HR 123, SpO2 99%, Temp 99.6 Ø RASH
0015	NIBP 96/54, ART 90/50, HR 123, SpO2 99%, Temp 99.8 Ø RASH
0030	NIBP 99/51, ART 93/52, HR 123, SpO2 99%, Temp 99.4 Ø RASH
0045	NIBP 98/51, ART 91/50, HR 122, SpO2 99%, Temp 99.2 Ø RASH
0100	NIBP 101/53, ART 103/56, HR 121, SpO2 99%, Temp 99.3 Ø RASH
0105	I (b)(6) TX finished. PT is now on cont dose @ 2.5 cc/hr. No adverse reactions noticed during the time. PT has bumps on chest/shoulders may be related to general dermatitis issues. Will be reported to MD. PT has had a gradual decrease in HR and SpO2. Fio2 on vent ↑ to 100%. Currently PT is receiving levophed 2.5 mcg/min @ 4.7 ml/h. MED DRIP was hung by (b)(6) PT's current VS are as follows: ART 97/51, NIBP 101/51, HR 119 SpO2 99%, Temp. 99.2. Will cont to monitor (b)(6)



STANDARD FORM 600 (REV. 6-97) BACK

STANDARD FORM 600 BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 June 06	PRBC infusion began @ 1815 by the Day shift. Rate of (b)(6)
1930	125 cc/hr.
	Initial VS
1815	Temp: 99.9^A, pulse 128, Bp 120/62
1930	Temp. 100.8^A, HR 130, Bp 118/55, SpO2 96%
1945	Temp. 101.3^A, HR 130, Bp 120/55, SpO2 95%
2000	Temp. 100.9°, HR 130, Bp 121/57, SpO2 95%
2050	Temp. 100.6, HR 130, BP 119/64, SpO2 94%
	2nd Bag
2115	Temp 101.2, HR 124, BP 115/63, SpO2 98% (b)(6)
2130	Temp 100.6, HR 130, BP 117/56 SpO2 95%
2145	Temp 100.0 HR 130, BP 117/59, SpO2 95%
~~2200~~	~~VT ASSESS. Pt [illegible]~~ (b)(6)
	~~[illegible] @ 6 LPM~~
DP ~~2345~~	
5 June 06	Blood transfusion complete, ∅ reaction to blood transfusion
2400	VS: Temp: 99.6, HR 123, NIBP 93/53, ART 90/51 SpO2 99% (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)

ICU Bed #3

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 June 06	PRBC infusion began @ 1815 by the Day shift. Rate of (b)(6)
1930	125 cc/hr.
	INITIAL VS
1815	Temp: 99.9^A, pulse 128, Bp 120/62
1930	Temp. 100.8^A, HR 130, Bp 118/55, spo2 96%
1945	Temp. 101.3^A HR 130, Bp 120/55, Spo2 95%
2000	Temp. 100.9°, HR 130, Bp 121/57, spo2 95%
2050	Temp. 100.6, HR 130, BP 119/64, SPO2 94%
	2nd BAG
2115	Temp 101.2, HR 124, BP 115/63, SPO2 98% (b)(6)
2130	Temp 100.6, HR 130, Bp 117/56 spo2 95%
2145	Temp 100.0 HR 130, BP 117/59, spo2 95%
(b)(6) ~~2200~~	~~VS ASSESS. RD [illegible]~~ (b)(6)
	~~[illegible] @ 6 AM~~
(b)(6) ~~2245~~	
5 June 06	Blood transfusion complete, ϕ reaction to blood transfusion
2400	VS: Temp: 99.6, HR 123, NIBP 93/53, ART 90/51, spo2 99% (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.)*

(b)(6)

REGISTER NO. | WARD NO.

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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

95 4

ICU

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4 June 00	18 g @ upper D/C due to INFILTRATION. Versed ON hold. Fent 1 to 200 mcg/h @ 10 ml/h will cont. to monitor (b)(6)
5 June 00 0200	MEVION 2 V's PEEC completed, NO REACTION NOTED. PT put on series of Imipenem infusion. Ø RASH, Ø hemodynamic instability. PT had ↓ HR, ↓ spo2. PT given 2 amps Calcium Chloride by (b)(6) RN, per verbal order (b)(6). Fluids: Imipenem @ 25 cc/h D5 @ 75 cc/hr, Versed 6.0 mg/h @ 6 ml/h, Fent 200 mcg/h @ 10 ml/h, levophed 4.0 mcg/min @ 7.5 cc/hr. VENT SETTINGS: Mode SIMV, PC, RATE 35, TV 850, FiO2 100%, PSV 10, Peep 15. PT pulling volumes b/w 250 – 450. Suplena @ 30 cc/hr. PT Face appears to be flushed, will cont. to monitor Ba (R) upper Arm D/c due to infiltration. (b)(6)
5 June End 0400	PT ASSESS. PT DELIVERED 3 mL morphine AND 2.5 mg HAL IN 2 mL NSS VIA IN LINE NEO @ b Arm VR
0630	CABG returned PH 7.028, Pco2 83.6, HCT 55, Hgb 18.7. See lab results. Abnormal results will be reported. Imipenem @ 25 cc/hr, DS 75 cc/hr, Versed @ 6.0 cc/hr, FENT @ 10 cc/hr levophed @ 3.8 cc/hr. VENT: RR 35, TV 850, FiO2 100% PS 10, Peep 15, mode SIMV/PC. O2 SATS fluctuated during shift, currently @ 98%. ↓ URINE OUTPUT b/w 30-80 cc/hr even after lasix. SYSTOLIC BP 90's prior to infusion of levophed. current BP 125/61. FACE APPEARS to be flushed, will pass on the next shift. ↓ temp in comparison to previous encounters 98-99. PT given tylenol 975mg PR @ 0110 due to temp of 101.3 BUN 11, CREAT 3.1. Earlier in shift during periph IV attempt pt told 'fluids' not blood to Elcath catheter. All abnormal findings and shift events will be reported. Will cont. to monitor (b)(6)

ATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30	IV adderlum!
5-06	After 2hrs of manual bagging his sats are in the 50%s given such poor oxygenation for prolonged period of time he has suffered significant anoxic brain injury. Placed back on the vent at previous setting- SIMV PC Rate = 28 (breathing 45) / set Tv = 850 pulling ~250 c peak pressures over 40 / FiO_2 = 100% / PEEP = 15. Current ABG on those setting pH 6.9 / pCO_2 104.8 / pO_2 35 / HCO_3 = 21.7 Pupils still reactive, BP: 90/47. Despite maximal efforts the patient continues to deteriorate. (b)(6)
1005	Death Note
5-5-06	Called to bedside by nursing staff. Patients pupils are fixed and dilated. He is unresponsive to painful, apneic, and not heart tones. Declared time of death @ 1005. (b)(6)

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EXHIBIT 4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5Jun06 0718	Assumed care of pt and performed assessment, Pt sedated with neg spontaneous eye opening. Pt in SF position with bilat leg wraps. Pt lungs sounds clear bilat with mechanical wheeze. (L) lobe diminished. CT x3 bindages CDI. (b)(6)
6-5-06 0900	ICU Note Called to bedside @ ~0730 → pat. desat & has been manually bagged, also ↓ SBP down to 70-80's. Started on levophed gtt. ABGs = pH 7.02 | pCO_2 83.6 | pO_2 143 | HCO_3 = 22 → all prior to desat. Aggressive suction performed, Bumex 2mg IVP given & Bumex gtt started. At this time pulse Ox = 67%, BP = 99/50, on max vent settings patient unable to tolerate Tv over ~350 so we have cont to Bag him for ~1½ hrs. Repeat ABGs = pH 6.96 | pCO_2 96 | pO_2 44 | HCO_3 22 → despite maximal efforts. Patient has agonal respirations on his own, however, Pupils are pinpoint & reactive, c bagging diffuse rhonchi, CV exam c distant tones c tachycardia & his peripheral edema is significantly worse this morning. I feel the current state is not compatible with life, but we will continue for now. (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)		

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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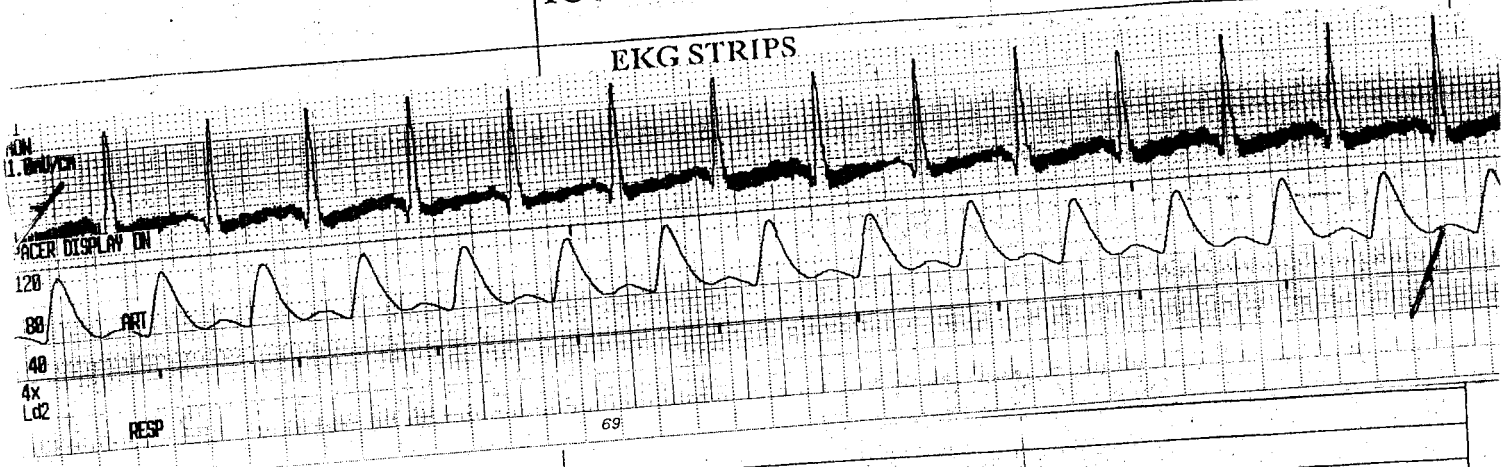
ICU FLOW SHEET

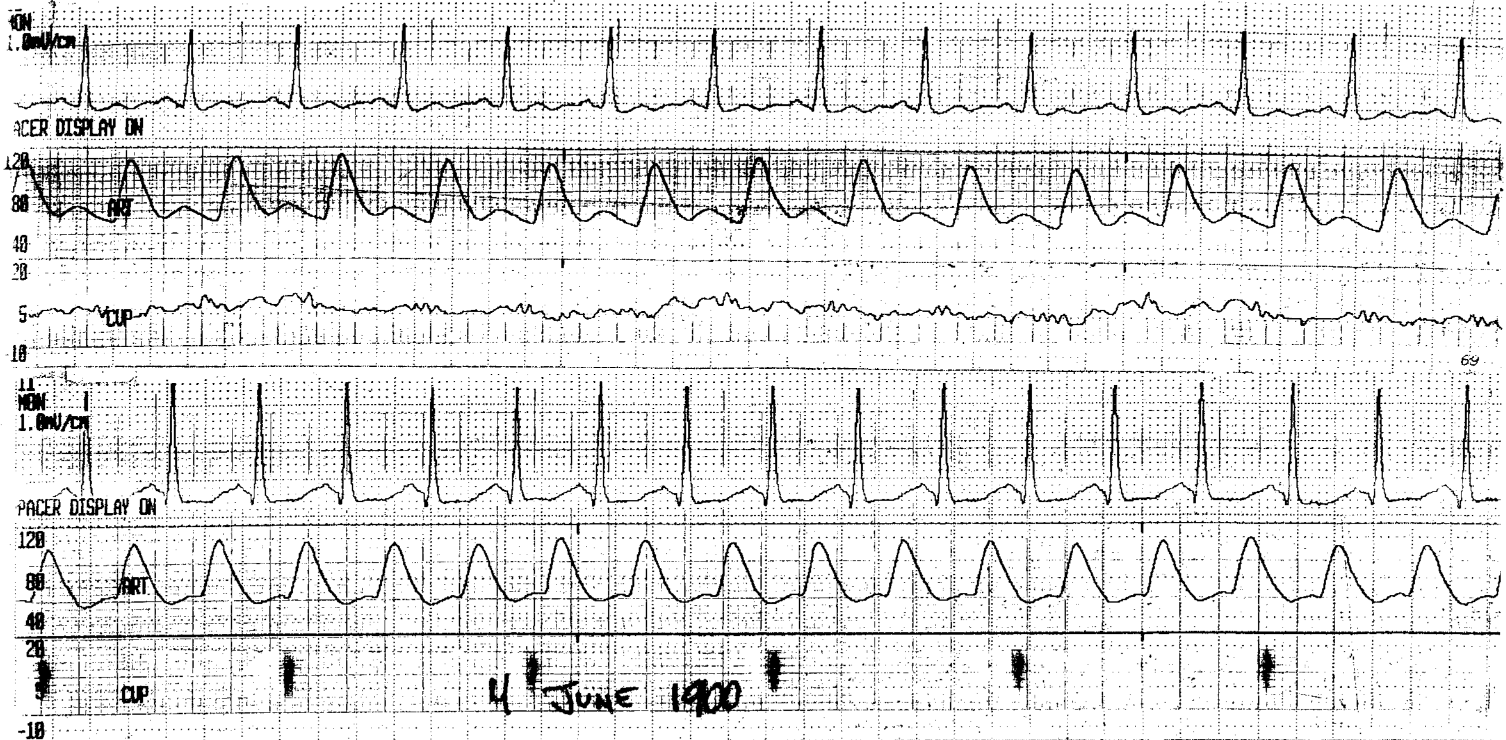
EKG STRIPS



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

DEVICE/SITE	START DATE	DISC	VASCULAR ACCESS ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESS
50					

ICU FLOW SHEET



RESTRAINTS: Ø

DAYS				NIGHTS			
00 site	pulse	cap. ref.	edema	1900	Site NO restraints pulse	cap. ref.	edema
00 site	pulse	cap. ref.	edema	2100	Site /	pulse	cap. ref.	edema
00 site	pulse	cap. ref.	edema	2300	Site /	pulse	cap. ref.	edema
00 site	pulse	cap. ref.	edema	0100	Site /	pulse	cap. ref.	edema
00 site	pulse	cap. ref.	edema	0300	Site /	pulse	cap. ref.	edema
00 site	pulse	cap. ref.	edema	0500	Site Ø restraints pulse	cap. ref	edema

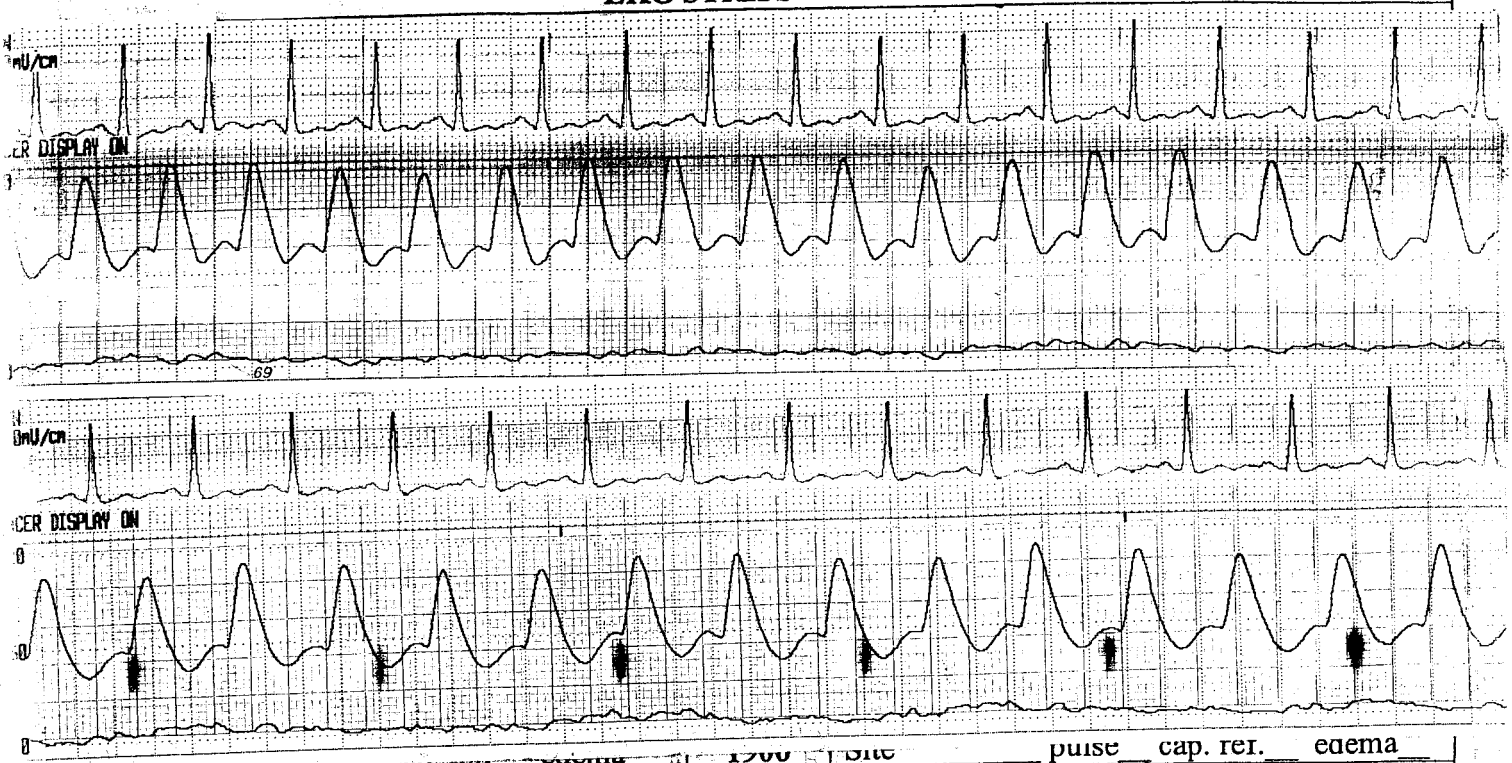
VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
1) SC	26 May	3 Jun 06	[illegible]	——	[illegible] CDI patent
2) [illegible]	[illegible] May	3 Jun 06	[illegible]	——	[illegible] CDI patent

[redacted]

ICU FLOW SHEET

EKG STRIPS



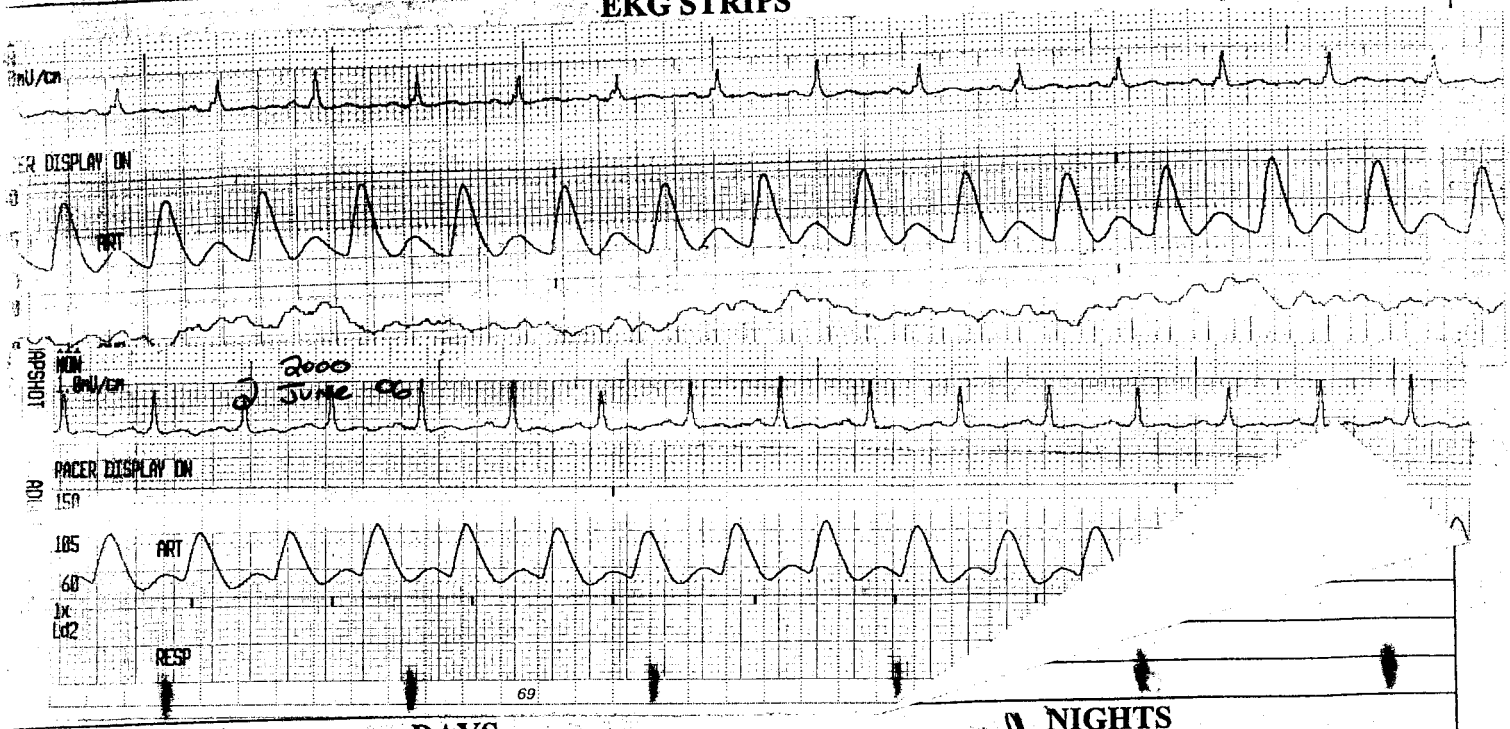
				1900	Site	pulse	cap. ref.	edema
00 site	pulse	cap. ref.	edema	2100	Site	pulse	cap. ref.	edema
00 site	pulse	cap. ref.	edema	2300	Site	pulse	cap. ref.	edema
00 site	pulse	cap. ref.	edema	0100	Site	pulse	cap. ref.	edema
00 site	pulse	cap. ref.	edema	0300	Site	pulse	cap. ref.	edema
00 site	pulse	cap. ref.	edema	0500	Site	pulse	cap.ref	edema

VASCULAR ACCESS

DEV	START DATE	DSC	# OF DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
SUB					
RAD					

ICU FLOW SHEET

EKG STRIPS



2000 June 96

STRAINTS: DAYS					NIGHTS				
00 site	pulse	cap. ref.	edema	1900	Site	pulse	cap. ref.	edema	
00 site	pulse	cap. ref.	edema	2100	Site	pulse	cap. ref.	edema	
00 site	pulse	cap. ref.	edema	2300	Site	pulse	cap. ref.	edema	
00 site	pulse	cap. ref.	edema	0100	Site	pulse	cap. ref.	edema	
00 site	pulse	cap. ref.	edema	0300	Site	pulse	cap. ref.	edema	
00 site	pulse	cap. ref.	edema	0500	Site	pulse	cap.ref	edema	

Dressing changed

Pharmacy restarted

VASCULAR ACCESS

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

SYSTEM	DAYS	NIGHTS
NEURO	0800 1200 1600	
Level of consciousness	GCS 10, Pearl's +3	Ø Facial grimaces, sedated.
Extremities: Movement	sedated / UTD	Unable to
Strength	sedated / UTD	
PAIN ASSESSMENT	Restless UTD / localizes to various stimuli	
CARDIOVASCULAR		
Rhythm/Lead	Sinus Tach	Sinus Tach HR 120-130's
Heart Sounds	S1 S2	S1 S2
Skin	Warm Dry	Warm Dry
Edema	+3 gen edema	Gen edema throughout body
JVD/Capillary refill	Ø JVD / L 3 sec	Ø JVD / cap refill < 3 secs
Pulses: Radial	+2 +2	+2 +2
Posterior Tibial	+1 +1	pulse present
Dorsalis Pedis	+1 +1	" "
RESPIRATORY		
Breath Sounds	diffuse rhonchi	Bilat coarse lung sounds
Oxygen Delivery	vent SIMV	Vent SIMV
Suctioning/Sputum	In-line PRN / blood tinged	In-line PRN / blood tinged mucous
ETT/Trach tube	8.0	#8
Size: Placement:		
Cough:		only during suction, + gag
Treatments:		Albuterol per RT
GASTROINTESTINAL		
Bowel Sounds	[illegible] Sounds	Hypoactive BS x 4 quads
Abdomen	[illegible]	soft, Distended
Date	[illegible]	[illegible]
NG	[illegible]	[illegible]

SYSTEM	DAYS	NIGHTS
NEURO	0930	
Level of consciousness	GCS 3, tubed, pharm sedated	GCS 7. pharm sedated Perrla 2mm sluggi
Extremities: Movement	PERRLA, 2mm, brisk	grimmaces to pain & moves mouth spontaneous
Strength		UTD - pharm sedated
PAIN ASSESSMENT	Pharm: sedated, versed, ggg reflex	Pharm sedated on Versed / Fentanyl drip
CARDIOVASCULAR		
Rhythm/Lead	Sinus Tachycardia	ST Lead II
Heart Sounds		S1 S2. NO c/R/m noted
Skin	warm, edematous	warm dry
Edema	+3 pitting	+ 3 pitted to all extremeties
JVD/ Capillary refill	Ø JVD, cap refill < 3 sec	Ø JVD noted, cap refill < 3 sec
Pulses: Radial	+2 +2	+ 2 bilat
Posterior Tibial	+2 +2	+1 bilat
Dorsalis Pedis	+2 +2	+2 bilat
RESPIRATORY		
Breath Sounds	Coarse, wet	fine Rhonchi bilateral throughout
Oxygen Delivery	Vent SIMV PC	Vent SIMV PC
Suctioning/Sputum	large amt thick bloody mucus	noted bloody mucous tan secretions
ETT/Trach tube	8.0 Trach c tan mucus around	8.0 Trach c stylet hanging @ HOB
Size: Placement:	site	
Cough:		with suction
Treatments:	Albuterol neb c mucomyst	albuterol Neb c mucomyst
GASTROINTESTINAL		
Bowel Sounds	hypo active x4 quads	hypo active x4 soft distended
Abdomen	large soft	UTD pain
Date of last BM	colostomy RUQ	Colostomy draining brown/black secretions
NG tube:	Oro Nare	Oro Nare clamped
GENITOURINARY		
Urine		

SYSTEM	DAYS	NIGHTS
NEURO	0700	2000
vel of consciousness	GCS=10 ⓑ pupils 3mm PERRLA	Doesn't respond to pain/verbal
tremities: Movement	Sedated	stimuli. Opens eyes grimaces
Strength	Unable to assess	on occasion. Sedation, unable
IN ASSESSMENT	grimace noted on reposition	to determine movement/strength.
CARDIOVASCULAR		
thym/Lead	ST/Lead II	↑ HR 130's
eart Sounds	S1, S2 noted	S1, S2 present
in	warm, dry	warm, dry
ema	+2 pitting edema in all extr.	+2 pit' edema
D/ Capillary refill	∅ / <3 sec	∅ JVD / cap refill < 3 sec
lses: Radial	+1 - Bilateral	+2
Posterior Tibial	+1 - Bilateral	present
Dorsalis Pedis	+1 - Bilateral	present
RESPIRATORY		
eath Sounds		bilat coarse lung sounds
xygen Delivery	Vent. SIMV/PC	Vent SIMV/PC FiO2 @ 100%
ctioning/Sputum	Tan/Blood Tinged to suction	blood tinged mucous
T/(Trach) tube	#8 fenestrated	Trach in place
ze: Placement:	8.0 cuffed stylet	# 8
ough:	⊕ cough ⊕ gag reflex	⊕ gag reflex
eatments:	Nebs, CPT	Albuterol Tx per RT
GASTROINTESTINAL		
owel Sounds	[illegible] 4 quads.	BS x 4 quads

[redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER	TIME OF ORDER		LIST TIME ORDER NOTED AND SIGN
6-4-06	2345	HOURS	
① ↑ Vent Rate to 35		None	4 June 2347
② ABGs in 1 hr			

(b)(6)

Transfer note

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER	TIME OF ORDER	
5 JUN 06	0030	HOURS

① levophed 2mcg/MIN titrate to MAP.

(b)(6)

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER	TIME OF ORDER	
05 JUN 06	0135	HOURS

① 1 G Calcium Chloride

(b)(6)

(b)(6)

[redacted]

CLINICAL RECORD - DOCTOR'S ORDERS
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PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 6-4-06 TIME OF ORDER 2031 HOURS

LIST TIME ORDER NOTED AN SIGN

Imipenem addendum:

(1) Take 100cc from BAG 1 & put in ~900cc of D5 & Label Bag 1A.

Rate:

1cc/hr x15

2cc/hr x15

4cc/hr x15

8cc/hr x15

16cc/hr x15

32cc/hr x15

then proceed with Bag 1 starting at the 1.6cc dose.

(2) Start PIV for the Vascath, or the Imipenem (Incomplete).

(b)(6)

(b)(6)

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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)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 6-4-06 TIME OF ORDER 1818 HOURS

LIST TIME ORDER NOTED AN SIGN

Imipenem!

BAG 1

84mg/800mL D5

Rate 0.05 cc/hr x 15 min

0.1 cc/hr x 15 min

0.2 cc/hr x 15 min

0.4 cc/hr x 15 min

0.8 cc/hr x 15 min

1.6 cc/hr x 15 min

3.2 cc/hr x 15 min then BAG 2

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

BAG 2

84mg/200mL D5

Rate 3cc/hr x 15 min

6cc/hr x 15 min

12cc/hr x 15 then Final Bag

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER TIME OF ORDER HOURS

Final Bag

84mg/100mL

[illegible] cc/hr x 15 min

[illegible] cc/hr x 15 min

[illegible] as final continuous

(b)(6)

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT ICU **ROOM NO.** **BED NO.** 3

DATE OF ORDER 6/4/06 1500 **TIME OF ORDER** ______ HOURS **LIST TIME ORDER NOTED SIG** (b)(6)

Lasix 20mg IV x1 now

↑ FiO2 80%

V.O. (b)(6) (b)(6)

(b)(6)

noted (b)(6)

PATIENT IDENTIFICATION

4June06 noted + transcribed Crowell CPT AN

NURSING UNIT **ROOM NO.** **BED NO.**

DATE OF ORDER 6-4-06 **TIME OF ORDER** 1700 HOURS

① Type & Cross, then transfuse 2u PRBC's

(b)(6)

PATIENT IDENTIFICATION

DATE OF ORDER 04June06 **TIME OF ORDER** 1800 HOURS

Done (b)(6) ① [illegible] x1 between [illegible]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER 6/4/06 1500 TIME OF ORDER ______ HOURS

LIST TIME ORDER NOTED AN[D] (b)(6)

Lasix 20mg IV x1 now
↑ FiO2 80%
V.O. (b)(6) (b)(6)
(b)(6)

NURSING UNIT 1CU | ROOM NO. | BED NO. 3

PATIENT IDENTIFICATION

4Jun06
noted
+
transcribed
(b)(6)

DATE OF ORDER 6-4-06 TIME OF ORDER 1700. HOURS

(b)(6)

(1) Type & Cross then transfuse 2u prbc's

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 04June06 TIME OF ORDER 1800 HOURS

[illegible] 20mg x1 [illegible]

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

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

PATIENT IDENTIFICATION
(b)(6)

DATE OF ORDER 6-2-06 TIME OF ORDER 1400 HOURS

LIST T ORDE NOTED SIGN

(b)(6)

1. D/C TF: Suplena @ 50cc/hr for 12hrs on & 12hrs off.
2. Abstract next labs.

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 3

PATIENT IDENTIFICATION
(b)(6)

DATE OF ORDER 6-2-06 TIME OF ORDER 1653 HOURS

(b)(6)

1. Lasix 10mg IV x1
2. NO Lasix x 120mg IV x 1

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

PATIENT IDENTIFICATION
(b)(6)

DATE OF ORDER 6-2-06 2000 HOURS

1. D5@ 75cc/hr - d/c D5 1/2NS
2. ↑ FiO2 100% wean to keep pO2 80-100
3. Hold TF but cont water boluses and ↓ to 100cc

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION
(b)(6)

TIME OF ORDER 0845 HOURS

240 Chart Check

IV - slow

(b)(6)

NU

EXHIBIT

111

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER 6-1-06 TIME OF ORDER 1720 HOURS — LIST TIME ORDER NOTED AND SIGN

(1) Δ Vent settings back to PC (b)(6)
ĩ PIP 24, PEEP 15, PS 10, F.O.
(2) D/c Vec gtt
(3) CT to water seal
(4) CXR in 1°
(5) Δ chem 7 to Q4°

NURSING UNIT: ICU | ROOM NO.: 3 | BED NO.:

(b)(6)

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER 2 Jun 06 TIME OF ORDER 0100 HOURS

① Change I:E to 2:1
② change RR to 20

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER 2 Jun TIME OF ORDER 0300 HOURS

Vent ↓
RR 25 PS 10
PEEP 15 I:E 1:2

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER 6-02-06 TIME OF ORDER 0845 HOURS

(1) Lasix 10mg IV XT
(2) Δ IVF to D5 ½NS @ 75cc/hr
(3) Sputum Culture

(b)(6)

EXHIBIT

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

(b)(6)

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

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

0089 06 CID789 784

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

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

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 3

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
6-3-06	1805 HOURS	(b)(6)
(1) Lasix 20mg IV X.I		
(2) ↓ F_iO_2 to 80% & ✓ ABG in 30min	(b)(6)	
24°chart ✓ done	(b)(6)	03JUN06@1930

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 3

DATE OF ORDER	TIME OF ORDER	
03JUN06	~~2000~~ 1900 HOURS	
(X) 2 amps CaCl X I now V.O.	(b)(6)	
(1) ↓ F_iO_2 to 80% + ✓ ABG V.O.	(b)(6)	
	(b)(6)	

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 3

DATE OF ORDER	TIME OF ORDER	
6-3-06	2200 HOURS	(b)(6)
(1) Lasix 30mg IV QAM	(b)(6)	

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 3

DATE OF ORDER	TIME OF ORDER	
6-4-06	HOURS	(b)(6)
(1) ↓ F_iO_2 to 70%		
(2) ABG in 1 hr		
(3) Resume Suplena @ 30cc/hr after placing new DHT		
	(b)(6)	
chart ✓ done	(b)(6)	04JUN06@2200

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

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EXHIBIT 113 4

0089 06 CID 789 78469

0-01-165-7294 519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
P CXR				ICU	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTE	(b)(6)			TELEPHONE/PAGE NO.
	SIGNAT	(b)(6)			DATE REQUESTED

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

CT's on Water Seal. R/o PTX.

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSACTION (Month, day, year)
Oct 1834		

RADIOLOGIC REPORT

Stable

R/O PTX

(b)(6)

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

(b)(6)

(b)(6)

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

(b)(6)

SIGN

Bed #3

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR
(41 CFR) 201-45.505

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1 - Medical Record

EXHIBIT 114

01/09/1989 11:17:42 PM

Rx:
Dx:

BP:

Dept:
Room:
Oper:

Rate	147	. Sinus tachycardia, rate 147
PR	97	. Diffuse Nonspecific T wave abnormalities
QRSD	81	
QT	257	
QTc	402	

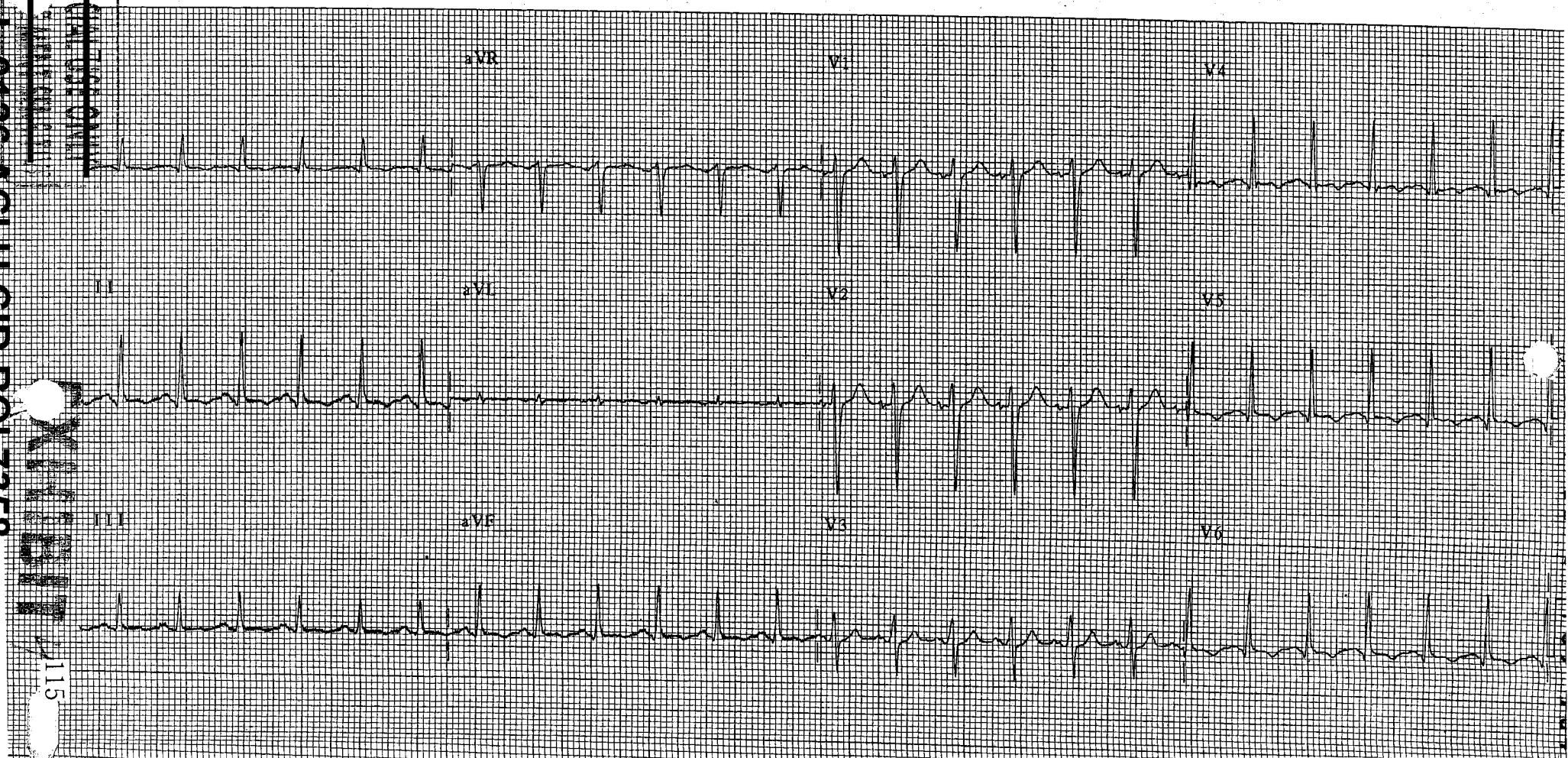
--AXIS--	
P	78
QRS	60
T	240

Normal P axis, rate >= 100
T waves -.10 mV ANT/LAT/INF

Requested by:

- ABNORMAL ECG -

PRELIMINARY-MD MUST REVIEW



0089 06 CID 789 - 78

NSN 7540-01-165-7294 519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
PCXR	33	M	(b)(6)	ICU (3)	
	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)*

2m Tube / Line placement. RO infiltrate

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSACTION (Month, day, year)
02 Jan 06 (b)(6)		

RADIOLOGIC REPORT T00500

Stable - allowing for differences in technique.

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
	(b)(6)

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 - Medical Record

STANDARD FORM 519-B (Rev. 8-83)
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(41 CFR) 201-45.505

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EXHIBIT 4
116

0089 06 CID 789 - 784

NSN 7540-01-165-7294 519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
PCXR	33	M	(b)(6)	ICU (3)	
	FILM NO.			PREGNANT ☐ YES ☐ NO	
	REQUI (b)(6)			TELEPHONE/PAGE NO.	
	SIGNATURE OF REQUESTOR			DATE REQUESTED	

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

n Tube / Line placement. RO infiltrate

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSACTION *(Month, day, year)*
02 Jan 06 (b)(6)		

RADIOLOGIC REPORT T 00500

Stable – allowing for differences in technique.

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

(b)(6)

RADIOLOGIC CONSULTATION REQUEST COPY

1 Medical Record

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STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR
(41 CFR) 201-45.505

EXHIBIT 117 4

0089 06 CJD 789 784

NSN 7540-01-165-7294

519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

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

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

R/O Pulmonary edema

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSACTION (Month, day, year)
3 JUNE 0815		

RADIOLOGIC REPORT

Stable

(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

(b)(6)

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RADIOLOGIC CONSULTATION REQUEST/REPORT

Medical Record

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR
(41 CFR) 201-45.505

EXHIBIT 118

0089 06 CID789 78469

NSN 7540-01-165-7294 519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

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

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

R/O Pulmonary edema

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSACTION (Month, day, year)
3 JUN 06 @ ~~0920~~ 0815		

RADIOLOGIC REPORT

Stable

(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

(b)(6)

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~~Medical Record~~

RADIOLOGIC CONSULTATION REPORT

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR/FIRMR
(41 CFR) 201-45.505

EXHIBIT 4

119

0089 06 CID 789 7846

NSN 7540-01-165-7294 519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN	WARD/CLINIC	REGISTER NO.
(b)(6)	34	M	(b)(6)	ICU 3	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUE (b)(6)				TELEPHONE/PAGE NO.
	SIGN (b)(6)				DATE REQUESTED

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

Am PCXR RO infiltrate. Line / tube placement.

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSACTION *(Month, day, year)*
4 June 06		

RADIOLOGIC REPORT 1005 0500

Stable
s/p PTX

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
	SIGI (b)(6)

(b)(6)

RADIOLOGIC CONSULTATION REQUEST/REPORT

1 - Medical Rec

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STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR
(41 CFR) 201-45.505

EXHIBIT 120 4

NSN 7540-01-165-7294 519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	(b)(6)	WARD/CLINIC	REGISTER NO.
(b)(6)	34	M		ICU-3	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUE (b)(6)				TELEPHONE/PAGE NO.
	SIGN (b)(6)				DATE REQUESTED

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

Am PCXR RO infiltrate. Line / tube placement.

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSACTION *(Month, day, year)*
15 June 06		

RADIOLOGIC REPORT 1005 0500

Stable

& PTX

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
	(b)(6)

(b)(6)

RADIOLOGIC CONSULTATION REQUEST/REPORT

1 - Medical Record

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STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45.505

EXHIBIT 121 4

0089 06 CID 789 78469

NSN 7540-01-165-7294 519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
KUB	1	M		ICU	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	(b)(6) (Print)				TELEPHONE/PAGE NO.
	(b)(6)				DATE REQUESTED 4 Jun 06

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

KUB S/P dobhoff Placement

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSACTION *(Month, day, year)*
04 JUN 06 @ 1060		

RADIOLOGIC REPORT

DHT overlies

antrum stomach

paucity of gas

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

(b)(6)

(b)(6)

CATION OF MEDICAL RECORDS

CATION OF RADIOLOGIC FACILITY

SIGN (b)(6)

ICU Bed #3

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RADIOLOGIC CONSULTATION REQUEST/REPORT
1 Medical Record

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR
and CFR 201-45.505

EXHIBIT 122

0089 06 CID 789 78469

NSN 7540-01-165-7294 519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
KUB	1	M		ICU	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	R (b)(6)	Print)			TELEPHONE/PAGE NO.
	SIG (b)(6)				DATE REQUESTED 4 Jun 06

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

KUB S/P dobhoff Placement

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSACTION *(Month, day, year)*
04 JUN 06 @ 1060		

RADIOLOGIC REPORT

DHT overlies

antrum stomach

pauerty of gas

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

(b)(6)

(b)(6)

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGN (b)(6)

ICU Bed #3

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

RADIOLOGIC CONSULTATION REQUEST/REPORT

1 - Medical Record

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR
(41 CFR) 201-45.505

EXHIBIT 123

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): 1U ML

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 30 May 06

DATE AND HOUR REQUIRED: 30 May 06 0945

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

REMARKS:

REQUESTING PHYSICIAN (Print): (b)(6)

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW to 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)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: 30 May 06

TIME VERIFIED: 30 May 06 0945

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO: O
Rh: POS

RECIPIENT
ABO: O
Rh: POS

TEST INTERPRETATION
ANTIBODY SCREEN: NEG
CROSSMATCH: comp

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 31 May 06

REMARKS: T & C expires 2 JUN 06 @ 2359

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature): (b)(6)

AT (Hour): 1101 ON (Date): 31 MAY 06

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.: 99.5 (A) PULSE: 105 BP: 111/48

DATE OF TRANSFUSION: 31 May 06 TIME STARTED: 1112

POST-TRANSFUSION DATA

AMOUNT GIVEN: 375 ML

TIME/DATE COMPLETED/INTERRUPTED: 31 May 06 1308 (3 Dec 06)

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
99.5	109	119/53

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)

(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)

SEX: M WARD: ICU

ICU Bed #

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record
STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-45.201

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 4
124

Medical Record Copy

0089 06 CID789 784

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)* 1U ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED ~~30t 30t~~ 31May06

DATE AND HOUR REQUIRED 31May06 0945

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: GW tUMBD

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 31May06

TIME VERIFIED 0945

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NEG	comp

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 31MAY06

DONOR	RECIPIENT
ABO O	ABO O
Rh POS	Rh POS

REMARKS: T&C expired 2JUN06 @ 2359

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* _____ ON *(Date)* _____

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)

(b)(6)

BP 126/56

DATE OF TRANSFUSION 31May06

TIME STARTED 1315

POST-TRANSFUSION DATA

AMOUNT GIVEN 381 ML

TIME/DATE COMPLETED/INTERRUPTED 31May06 1605

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100.3 (A)	115	134/66

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)*

(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)

SEX M

WARD TCU

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-91)
Prescribed by GSA/ICMR, FIRMR (41CFR) 125 202-1

EXHIBIT 4

Medical Record Copy

0089 06 CID 789 78469

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)*: 1U ML

REMARKS: (b)(6)

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 4 June 06

DATE AND HOUR REQUIRED: 4 June 06 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: GSW to 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.

(b)(6)

DATE VERIFIED: 4 Jun 06

TIME VERIFIED: 1705

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO O Rh Pos

RECIPIENT: ABO O Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
Neg	comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT

REMARKS: 1930 BP 118/55 T 100.8 HR 130 Expires 7 Jun 06 @ 2359 SEE ATTCH PAPER

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [X] NO RECORD

(b)(6)

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED (b)(6)

AT *(Hour)* _____ ON *(Date)* 1800 4 Jun 06

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)

(b)(6) PULSE 120 BP 114/62

TIME STARTED 0615

USE EMBOSSER (For typed or written entries) (Name of hospital or medical facility)

(b)(6)

POST-TRANSFUSION DATA

AMOUNT GIVEN: 351 ML

TIME/DATE (COMPLETED) INTERRUPTED: 2105 04 JUNE 2006

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100.6	130	119/64

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

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

ICU Bed #3

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

EXHIBIT 4
126

STANDARD FORM 518 (REV. 9-92)
Prescribed by DOD/HCFA, DMR, FIRMR (41 CFR) 201-9.202-1

0089 06 CID 789 78

NSN 7540-00-634-4159

518-124

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)* 1U ML

REMARKS: (b)(6)

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 4 June

DATE AND HOUR REQUIRED 4 Jun 06 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 GSW to 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.

(b)(6)

DATE VERIFIED 4 Jun 06

TIME VERIFIED 1705

EXP 21 JUN 06

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO O
Rh Pos

RECIPIENT
ABO O
Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
Neg	comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT

REMARKS:
1930
BP 118/55 T. 100.8°
HR-130
Cespires 7 Jun 06 @ 2359
SEE ATTCH PAPER

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

(b)(6)

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED (b)(6)

AT *(Hour)* ON *(Date)* 1800 4 Jun 06

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)

(b)(6)

PULSE 120 BP 124/62

TIME STARTED 0615

POST-TRANSFUSION DATA

AMOUNT GIVEN 351 ML

TIME/DATE COMPLETED / INTERRUPTED 2105 04 June 2006

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100.6	130	119/64

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

USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; hospital or medical facility)

(b)(6)

ICU Bed

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

BLOOD OR BLOOD COMPONENT TRANSFUSION

EXHIBIT 4

Medical Record 127

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

0089 06 CID 789 7846

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)* 1U ML

REMARKS: (b)(6)

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 4JUN06

DATE AND HOUR REQUIRED 4JUN06 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 GSW TO 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.

SI (b)(6)

DATE VERIFIED 4JUN06

TIME VERIFIED 1105

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)

TRANSFUSION NO. (b)(6)

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
Neg	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT RE

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

SI (b)(6)

DONOR	RECIPIENT
ABO O	ABO O
Rh POS	Rh POS

REMARKS: Exp. 15 JUN 2006

SEE ATTCH PAPER

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)

AT *(Hour)* 2112 ON *(Date)* 04 JUN06

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)

PRE-TRANSFUSION

TEMP.	PULSE	BP
101.2	129	115/63

DATE OF TRANSFUSION 04 JUNE 2006

TIME STARTED 2115

POST-TRANSFUSION DATA

AMOUNT GIVEN ~~350~~ 417 ML

TIME/DATE COMPLETED/INTERRUPTED 5 JUNE 06/2400

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
99.6	123	93/53 NIB

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)*

(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)

SEX M WARD W

Exh #3

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 4

☒ 0089 06 CID 789 7846

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)*: 1U ML

REMARKS: (b)(6)

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 4JUN06

DATE AND HOUR REQUIRED: 4JUN06 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: GSW TO 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.

SI (b)(6)

DATE VERIFIED: 4JUN06

TIME VERIFIED: 1705

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)

TRANSFUSION NO. (b)(6)

TEST INTERPRETATION	
ANTIBODY SCREEN	CROSSMATCH
Neg	Comp

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

S (b)(6)

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT R

DONOR	RECIPIENT
ABO O	ABO O
Rh POS	Rh POS

REMARKS: Exp. 15 JUN 2006

SEE ATTCH PAPER

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)

AT *(Hour)*: 2112 ON *(Date)*: 04JUN06

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)

PRE-TRANSFUSION

TEMP. 101.2 PULSE 129 BP 115/63

DATE OF TRANSFUSION: 04 JUNE 2006 TIME STARTED: 2115

POST-TRANSFUSION DATA

AMOUNT GIVEN: ~~350~~ 417+ ML

TIME/DATE COMPLETED/INTERRUPTED: 5 JUNE 06/2400

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[x] NONE [ ] SUSPECTED	99.6	123	93/53 NIBP

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)*

(b)(6)

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX M WARD 1W

(b)(6)

Bed #3

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXPIRED

Task Force

Ventilator Flow Sheet

Patient Info: Name: (b)(6) Date: 2 June

Age: ____ DOB: ____ Vent Day #: 20

Gender: M Pt. ID: (b)(6) Vent Unit #: (b)(6)

Date	2 June	2 June	2 June	2 June	2 June	2 June	2 June	2 June	2 June	2 June	3 June	3 June	3 June	3 June	3 June	3 June	3 June
Time	0130	0300	0530	0800	0915	1235	1425	1815	2000	2200	0000	0200	0400	0550	0730	1040	1330
Mode	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC
Set	20	20	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25
Spont.	—	—	—	—	5	1	7	0	—	—	5	8	10	5	5	3	0
Total	20	20	25	25	30	26	32	25	25	25	30	33	35	30	30	28	25
Set	—	—	—	—	—	—	—		—	—	—	—	—	—			
Spont.	670	640	650	667	720	666	444	790	657	680	519	593	544	549	559	785	666
MV	18.1	17.6	23.5	24.7	18.8	19.6	13.3	21.2	21.3	21.7	19.3	19.8	15.5	16.6	15.5	19.0	23.0
FiO2	80	80	80	80	.80	.80	100	100	100	100	100	100	100	100	100	100	100
Peep	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
~~I/E~~	~~1:2~~	~~1:2~~	1:2	1:1	1:2.1	1:1.2	1:2.1	1:1.2	1:1.2	1:1.2	1:1.2	1:1.2	1:1.2	1:1.2	1:1	1:1	1:1
~~Flow~~ P.in	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24
Sens.	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2
PIP	41	41	41	41	41	40	41	41	41	41	41	41	41	41	41	41	41
MAP	23	25	22	21	22	22	24	24	24	24	24	22	21	24	23	23	23
Sats.	90	90	98	93	99	99	90	98	98	97	98	99	97	99	100	100	100
PIP Alarm Hi/Lo	24/10	44/10	50/10	50/10	59/10	50/10	50/10	50/10	50/10	50/10	50/10	54/10	80/10	54/10	50/10	54/10	50/10
PS	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Initials	(b)(6)																

ET/Trach

Size	Position	Cuff

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	Hco3	Sat
2 June	0130	7.26	52.4	69	25	-4	23.5	90
2 June	0230	7.24	53.5	73	25	-4	22.9	91
2 June	0530	7.317	42.6	75	23	-4	21.8	93.6
2 June	1423	7.156	68.5	65	26	-5	24.2	85%
3 June	0410	7.17	60.6	101	24	-6	22.5	96

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

Task Force

Ventilator Flow Sheet

Patient Info: Name: _____ Date: 3 June 06

Age: _____ DOB: _____ Vent Day #: 21

Gender: _____ Pt. ID: (b)(6) Vent Unit #: (b)(6)

Date	3 June	3 June	3 June	4 June	4 June	4 June	4 June	4 June	4 June	4 June	4 June	4 June	4 June
Time	1530	1605	1740	1805	2000	2200	0000	0145	0515	0600	0800	0850	0940	1710
Mode		SIMV PC	SIMV		SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC			SIMV PC
Set		25	15		25	25	25	25	25	25	25		28	33
Spont.		0	0		3	/	/	/	/	/	0			0
Total		25	25		28	25	25	25	25	25	25			33
Set		/	/		/	/	/	/	/	/	/			/
Spont.		740	730		873	764	647	650	690	670	633			447
MV		23.1	21.3		20.8	20.4	19.1	18.5	20.1	16.9	16.1			14.8
FiO2	.90	.90	.90	85	.80	80	80	80	80	80	.80	.70	.60	.90
Peep		15	15		15	15	15	15	15	15	15			15
I/E		1:2	1:1		1:1.2	1:1.2	1:1.2	1:1.2	1:1.2	1:1.2	1:1.2			1:1
IP ~~Flow~~		24	24		24	24	24	24	24	24	24			24
Sens.		-2	-2		-2	-2	-2	-2	-2	-2	-2			-2
PIP		41	41		41	41	41	41	41	41	41			41
MAP		23	23		22	23	23	22	23	22	23			24
Sats.		100	100		100	100	100	100	100	100	100			98
PIP Alarm Hi/Lo		50/10	50/10		50/10	50/10	50/10	50/10	50/10	50/10	50/10			45/16
PS		10	10		10	10	10	10	10	10	10			16
Initials	(b)(6)													

ETT/Trach

Size	Position	Cuff

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	HCO3	O2 Sat
3 June 06	1585	7.275	46.8	143	23	-5	21.7	99%
3 June 06	1630	7.298	44.1	107	23	-5	21.6	97.7
3 June	2000	7.32	40.1	87	22	-5	21.2	96
4 June	0400	7.299	41.8	107	22	-6	20.5	98
4 June	1140	7.253	53.5	70	25	-4	23.6	90%
4 June	1385	7.188	62.6	103	26	-4		96%

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

EXHIBIT 131 4

Task Force
Ventilator Flow Sheet

Patient Info: Name: _____ Date: 4 June 06
Age: _____ DOB:
Gender: _____ Pt. ID: (b)(6) Vent Day #: 22
Vent Unit #: (b)(6)

Date	4 June	4 June	5 June	5 June	5 June	5 June	5 June
Time	1600	2000	0005	0200	0400	0600	0900
Mode	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC
Set	33	33	35	35	35	35	28
Spont.	—	—	—	—	—	—	13
Total	33	33	35	35	35	35	41
Set							
Spont.	354	397	435	450	34	326	357
MV	15.8	15.3	15.5	15.5	11.9	15.7	14.0
FiO2	90	90	100	100	100	100	100
Peep	15	15	15	15	15	15	15
~~I:E~~	24	24	24	24	24	24	24
Flow	—	—	—	—	—	—	
Sens.	-2	-2	-2	-2	-2	-2	-2
PIP	41	41	41	41	41	41	41
MAP	23	23	24	23	24	23	20
Sats.	94	95	97	99	100	100	56
PIP Alarm Hi/Lo	45/15	45/15	45/10	45/10	45/10	45/10	45/10
PS	10	10	10	10	10		10
Initials	(b)(6)						

ETT/Trach

Size	Position	Cuff

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	HCO3	Sat
4 June	1822	7.055	81.5	98			22.8	93.7
4 June	2314	7.070	76.4	78	24	-8	22.1	88
5 June	0105	7.043	84	152	25	-8	22.9	98
5 June	0858	6.968	95	44	28	-10	22.	95%

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

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

EXT

344th Task Force
Ventilator Flow Sheet

Patient Info: Name: (b)(6)
Age: _____ DOB: _____
Gender: _____ Pt. ID: (b)(6)

Date: _____
Vent Day #: 0
Vent Unit #: (b)(6)

Date	5/14	5/15	5/15	5/15	15 May	15 May	15 May	15 May	15 May	16 May	16 May	16 May	16 May	16 May	16 May	16 May
Time	2330	0220	0315	0640	0945	1040	1225	1505	1810	2100	0150	0540	0451	1209	1400	1600	1830
Mode	A/C	A/C	A/C	A/C	AC		AC	AC	AC	A/C	A/C	A/C	AC	AC		AC	AC
Set	12	10	10	10	10		10	10	10	10	10	10	10	10		10	10
Spont.	—	3	3	3	11		6	7	8	20	5	4	4	5		0	1
Total	12	15	14	18	21		16	17	18	30	15	14	14	15		10	11
Set	700	700	650	650	650		650	650	650	650	650	650	650	650		650	650
Spont.	728	735	721	720	696		720	665	681	789	782	779	703	696		732	702
MV	9.0	11.7	12.9	13.2	14.3		12.9	13.3	11.9	19.9	12.0	10.5	10.3	11.6		11.0	10.4
FiO2	60	60	60	50	50%	65	65%	65%	65%	65%	65%	65%	65%	65%		50%	50%
Peep	5	5	5	5	5	10	10	10	10	10	10	10	10	10		10	10
I/E	1:2	1:2	1:2	1:2	1:1.6		1:2	1:2.8	1:2.4	1:2	1:3.5	1:3.5	1:1.5	1:1.5		1:1.6	1:1.7
Flow	45	54	45	45	45		65	62	62	56	67	66	45	50		40	40
Sens.	-2	-2	-2	-2	-2		-2	-2	-2.0	-2	-2	-2	-2	-2		-2	-2
PIP	27	35	35	35	35		35	35	35	37	41	41	45	45		42	42
MAP	11	14	14	13.5	13.0		17	16	16	20	16	15	13	14		13	12
Sats.	100	100	100	95	96%		100%	100%	100%	100	100	100	99	100		99%	99
PIP Alarm Hi/Lo	40/5	40/5	40/5	40/5	40/5		40/5	40/5	40/5	40/5	40/5	40/5	40/5	40/5		40/5	40/5
PS	—	—	—	—			—	—		—	—	—	—	—	—	—	—
Initials	(b)(6)																

ETT/Trach

Size	Position	Cuff
7.5	23L lip	30

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	HCO3	SaO2
15 May	0145	7.254	34.7	153	19	-10	17.6	99
15 May	0300	7.26	39.2	164	19	-9	17.8	99
15 May	0640	7.299	35.3	82	18	-9	17.3	95
15 MAY 06	1026	7.352	33.3	67	19	-7	18.5	92%
16 May 06	1430	7.432	40.8	91	28	3	27.2	97%
16 May 06	2030	7.43	45.7	83	32	6	30.6	

Time	Vt	Rate	NIF	MV

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 4
133

(b)(6)

344th Task Force
Ventilator Flow Sheet

Patient Info: Name: (b)(6)
Age: _____ DOB: _____
Gender: _____ Pt. ID: (b)(6)

Date: _____
Vent Day #: 0
Vent Unit #: (b)(6)

Date	5/14	5/15	5/15	5/15	15 MAY	15 MAY	15 MAY	15 MAY	15 MAY	16 MAY	16 MAY	16 MAY	16 MAY	16 MAY	16 MAY
Time	2330	0210	0315	0640	0945	1040	1235	1505	1810	2100	0900	1050	0951	1207	1400	1600	1830
Mode	A/C	A/C	A/C	A/C	AC		AC	AC	AC	A/C	A/C	A/C	AC	AC		AC	AC
Set	12	10	10	10	10		10	10	10	10	10	10	10	10		10	10
Spont.	—	3	3	3	11		6	7	8	20	5	4	4	5		0	1
Total	12	15	14	18	21		16	17	18	30	15	14	14	15		10	11
Set	700	700	650	650	650		650	650	650	650	650	650	650	650		650	650
Spont.	728	735	721	720	696		720	665	661	709	782	779	703	696		732	722
MV	9.0	11.7	12.9	13.2	14.3		12.9	13.3	11.9	19.9	17.0	10.5	10.3	11.6		9.0	10.4
FiO2	60	60	60	50	50%	65	65%	65%	65%	65%	65%	65%	65%	65%		50	50%
Peep	5	5	5	5	5	10	10	10	10	10	10	10	10	10		10	10
I/E	1:2	1:2	1:2	1:2	1:1.6		1:2	1:2.8	1:2.4	1:2	1:3.5	1:3.5	1:1.5	1:4.5		1:1.6	1:1.7
Flow	45	54	45	45	45		65	62	62	56	67	60	45	50		40	40
Sens.	-20	-20	-20	-20	-20		-20	-2	-2.0	-20	-20	-20	-2	-2		-45	-45
PIP	27	35	35	35	35		35	35	35	37	41	41	45	45		48	42
MAP	11	14	14	13.5	13.0		17	16	16	20	16	15	13	14		13	12
Sats.	100	100	100	95	96%		100%	100%	100%	100	100	100	99	100		99%	99
PIP Alarm Hi/Lo	40/5	40/5	40/5	40/5	40/5		40/5	40/5	40/5	40/5	40/5	40/5	40/5	40/5		40/5	40/5
PS	—	—	—	—			—	—		—	—	—	—	—	—	—	—
Initials	(b)(6)																

ETT/Trach

Size	Position	Cuff
7.5	23L lip	30

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	HCO3	Sat. O2
15 MAY	0145	7.254	34.7	153	19	-10	17.6	99
15 MAY	0300	7.26	39.2	164	19	-9	17.8	95
15 MAY	0640	7.299	35.3	82	18	-9	17.3	95
15 MAY 06	1026	7.352	33.3	67	19	-7	18.5	92%
16 MAY	0430	7.432	40.8	91	28	3	27.2	97%
16 MAY	2030	7.43	45.7	83	32	6	30.6	

Weaning Parameters

Time	Vt	Rate	NIF	MV

~~FOR OFFICIAL USE ONLY~~
~~ANY UNAUTHORIZED DISCLOSURE MAY RESULT IN CRIMINAL PROSECUTION~~
~~UNDER THE ENFORCE MENT SENSITIVE~~

EXHIBIT 134

344th Task Force
Ventilator Flow Sheet

Patient Info: Name: (b)(6)
Age: _____ DOB: _____
Gender: M Pt. ID: (b)(6)

Date: 16 May 06
Vent Day #: 3
Vent Unit #: (b)(6)

Date	16 May	17 May	17 May	17 May	17 May	17 May	17 May	17 May	17 May	17 May	18 May	18 May	18 May	18 May	18 May
Time	2100	0000	0535	0905	1100	1201	1445	1645	1835	2000	2330	0025	0500	0710	1100	1450	1712
Mode	A/C	A/C	A/C	SIMV		SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS
Set	10	10	10			10	10	10	10	10	10		10	10	10	10	10
Spont.	5	4	3			1	0	0	1	2	7	7	4	3	10	4	4
Total	15	14	13			11	10	10	11	12	17	17	14	13	20	14	14
Set	650	650	650		750	750	750	750	750	750	750	750	750	750	750	750	750
Spont.	696	631	747			894	850	898	871	814	849	886	751	864	724	800	783
MV	19.2	15.3	9.4			9.8	8.1	8.1	8.4	9.1	10.7	11.7	9.5	9.2	11.9	10.0	10.0
FiO2	50	50	50%			50%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%
Peep	10	10	10			10	10	10	10	10	10	10	10	10	10	10	10
I/E	1:4.5	1:6	1:3.2			1:1.4	1:4.5	1:4.5	1:3.5	1:3.5	1:2.4	1:1.6	1:3.2	1:3.5	1:2.8	1:2.6	1:1.46
Flow	40	40	40			40	46	40	40	40	40	40	40	40	40	46	40
Sens.	-2cm	-2cm	-2			-2	-2	-2	-2	-2cm	-2cm	-2cm	-2cm	-2	-2	-2	-2
PIP	35	36	35			45	45	46	31	46	46	46	46	46	43	46	40
MAP	13	13	15			14	15	15	15	15	15	16	15	15	14	15	14
Sats.	100	97	98%			100	99	99%	98%	97%	97%	96%	97%	97	96%	99%	95
PIP Alarm Hi/Lo	40/5	40/5	45/10			45/10	45/10	45/10	45/10	50/10	50/10	50/10	50/10	50/10	50/10	50/10	50/10
PS	/	/	/			5	5	5	5	5	5	5	5	5	5	5	5
Initials	(b)(6)																

ETT/Trach

Size	Position	Cuff
7.5	21cm	25

as of 16 May 2006 2300

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	Hco3	Sat
17 May	0100	7.442	45	87	32	7	30.7	97
17 May	0943	7.429	47.1	90	32	7	31.1	97%
17 May	1140	7.452	43	103	31	6	30.1	98%
~~17 May~~		7.42	48.3	99	32		31.0	96%
18 May	0500	7.45	43.8	80	35	10	33.4	97%

Time	Vt	Rate	NIF	MV

EXHIBIT 135

ıtilator Flow Sheet

Patient Info: Name: (b)(6)

Age: _____ DOB:

Gender: M Pt. ID: (b)(6)

Date: 18 MAY 06

Vent Day #: 5

Vent Unit #: (b)(6)

Date	18 May	18 May	18 May	19 May	19 May	19 May	19 May	19 May	19 May	19 May	19 May	20 May	20 May	20 May	20 May	20 May
Time	1800	2230	0130	0530	0730	1245	1500	1810	1940	2023	0230	0500	0840	1110	1401	1640	1810
Mode	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	AC PC	AC PC	AC PC
Set	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Spont.	2	0	5	12	24	2	4	8	10	6	8	12	15	10	0	0	0
Total	12	10	15	12	14	12	14	18	20	16	18	22	25	20	10	10	10
Set	750	750	750	750	750	750	750	750	750	750	750	750	750	750	—	—	—
Spont.	885	803	586	860	764	943	823	946	785	810	847	822	772	713	832	827	733
MV	9.5	8.8	11.8	10.6	11.3	12.1	11.4	12.2	12.4	11.5	12.6	11.8	14.7	13.4	10.2	11.9	8.8
FiO2	40%	40%	40%	40%	40%	40%	40%	40%	50%	80%	50%	50%	50%	50%	100%	100%	100%
Peep	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
I/E	1:3.8	1:4.5	1:2	1:3.8	1:4.5	1:3.8	1:1.3	1:3.2	1:2.4	1:2.4	1:3.5	1:2.4	1:2.2	1:4.7	1:2.4	1:3.2	1:2.8	1:3.2
Flow	40	40	40	40	40	40	40	40	40	40	40	40	40	40	40	22	22	22
Sens.	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2
PIP	46	45	47	46	40	46	46	41	41	40	41	42	43	44	33	33	33
MAP	14	16	15	14	13	14	15	14	14	15	14	15	15	15	15	16	16
Sats.	95	100	100	94	94	97%	94%	94%	94	95	94	95	95	95	99	99	98
PIP Alarm Hi/Lo	50/10	50/10	50/100	50/10	50/10	50/10	50/10	60/10	50/10	50/10	50/10	50/10	50/10	50/10	37/10	37/10	37/10
PS	5	5	5	10	10	10	10	10	10	10	10	10	10	10	—	—	—
Initials	(b)(6)																

T. P

ETT/Trach

Size	Position	Cuff

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	HCO3	Sat
19 May	0530	7.464	45.5	218		9	32.6	100
19 May	2018	7.452	43.8	65	32	6	30.5	93

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

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EXHIBIT 4

tilator Flow Sheet

Patient Info: Name: _____ Date: 22 May 06
Age: _____ DOB: _____ Vent Day #: 8
Gender: M Pt. ID: (b)(6) Vent Unit #: (b)(6)

Date	22 May	23 May	23 May	23 May	23 May	24 May	24 May	24 May	24 May	24 May	24 May	24 May	24 May	24 May	24 May	24 May
Time	1100	1600	0300	0545	1000	1650	1801	1850	2400	0000	0300	0600	0630	1517	1735	1815	2100
Mode	AC	AC PC	AC PC	AC PC	AC PC	AC PC	AC		AC VC	AC VC	AC VC	AC VC	AC	AC	AC	AC	AC VC
Set	14	14	14	14	14	14	14		14	14	14	14	14	14	10	10	10
Spont.	—	—	—	—	—		0		—	2	2	0	—	3	14	16	9
Total	14	14	14	14	14	14	14		14	16	16	14	14	17	24	26	18
Set	—	—	—	—	—		850		850	850	850	850	850	850	850	850	850
Spont.	901	925	860	990	800	806	880		888	894	890	923	886	911	878	864	870
MV	13.4	14.2	16.2	14.9	15.3	14.4	16.4		17.0	13.0	16.1	13.5	12.8	16.8	18.7	19.8	18.6
FiO2	80	80	80	80	80	100	100		100	100	100	~~100~~ 40	100	90%	90%	90	90
Peep	10	10	10	10	10	10	10	12	12	10	10	10	10	10	10	10	10
I/E	1:1.6	1:1.4	1:1.6	1:1.6	1:1.4	1:1.1	1:2.8		1:2	1:2.8	1:2.6	1:2.2	1:2.2	1:1.4	1:1.4	1:1.2	1:1.3
Flow	—	—	—	—	16	20	36		45	45	45	45	45	50	50	50	50
Sens.	-2	-2	-2	-2	-2	-2	-2		-2	-2	-2	-2	-2	-2	-2	-2	-2
PIP	31	31	31	31	27	31	37		36	36	37	36	36	36	36	36	36
MAP	18	17	18	18	18	24			19	15	16	18	17	19	18	19	20
Sats.	100	98	95	100	99	94	88		98	96	100	100	100	98	100	100	100
PIP Alarm Hi/Lo	40/10	40/10	40/10	40/10	40/10	40/10	40/10		50/12	50/12	50/12	50/12	50/12	50/12	50/12	50/12	40/12
PS	—	—	—	—	—				—	—	—	—					
Initials	(b)(6)																

ETT/Trach

Size	Position	Cuff

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	HCO3	SAT
23 May	0530	7.49	40.4	106	32	7	30.8	97
23 May	1645	7.335	59.7	64	39	6	31.8	90
24 May	0600	7.456	40.4	109	32	7	30.6	99
24 May	1400	7.463	46.2	119	34	9	33.1	98
24 May	1650	7.55	32.5	75	30	6	28.6	97
24 May	1850	7.58	32.7	69	32	9	30.6	98

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

EXHIBIT 137

[redacted] Task Force 21st CAB
Ventilator Flow Sheet

Patient Info: Name: _____ Date: 20 MAY 06
Age: _____ DOB: _____ Vent Day #: 6
Gender: M Pt. ID: (b)(6) Vent Unit #: _____

Date	19	20	21	21 May	21 May	21 May	21 May	21 May	21 May	21 May	21 May	22 MAY	22 May	22 May	22 May
Time	2000	0000	0600	0915	0950	1205	1625		1830	2206	1330	0248	0600	0700	1230	1515	1800
Mode	AC/PC	AC/PC	AC/PC	AC/PC		AC/PC	AC/PC		AC/PC	AC/PC	AC/PC	AC/PC	AC/PC	AC/PC	AC/PC	AC/PC	AC/PC
Set	10Δ	14	14	14		14	14		14	14	14	14	14	14	14	14	14
Spont.	0	0	0				3		0	0	0	/	/		3	/	/
Total	10	14	14	14		14	17		14	14	14	14	14	14	17	15	14
Set	600	600	600	/		/	/		/	/	/	/	/	/	/	/	/
Spont.	749	749	644	708		747	894		930	825	825	805	732	731	860	916	896
MV	9.2	9.8	9.8	9.6		10.1	9.1		18.9	11.9	22.7	12.5	16.9	17.7	14.8	14.4	13.5
FiO2	100	100	100	100	80	100	100		100%	80%	80	80	80	80%	70%	80%	80%
Peep	10	10	10	10		10	+13	↓12	+12	+12	+10	+10	+10	+10	10	+10	+10
I/E	1:2	1:2	1:2	1:2		1:1.8	1:1.4		1:1.6	1:1.6	1:1.6	1:1.6	1:1.6	1:1.6		1:1.6	1:1.6
Flow	—	—	—	22		28	↑35	↓28	↓22	22	14	16	16	16	20	20	20
Sens.	-2	-2	-2	-2		-2	-2		-2	-2	-2	-2	-2	-2	-2	-2	-2
PIP	33	33	33	33		39	48		35	35	27	27	27	27	31	31	31
MAP	14	18	17	17		19	24		21	19	16	16	15	18.8	14.2	18	18
Sats.	100	100	100	97		99	100%		100%	96%	95	100	94	96	97	100	100%
PIP Alarm Hi/Lo	37/10	37/10	37/10	37/10		37/10	52/12	49/12	39/12	41/12	31/10	31/10	31/10	31/10	34/10	31/10	49/10
PS	[redacted]																
Initials	(b)(6)																

ETT/Trach

Size	Position	Cuff
7.5	21cm @ teeth	25cm H_2O

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	HCO3	Sat
21 May	1900	7.37	56.3	293	34	7	32.6	100%
22 May	0023	7.35	56.5	75	36	9	34.7	94
22 May	0530	7.334	59.3	75	35	8	33.4	94
22 May	0248	7.48	44.4	65	35	10	33.5	94
22 May	1400	7.46	42.6	105	35	10	33.8	98

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

EXHIBIT 1384

344th Task Force
Ventilator Flow Sheet

Patient Info: Name: _____ Date: 27 May

Age: _____ DOB: _____ Vent Day #: 14

Gender: M Pt. ID: (b)(6) Vent Unit # (b)(6)

Date	27 May	27 May	27 May	27 May	27 May	27 May	27 May	27 May	28 May	28 May	28 May	28 May	28 May	28 May	28 May	28 May
Time	0215	0500	0730	1055	1220	1400	1600	1816	2115	2345	0233	0400	0530	0755	1301	1625	1905
Mode	SIMV PC	SIMV VC	SIMV PC	SIMV PS	SIMV PC	SIMV PC	1645	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC
Set	17	17	17	18	18	18	18	18	18	18	18	18	18	18	14	18	18
Spont.	17	18	14	12	18	0	1	9	16	24	22	22	23	12	20	27	6
Total	34	35	31	30	28	18	19	27	34	42	40	40	41	30	38	45	24
Set	850	850	850	850	850		850	850	850	850	850	850	850	850	850	850	850
Spont.	585	542	575	555	570	670	560	444	487	365	389	382	323	466	435	405	537
MV	17.3	19.2	16.1	13.4	11.3	12.3	11.5	11.4	14.2	16.1	14.0	15.7	14.2	11.4	14.6	9.5	9.9
FiO2	90	90	90%	90%	90%	90%	90%	80	80	80	80	80	80	80%	80%	80	80
Peep	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
I/E	1:1.6	1:1.2	1:1.8	1:1.4	3:1	1:4.1	1:4:1	1:8:1	1:1.2	1:1.2	1:1.2	1:2.1	2.1:1	1:1.4	1:1.1	3.1	1:8:1
Flow	55	55	55	58	60	20	20	20	20	20	20	20	20	20	20	20	20
Sens.	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2
PIP	27	23	36	36	29	32	31	32	31	24	23	24	23	31	31	31	23
MAP	14	15	15	15	19	19	20	20	15	16	16	16	16	15	16	19	19
Sats.	97	97	100	100	100	97	100	100	100	100	91	99	95	100	96	98	99
PIP Alarm Hi/Lo	40/10	40/10	40/10	40/10	40/10	40/10	35/10	35/10	35/80	35/40	35/10	35/10	35/10	35/10	35/10	35/10	35/10
PS	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Initials	(b)(6)																

ETT/Trach

Size	Position	Cuff

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	Hr.3	Sat
27 May	0430	7.44	47.5	82	34	9	32.9	96
27 May	1209	7.386	52.1	73	33	5	31.2	96%
27 May	1330	7.353	55.1	90	32	5	30.6	96%
27 May	1430	7.372	54.0	113	33	6	31.4	98%
27 May	1905	7.40	51.6	78	34	7	32.2	95
27 May	2305	7.39	53.9	84	34	8	32.7	96
28 May	0500	7.377	53.4	77	33	6	31.4	95

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 4

[redacted]" Task Force 21st C[redacted]

Ventilator Flow Sheet

Patient Info: Name: _____ Date: 25 May

Age: _____ DOB: _____ Vent Day #: _____

Gender: M Pt. ID: (b)(6) Vent Unit #: (b)(6)

Date	25 May	25 May	25 May	25 May	25 May	25 May	25 May	25 May	25 May	26 May	26 May	26 May	26 May	26 May	26 May	26 May
Time	0400	0600	0745	1320	1609	1622	1828	2000	2355	0350	0545	0640	1620	1800	1840	2110	0030
Mode	APC	AC VC	SIMV	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV PS	PS	AC VC	SIMV VC	SIMV PS	SIMV PS	SIMV PS	SIMV PS	SIMV VC	SIMV VC
Set	10	10	10	10	10	10	10	14	14	14	14	14	17	17	17	17	17
Spont.	16	24	29	29	16	20	0	0	0	8	/	15	12	14	15	13	13
Total	26	34	14	19	16	30	10	14	14	14	14	29	29	31	32	30	30
Set	850	850	800	800	800	800	800	800	800	800	810	800	850	850	850	850	850
Spont.	515	641	699	454	600	654	765	800	824	825	845	501	474	482	633	472	564
MV	14.2	20.5	16	17.1	14.5	16.1	12.2	11.1	13.5	1:1.4	13.4	13.8	15.3	14.8	19.0	18.4	16.8
FiO2	90	90	90	90%	80%	80%	80%	80%	80%	90	80	85%	85	90%	90%	90	90
Peep	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
I/E	1:4.1	1:1	1:1.4	1:1.3	1:1.3	1:8.1	1:28	1:2	1:1.4	1:1.4	1:1.2	1:25	1:1.6	1:1.6	1:1.4	1:1.2	1:1.6
Flow	50	50	60	80	50	50	50	50	50	50	80	56	55	55	55	55	55
Sens.	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2
PIP	36	36	36	22	23	21	36	36	36	36	36	36	27	24	25	30	36
MAP	22	18	14	14	14	16	16	17	18	17	20	20	12	12	14	15	14
Sats.	100	100	100	100	100	100	96	98	98	100	100	100	100	96	96	99	100
PIP Alarm Hi/Lo	46/10	46/10	46/10	46/10	46/10	49/10	40/10	29/10	40/10	40/10	40/10	49/10	49/10	49/10	49/10	40/10	40/10
PS	—	—	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Initials	(b)(6)																

ETT/Trach

Size	Position	Cuff
	[redacted]	

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	HCO3	Sat
25 May	0600	7.559	29	78	29	4	27	97
25 May	1900	7.25	69.4	77.6	33	4	30.8	98
26 May	0600	7.351	51.2	71	30	3	28.3	93
26 May	1150	7.36	52.4	76	31	4	29.6	94

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

EXHIBIT 4

Name: (b)(6)
ID:
Bed #: 3
Vent Day: 14
(b)(6)

(b)(6)

0089 06 CID789 784

TASK FORCE 21th MED
VENTILATOR FLOW SHEET

* How do decrease MAP?
* VT ?

VENT	A-15	A15	A15	A15	A17	A15	A15	A16	A15	A15	A18	A15	A15	Change vent out to A14	Due to A/C mode pt desat	A14	A14	A14	A14
DATE	28 may	28 may	29 may	29 may	29 may	29 may	29 May	29 May	29 May	29 MAY	29 May	29 May	30 May			[illegible]	30 May	30 May	30 MAY
TIME	1815	2100	0000	0200	0400	0600	0830	1135	1435	180	2000	2200	0000			0200	0400	0615	1235
MODE	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC			SIMV PC	SIMV PC	SIMV PC	SIMV PC
SET RATE	18	18	18	18	18	18	18	18	18	20	20	20	20			20	20	20	20
SPONT RATE	19	15	17	5	5	7	2	Ø	18	Ø	2	—	—			—	—	—	Ø
TOTAL	37	33	35	23	23	25	20	18	36	20	22	20	20			20	20	20	20
MV	12.8	11.4	12.1	11.1	11.7	12.2	12.2	9.8	9.1	10.1	21.6	13.8	13.6			14.7	14.5	14.3	14.5
FiO2	80%	80	80	80	80	80	80	80%	.80	100	100	100	100			100	80	60	50
PEEP	10	10	10	10	10	10	10	10	10	15	15	15	15			15	15	15	15
PS+	10	10	10	10	10	10	10	10	10	10	10	10	10			10	10	10	10
I/E	1:1	1:1.4	1:1.2	1:2.4	1:2.2	1:2	1:2.4	1:3	1:1	1:2.6	1:2.4	2.8:1	2.8:1			2.5:1	2.2:1	2.2:1	1:2.1
IP ~~FLOW~~	24	24	24	24	24	24	24	24	24	20	24	24	24			24	20	20	20
SENS.	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2			-2	-2	-2	-2
PIP	35	35	35	35	35	35	35	35	35	36	25	40	40			39	34	36	36
MAP	16	16	15	15	15	15	15	15	16	19	20	30	31			19	28	27	27
SpO2	99	99	97	99	99	99	100	100	100	90	92	•	100			100	100	99	100
PIP ALARM HI/LO	39/10	39/10	39/10	35/10	35/10	35/10	35/10	35/10	35/10	35/10	35/10	35/10	35/10			40/10	40/10	40/10	40/10
TEMP.	102	102.9	102.8	102.7	102.4	101.9			103		103.7					102		103	
PSI	1500	500	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]						
INITIALS	(b)(6)																		

ETT/TRACH

SIZE	POSITION	CUFF

ABG RESULTS

DATE	TIME	PH	PCO2	PO2	TCO2	HCO3	BE	O2 SAT
28 May 06	1400	7.366	51.3	65	31	29.4	4	91%
28 MAY	1755	7.304	62.2	118	33	30.9	5	98%
28 may	2000	7.33	57.9	109	32	30.2	4	98
29 may	0420	7.334	54.1	99	30	28.8	3	97
29 may	1930	7.18	79.9	67	32	29.9	2	86%
29 May	2123	7.317	55	89	30	28.1	2	96
30 May	0100	7.45	37.2	138	27	25.6	2	99%
30 May	0430	7.44	38.7	227	28	26.5	2	100
30 May	0541	7.454	37	141	27	25.9	2	99
30 May	0645	7.43	40.4	83	28	26.9	3	96

(b)(6)

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~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT 4

141

Patient Name:
Pt. I.D: (b)(6)
Bed #: 3
Vent Day: (b)(6)

0089 06 CID789 7846

TASK FORCE 21th MED
VENTILATOR FLOW SHEET

VENT	A-14	STARTED A NEW FLOW SHEET																	
DATE	28 MAR																		
TIME	1505																		
MODE	[illegible]																		
SET RATE	20																		
SPONT RATE	/																		
TOTAL	20																		
MV	14.9																		
FiO2	55																		
PEEP	15																		
PS+	10																		
I/E	1:2.1																		
FLOW	60																		
SENS.	-2																		
PIP	36																		
MAP	27																		
SpO2	100																		
PIP ALARM HI/LO	40/10																		
TEMP.																			
PSI	1450																		
INITIALS	(b)(6)																		

ETT/TRACH

SIZE	POSITION	CUFF

ABG RESULTS

DATE	TIME	PH	PCO2	PO2	TCO2	HCO3	BE	O2 SAT

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 4

2d Task Force
Ventilator Flow Sheet

0089 06 CID 789 784

Patient Info: Name: _____ Date: 30 May 06
Age: _____ DOB: _____ Vent Day #: _____
Gender: M Pt. ID: (b)(6) Vent Unit #: (b)(6)

Date	30 May	30 May	30 May	30 May	30 May	31 May	31 May	31 May	31 May	31 May	31 May		31 May	31 May	1 June	1 June	1 June
Time	1710	1810	2100	2300	0100	0300	0520	0820	1150	1630	1810		2000	2200	0000	0200	0500
Mode	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC		SIMV PC	SIMV PC	SIMV PC	SIMV PC	SIMV PC
Set	20	20	20	20	20	20	20	20	20	20	20		20	20	20	20	20
Spont.	/	/	/	/	/	/	/	/	/	6	3		/	/	/	/	/
Total	20	20	20	20	20	20	20	20	20	26	23		20	20	20	20	20
Set	/	/	/	/	/	/	/	/	/	/	/		/	/	/	/	/
Spont.	769	776	750	737	687	659	600	579	666	723	722		655	760	680	639	659
MV	15.0	16.0	14.6	13.8	14.0	12.2	12.2	11.8	12.7	17.6	18.4		18.5	23.5	22.0	15.6	16.9
FiO2	.55	.55	.50	50	50	50	50	.50	.50	.80	.80		.70	.60	60	60	60
Peep	15	15	15	15	15	15	18	15	15	15	15		15	15	15	15	15
I/E	1:2.1	1:2.1	2.2:1	2.2:1	2.2:1	2.2:1	2.2:1	2.2:1	2:2.1	1:1.8	1:1.4		1:1.6	1:1.8	2.2:1	2.2:1	2.2:1
Flow	20	20	20	20	20	20	20	20	20	20	20		20	20	20	20	20
Sens.	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2		-2	-2	-2	-2	-2
PIP	36	36	36	36	36	36	36	36	36	36	37		36	37	37	34	34
MAP	27	28	27	28	28	28	28	28	28	18	21		21	20	21	27	27
Sats.	100	97	100	100	100	100	100	98%	100	98	100		100	100	100	100	100
PIP Alarm Hi/Lo	40/10	40/10	40/15	40/15	40/15	40/15	40/15	40/15	40/15	45/15	45/15		45/15	45/15	45/15	45/15	45/15
PS	10	10	10	10	10	10	10	10	10	10	10		10	10	10	10	
Initials	(b)(6)																

TP

ETT/Trach

Size	Position	Cuff

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	HCO3	SAT
30 May	1300	7.435	36.1	68	25	0	24.3	99%
30 May	1530	7.45	34.1	73	25	0	23.7	95%
30 May	2100	7.40	38.0	84	23.3	-2	23.3	96
31 May	0531	7.326	45.7	79	25	-2	23.8	95
31 May	1551	7.250	54.4	87	26	-3	24.2	95%
31 May	2100	7.30	47.3	118	25	-3	23.4	98
31 May	2320	7.34	43.1	87	25	-2	22.7	96
31 May	0120	7.35	41.6	117	24	-3		98

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

EXHIBIT 4

24th Task Force
Ventilator Flow Sheet

0089 06 CID 789 78469

Patient Info: Name: _____ Date: 1 June

Age: _____ DOB: _____ Vent Day #: _____

(b)(6) Gende (b)(6) Pt. ID: (b)(6) Vent Unit #: (b)(6)

Date	1 June	1 June	1 June	1 June	1 June	1 June	1 June	1 June	1 June	1 June	1 June	2 June
Time	0500	0545	0800	09:01	1150	1500	1555	1610	1946	2000	2200	0000
Mode	SIMV PC	SIMV PC	SIMV PC	SIMV 20	SIMV	SIMV PC	SIMV PC		SIMV	SIMV PC	SIMV PC	SIMV PC
Set	20	20	20	20	20	25	27		27	27	27	27
Spont.	/	/	2	0	/	/	0		/	/	/	/
Total	20	20	22	20	20	25	27		27	27	27	27
Set	/	/	/	/	800	800				/	/	/
Spont.	540	657	734	394	151	649	571		671	670	650	650
MV	12.6	13	15.7	9.1	15.5	15.7	18.2		18.6	18.3	18.4	18.2
FiO2	60	50	50	50	100	90	.90	.80	.80	80	70	480
Peep	15	15	10	20	15	15	15		15	15	15	15
~~I:E~~	20	20	20	20	1:2	1:1	1:1.2		1:1.2	1:1.2	1:1.2	1:1.2
Flow	/	/	/	/	45	40	20	24	24	24	24	24
Sens.	-2	-2	-2	-2	-2	-2	-2		-2	-2	-2	-2
PIP	36	36	37	31	41	40	37		41	41	41	41
MAP	27	26	15	23	26	27	21		22	23	23	22
Sats.	100	100	100	100	99	99	99		96	97	98	87
PIP Alarm Hi/Lo	45/15	45/15	45/15	35/10	45/10	45/10	40/10		49/10	44/10	44/10	44/10
PS	10	10	10	10	5	5	10		10	10	10	
Initials	(b)(6)											

ETT/Trach

Size	Position	Cuff

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE	HCO3	Sat
1 Jun	0445	7.36	40.3	193	24	-2	23	100
1 June	0935	7.153	66.3	61	25	-6	23.2	82
1 June	1035	7.126	73.8	94	27	-5	24.4	94
1 June	1510	7.191	63.0	198	26	-4	24.1	99
1 June	1821	7.208	59.1	113	25	-4	23.5	97%
1 June	2005	7.26	57.1	67	24	-4	22.9	90
2 June	0000	7.26	50.7	61	25	-4	23.1	87

Weaning Parameters

Time	Vt	Rate	NIF	MV

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~~LAW ENFORCE MENT SENSITIVE~~

EXHIBIT

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician Drawn by: (b)(6) Ward: ICU Bed: 3 Gender M or F (circle) Stat or Routine (circle)

TF 21, ABU LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 0000 2 June 06

Signs and Symptoms:

(b)(6) Date and Time 2 June 0

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH.	7.267	7.35-7.45
	PCO2	50.7	35-45 mmHg
	PO2	61	80-100 mmHg
	TCO2	25	18-33 mmol/L
	HCO3	23.1	22-26 mmol/L
	sO2	87%	95-99%
	BEecf	-4	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.25	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 (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT	REF. RANGE
	ALB	1.4	3.3-5.5 g/dL
	ALP	144	26-184 U/L
	ALT	204	10-47 U/L
	AMY		14-110 U/L
	AST	303	11-38 U/L
	Tbil	0.7	0.2-1.6 mg/dL
	BUN	85	7-22 mg/dL
	Ca	7.8	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
	CL	125	98-109 mmol/L
	TCO2	22	18-33 mmol/L
	Creat	2.9	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	133	73-118 mg/dL
	K	4.9	3.3-4.9 mmol/L
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	TProtein	6.0	6.4-8.1 g/dL
	Na	166*	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
Ova / Parasite		No Ova / Parasite
OccBld		Negative
Wet Mount		Negative
KOH		Negative

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LAW ENFORCEMENT SENSITIVE

Hematology / Purple Top

CBCN (no diff) | CBC | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle)/Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

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

SECRET

(b)(6) reviewed by:

Critical values reported to 145

revised 31July05 mc

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6) Ward: ICU

Drawn by: Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

TF 21, ABU

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 1120 2 June

Signs and Symptoms:

Reported by: (b)(6)

Date and Time: 02JUN06/0131

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.26	7.35-7.45
	PCO2	52.4 H	35-45 mmHg
	PO2	69 L	80-100 mmHg
	TCO2	25	18-33 mmol/L
	HCO3	23.5	22-26 mmol/L
	sO2	90	95-99%
	BEecf	-4	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.18	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 (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (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

CBCN (no diff) | CBC | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle)/Purple Top

Hemoglobin S	Negative

Body Fluid Panel- Sterile Cont.

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis test (C[illegible]ly)

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LAW ENFORCEMENT SENSITIVE

reviewed by:

Revised 31July05.mp

TF 21, ABU

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6) Ward: 1C4

Drawn by: Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 0230 2 Jun 06

Signs and Symptoms:

Reported by: (b)(6)

Date and Time: 02JUN06/0[illegible]

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.24	7.35-7.45
	PCO2	53.5	35-45 mmHg
	PO2	73L	80-100 mmHg
	TCO2	25	18-33 mmol/L
	HCO3	22.9	22-26 mmol/L
	sO2	91 L	95-99%
	BEecf	-4	(-2) - (+3)
	AGap		8-16 mmol/L
X	iCa	1.15	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 (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (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

CBCN (no diff) | CBC | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle)/ Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis test (147 only)

Reviewed by:

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LAW ENFORCEMENT SENSITIVE

revised 31july05 mc

Task Force 21 Med
Abu Ghraib, Iraq

0089 06 CID789 78469

Microbiology Laboratory Report

Accession #	(b)(6)
Collection Date	(b)(6)
Patient Name	
SSN or ID	(b)(6)
Sample Type	Respiratory
Sample Site	Tracheal Aspirate
Patient Location	ICU
Provider	(b)(6
Result Type	Preliminary 1
[X] Gram's Stain	Moderate Gram negative rods; many WBC's/low power field (LPF); <10 epithelial cells/LPF
[ ] Acid-fast Stain	(b)(6)
[ ] Rapid Group A Strep Antigen	
[ ] L pneumophila Urinary Antigen	
[ ] S pneumoniae Urinary Antigen	
[ ] Influenza Virus Antigen	
[ ] RSV Antigen	
[X] Culture	
Qty isolate #1	
Isolate #1	
Qty isolate #2	
Isolate #2	
Qty isolate #3	
Isolate #3	
Comments	
Report Date	(b)(6
Tech	(b)(6)
Reviewed By	

Isolate 1		Isolate 2		Isolate 3	
Amikacin		Amikacin		Amikacin	
Amox/K Clav		Amox/K Clav		Amox/K Clav	
Amp/Sulbactam		Amp/Sulbactam		Amp/Sulbactam	
Ampicillin		Ampicillin		Ampicillin	
Azithromycin		Azithromycin		Azithromycin	
Aztreonam		Aztreonam		Aztreonam	
Cefazolin		Cefazolin		Cefazolin	
Cefepime		Cefepime		Cefepime	
Cefotaxime		Cefotaxime		Cefotaxime	
Cefotetan		Cefotetan		Cefotetan	
Cefoxitin		Cefoxitin		Cefoxitin	
Ceftazidime		Ceftazidime		Ceftazidime	
Ceftriaxone		Ceftriaxone		Ceftriaxone	
Cefuroxime		Cefuroxime		Cefuroxime	
Cephalothin		Cephalothin		Cephalothin	
Chloramphenicol		Chloramphenicol		Chloramphenicol	
Ciprofloxacin		Ciprofloxacin		Ciprofloxacin	
Clindamycin		Clindamycin		Clindamycin	
Erythromycin		Erythromycin		Erythromycin	
Gatifloxacin		Gatifloxacin		Gatifloxacin	
Gentamicin		Gentamicin		Gentamicin	
Imipenem		Imipenem		Imipenem	
Levofloxacin		Levofloxacin		Levofloxacin	
Linezolid		Linezolid		Linezolid	
Meropenem		Meropenem		Meropenem	
Moxifloxacin		Moxifloxacin		Moxifloxacin	
Nitrofurantoin		Nitrofurantoin		Nitrofurantoin	
Norfloxacin		Norfloxacin		Norfloxacin	
Ofloxacin		Ofloxacin		Ofloxacin	
Oxacillin		Oxacillin		Oxacillin	
Penicillin		Penicillin		Penicillin	
Pip/Tazo		Pip/Tazo		Pip/Tazo	
Piperacillin		Piperacillin		Piperacillin	
Rifampin		Rifampin		Rifampin	
Synercid		Synercid		Synercid	
Tetracycline		Tetracycline		Tetracycline	
Ticar/K Clav		Ticar/K Clav		Ticar/K Clav	
Tobramycin		Tobramycin		Tobramycin	
Trimeth/Sulfa		Trimeth/Sulfa		Trimeth/Sulfa	
Vancomycin		Vancomycin		Vancomycin	

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LAW ENFORCEMENT SENSITIVE

EXHIB 148 4

Task Force 21 Med
Abu Ghraib, Iraq

0089 06 CID789 78469

Microbiology Laboratory Report

Accession #	(b)(6)
Collection Date	(b)(6)
Patient Name	
SSN or ID	(b)(6)
Sample Type	Blood
Sample Site	Central line
Patient Location	ICU Bed #3
Provider	(b)(6)
# bottles	2 (aerobic and anaerobic)
Result Type	FINAL
Gram's Stain	
Verbal Report	(b)(6)
Culture	No growth after 5 days
Isolate #1	
Isolate #2	
Isolate #3	
Comments	
Report Date	(b)(6)
Tech	(b)(6)
Reviewed By	

	Isolate 1	Isolate 2	Isolate 3
Amikacin			
Amox/K Clav			
Amp/Sulbactam			
Ampicillin			
Azithromycin			
Aztreonam			
Cefazolin			
Cefepime			
Cefotaxime			
Cefotetan			
Cefoxitin			
Ceftazidime			
Ceftriaxone			
Cefuroxime			
Cephalothin			
Chloramphenicol			
Ciprofloxacin			
Clindamycin			
Erythromycin			
Gatifloxacin			
Gentamicin			
Imipenem			
Levofloxacin			
Linezolid			
Meropenem			
Moxifloxacin			
Nitrofurantoin			
Norfloxacin			
Ofloxacin			
Oxacillin			
Penicillin			
Pip/Tazo			
Piperacillin			
Rifampin			
Synercid			
Tetracycline			
Ticar/K Clav			
Tobramycin			
Trimeth/Sulfa			
Vancomycin			

EXHIBIT 149 4

SSN or ISN: (b)(6)

LAST, FIRST, MI:

Physician: (b)(6) Ward: ICU

Drawn by: Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

TF 21, ABU

LAB[illegible]RY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 02 JUN 06

Signs and Symptoms:

Reported by: (b)(6)

Date and Time: 02JUN06/0930

Chemistry (i-STAT) / Green Top / Syringe		
Bld Gas	Bld Gas w/ lytes	Glu Crea
TEST	RESULT	REF. RANGE
Na	~~145~~	138-145 mmol/L
K		3.3-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.317	7.35-7.45
PCO2	42.6	35-45 mmHg
PO2	75	80-100 mmHg
TCO2	~~23~~ 23	18-33 mmol/L
HCO3	21.8	22-26 mmol/L
sO2	93%	95-99%
BEecf	-4	(-2) - (+3)
AGap		8-16 mmol/L
iCa	1.15	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:

(b)(6)

(b)(6)

Chemistry (Piccolo)/Green or red/tiger top			
Comp Pan	BMP	Hepatic Pan	Lipid Pan Renal Pan
X	TEST	RESULT	REF. RANGE
	ALB	1.4 L	3.3-5.5 g/dL
	ALP	138	26-184 U/L
	ALT	203 H	10-47 U/L
	AMY		14-110 U/L
	AST	271 H	11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	87 H	7-22 mg/dL
	Ca	7.8 L	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
	CL	125 H	98-109 mmol/L
	TCO2	20	18-33 mmol/L
	Creat	2.7 H	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	151 H	73-118 mg/dL
	K	4.4	3.3-4.9 mmol/L
	Mg		1.6-2.3 mg/dL
X	Phosphorus	5.4 H	2.2-4.5 mg/dL
	TProtein	5.9	6.4-8.1 g/dL
	Na	154 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

Rapid Tests (Green Top)		
Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)		
RPR		Negative
HCG (or urine)		Negative

Rapid Tests		
Strep A		Negative
Drug Screen (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

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

Hematology / Purple Top		
CBCN (no diff)	CBC	Malaria H/H
X	TEST	RESULT	REF. RANGE
	WBC	19.1 H	4.8-10.8 x10(3)/uL
	RBC	3.11	4.2-6.1 x10(6)/uL
	Hgb	9.4	12.0-18.0 g/dL
	Hct	28.5	M: 42.0-52.0%
			F: 37-47%
	MCV	91.5	80.0-99.0 fl
	MCH	30.4	27.0-31.0 pg
	MCHC	33.2	33.0-37.0 g/dL
	Plt	269	130-400 x10(3)/uL
	LY%	6.2	20.0-44.0%
	LY#	1.2	0.7-4.3 x10(3)/uL

X	Differential			
	Segs(50-70%)	74	Mono(4-10%)	3
	Bands(1-10%)	10	Eos(0-4%)	1
	Lymph(20-44%)	12	Baso(0-2%)	
	Atyp Ly		Immature cells	

RBC Abn Morph:	
Plt Abn Morph:	
WBC Abn Morph:	

Malaria / Purple Top		
Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top		
Sed Rate		1hr = 0-20 mm

X	Coagulation (Blue Top - Sodium Citrate)		
	PT	14.3	7.0-14.0 sec
	APTT		21.0-50.0 sec
	INR	1.4	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 (sickle) / Purple Top	
Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.	
Panel includes: Culture, Gram Stain, Cell Count, WBC Diff, Meningitis test (C150ly)	

reviewed by:

4

TF 21, ABU

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6) Ward: ICU Gender: M or F (circle)

Drawn by: Bed: 3 Stat or Routine (circle)

Specimen Date and time: 02 Jun 06 0745

Signs and Symptoms:

(b)(6) Date and Time: 02 Jun 06

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

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

Urinalysis

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 (Piccolo) / Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT	REF. RANGE
	ALB	3.0	3.3-5.5 g/dL
	ALP	115	26-184 U/L
	ALT	151	10-47 U/L
	AMY		14-110 U/L
	AST	194	11-38 U/L
	Tbil	0.5	0.2-1.6 mg/dL
	BUN	64	7-22 mg/dL
	Ca	6.3	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
	CL	102	98-109 mmol/L
	TCO2	18	18-33 mmol/L
	Creat	2.8	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	116	73-118 mg/dL
	K	3.1	3.3-4.9 mmol/L
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	TProtein	4.7	6.4-8.1 g/dL
	Na	125	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
Occ Bld		Negative
Wet Mount		Negative
[illegible]		Negative

Hematology / Purple Top

WBC | RBC | Hgb | Hct | MCV | MCH | MCHC | Plt | LY% | LY# | Differential | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel / Purple Top

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

Hemoglobin S (sickle) / Purple Top

Hemoglobin S	Negative

Body Fluid Panel / Sterile Cont

Panel includes: Culture, Gram Stain & Cell Count, WBC Diff., Meningitis tes 151 F only)

reviewed by:

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 4

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6)

Drawn by:

Ward: ICU

Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

TF 21, ABU

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 2 June 06 1040

Signs and Symptoms:

(b)(6)

Date and Time: 2 Jun 06 1053

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na	148 m/c	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 request: ALB/BMP/CL - Critical

(b)(6)

Chemistry (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT	REF. RANGE
	ALB	1.4	3.3-5.5 g/dL
	ALP	138	26-184 U/L
	ALT	196	10-47 U/L
	AMY		14-110 U/L
	AST	232	11-38 U/L
	Tbil	0.7	0.2-1.6 mg/dL
	BUN	84	7-22 mg/dL
	Ca	7.4	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
	CL	122	98-109 mmol/L
	TCO2	22	18-33 mmol/L
	Creat	2.4	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	139	73-118 mg/dL
	K	4.0	3.3-4.9 mmol/L
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	TProtein	6.2	6.4-8.1 g/dL
	Na	148	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (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

CBCN (no diff) | CBC | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle)/Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis test (CS

reviewed by: (b)(6)

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(b)(6)

0089 06 C10789 78469

N or ISN: (b)(6)

_AST, FIRST, MI.

Physician: (b)(6) Ward: ICU

Drawn by: Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

TF 21, ABU

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 02Jun06 1830

Signs and Symptoms:

(b)(6) Date and Time: 2JUN06

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

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

Urinalysis

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 (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT		REF. RANGE
*	ALB	1.3	L!	3.3-5.5 g/dL
	ALP	128		26-184 U/L
	ALT	181	H	10-47 U/L
	AMY			14-110 U/L
	AST	205	!H	11-38 U/L
	Tbil			0.2-1.6 mg/dL
*	BUN	88	!H	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	127	H!	98-109 mmol/L
	TCO2	22		18-33 mmol/L
	Creat	2.07	H	0.6-1.3 mg/dL
	GGT			5-65 U/L
	Glu	156	H	73-118 mg/dL
	K	3.9		3.3-4.9 mmol/L
	Mg			1.6-2.3 mg/dL
	Phosphorus			2.2-4.5 mg/dL
	TProtein	6.0	L	6.4-8.1 g/dL
*	Na	164	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

Rapid Tests (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
Ova / Parasite		No Ova / Parasite
OccBld		Negative
Wet Mount		Negative
KOH		Negative

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

Hematology / Purple Top

CBCNH (no diff) | CBC | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle) / Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff, Meningitis (153 only)

(b)(6) reviewed by: (b)(6)

1(7396

0089 06 CID 789 784

SN or ISN: (b)(6)

AST, FIRST, MI.

Physician: (b)(6) Ward: ICU Gender M or F (circle)

Drawn by: Bed: 3 Stat or Routine (circle)

TF 21, ABU

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 25JN06 1605

Signs and Symptoms:

(b)(6)

Date and Time: 25JN06

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

TEST	RESULT		REF. RANGE
Na	167	H	138-145 mmol/L
K	3.2	L	3.3-4.9 mmol/L
Cl			98-109 mmol/L
pH	7.274	L	7.35-7.45
PCO2	52.4	H	35-45 mmHg
PO2	90		80-100 mmHg
TCO2	26		18-33 mmol/L
HCO3	24.3		22-26 mmol/L
sO2	96%		95-99%
BEecf	-3		(-2) - (+3)
AGap			8-16 mmol/L
iCa	1.12		1.12-1.32 mmol/L
BUN			7-22 mg/dL
Glu			73-118 mg/dL
Creat			0.6-1.3 mg/dL
Hct	35%	L	37.0-52.0%
Hgb	11.9	L	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 (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT		REF. RANGE
	ALB	1.4	L	3.3-5.5 g/dL
	ALP	131		26-184 U/dL
	ALT	166	H	10-47 U/dL
	AMY	~~0.66~~		14-110 U/dL
	AST	180	H	11-38 U/dL
	Tbil	0.6		0.2-1.6 mg/dL
	BUN	83		7-22 mg/dL
	Ca	7.4	L	8.0-10.3 mg/dL
	Chol			100-200 mg/dL
	CK			M: 39-380 U/L F: 30-190 U/L
	CL	127	H	98-109 mmol/L
	TCO2	22		18-33 mmol/L
	Creat	2.5	H	0.6-1.3 mg/dL
	GGT			5-65 U/L
	Glu	135	H	73-118 mg/dL
	K	4.3		3.3-4.9 mmol/L
	Mg			1.6-2.3 mg/dL
	Phosphorus			2.2-4.5 mg/dL
	TProtein	6.0		6.4-8.1 g/dL
	Na	167	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

Rapid Tests (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (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

CBCN (no diff) | CBC | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle) / Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis test (cs154)

(b)(6)

reviewed by:

SSN or ISN: (b)(6)

Arterial sample

TF 21, ABU

LAB RY RESULTS FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI.

Specimen Date and time: 2Jan06 1723

Signs and Symptoms:

Physician: (b)(6)

Drawn by:

Ward: ICU

Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

(b)(6)

Date and Time: 2Jan06

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na	167	138-145 mmol/L
	K	3.4	3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.156	7.35-7.45
	PCO2	68.5	35-45 mmHg
	PO2	65	80-100 mmHg
	TCO2	26	18-33 mmol/L
	HCO3	24.2	22-26 mmol/L
	sO2	85	95-99%
	BEecf	-5	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.15	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct	35	37.0-52.0%
	Hgb	11.9	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 (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT	REF. RANGE

======= PICCOLO =======

06/02/06 05:44 PM

PATIENT TYPE: MALE

PATIENT #: (b)(6)

COMPREHENSIVE METABOLIC

DISC LOT #: 6103AA4

OPERATOR #: (b)(6)

DOCTOR #:

SERIAL #: (b)(6)

NA+	161*	128-145	MMOL
K+	4.2	3.6-5.1	MMOL
tCO2	20	18-33	MMOL
CL-	126*	98-108	MMOL
GLU	135*	73-118	MG/DL
CA	7.2*	8.0-10.3	MG/DL
BUN	87*	7-22	MG/DL
CRE	2.4*	0.6-1.2	MG/DL
ALP	127	53-128	U/L
ALT	168*	10-47	U/L
AST	172*	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
ALB	1.4*	3.3-5.5	G/DL
TP	6.0*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 0 LIP 0 ICT 0

Hematology / Purple Top

CBCN (no diff) | CBC | Malaria | H/H

X	TEST	RESULT	REF. RANGE

======= PICCOLO =======

06/02/06 05:28 PM

PATIENT TYPE: MALE

PATIENT #: (b)(6)

COMPREHENSIVE METABOLIC

DISC LOT #: 6103AA4

OPERATOR #: (b)(6)

DOCTOR #:

SERIAL #: (b)(6)

NA+	>170*	128-145	MMOL
K+	4.6	3.6-5.1	MMOL
tCO2	21	18-33	MMOL
CL-	127*	98-108	MMOL
GLU	139*	73-118	MG/DL
CA	8.0	8.0-10.3	MG/DL
BUN	83*	7-22	MG/DL
CRE	2.6*	0.6-1.2	MG/DL
ALP	130*	53-128	U/L
ALT	168*	10-47	U/L
AST	174*	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
ALB	1.4*	3.3-5.5	G/DL
TP	6.0*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 0 LIP 0 ICT 0

Seg

Ban

Lym

Aty

Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
Wet Mount		Negative
KOH		Negative

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

Hemoglobin S (sickle) / Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff, Meningitis test

reviewed by:

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

(b)(6)

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6)
Drawn by:

Ward: ICU
Bed: 3

Gender M or F (circle)
Stat or Routine (circle)

TF 21, ABU
LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

Specimen Date and time: 0858 5Jun06

Signs and Symptoms: Intub Sedated

(b)(6)

(b)(6)

Date and Time: 5 June

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas Bld Gas w/ lytes Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	6.968	7.35-7.45
	PCO2	95.9	35-45 mmHg
	PO2	44	80-100 mmHg
	TCO2	25	18-33 mmol/L
	HCO3	22	22-26 mmol/L
	sO2	52	95-99%
	BEecf	-10	(-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 request:

Chemistry (Piccolo)/Green or red/tiger top

Comp Pan BMP Hepatic Pan Lipid Pan Renal Pan

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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (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

CBCN (no diff) CBC Malaria H/

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle) / Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff. Meningitis tes[illegible] only)

reviewed by: (b)(6)

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

(b)(6)

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6) Ward: ICU Gender M or F (circle)
Drawn by: Bed: #3 Stat or Routine (circle)

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

Specimen Date and time: 5 June 06

Signs and Symptoms:

(b)(6)

Date and Time: 05 Jun 06 0540

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na	162	138-145 mmol/L
	K	3.7	3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.028	7.35-7.45
	PCO2	83.6	35-45 mmHg
	PO2	143	80-100 mmHg
	TCO2	25	18-33 mmol/L
	HCO3	22.0	22-26 mmol/L
	sO2	97	95-99%
	BEecf	-9	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.23	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct	55	37.0-52.0%
	Hgb	18.7	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 (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT	REF. RANGE
	ALB	1.3	3.3-5.5 g/dL
	ALP	140	26-184 U/L
	ALT	128	10-47 U/L
	AMY		14-110 U/L
	AST	126	11-38 U/L
	Tbil	0.6	0.2-1.6 mg/dL
	BUN	11	7-22 mg/dL
	Ca	8.4	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
	CL	124	98-109 mmol/L
	TCO2	20	18-33 mmol/L
	Creat	3.7	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	167	73-118 mg/dL
	K	4.8	3.3-4.9 mmol/L
X	Mg		1.6-2.3 mg/dL
X	Phosphorus	10.2	2.2-4.5 mg/dL
	TProtein	6.6	6.4-8.1 g/dL
	Na	160	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (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

CBCN (no diff) | CBC | Malaria | H/H

X	TEST	RESULT	REF. RANGE
	WBC	19.6	4.8-10.8 x10(3)/uL
	RBC	3.25	4.2-6.1 x10(6)/uL
	Hgb	9.9	12.0-18.0 g/dL
	Hct	30.3	M: 42.0-52.0%
			F: 37-47%
	MCV	93.3	80.0-99.0 fl
	MCH	30.4	27.0-31.0 pg
	MCHC	32.6	33.0-37.0 g/dL
	Plt	256	130-400 x10(3)/uL
	LY%	9.6	20.0-44.0%
	LY#	1.9	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:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

PT	17.3	7.0-14.0 sec
APTT		21.0-50.0 sec
INR	1.7	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 (sickle)/ Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

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

reviewed by:

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

(b)(6)

(b)(6)

157

SSN or ISN: (b)(6)

LAST, FIRST, MI:

Physician: (b)(6) Ward: ICU Gender M or F (circle)

Drawn by: Bed: #3 Stat or Routine (circle)

TF 21, ABU
LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

Specimen Date and time: 5 June 0105

Signs and Symptoms: (b)(6)

Date and Time: 0115

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
X	Na	164 H	138-145 mmol/L
	K	3.8	3.3-4.9 mmol/L
	Cl		98-109 mmol/L
X	pH	7.043 L	7.35-7.45
X	PCO2	84.0 H	35-45 mmHg
	PO2	152 H	80-100 mmHg
	TCO2	25	18-33 mmol/L
	HCO3	22.9	22-26 mmol/L
	sO2	98	95-99%
	BEecf	-8 H	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.084 L	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct	31 L	37.0-52.0%
	Hgb	10.5	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:

Critical Na, pH, PCO2 report to (b)(6)

(b)(6)

Chemistry (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
[illegible]		Negative
KOH		Negative

Hematology / Purple Top

CBCN (no diff) | CBC | Malaria

X	TEST	RESULT	REF. RANG
	WBC		4.8-10.8 x10(3
	RBC		4.2-6.1 x10(6)
	Hgb		12.0-18.0 g/d
	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)/
	LY%		20.0-44.0%
	LY#		0.7-4.3 x10(3)/u

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium See
Thick		No Plasmodium See

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-
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/m

Hemoglobin S (sickle) / Purple T

Hemoglobin S	Negative

Body Fluid Panel - Sterile Con

Panel includes: Culture, Gram Stain, Cel Count, WBC Diff., Meningitis test

Reviewed by:

(b)(6)

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 158

0084 06 [illegible] 89 784

= 21, ABU

LAB[illegible]RY RESULTS FORM

(Subject to Privacy Act of 1974)

SSN or ISN: (b)(6)

(b)(6)

LAST, FIRST, MI.

Physician: (b)(6) Ward: ICU

Drawn by: Bed: 7

Gender: M or F (circle)

Stat or Routine (circle)

Specimen Date and time: 04 June 06

Signs and Symptoms:

(b)(6) Date and Time: 04 Jun 2[illegible]

Chemistry (i-STAT) / Green Top / Syringe			
Bld Gas / Bld Gas w/ lytes / Glu / Crea			
X	TEST	RESULT	REF. RANGE
X	Na	166	138-145 mmol/L
X	K	3.8	3.3-4.9 mmol/L
X	Cl		98-109 mmol/L
X	pH	7.070	7.35-7.45
X	PCO2	76.4	35-45 mmHg
X	PO2	78	80-100 mmHg
X	TCO2	24	18-33 mmol/L
X	HCO3	22.1	22-26 mmol/L
X	sO2	88	95-99%
X	BEecf	-3	(-2) - (+3)
X	AGap		8-16 mmol/L
X	iCa	1.11	1.12-1.32 mmol/L
X	BUN		7-22 mg/dL
X	Glu		73-118 mg/dL
X	Creat		0.6-1.3 mg/dL
X	Hct	28	37.0-52.0%
X	Hgb	9.5	12.0-18.0 g/dL
X	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 (Piccolo)/Green or red/tiger top			
Comp Pan / BMP / Hepatic Pan / Lipid Pan / Renal Pan			
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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)		
Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)		
RPR		Negative
HCG (or urine)		Negative

Rapid Tests		
Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
Wet Prep		Negative
KOH		Negative

Hematology / Purple Top			
CBCN (no diff) / CBC / Malaria / H/H			
X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		M: 42.0-52.0%
			F: 37-47%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		20.0-44.0%
	LY#		0.7-4.3 x10(3)/uL

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top		
Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top		
Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)		
PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3
D Dimer		Negative

Cardiac Panel/Purple Top		
Myoglobin		0-107 ng/mL
CK-MB		0-4.3 ng/mL
Troponin		0.0-0.4 ng/mL

Hemoglobin S (sickle)/ Purple Top	
Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.
Panel includes: Culture, Gram Stain, Cell Count, WBC Diff, Meningitis test 159 only)

reviewed by:

(b)(6)

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

SSN or ISN: (b)(6)

LAST, FIRST, MI (b)(6)

Physician:

Drawn by:

Ward: ICU

Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

TF 21, ABU

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 9 JAN 08 1822

Signs and Symptoms:

(b)(6)

Date and Time: 4 Jan 08

Chemistry (i-STAT) / Green Top / Syringe: Bld Gas / Bld Gas w/ lytes / Glu / Crea			
X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.055	7.35-7.45
	PCO2	81.5	35-45 mmHg
	PO2	98	80-100 mmHg
	TCO2		18-33 mmol/L
	HCO3	22.8	22-26 mmol/L
	sO2	93%	95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.15	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct	27%	37.0-52.0%
	Hgb	9.2	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 (Piccolo)/Green or red/tiger top: Comp Pan / BMP / Hepatic Pan / Lipid Pan / Renal Pan			
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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)		
Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)		
RPR		Negative
HCG (or urine)		Negative

Rapid Tests		
Strep A		Negative
Drug Screen (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

Gel / Hematology / Purple Top: CBCN (no diff) / CBC / Malaria / H/H			
X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		M: 42.0-52.0%
			F: 37-47%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		20.0-44.0%
	LY#		0.7-4.3 x10(3)/uL

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top		
Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top		
Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)		
PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3
D Dimer		Negative

Cardiac Panel/Purple Top		
Myoglobin		0-107 ng/mL
CK-MB		0-4.3 ng/mL
Troponin		0.0-0.4 ng/mL

Hemoglobin S (sickle) / Purple Top	
Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont:

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

Reviewed by:

(b)(6)

160

(b)(6)

0089 06 [illegible] 789 784

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6)

Drawn by:

Ward: 160

Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

TF 21, ABU
LAB ...TORY RESULTS FORM
(Subject to Privacy Act of 1974)

Specimen Date and time: 4 Jun 08 1645

Signs and Symptoms:

(b)(6) Date and Time: 4 June

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas Bld Gas w/ lytes Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.110	7.35-7.45
	PCO2	70.6	35-45 mmHg
	PO2	76	80-100 mmHg
	TCO2	25	18-33 mmol/L
	HCO3	22.5	22-26 mmol/L
	sO2	88%	95-99%
	BEecf	-7	(-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 request:

Chemistry (Piccolo)/Green or red/tiger top

Comp Pan BMP Hepatic Pan Lipid Pan Renal Pan

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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (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

CBCN (no diff) CBC Malaria H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle)/Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff, Meningitis test

reviewed by:

(b)(6)

(b)(6)

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

0084 06 U10789 7846

SSN or ISN (b)(6)

LAST, FIRST, MI.

Physician (b)(6) Ward: ICU Gender M or F (circle)

Drawn by Bed: 3 Stat or Routine (circle)

TF 21, ABU

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 9 Jun 06 1445

Signs and Symptoms:

(b)(6)

Date and Time: 9 Jun 06

Chemistry (STAT) / Green Top / Syringe				Chemistry (Piccolo)/Green or red/tiger top				Hematology / Purple Top			
Bld Gas	Bld Gas w/ lytes	Glu	Crea	Comp Pan	BMP	Hepatic Pan	Lipid Pan	Renal Pan	CBCN (no diff)	CBC	Malaria	H/H
X	TEST	RESULT	REF. RANGE	X	TEST	RESULT		REF. RANGE	X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L		ALB			3.3-5.5 g/dL		WBC		4.8-10.8 x10(3)/uL
	K		3.3-4.9 mmol/L		ALP			26-184 U/L		RBC		4.2-6.1 x10(6)/uL
	Cl		98-109 mmol/L		ALT			10-47 U/L		Hgb		12.0-18.0 g/dL
	pH	7.117	7.35-7.45		AMY			14-110 U/L		Hct		M: 42.0-52.0%
	PCO2	69	35-45 mmHg		AST			11-38 U/L				F: 37-47%
	PO2	76	80-100 mmHg		Tbil			0.2-1.6 mg/dL		MCV		80.0-99.0 fl
	TCO2	24	18-33 mmol/L		BUN	100		7-22 mg/dL		MCH		27.0-31.0 pg
	HCO3	22.3	22-26 mmol/L		Ca	8.4		8.0-10.3 mg/dL		MCHC		33.0-37.0 g/dL
	sO2	89%	95-99%		Chol			100-200 mg/dL		Plt		130-400 x10(3)/uL
	BEecf	-7	(-2) - (+3)		CK			M: 39-380 U/L F: 30-190 U/L		LY%		20.0-44.0%
	AGap		8-16 mmol/L		CL	128		98-109 mmol/L		LY#		0.7-4.3 x10(3)/uL
	iCa		1.12-1.32 mmol/L		TCO2	21		18-33 mmol/L		Differential		
	BUN		7-22 mg/dL		Creat	2.9	H	0.6-1.3 mg/dL	Segs(50-70%)		Mono(4-10%)	
	Glu		73-118 mg/dL		GGT			5-65 U/L	Bands(1-10%)		Eos(0-4%)	
	Creat		0.6-1.3 mg/dL		Glu	136	H	73-118 mg/dL	Lymph(20-44%)		Baso(0-2%)	
	Hct	48%	37.0-52.0%		K	4.2		3.3-4.9 mmol/L	Atyp Ly		Immature cells	
	Hgb	16.3	12.0-18.0 g/dL		Mg			1.6-2.3 mg/dL	RBC Abn Morph:			
	Lactate		0.90-1.70 mmol/L		Phosphorus			2.2-4.5 mg/dL				
Urinalysis					TProtein			6.4-8.1 g/dL	Plt Abn Morph:			
	Color		Straw/Yellow		Na	157	H	128-145 mmol/L				
	Clarity		Clear		HDL Chol			30-75 mg/dL	WBC Abn Morph:			
	Glucose		Negative		LDL Chol			50-130 mg/dL				
	Bilirubin		Negative		Triglycerides			60-160 mg/dL	Malaria / Purple Top			
	Ketone		Negative		VLDL			≤30 mg/dL	Thin		No Plasmodium Seen	
	SG		1.010-1.025		Chol/HDL Ratio			≤4.5	Thick		No Plasmodium Seen	
	Blood		Negative	Rapid Tests (Green Top)					Sed Rate / Purple Top			
	pH		5.0-8.0		Mono			Negative	Sed Rate		1hr = 0-20 mm	
	Protein		Negative-Trace		H.pylori IgG			Negative	Coagulation (Blue Top - Sodium Citrate)			
	Urobili		0.1-1.0 Ehrlich U/dL	Rapid Tests (SST or Red Top)					PT		7.0-14.0 sec	
	Nitrite		Negative		RPR			Negative	APTT		21.0-50.0 sec	
	Leuko		Negative		HCG (or urine)			Negative	INR		0.5-1.5/therap 2-3	
Urine Microscopic				Rapid Tests					D Dimer		Negative	
	WBC		Epi		Strep A			Negative	Cardiac Panel/Purple Top			
	RBC		Mucus		Drug Screen (urine)			Negative	Myoglobin		0-107 ng/mL	
	Bacteria		Yeast		Chlamydia			Negative	CK-MB		0-4.3 ng/mL	
	Casts:		Spermatozoa		Flu A&B			Negative	Troponin		0.0-0.4 ng/mL	
	Crystals:		Amorph Sed		C. difficile (stool)			Negative	Hemoglobin S (sickle)/Purple Top			
	Other:				O&P (stool)			No Ova / Parasite	Hemoglobin S		Negative	
Other lab request:					OccBld			Negative	Body Fluid Panel - Sterile Cont			
					Wet Mount			Negative	Panel includes: Culture, Gram Stain, Cell Count, WBC Diff, Meningitis test (C: 160			
					KOH			Negative				

(b)(6)

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

reviewed by:

(b)(6)

0089 06 GID 789 784

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician (b)(6)
Drawn by

Ward: ICU
Bed: 3

Gender M or F (circle)
Stat or Routine (circle)

TF 21, ABU
LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

Specimen Date and time: 4JUN06

Signs and Symptoms:

(b)(6)

Date and Time: 4 Jun 06

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bd Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.356 / 7.126	7.35-7.45
	PCO2	68.6	35-45 mmHg
	PO2	61	80-100 mmHg
	TCO2	24	18-33 mmol/L
	HCO3	22.6	22-26 mmol/L
	sO2	81%	95-99%
	BEecf	-7	(-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		12.0-17.0 g/dL
	Lactate		0.90-1.70 mmol/L

Sample appears hemolyzed

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 (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

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*	102	CV! 7-22 mg/dL
	Ca	8.6	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
	CL	129	Ho 98-109 mmol/L
	TCO2	2L	18-33 mmol/L
	Creat	3.0	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	128	H 73-118 mg/dL
	K	4.2	3.3-4.9 mmol/L
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	TProtein		6.4-8.1 g/dL
	Na	161	Ho 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 (Green Top)

	Mono		Negative
	H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

	RPR		Negative
	HCG (or urine)		Negative

Rapid Tests

	Strep A		Negative
	Drug Screen (urine)		Negative
	Chlamydia		Negative
	Flu A&B		Negative
	C. difficile (stool)		Negative
	O&P (stool)		No Ova / Parasite
	Occ Bld		Negative
	Wet Mount		Negative
	KOH		Negative

Hematology / Purple Top

CBCN (no diff) | CBC | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

	Thin		No Plasmodium See
	Thick		No Plasmodium See

Sed Rate / Purple Top

	Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle)/Purple Top

	Hemoglobin S	Negative

Body Fluid Panel / Sterile Cont.

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

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

reviewed by: (b)(6)

(b)(6)

ACLU-RDI 5531 p.153

10-L-0126 ACLU CID ROI 7406

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6) Ward: ICU Gender M or F (circle)

Drawn by: Bed: 3 Stat or Routine (circle)

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 4Jun06 1335

Signs and Symptoms:

(b)(6) Date and Time: 4Jun06

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.188	7.35-7.45
	PCO2	62.6	35-45 mmHg
	PO2	103	80-100 mmHg
	TCO2	26	18-33 mmol/L
	HCO3		22-26 mmol/L
	sO2	96%	95-99%
	BEecf	-4	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.19	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 (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (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

CBCN (no diff) | CBC | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle)/ Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

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

Reviewed by:

(b)(6)

0089 06 CID789 784

SSN or ISN (b)(6)

LAST, FIRST, MI.

Physician (b)(6) Ward: ICU Gender M or F (circle)

Drawn by Bed: 3 Stat or Routine (circle)

TF 21, ABU LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 4 JUNE 1140

Signs and Symptoms:

Reported by: (b)(6) Date and Time: 4 June

Chemistry i-STAT) / Green Top / Syringe:

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na	[redacted]	138-145 mmol/L
	K	[redacted]	3.3-4.9 mmol/L
	Cl	[redacted]	98-109 mmol/L
	pH	[redacted] 7.25	7.35-7.45
	PCO2	53.5	35-45 mmHg
	PO2	70	80-100 mmHg
	TCO2	25	18-33 mmol/L
	HCO3	23.6	22-26 mmol/L
	sO2	90%	95-99%
	BEecf	-4	(-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 request:

Chemistry (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)

	Mono		Negative
	H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

	RPR		Negative
	HCG (or urine)		Negative

Rapid Tests

	Strep A		Negative
	Drug Screen (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

CBCN (no diff) | CBC | Malaria | H/

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

	Thin		No Plasmodium See
	Thick		No Plasmodium See

Sed Rate / Purple Top

	Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle)/Purple Top

Hemoglobin S		Negative

Body Fluid Panel - Sterile Cont.

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis te[illegible] F only)

reviewed by: (b)(6)

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EXHIBIT 165

(b)(6)

0089 06 CID 789 7846

SSN ~~or ISN~~ (b)(6)

LAST, FIRST, MI.

TF 21, ABU

LAB( )TORY RESULTS FORM

(Subject to Privacy Act of 1974)

Physician: (b)(6) Ward: CCU

Drawn by: Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

Specimen Date and time: 6/4/06 1300

Signs and Symptoms:

(b)(6)

Date and Time: 4JUN06

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas ~~Bld Gas w/ lytes~~ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	167	138-145 mmol/L
	K	3.1	3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.197	7.35-7.45
	PCO2 !	60.3 H	35-45 mmHg
	PO2	105	80-100 mmHg
	TCO2	25	18-33 mmol/L
	HCO3	23.4	22-26 mmol/L
	sO2	96%	95-99%
	BEecf	-5	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.21	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct	25%	37.0-52.0%
	Hgb	8.5	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 (Piccolo)/Green or red/tiger top

Comp Pan BMP Hepatic Pan Lipid Pan Renal Pan

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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
Mount		Negative
KOH		Negative

Hematology / Purple Top

CBCN (no diff), CBC, Malaria, H/H

X	TEST	RESULT	REF. RANGE
	W		4.8-10.8 x10(3)/uL
	R		
	H		
	H		
	M		
	P		
	I		
	Se		
	Ba		
	Ly		
	At		

Seen

Seen

nm

rate)

ec

sec

p 2-3

ve

g/mL

g/mL

g/mL

CK-MB	
Troponin	

Hemoglobin S (sickle) Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

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

i-STAT EG7+

Pt: (b)(6)

Pt Name:

Na 167 mmol/L
K 3.1 mmol/L
TCO2 25 mmol/L
iCa 1.21 mmol/L
Hct 25 %PCV
Hb* 8.5 g/dL
*via Hct

At 37C
PH 7.197
PCO2 60.3 mmHg
PO2 105 mmHg
HCO3 23.4 mmol/L
BEecf -5 mmol/L
SO2* 96 %
*calculated

Sample Type_:

04JUN06 18:13

Oper: 6650

Physician:

Ser# (b)(6)

Ver: (b)(6)

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LAW ENFORCEMENT SENSITIVE

Revised 31iulv05 mc

Reviewed by:

(b)(6)

Task Force 21 Med
Abu Ghraib, Iraq

0089 06 CID 789 784

Microbiology Laboratory Report

Accession #	(b)(
Collection Date	(b)(6)
Patient Name	
SSN or ID	(b)(6)
Sample Type	Respiratory
Sample Site	Tracheal Aspirate
Patient Location	ICU
Provider	(b)(
Result Type	FINAL
[X] Gram's Stain	Moderate Gram negative rods; many WBC's/low power field (LPF); <10 epithelial cells/LPF
[ ] Acid-fast Stain	
[ ] Rapid Group A Strep Antigen	
[ ] L pneumophila Urinary Antigen	
[ ] S pneumoniae Urinary Antigen	(b)(6)
[ ] Influenza Virus Antigen	
[ ] RSV Antigen	
[X] Culture	
Qty isolate #1	Many
Isolate #1	Acinetobacter baumanii/haemolyticus
Qty isolate #2	
Isolate #2	
Qty isolate #3	
Isolate #3	
Comments	
Report Date	6/4/06
Tech	MAJ Mahler, Steven
Reviewed By	MAJ Mahler, Steven

	Isolate 1	Isolate 2	Isolate 3
Amikacin	S		
Amox/K Clav			
Amp/Sulbactam	R		
Ampicillin			
Azithromycin			
Aztreonam	R		
Cefazolin			
Cefepime	R		
Cefotaxime	R		
Cefotetan			
Cefoxitin			
Ceftazidime	R		
Ceftriaxone	R		
Cefuroxime			
Cephalothin			
Chloramphenicol	R		
Ciprofloxacin	R		
Clindamycin			
Erythromycin			
Gatifloxacin			
Gentamicin	R		
Imipenem	S		
Levofloxacin	R		
Linezolid			
Meropenem	S		
Moxifloxacin			
Nitrofurantoin			
Norfloxacin			
Ofloxacin			
Oxacillin			
Penicillin			
Pip/Tazo			
Piperacillin	R		
Rifampin			
Synercid			
Tetracycline	R		
Ticar/K Clav	I		
Tobramycin	S		
Trimeth/Sulfa	R		
Vancomycin			

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 167 (b)(6)

SSN or ISN: (b)(6)

[redacted] ST, MI.

Physician: (b)(6) Ward: ICU

Drawn by: Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

0089 06 C10 789 7846

TF 21, ABU

LAB[redacted]TORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 0400 4 Jun 06

Signs and Symptoms:

Reported by: (b)(6)

Date and Time: 20060604 0410

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
*	Na	166 H	138-145 mmol/L
*	K	2.6 L	3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.299	7.35-7.45
*	PCO2	41.8	35-45 mmHg
	PO2	*** 107 H	80-100 mmHg
	TCO2	22	18-33 mmol/L
	HCO3	20.5	22-26 mmol/L
*	sO2	*** 98	95-99%
	BEecf	-6	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.19	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct	29 L	37.0-52.0%
	Hgb	9.9 L	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: Critical ALB, BUN, CL reported to Big 5:10

Other lab request: BNP = 338 pg/mL

Chemistry (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT	REF. RANGE
*	ALB	1.3 L	3.3-5.5 g/dL
	ALP	113	26-184 U/L
	ALT	120 H	10-47 U/L
	AMY		14-110 U/L
	AST	101 H	11-38 U/L
	Tbil	0.7	0.2-1.6 mg/dL
*	BUN	95 H	7-22 mg/dL
	Ca	8.0	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
*	CL	129 H	98-109 mmol/L
	TCO2	21	18-33 mmol/L
	Creat	2.8 H	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	126 H	73-118 mg/dL
	K	3.5 L	3.3-4.9 mmol/L
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	TProtein	5.9 L	6.4-8.1 g/dL
	Na	156 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

Rapid Tests (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
[illegible]		Negative
[illegible]		Negative
[illegible]		Negative

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LAW ENFORCEMENT SENSITIVE

Hematology / Purple Top

CBCN (no diff) | CBC | Malaria | H/H

X	TEST	RESULT	REF. RANGE
	WBC	16.2 H	4.8-10.8 x10(3)/uL
	RBC	2.49 L	4.2-6.1 x10(6)/uL
	Hgb	7.6 L	12.0-18.0 g/dL
	Hct	22.7 L	M: 42.0-52.0%
			F: 37-47%
	MCV	91.0	80.0-99.0 fl
	MCH	30.6	27.0-31.0 pg
	MCHC	33.6	33.0-37.0 g/dL
	Plt	250	130-400 x10(3)/uL
	LY%	8.5 L	20.0-44.0%
	LY#	1.4	0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

PT	13.9	7.0-14.0 sec
APTT		21.0-50.0 sec
INR	1.4	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 (sickle) / Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis test (CSF c[illegible]

PCA[illegible] sample

reviewed by:

(b)(6)

168

(b)(6)

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6) Ward: ICU

Drawn by: Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

TF 21, ABU
LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

Specimen Date and time: 2000 3 Jun 06

Signs and Symptoms:

Reported by: (b)(6)

Date and Time 03JUN06/20

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
(b)(6)	Na	168 H	138-145 mmol/L
	K	2.9 L	3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.329 L	7.35-7.45
	PCO2	40.1	35-45 mmHg
	PO2	87	80-100 mmHg
	TCO2	22	18-33 mmol/L
	HCO3	21.1 L	22-26 mmol/L
	sO2	96	95-99%
	BEecf	-5 L	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.34 H	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct	32 L	37.0-52.0%
	Hgb	11.6 L	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: Critical for BNP F369

Chemistry (Piccolo) / Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT	REF. RANGE
	ALB	1.4 L	3.3-5.5 g/dL
	ALP	113	26-184 U/L
	ALT	128 H	10-47 U/L
	AMY		14-110 U/L
	AST	116 H	11-38 U/L
	Tbil	0.7	0.2-1.6 mg/dL
	BUN	95 H	7-22 mg/dL
	Ca	9.2	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
	CL	129 H	98-109 mmol/L
	TCO2	21	18-33 mmol/L
	Creat	2.8 H	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	138 H	73-118 mg/dL
	K	4.0	3.3-4.9 mmol/L
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	TProtein	5.8 L	6.4-8.1 g/dL
	Na	154 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

Rapid Tests (Green Top)

	Mono		Negative
	H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

	RPR		Negative
	HCG (or urine)		Negative

Rapid Tests

	Strep A		Negative
	Drug Screen (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

CBCN (no diff) | CBC | Malaria | H

X	TEST	RESULT	REF. RANGE
	WBC	16.1 H	4.8-10.8 x10(3)/u
	RBC	2.52 L	4.2-6.1 x10(6)/ul
	Hgb	7.2 L	12.0-18.0 g/dL
	Hct	23.2 L	M: 42.0-52.0%
			F: 37-47%
	MCV	92.1	80.0-99.0 fl
	MCH	28.5	27.0-31.0 pg
	MCHC	30.9 L	33.0-37.0 g/dL
	Plt	250	130-400 x10(3)/uL
	LY%	8.3 L	20.0-44.0%
	LY#	1.3	0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

	Thin		No Plasmodium Seer
	Thick		No Plasmodium Seer

Sed Rate / Purple Top

	Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (Sickle) / Purple Top

Hemoglobin S		Negative

Body Fluid Panel - Sterile Cont.

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

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 169

(b)(6) reviewed by: (b)(6)

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician (b)(6) Ward: ICU

Drawn by Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

F 21, ABU

LABO[illegible]RY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 3JUN08 1835

Signs and Symptoms:

(b)(6) Date and Time: 3JUN08

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na	167	138-145 mmol/L
	K	2.9	3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.309	7.35-7.45
	PCO2	41.2	35-45 mmHg
	PO2	94	80-100 mmHg
	TCO2	22	18-33 mmol/L
	HCO3	20.6	22-26 mmol/L
	sO2	967.	95-99%
	BEecf	-6	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	0.99	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct	30%	37.0-52.0%
	Hgb	10.2	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 (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
KOH		Negative

Hematology / Purple Top

CBCN (no diff) | CBC | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle)/ Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff, Meningitis test, CSF

DELETED (b) (6)

reviewed by:

-170-

(b)(6)

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6) Ward: ICU

Drawn by: Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

TF 21, ABU

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 3JUN00 1630

Signs and Symptoms:

(b)(6)

Date and Time: 3 Jun 00

Chemistry (i-STAT) / Green Top / Syringe: Bld Gas / Bld Gas w/ lytes / Glu / Crea			
X	TEST	RESULT	REF. RANGE
	Na	166	138-145 mmol/L
	K	3.1	3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.298	7.35-7.45
	PCO2	44.1	35-45 mmHg
	PO2	107	80-100 mmHg
	TCO2	23	18-33 mmol/L
	HCO3	21.6	22-26 mmol/L
	sO2	97%	95-99%
	BEecf	-5	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.00	1.12-1.32 mmol/L
	BUN	=5 wg	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 (Piccolo) / Green or red/tiger top: Comp Pan / BMP / Hepatic Pan / Lipid Pan / Renal Pan				
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	92		7-22 mg/dL
	Ca	7.4	L	8.0-10.3 mg/dL
	Chol			100-200 mg/dL
	CK			M: 39-380 U/L F: 30-190 U/L
	CL	130	H	98-109 mmol/L
	TCO2	21		18-33 mmol/L
	Creat	2.8	H	0.6-1.3 mg/dL
	GGT			5-65 U/L
	Glu	139	H	73-118 mg/dL
	K	4.3		3.3-4.9 mmol/L
	Mg			1.6-2.3 mg/dL
	Phosphorus			2.2-4.5 mg/dL
	TProtein			6.4-8.1 g/dL
	Na	150	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

Rapid Tests (Green Top)		
Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)		
RPR		Negative
HCG (or urine)		Negative

Rapid Tests		
Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
[illegible]		Negative
[illegible]		Negative

Hematology / Purple Top: CBC/N (no diff) / CBC / Malaria / ETI			
X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/u
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		M: 42.0-52.0%
			F: 37-47%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		20.0-44.0%
	LY#		0.7-4.3 x10(3)/uL

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

RBC Abn Morph:	
Plt Abn Morph:	
WBC Abn Morph:	

Malaria / Purple Top		
Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top		
Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)		
PT	14.3	7.0-14.0 sec
APTT		21.0-50.0 sec
INR	1.4	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 (sickle)/Purple Top	
Hemoglobin S	Negative

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

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 171

(b)(6) reviewed by: (b)(6)

SSN or ISN: (b)(6)

TF 21, ABU

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI.

100% FiO2

Physician: (b)(6) Ward: ICU Gender: M or F (circle) Specimen Date and time: 3 June 06 1515 Signs and Symptoms:

Drawn by: Bed: 3 Stat or Routine (circle) (b)(6) Date and Time: 3 June 06

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas Bld Gas w/ lytes Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	167	138-145 mmol/L
	K	3.2	3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.275	7.35-7.45
	PCO2	46.8	35-45 mmHg
	PO2	143	80-100 mmHg
	TCO2	23	18-33 mmol/L
	HCO3	21.7	22-26 mmol/L
	sO2	99%	95-99%
	BEecf	-5	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.03	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct	27	37.0-52.0%
	Hgb	9.2	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 (Piccolo)/Green or red/tiger top

Comp Pan BMP Hepatic Pan Lipid Pan Renal Pan

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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
[illegible]		Negative
[illegible]		Negative

Hematology / Purple Top

CBCN (no diff) CBC Malaria H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle)/ Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

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

CANCELLED

(b)(6)

reviewed by:

Task Force 21 Med
Abu Ghraib, Iraq

0089 06 CID/89 78

Microbiology Laboratory Report

Accession #	(b)(
Collection Date	(b)(6)
Patient Name	
SSN or ID	(b)(6)
Sample Type	Respiratory
Sample Site	Induced Sputum
Patient Location	ICU
Provider	(b)(
Result Type	FINAL
☐ Gram's Stain	
☒ Acid-fast Stain	No acid-fast bacilli seen.
☐ Rapid Group A Strep Antigen	(b)(6)
☐ L pneumophila Urinary Antigen	
☐ S pneumoniae Urinary Antigen	
☐ Influenza Virus Antigen	
☐ RSV Antigen	
☐ Culture	
Qty isolate #1	
Isolate #1	
Qty isolate #2	
Isolate #2	
Qty isolate #3	
Isolate #3	
Comments	
Report Date	(b)(6)
Tech	(b)(6)
Reviewed By	

	Isolate 1	Isolate 2	Isolate 3
Amikacin			
Amox/K Clav			
Amp/Sulbactam			
Ampicillin			
Azithromycin			
Aztreonam			
Cefazolin			
Cefepime			
Cefotaxime			
Cefotetan			
Cefoxitin			
Ceftazidime			
Ceftriaxone			
Cefuroxime			
Cephalothin			
Chloramphenicol			
Ciprofloxacin			
Clindamycin			
Erythromycin			
Gatifloxacin			
Gentamicin			
Imipenem			
Levofloxacin			
Linezolid			
Meropenem			
Moxifloxacin			
Nitrofurantoin			
Norfloxacin			
Ofloxacin			
Oxacillin			
Penicillin			
Pip/Tazo			
Piperacillin			
Rifampin			
Synercid			
Tetracycline			
Ticar/K Clav			
Tobramycin			
Trimeth/Sulfa			
Vancomycin			

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~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT (b)(6)
173

NSN 7540-01-165-7294 519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
PCXR					

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY: (b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

DATE REQUESTED

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

VENTILATOR
CHEST TUBES (B)
PNEUMOTHORAX

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSACTION *(Month, day, year)*
Ø3JUN Ø6 Ø450		

RADIOLOGIC REPORT (b)(6)

Ø int PTX
↑ opacity RLL
s/ B/L ASD

(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 (b)(6)

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR
(41 CFR) 201-45.505

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

174

(b)(

Task Force 21 Med
Abu Ghraib, Iraq

0089 06 CID 789 78

Microbiology Laboratory Report

Accession #	(b)(6)
Collection Date	(b)(6)
Patient Name	
SSN or ID	(b)(6)
Sample Type	Respiratory
Sample Site	Tracheal Aspirate
Patient Location	ICU
Provider	(b)(6
Result Type	Preliminary 2
[X] Gram's Stain	Moderate Gram negative rods; many WBC's/low power field (LPF); <10 epithelial cells/LPF
[ ] Acid-fast Stain	
[ ] Rapid Group A Strep Antigen	
[ ] L pneumophila Urinary Antigen	
[ ] S pneumoniae Urinary Antigen	
[ ] Influenza Virus Antigen	(b)(6)
[ ] RSV Antigen	
[X] Culture	Many Gram-negative rods; one isolate; ID and sensitivities to follow
Qty isolate #1	
Isolate #1	
Qty isolate #2	
Isolate #2	
Qty isolate #3	
Isolate #3	
Comments	
Report Date	6/3/06
Tech	(b)(6)
Reviewed By	

	Isolate 1	Isolate 2	Isolate 3
Amikacin			
Amox/K Clav			
Amp/Sulbactam			
Ampicillin			
Azithromycin			
Aztreonam			
Cefazolin			
Cefepime			
Cefotaxime			
Cefotetan			
Cefoxitin			
Ceftazidime			
Ceftriaxone			
Cefuroxime			
Cephalothin			
Chloramphenicol			
Ciprofloxacin			
Clindamycin			
Erythromycin			
Gatifloxacin			
Gentamicin			
Imipenem			
Levofloxacin			
Linezolid			
Meropenem			
Moxifloxacin			
Nitrofurantoin			
Norfloxacin			
Ofloxacin			
Oxacillin			
Penicillin			
Pip/Tazo			
Piperacillin			
Rifampin			
Synercid			
Tetracycline			
Ticar/K Clav			
Tobramycin			
Trimeth/Sulfa			
Vancomycin			

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

EXHIBIT 175 (b) (6)

0089 06 CID 789 78

NSN 7540-01-165-7294 519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
C-Xray				ICU	#3
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) (b)(6)				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED 04 Jun 06

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

Repeat C-Xray

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSACTION (Month, day, year)
04 June @ 1841		

RADIOLOGIC REPORT

Tiny (R) apical PTX

RT midlung ATX

B/L RSD s/w stable

(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

SIGNAT (b)(6)

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR
(41 CFR) 201-45.505

Medical Record

EXHIBIT 4
176

ICU #3

NSN 7540-01-165-7294

0089 06 CID789 784

519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
PORTABLE CHEST	1	M		ICU	

FILM NO.

PREGNANT ☐ YES ☐ NO

(b)(6)

REQUESTED BY (Print)

(b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUE

DATE REQUESTED 27JUN06

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

R/O PNEUMOTHORAX

CHEST TUBE TO WATERSEAL

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSACTION (Month, day, year)
27JUN06		

RADIOLOGIC REPORT

17:34

SMALL (R) PTX

T. DENSITY @ LUNG RUL

C/W STABLE.

(b)(6)

PATIENT'S IDENTIFICATION (F
Name - last, first, middle, Medica

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

(b)(6)

(b)(6)

ICU BED 3

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

RADIOLOGIC CONSULTATION REQUEST/REPORT

Medical Record

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR-FIRMR (41 CFR) 201-45.505

EXHIBIT 17

(b)(6)

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6) Ward: ICU

Drawn by: Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

TF 21, ABU

LABOR[illegible]RY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 0830 3 June 06

Signs and Symptoms:

(b)(6)

Date and Time: 3 Jun 06

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas Bld Gas w/ lytes Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	167	138-145 mmol/L
	K	3.6	3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.229	7.35-7.45
	PCO2	54.3	35-45 mmHg
	PO2	85	80-100 mmHg
	TCO2	24	18-33 mmol/L
	HCO3	22.7	22-26 mmol/L
	sO2	94%	95-99%
	BEecf	-5	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.06	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct	24%	37.0-52.0%
	Hgb	8.2	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 (Piccolo)/Green or red/tiger top

Comp Pan BMP Hepatic Pan Lipid Pan Renal Pan

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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
Wet Mount		Negative
[illegible]		Negative

Hematology / Purple Top

CBC N (no diff), CBC Malaria / H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle)/Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

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

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LAW ENFORCEMENT SENSITIVE

reviewed by: 178

(b)(6)

(b)(6)

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician (b)(6)

Drawn by

Ward: ICU

Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

TF 21, ABU

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 3 JUNE 0535

Signs and Symptoms:

(b)(6)

Date and Time: 3 Jun 06

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

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

Urinalysis

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:

Chem7

(b)(6)

Chemistry (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT		REF. RANGE
	ALB	1.5	L	3.3-5.5 g/dL
	ALP	116		26-184 U/L
	ALT	151	H	10-47 U/L
	AMY			14-110 U/L
	AST	150	H	11-38 U/L
	Tbil	0.7		0.2-1.6 mg/dL
	BUN	88	!H	7-22 mg/dL
	Ca	7.1	L	8.0-10.3 mg/dL
	Chol			100-200 mg/dL
	CK			M: 39-380 U/L F: 30-190 U/L
	CL	126	H!	98-109 mmol/L
	TCO2	21		18-33 mmol/L
	Creat	3.1	H	0.6-1.3 mg/dL
	GGT			5-65 U/L
	Glu	119	H	73-118 mg/dL
	K	4.7		3.3-4.9 mmol/L
	Mg			1.6-2.3 mg/dL
	Phosphorus			2.2-4.5 mg/dL
	TProtein	6.2	L	6.4-8.1 g/dL
	Na	156	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

Rapid Tests (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
		Negative
KOH		Negative

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Hematology / Purple Top

CBCN (no diff) | CBC | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle) / Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis test (b)(6)

Reviewed by:

179

SSN or ISN: (b)(6)

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

LAST, FIRST, MI.

Specimen Date and time: 4 JUN 06 0410

Signs and Symptoms: Cathed removed to

(b)(6)

Physician Drawn by: (b)(6)

Ward: ICU Bed: 3

Gender M or F (circle) Stat or Routine (circle)

R (b)(6)

Date and Time: 3 June 06

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
X	pH ↓	7.178	7.35-7.45
X	PCO2 ↑	60.6	35-45 mmHg
X	PO2	101	80-100 mmHg
X	TCO2	24	18-33 mmol/L
X	HCO3	22.5	22-26 mmol/L
X	sO2	96	95-99%
X	BEecf	-6	(-2) - (+3)
X	AGap		8-16 mmol/L
X	iCa	1.05	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 (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT	REF. RANGE
X	ALB	1.5 *	3.3-5.5 g/dL
X	ALP	126	26-184 U/L
X	ALT	163 *	10-47 U/L
	AMY		14-110 U/L
X	AST	161 *	11-38 U/L
X	Tbil	0.8	0.2-1.6 mg/dL
X	BUN	83 *	7-22 mg/dL
X	Ca	7.3 *	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
X	CL	126 *	98-109 mmol/L
X	TCO2	20	18-33 mmol/L
X	Creat	3.2 *	0.6-1.3 mg/dL
	GGT		5-65 U/L
X	Glu	118	73-118 mg/dL
X	K	4.6	3.3-4.9 mmol/L
	Mg		1.6-2.3 mg/dL
X	Phosphorus	5.8	2.2-4.5 mg/dL
X	TProtein	6.3 *	6.4-8.1 g/dL
X	Na	164 *	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (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

CBCN (no diff) | CBC | Malaria | H/H

X	TEST	RESULT	REF. RANGE
X	WBC	20.1	4.8-10.8 x10(3)/uL
X	RBC	2.97	4.2-6.1 x10(6)/uL
X	Hgb	8.6	12.0-18.0 g/dL
X	Hct	27.5	M: 42.0-52.0%
			F: 37-47%
X	MCV	92.7	80.0-99.0 fl
X	MCH	28.9	27.0-31.0 pg
X	MCHC	31.1	33.0-37.0 g/dL
X	Plt	256	130-400 x10(3)/uL
X	LY%	7.9	20.0-44.0%
X	LY#	1.6	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%) 78	Mono(4-10%) 7
Bands(1-10%) 11	Eos(0-4%)
Lymph(20-44%) 6	Baso(0-2%)
Atyp Ly 5	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

PT	17.9	7.0-14.0 sec
APTT		21.0-50.0 sec
INR	1.8	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 (sickle)/ Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

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

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

(b)(6)

reviewed by: 18 (b)(6)

SSN or ISN: (b)(6)

LAST, FIRST, MI.

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

Physician: (b)(6) Ward: ICU Gender M or F (circle) Specimen Date and time: 3 June 06 Signs and Symptoms: (b)(6) Date and Time: 20060603

Drawn by: Bed: #3 Stat or Routine (circle) 2400 0947

Chemistry (i-STAT) / Green Top / Syringe			Chemistry (Piccolo) / Green or red/tiger top			Hematology / Purple Top		
Bld Gas Bld Gas w/ lytes Glu Crea			Comp Pan BMP Hepatic Pan Lipid Pan Renal Pan			CBCN (no diff) CBC Malaria H/H		
X TEST	RESULT	REF. RANGE	X TEST	RESULT	REF. RANGE	X TEST	RESULT	REF. RANGE
Na		138-145 mmol/L	ALB	1.7 L	3.3-5.5 g/dL	WBC		4.8-10.8 x10(3)/uL
K		3.3-4.9 mmol/L	ALP	132	26-184 U/L	RBC		4.2-6.1 x10(6)/uL
Cl		98-109 mmol/L	ALT	169 H	10-47 U/L	Hgb		12.0-18.0 g/dL
pH		7.35-7.45	AMY		14-110 U/L	Hct		M: 42.0-52.0%
PCO2		35-45 mmHg	AST	156 H	11-38 U/L			F: 37-47%
PO2		80-100 mmHg	Tbil	0.6	0.2-1.6 mg/dL	MCV		80.0-99.0 fl
TCO2		18-33 mmol/L	BUN	85 H	7-22 mg/dL	MCH		27.0-31.0 pg
HCO3		22-26 mmol/L	Ca	7.7 L	8.0-10.3 mg/dL	MCHC		33.0-37.0 g/dL
sO2		95-99%	Chol		100-200 mg/dL	Plt		130-400 x10(3)/uL
BEecf		(-2) - (+3)	CK		M: 39-380 U/L F: 30-190 U/L	LY%		20.0-44.0%
AGap		8-16 mmol/L	CL	126 H	98-109 mmol/L	LY#		0.7-4.3 x10(3)/uL
iCa		1.12-1.32 mmol/L	TCO2		18-33 mmol/L	Differential		
BUN		7-22 mg/dL	Creat	2.3 H	0.6-1.3 mg/dL	Segs(50-70%)		Mono(4-10%)
Glu		73-118 mg/dL	GGT		5-65 U/L	Bands(1-10%)		Eos(0-4%)
Creat		0.6-1.3 mg/dL	Glu	120 H	73-118 mg/dL	Lymph(20-44%)		Baso(0-2%)
Hct		37.0-52.0%	K	4.3	3.3-4.9 mmol/L	Atyp Ly		Immature cells
Hgb		12.0-18.0 g/dL	Mg		1.6-2.3 mg/dL	RBC Abn Morph:		
Lactate		0.90-1.70 mmol/L	Phosphorus		2.2-4.5 mg/dL			
Urinalysis			TProtein	6.4	6.4-8.1 g/dL	Plt Abn Morph:		
Color		Straw/Yellow	Na	163 H	128-145 mmol/L			
Clarity		Clear	HDL Chol		30-75 mg/dL	WBC Abn Morph:		
Glucose		Negative	LDL Chol		50-130 mg/dL			
Bilirubin		Negative	Triglycerides		60-160 mg/dL	Malaria / Purple Top		
Ketone		Negative	VLDL		≤30 mg/dL	Thin		No Plasmodium Seen
SG		1.010-1.025	Chol/HDL Ratio		≤4.5	Thick		No Plasmodium Seen
Blood		Negative	Rapid Tests (Green Top)			Sed Rate / Purple Top		
pH		5.0-8.0	Mono		Negative	Sed Rate		1hr = 0-20 mm
Protein		Negative-Trace	H.pylori IgG		Negative	Coagulation (Blue Top - Sodium Citrate)		
Urobili		0.1-1.0 Ehrlich U/dL	Rapid Tests (SST or Red Top)			PT		7.0-14.0 sec
Nitrite		Negative	RPR		Negative	APTT		21.0-50.0 sec
Leuko		Negative	HCG (or urine)		Negative	INR		0.5-1.5/therap 2-3
Urine Microscopic			Rapid Tests			D Dimer		Negative
WBC		Epi	Strep A		Negative	Cardiac Panel / Purple Top		
RBC		Mucus	Drug Screen (urine)		Negative	Myoglobin		0-107 ng/mL
Bacteria		Yeast	Chlamydia		Negative	CK-MB		0-4.3 ng/mL
Casts:		Spermatozoa	Flu A&B		Negative	Troponin		0.0-0.4 ng/mL
Crystals:		Amorph Sed	C. difficile (stool)		Negative	Hemoglobin S (sickle) / Purple Top		
Other:			O&P (stool)		No Ova / Parasite	Hemoglobin S		Negative
Other lab request:			OccBld		Negative	Body Fluid Panel - Sterile Cont		
criticals report to (b)(6)			KOH		Negative	Panel includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis test (CSF only)		

WBC, Hct, Na

(b)(6)

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

Reviewed by: (b)(6) 181

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6) Ward: ICU Gender M or F (circle)
Drawn by: Bed: #3 Stat or Routine (circle)

P 21, ABU LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

Specimen Date and time: 2 June 06 2000

Signs and Symptoms:

(b)(6)

Date and Time: 2 June 06

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

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

Urinalysis

	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 (Piccolo) / Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT	REF. RANGE
X	ALB	3.5	3.3-5.5 g/dL
X	ALP	122	26-184 U/L
X	ALT	160	10-47 U/L
	AMY		14-110 U/L
X	AST	154	11-38 U/L
	Tbil	0.6	0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca	7.6	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
X	CL 129	133 X	98-109 mmol/L
	TCO2	26 21	18-33 mmol/L
X	Creat	2.2	0.6-1.3 mg/dL
	GGT		5-65 U/L
X	Glu	128	73-118 mg/dL
	K	4.3	3.3-4.9 mmol/L
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	TProtein	6.2	6.4-8.1 g/dL
X	Na	152 158	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 (Green Top)

	Mono		Negative
	H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

	RPR		Negative
	HCG (or urine)		Negative

Rapid Tests

	Strep A		Negative
	Drug Screen (urine)		Negative
	Chlamydia		Negative
	Flu A&B		Negative
	C. difficile (stool)		Negative
	O&P		No Ova / Parasite
	OccBld		Negative
	Wet Mount		Negative
	KOH		Negative

FOR OFFICIAL USE ONLY
[illegible]

Hematology / Purple Top

CBC | CBC w/ diff | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen

Sed Rate / Purple Top

	Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel / Purple Top

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

Hemoglobin S (sickle) / Purple Top

	Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

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

(b)(6) Critical reported to (b)(6) Reviewed by: 182 (b)

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6) Ward: ICU

Drawn by: Bed: 3

Gender M or F (circle)

Stat or Routine (circle)

TF 21, ABU LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 07Jun06 1840

Signs and Symptoms:

(b)(6) Date and T 1854

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na	167	138-145 mmol/L
	K	3,4	3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7,215	7.35-7.45
	PCO2	57,0	35-45 mmHg
	PO2	45	80-100 mmHg
	TCO2	25	18-33 mmol/L
	HCO3	23,0	22-26 mmol/L
	sO2	95	95-99%
	BEecf	-5	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1,09	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct	28	37.0-52.0%
	Hgb	9,5	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 (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

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
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.5 mg/dL
	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 (Green Top)

Mono		Negative
H.pylori IgG		Negative

Rapid Tests (SST or Red Top)

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (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

FOR TRAINING USE ONLY

LAUREL HIGHLANDS SCHOOL OF PHLEBOTOMY

Hematology / Purple Top

CBCN (no diff) | CBC | Malaria

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S (sickle)/ Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

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

(b)(6)

Reviewed by:

(b)(6)

SSN or ISN: (b)(6)

LAST, FIRST, MI.

Physician: (b)(6) Ward: ICU

Drawn by: Bed: 3

Gender (M) or F (circle)

Stat or Routine (circle)

LA[illegible]RY RESULTS FORM

(Subject to Privacy Act of 1974)

Specimen Date and time: 2Jun06 1745

Signs and Symptoms:

(b)(6) Date and Time: 2 Jun 06 18

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas Bld Gas w/ lytes Glu Crea

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

Urinalysis

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 (Piccolo)/Green or red/tiger top

Comp Pan BMP Hepatic Pan Lipid Pan Renal Pan

X	TEST	RESULT	REF. RANGE
	Flu A&B		Negative
	C. difficile (stool)		Negative
	O&P (stool)		No Ova / Parasite
	Occ Bld		Negative
	Wet Mount		Negative
	[illegible]		Negative

Venous

======= PICCOLO =======

06/02/06 06:02 PM

PATIENT TYPE: MALE

PATIENT #: (b)(6)

COMPREHENSIVE METABOLIC

DISC LOT #: 6103AA4

OPERATOR #: (b)(6)

DOCTOR #:

SERIAL #: (b)(6)

NA+	160*	128-145	MMOL
K+	4.6	3.6-5.1	MMOL
tCO2	23	18-33	MMOL
CL-	126*	98-108	MMOL
GLU	135*	73-118	MG/DL
CA	8.1	8.0-10.3	MG/DL
BUN	85*	7-22	MG/DL
CRE	2.6*	0.6-1.2	MG/DL
ALP	144*	53-128	U/L
ALT	187*	10-47	U/L
AST	188*	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
ALB	1.5*	3.3-5.5	G/DL
TP	6.6	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 0, LIP 1+, ICT 0

Hematology / Purple Top

CBCN (no diff) CBC Malaria H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel / Purple Top

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

Hemoglobin S (sickle) / Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

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

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LAW ENFORCEMENT SENSITIVE

(b)(6)

reviewed by: 184

(b)(

SSN or ISN: (b)(6)

LABOR[illegible]RY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.

Physician: (b)(6) Ward: 1 Ch Gender: M or F (circle)
Drawn by: Bed: 3 Stat or Routine (circle)

Specimen Date and time: 5 June 06 0124

Signs and Symptoms: Cyanotic around lips (b)(6)

(b)(6) Date and Time:

Chemistry (i-STAT) / Green Top / Syringe			Chemistry (Piccolo)/Green or red/tiger top			Hematology / Purple Top		
Bld Gas Bld Gas w/ lytes Glu Crea			Comp Pan BMP Hepatic Pan Lipid Pan Renal Pan			CBCN (no diff) CBC Malaria H/H		
X TEST	RESULT	REF. RANGE	X TEST	RESULT	REF. RANGE	X TEST	RESULT	REF. RANGE
Na		138-145 mmol/L	ALB		3.3-5.5 g/dL	WBC		4.8-10.8 x10(3)/uL
K		3.3-4.9 mmol/L	ALP		26-184 U/L	RBC		4.2-6.1 x10(6)/uL
Cl		98-109 mmol/L	ALT		10-47 U/L	Hgb		12.0-18.0 g/dL
pH	6.924	7.35-7.45	AMY		14-110 U/L	Hct		M: 42.0-52.0%
PCO2	104.9	35-45 mmHg	AST		11-38 U/L			F: 37-47%
PO2	35	80-100 mmHg	Tbil		0.2-1.6 mg/dL	MCV		80.0-99.0 fl
TCO2	25	18-33 mmol/L	BUN		7-22 mg/dL	MCH		27.0-31.0 pg
HCO3	21.7	22-26 mmol/L	Ca		8.0-10.3 mg/dL	MCHC		33.0-37.0 g/dL
sO2	34	95-99%	Chol		100-200 mg/dL	Plt		130-400 x10(3)/uL
BEecf	-11	(-2) - (+3)	CK		M: 39-380 U/L F: 30-190 U/L	LY%		20.0-44.0%
AGap		8-16 mmol/L	CL		98-109 mmol/L	LY#		0.7-4.3 x10(3)/uL
iCa		1.12-1.32 mmol/L	TCO2		18-33 mmol/L	Differential		
BUN		7-22 mg/dL	Creat		0.6-1.3 mg/dL	Segs(50-70%)		Mono(4-10%)
Glu		73-118 mg/dL	GGT		5-65 U/L	Bands(1-10%)		Eos(0-4%)
Creat		0.6-1.3 mg/dL	Glu		73-118 mg/dL	Lymph(20-44%)		Baso(0-2%)
Hct		37.0-52.0%	K		3.3-4.9 mmol/L	Atyp Ly		Immature cells
Hgb		12.0-18.0 g/dL	Mg		1.6-2.3 mg/dL	RBC Abn Morph:		
Lactate		0.90-1.70 mmol/L	Phosphorus		2.2-4.5 mg/dL			
Urinalysis			TProtein		6.4-8.1 g/dL	Plt Abn Morph:		
Color		Straw/Yellow	Na		128-145 mmol/L			
Clarity		Clear	HDL Chol		30-75 mg/dL	WBC Abn Morph:		
Glucose		Negative	LDL Chol		50-130 mg/dL			
Bilirubin		Negative	Triglycerides		60-160 mg/dL	Malaria / Purple Top		
Ketone		Negative	VLDL		≤30 mg/dL	Thin		No Plasmodium Seen
SG		1.010-1.025	Chol/HDL Ratio		≤4.5	Thick		No Plasmodium Seen
Blood		Negative	Rapid Tests (Green Top)			Sed Rate / Purple Top		
pH		5.0-8.0	Mono		Negative	Sed Rate		1hr = 0-20 mm
Protein		Negative-Trace	H.pylori IgG		Negative	Coagulation (Blue Top - Sodium Citrate)		
Urobili		0.1-1.0 Ehrlich U/dL	Rapid Tests (SST or Red Top)			PT		7.0-14.0 sec
Nitrite		Negative	RPR		Negative	APTT		21.0-50.0 sec
Leuko		Negative	HCG (or urine)		Negative	INR		0.5-1.5/therap 2-3
Urine Microscopic			Rapid Tests			D Dimer		Negative
WBC		Epi	Strep A		Negative	Cardiac Panel/Purple Top		
RBC		Mucus	Drug Screen (urine)		Negative	Myoglobin		0-107 ng/mL
Bacteria		Yeast	Chlamydia		Negative	CK-MB		0-4.3 ng/mL
Casts:		Spermatozoa	Flu A&B		Negative	Troponin		0.0-0.4 ng/mL
Crystals:		Amorph Sed	C. difficile (stool)		Negative	Hemoglobin S (sickle)/Purple Top		
Other:			O&P (stool)		No Ova / Parasite	Hemoglobin S		Negative
Other lab request:			Occ Bld		Negative	Body Fluid Panel - Sterile Cont.		
			Wet Mount		Negative	Panel includes: Culture, Gram Stain, Cell Count, WBC Diff, Meningitis test (CSF only)		
			KOH		Negative			

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LAW ENFORCEMENT SENSITIVE

(b)(6)

reviewed by:

4185

0089 06 CID789 784

NSN 7540-01-165-7294

519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
~~PXE~~ DP PCXR			(b)(6)	ICU	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Prin	(b)(6)			TELEPHONE/PAGE NO.
	(b)(6)				DATE REQUESTED

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

ROUTINE

DATE OF EXAMINATION (Month, day, year)	(b)(6)	DATE OF REPORT (Month, day, year)	DATE OF TRANSACTION (Month, day, year)
05 JUNE 06			

RADIOLOGIC REPORT

TD 0500

↑ ASD @ mid lung
o/w stable Diffuse R>L ASD
Stable lines

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

(b)(6)

ICU

BED

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~~LAW ENFORCEMENT SENSITIVE~~

RADIOLOGIC CONSULTATION REQUEST/REPORT

1 - Medical Record

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR
(41 CFR) 201-45.505

EXHIBIT 186 (b)(6)

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN

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

NS) Mo. Jun Yr. 06

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6
	(b)(6)								
1 Jun 06		Levaquin 500 mg IV QD	10	/	(b)(6)				
1 Jun 06		DIflucan 400 mg IV QD	12	/					
1 Jun 06		TF Optimental @ 40 ml/hr	07	/	(b)(6)	→ D/C	02 Jun 06 1400		
			19	(b)(6)					
1 Jun 06		Sucralfate per NGT TID	06	/	(b)(6)	(b)(6)			
			14	/					
			22	(b)(6)					
1 Jun 06		Flush Dobhoff ∈ 200 ml	06	/		→ D/C	2 June 06 2000		
		Free H2O TID	14	/					
			22	(b)(6)					
2 Jun 06		Δ NF to D5½NS @ 75 ml/hr	07	/		→ D/C	2 June 06 2000		
			19	/					
2 Jun 06		ΔTF: Suplena @ 50 cc/hr	07	/	/	→ D/C	2 June 06 2000		
		for 12 hrs on + 12 hrs off	19	/	/				
2 June 06		D5 @ 75 cc/hr	07	/	/	(b)(6)	(b)(6)		
2 June			19	/	/	(b)(6)			
2 June		Hold TF but cont water	04	/	/				
		bolus QID ∈ ↓ to 100 cc	10	/	/				
			16	/	/	(b)(6)			
			22	/					
~~3 Jun 06~~		ASA 30 mg IV QAM	06	/	/	(b)(6)			
4 Jun 06									
4 Jun 06		Suplena @ 30 ml/hr to	07	/	/	/	(b)(6)		
		Dobhoff	19	/	/	/			
05 Jun 06		Levophed (Norepinephrine)	07	/	/	/	/	(b)(6)	
		2 mcg/min titrate to	19	/	/	/	(b)(6)		
		MAP > 70							

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: GSW to ABD

ADDITIONAL PAGES IN ☐ YES ☐ NO PAGE NO.

PATIENT IDENTIFICATION: 10U Bed #2 (b)(6)

DISPENSING TIME

USE PENCIL. CIRCLE

D 7 8 9 10 1

E 15 16 17 18

N 23 24 01 0

4 FORM 4678

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

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

EXHIBIT 187 (b)(6)

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (DRUGS)

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

Mo. Jun Yr. 06

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6
1 Jun 06	(b)(6)	Levaquin 500 mg IV QD	10	/	(b)(6)				
1 Jun 06		Diflucan 400 mg IV QD	12	/					
1 Jun 06		TF Optimental @ 40 ml/hr	07	/	(b)(6)	→ D/C 02 Jun 06 1400			
			19		(b)				
1 Jun 06		Sucralfate per NGT TID	06	/	(b)(6)				
			14	/					
			22	Jm					
1 Jun 06		Flush dobhoff ē 200 ml	06	/	(b)(6)				
		Free H2O TID	14	/		→ D/C 2 June 06 2000			
			22	Jm					
2 Jun 06		Δ NF to D5½NS @ 75 ml/hr	07	/		→ D/C 2 June 06 2000			
			19	/					
2 Jun 06		ΔTF; Suplena @ 50 cc/hr	07	/	/	→ D/C 2 June 06 2000			
		for 12 hrs on + 12 hrs off	19	/	/				
2 June 06		D5 @ 75 cc/hr	07	/	/	(b)(6)			
~~02 June~~			19	/	(b)(6)				
2 June		Hold TF but cont water	04	/	/				
		bolus QID ē ↓ to 100 cc	10	/	/				
			16	/	/				
			22	/	(b)(				
~~3 JUN 06~~		Lasix 20 mg IV QAM	06	/	/				
4 JUN 06									
4 Jun 06		suplena @ 30 ml/hr to	07	/	/	/	(b)(6)		
		clobhoff	19	/	/	/			
05 Jun 06		Levophed (Norepinephrine)	07	/	/	/	/	(b)(	
		2 mcg/min titrate to	19	/	/	/	(b)(6)		
		MAP > 70							

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: GSW to ABD

ADDITIONAL PAGES IN ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: (b)(6)

DISPENSING TIME

USE PENCIL. CIRCLE

D 7 8 9 10 11

E 15 16 17 18

N 23 24 01 02

FORM 4678

(b)(6)

DA FORM 467.8, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

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

EXHIBIT 180

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo.

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMIN.

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 04 05
04Jun06	-----	Imipenum 1A		
	-----	TAKE 100 mL from bag 1 + put		
	-----	in 900 mL of DS		
	-----	1 mL/hr x 15	2145	
	-----	2 mL/hr x 15	2200	
	-----	4 mL/hr x 15	2215	
	-----	8 mL/hr x 15	2230	
	-----	16 mL/hr x 15	2245	
	-----	32 mL/hr x 15 then	2300	
	-----	BAG 1 84mg/100mL DS		
	-----	1.6 mL/hr x 15	2315	
	-----	3.2 mL/hr x 15 then	2330	
	-----	BAG 2 84mg/200mL DS		
	-----	3mL/hr x 15	2345	
	-----	6mL/hr x 15	00	
	-----	12mL/hr x 15 then	0015	
	-----	FINAL BAG 84mg/100mL DS		
	-----	6mL/hr x 15	0030	
	-----	12mL/hr x 15	0045	
	-----	25mL/hr x 15	01	
	-----	Imipenum 84mg/100mL DS		
	-----	25mL/hr cont infusion	07	
	-----	DO NOT stop infusion	19	
04Jun06	(b)(6)	Flush Dobhoff QID	04	
	-----	@ 100mL H_2O	10	
	-----		16	
	-----		22	

Allergic to nitrofurantoin

Steps completed

05Jun06 0730

(b)(6)

(b)(6)

(b)(6)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to Abd

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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EDITION OF 1 DEC 74 MAY BE USED UNTIL EXHAUSTED.

DA FORM 4678, 1 FEB 79

EXHIBIT 189 (b)(6)

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo.

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMIN.*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 04 05
04JUN05	-----	Imipenum 1A		
	-----	TAKE 100 mL from bag 1 + put		
	-----	in 900 mL of D5		
	-----	1 mL/hr x 15	2145	
	-----	2 mL/hr x 15	2200	
	-----	4 mL/hr x 15	2215	
	-----	8 mL/hr x 15	2230	
	-----	16 mL/hr x 15	2245	
	-----	32 mL/hr x 15 then	2300	
	-----	BAG 1 84mg/100mL D5		
	-----	1.6 mL/hr x 15	2315	
	-----	3.2 mL/hr x 15 then	2330	
	-----	BAG 2 84mg/200mL D5		
	-----	3mL/hr x 15	2345	
	-----	6mL/hr x 15	00	
	-----	12mL/hr x 15 then	0015	
	-----	FINAL BAG 84mg/100mL D5		
	-----	6mL/hr x 15	0030	
	-----	12mL/hr x 15	0045	
	-----	25mL/hr x 15	01	
	-----	Imipenum 84mg/100mL D5		
	-----	25mL/hr cont infusion	07	
	-----	DO NOT STOP infusion	19	
04JUN05	(b)(6)	Flush Dobhoff QID	04	
		@ 100mL H_2O	10	
	-----		16	
	-----		22	

Allergic sensitivity
steps completed
05JUN05 @ 0730

(b)(6)

(b)(6)

(b)(6)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to Abd

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 4678, 1 FEB 79

~~FOR OFFICIAL USE ONLY~~

~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT 190

WILL BE USED UNTIL EXHAUSTED.

USA PA

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

Mo. May Yr. 06

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
				4 Jun
4 Jun 06	(b)(6)	Flush dobhoff QID	04	(b)(6)
		c 100ml water	10	
			16	
			22	
04 Jun 06	(b)(6)	Imipenem BAG 1		
		84mg/100mL D5		
		Rate 0.05 mL/hr x 15 min		
		0.1 mL/hr x 15 min		
		0.2 mL/hr x 15 min		
		0.4 mL/hr x 15 min		
		0.8 mL/hr x 15 min		
		1.6 mL/hr x 15 min		
		3.2 mL/hr x 15 min then		
		BAG 2		
		84mg/200mL D5		
		3 mL/hr x 15 min		
		6 mL/hr x 15 min		
		12 mL/hr x 15 then		
		FINAL BAG		
		84mg/100mL		
		6 mL/hr x 15 min		
		12 mL/hr x 15 min		
		25 mL/hr as final		
		cont. infusion rate		
		DO NOT STOP		
		CONT. INFUSION		

D/C 4 Jun 06 2130

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
GSW to ABD

ADDITIONAL PAGES IN USE ☐ YES ☐ NO
PAGE NO.

PATIENT IDENTIFICATION:
(b)(6)

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT (b)(6) 19

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

USAPA V1.01
PAGE 1 OF 2

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

Mo. May Yr. 06

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY
4Jun06	(b)(6)	Flush dobhoff QID
		@ 100ml water
04Jun06	(b)(6)	Imipenium BAG 1
		84mg/800mL D5
		Rate 0.05 mL/hr x 15min
		0.1mL/hr x 15min
		0.2mL/hr x 15min
		0.4mL/hr x 15min
		0.8mL/hr x 15min
		1.6mL/hr x 15min
		3.2mL/hr x 15min then
		BAG 2
		84mg/200mL D5
		3mL/hr x 15min
		6mL/hr x 15min
		12mL/hr x 15 then
		FINAL BAG
		84mg/100mL
		6mL/hr x 15min
		12mL/hr x 15min
		25mL/hr as final
		cont. infusion rate
		DO NOT STOP
		CONT. INFUSION

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

HR	DATE DISPENSED
04	(b)(6)
10	(b)(6)
16	
22	

D/C
4 JUNE
2130

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
GSW to ABD

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

PATIENT IDENTIFICATION:
(b)(6)

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14	
E	15	16	17	18	19	20	21	22	
N	23	24	01	02	03	04	05	06	(b)(6)

EXHIBIT

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LAW ENFORCEMENT SENSITIVE

DA FORM 4678, 1 FEB 79 ...LL BE USED UNTIL EXHAUSTED. USAPA V1.. PAGE 1 OF 2

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Verify by Initialing

(NON-MEDICATION)

Mo 06 Yr 2006

Order Date	Clerk Nurse / (b)(6)	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials / (b)(6)
6/8		Sputum Culture	7Jun06	1035	1035	
6/8		ABG & next lab.	7Jun06	1600	1600	

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

USAPA V1.00

EXHIBIT (b)(6)

THER UTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 06 Yr 2006

Verify by Initialing: Order Date	Clerk Nurse /	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials /
6/8	(b)(6)	Sputum Culture	7Jun06	1035	1035	(b)(6)
6/8		ABG's next lab.	7Jun06	1600	1600	

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

USAPA V1.00

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SENSITIVE

EXHIBIT 194 (b)(6)

CLINICAL RECORD

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

Mo. 6 Yr. 06

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5
1 Jun 06	(b)(6)	Chem 7 q4hr	04	✓ (b)(6)		(b)(6)		
			08	✓				
			12	✓				
			16	✓				
			20	(b)(6)				
			24					
1 Jun 06	(b)(6)	chest tube x3 ~~to H2O seal~~ on DCT to H2O seal (R) ant/post. CT to 20cm suction	07			(b)(6)		
			19					
1 Jun 06		In the event of code: Ø CPR, Ø cardioversion, Ø acls meds, may give pressors	07					
			19					
1 Jun 06		Vent settings: SIMV/PC Rate 25, IP 24, PEEP 15, PSV 10, FiO2 80%	07					
			19					
1 Jun 06		hand Vac to wall suction 125mmHg	07					
			19					
1 Jun 06		Am labs: CBC, cmp, mg phos, ABG	05					
		Cxrays. abnormal results call MD						
1 Jun 06		Am CXR	05					
1 Jun 06		VS Q 1 hr . I & O Q1h	07					
			19					
1 Jun 06		Foley to gravity NS Flush PRN	07					
1 Jun 06		ACE wraps (B) LE	01					
1 Jun 06		chest PT, per RT TID	02					
			10					
			18					

D/C 3 June 06

Replaced 4 June 06 (b)(6)

Renewed 04 Jun 06 (b)(6)

2 June 06 2000

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
GSW to ABD

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

PATIENT IDENTIFICATION:
(b)(6)

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

DA FORM 4677, 1 OCT 78

EXHIBIT
105
(b)(6)

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. 6 Yr. 06

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1 2 3 4 5
1 Jun 06	(b)(6)	Chem 7 q 4 hr	04	(b)(6)
			08	
			12	D/C 3 June 06
			16	
			20	
			24	
1 Jun 06	(b)(6)	chest tube x3 ~~to H2O seal~~ on DCT to H2O seal R ant/post. CT to 20cm suction	07	(b)(6)
			19	
1 Jun 06		In the event of code: Ø CPR, Ø cardioversion, Ø ACLS meds, may give pressors	05	(b)(6) Renewed 4 June 06
			19	Renewed 04 Jun 06 RRP
1 Jun 06		Vent settings: SIMV/PC Rate 25, IP 24, PEEP 15, PSV 10, FiO2 80%	05	2 June 06 2000
			19	
1 Jun 06		hand vac to wall suction 125 mmHg	05	
			19	
1 Jun 06		Am labs: CBC, cmp, mg phos, ABG	05	
		Cxrays. abnormal results call MD		
1 Jun 06		Am CXR	05	
1 Jun 06		VS Q 1 hr. I & O Q 1 h	05	
		Foley to gravity, NS flush PRN	12	
1 Jun 06		ACE wraps (B) LE	08	
			12	
1 Jun 06		chest PT, per RT TID	08	
			12	
			16	

ALLERGIES: ☐ YES ☑ NO
NICDA

PRIMARY DIAGNOSIS:
GSW to ABD

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

PATIENT IDENTIFICATION:
(b)(6)

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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EDITION PRIOR TO BE USED.

DA FORM 4677, 1 OCT 78

EXHIBIT (b)(6)

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THERAPEUTIC DOCUMENTATION CARE F
(NON-MEDICATION)

Mo ____ Yr ____

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3 June	(b)(6)	PT/PTT & next labs @ 1700	3 June	1700	1700	(b)(6)
3 June		Check ABG in 30 min	3 June 06	1835	1835	
03 June		Check ABG	03 June 06	1930	2000	
4 June		UP to 2 30%	4 June	0900		
4 June		ABG on 2 L NV	4 June	1000	done	
4 June		T to 02 88%				
04 June		Type + Cross then transfuse 2u PRBC	04 June	ASAP	1700	
04 June		Start PIV for versed or Zmipenem (incompatible)	04 June	ASAP	2030	
4 June		ABG IN 1 hr	4 June	ASAP	2145	

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

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

USAPA V1.00

EXHIBIT 197 (b)(6)

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo ______ Yr ______

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3 June	(b)(6)	PT/PTT c̄ next labs @ 1700	3 June	1700	1700	(b)(6)
3JUN06		Check ABG in 30min	3JUN06	1835	1835	
03JUN06		Check ABG	03JUN06	1930	2000	
4Jun		UFiO2 70%	4Jun	0900		
4Jun		ABG in 1hr	4Jun	1000	done	
4Jun		↑ FiO2 80%				
04Jun		Type + cross then transfuse 2u PRBC 1st u 2nd u	04Jun	ASAP	1700	
04Jun		Start PIV for versed or Imipenem (incompatible)	04Jun	ASAP	2030	
4 June		ABG in 1 hr	4 Jun	ASAP	2445	

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

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

USAPA V1.00

EXHIBIT 198

CLINICAL RECORD

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

Mo. ___ Yr. ___

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2 3 4 5 6
2 Jun	(b)(6)	VENT SETTINGS: SIMV/PC rate	07	(b)(6)
		25, PEEP 15, PSV 10, FiO2	19	
		40% to 100% wean to	/	
		Keep PO2 80-100		
3 Jun		BMP BID	05	(b)(6)
			17	
3 Jun		Chem 7 Q24hr	24	
			04	
			08	
			12	
			16	
			20	
03 Jun 10		Vent: SIMV/PC Rate 25, PIP 24	07	
		PEEP 15, PS 10, FiO2 80%	19	(b)(6)
		Wean to keep PO2 80-100%	/	
04 Jun		In the Event of code:	07	(b)(6)
		Ø CPR, Ø cardioversion	19	(b)(6)
		Ø ACLS meds, may give		
		Pressors		
		Start PIV / [illegible]		
4 June		Vent: SIMV/PC RATE 35,	07	(b)(6)
		Peep 15, ps 10, FiO2 100%,	19	(b)(6)
		pip 24	/	
4 June		Chest Tube X3 to wall	07	(b)(6)
		SUCTION	19	(b)(6)

DC'd

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: Gsw to ABD

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO: ___

PATIENT IDENTIFICATION:

(b)(6)

In Bed #3

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 MAY BE USED

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

USAPA V1.00

(b)(6)

CLINICAL RECORD

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

Mo. ____ Yr. ____

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5	6
2 June	(b)(6)	VENT SETTINGS: SIMV/PC rate	07		(b)(6)			
		25, PEEP 15, PSV 10, FiO2	19	(b)(6)				
		40% to 100% wean to						
		Keep PO2 80-100						
3 Jun		BMP BID	05			(b)(6)		
			17					
3 Jun 0		Chem 7 Q4hr	24					
			04					
			08					
			12					
			16					
			20					
03 Jun 06		Vent: SIMV/PC Rate 25, PIP 24	07					
		PEEP 15, PS 10, F, O2 80-100%	19		(b)			
		Wean to keep PO2 80-100%						
04 Jun		In the Event of code:	07				(b)	
		@ CPR, @ cardioversion,	19			(b)(6)		
		@ ACLS meds, may give						
		Pressors						
		Start PIV / [redacted]						
4 June	(b)(6)	Vent: SIMV/PC RATE 35,	07				(b)	
		Peep 15, ps 10, FiO2 100%,	19			(b)(6)		
		pip 24						
4 June	(b)(6)	Chest Tube X3 to wall	07				(b)(6)	
		SUCTION	19			(b)(6)		

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: GSW to ABD

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO: ____

PATIENT IDENTIFICATION: (b)(6)

ICU Bed #3

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)

DA FORM 4677, 1 OCT 78

~~FOR OFFICIAL USE ONLY~~
EDITION OF 1 DEC 77 MAY BE USED.
~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT (b)(6)

200

Verify by Initialing

THEF UTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 06 Yr. 2006

Order Date	Clerk/ Nurse/	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6/2	(b)(6)	Lasix 10mg/IV x 1	6/2/06	0845	0845	(b)(6)
6/2		Lasix ~~40mg~~ 20mg IV x 1 20mg	6/2/06	1700	1700	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
-----	-----		
-----	-----		
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FORM 4678, 1 FEB 79

EXHIBIT 20 (b) (6)

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 06 Yr. 2006

Order Date	Clerk/ Nurse/	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6/2	(b)(6)	Lasix 10mg/IV X T	6/2/06	0845	0845	(b)(6)
6/2		Lasix ~~10mg~~ 20mg IV X T 20mg	6/2/06	1700	1700	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
-----	-----		
-----	-----		
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FORM 4678, 1 FEB 79

EXHIBIT (b)(6)

202

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

Mo. JUN Yr. 06

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1 2 3 4 5 6
1Jun06	(b)(6)	Albuterol nebs QID give E	0	(b)(6)
		mucomyst	1	
			1	
			2	
1Jun06	(b)(6)	lovenox 30mg SQ BID	1	
			2	
1 Jun 06		FSQID insulin SS Reg SQ.	0	
		If FS < 70 give 1 amp	FS	
		D50 → call MD		
		71-150 0U	F	
		151-200 2U		
		201-250 4U	F	
		251-300 6U		
		301-350 8U	FS	
		351-400 10U		
		>400 12U call MD		
2Jun06	(b)(6)	erythromycin eye ointment to	1	
		OD BID	22	
1 Jun 06		Fentanyl gtt titrate ↓	07	
			19	
1Jun06		Versed Drip 2mg/hr titrate ↓	07	
		PRN dont exceed 15mg/hr	19	
1 Jun 06		zantac 50mg IVPB Q12	10	
			22	
1 Jun 06		Mycostatin Powder to groin	07	
		Q12 hrs	19	

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: GSW to ABD

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

PATIENT IDENTIFICATION: (b)(6)

1W Bed #3

(b)(6)

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14	
E	15	16	17	18	19	20	21	2	
N	23	24	01	02	03	04	05		

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

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 203

DA (b)(6)

Verify by Initialing	THE EUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 06 Yr. 2006			
Order Date / Clerk/ Nurse (b)(6)	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials (b)(6)
6/2	Lasix 10mg/IV x 1	6/2/06	0845	0845	
6/2	Lasix ~~10mg~~ and 1V x 1 20mg	6/2/06	1700	1700	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
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EXHIBIT 204

(b)(6)

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 06 Yr. 2006			
Order Date / Clerk/ Nurse/	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6/2 (b)(6)	Lasix 10mg/IV x 1	6/2/06	0845	0845	(b)(6)
6/2	Lasix ~~10mg~~ 20mg IV x 1 20mg	6/2/06	1700	1700	

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

FORM 4678, 1 FEB 79

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~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT USA/BA V1D1 PAGE 205

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

Mo. Jun Yr. 06

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1 2 3 4 5 6
1 Jun 06	(b)(6)	Albuterol nebs QID give e		(b)(6)
		mucomyst		
1 Jun 06	(b)(6)	lovenox 30mg SQ BID		
1 Jun 06		FS QID instin SS Reg SQ.		
		If FS < 70 give 1 amp		(b)
		D50 → call MD		
		71-150 0U		(b) (6)
		151-200 2U		
		201-250 4U		
		251-300 6U		
		301-350 8U		
		351-400 10U		
		>400 12U call MD		
2 Jun 06	(b)(6)	erythromycin eye ointment to	10	
		OD BID	22	
1 Jun 06		Fentanyl gtt titrate ↓	07	
			19	
1 Jun 06		Versed drip 2mg/hr titrate ↓	07	
		PRN dont exceed 15mg/hr	19	
1 Jun 06		zantac 50mg IVPB Q12	10	
			22	
1 Jun 06		Mycostatin Powder to groin	07	
		Q12 hrs	19	

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: GSW to ABD

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: (b)(6)

1 W Bed #3

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

(b)(6)

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

EXHIBIT 206

(b)(6)

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 06 Yr. 06

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

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
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EXHIBIT

(b) (6)

USAPA V1.01

DA FORM 4678, 1 FEB 79

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINI...

Mo.

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 04 05
04JUN06		Imipenum 1A		
		TAKE 100 mL from Bag 1 + put		
		in 900mL of D5		
		1 mL/hr x 15	2145	
		2mL/hr x 15	2200	
		4mL/hr x 15	2215	
		8mL/hr x 15	2230	
		1.6mL/hr x 15	2245	
		32mL/hr x 15 then	2300	
		BAG 1 84mg/100mL D5		
		1.6mL/hr x 15	2315	
		3.2mL/hr x 15 then	2330	
		BAG 2 84mg/200mL D5		
		3mL/hr x 15	2345	
		6mL/hr x 15	00	
		12mL/hr x 15 then	0015	
		FINAL BAG 84mg/100mL D5		
		6mL/hr x 15	0030	
		12mL/hr x 15	0045	
		25mL/hr x 15	01	
		Imipenum 84mg/100mL D5		
		25mL/hr cont infusion	07	
04JUN06	(b)(6)	DO NOT stop infusion	19	
		Flush Dobhoff QID	04	
		@ 100mL H_2O	10	
			16	
			22	

Allergic & sensitized to
steps completed
05 JUN 06 @ 0230
(b)(6)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to Abd

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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LAW ENFORCEMENT SENSITIVE

FORM 4678, 1 FEB 79

EDITION OF DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.01

EXHIBIT 208

(b)(6)

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 06 Yr. 2006			
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
3 June (b)(6)	IV Lasix 20mg	3 June	0815	0815	(b)(6)
3JUN06	Vitamin K 10mg IV - Slow infusion	3JUN06	ASAP	1050	
3JUN06	Lasix 20mg IV x1	3JUN06	NOW	1820	
3JUN06	+ F:O2 to 85%.	3JUN06	NOW	1805	
03JUN06	Hold lovenox	03JUN06	ASAP	1000	
03Jun	2 amps CaCl x1 now	03JUN06	ASAP	1930	
4 Jun	Lasix 20mg IV q AM	4 Jun		0832	
4 Jun	Resume Systera after placing new DHT	4 Jun		1100	
6/4	Lasix 20mg IV	4 Jun		1500	
4 Jun	Type + Cross + than transfuse 2U PRBCS 1st	4 Jun	1700	1815	
	~~Lasix 20mg x1~~ 2nd unit	04JUN	ASAP	2115	
04JUN	Lasix 20mg x1 IVP between blood	04JUN	ASAP	2110	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
1 Jun 06	(b)(6)	Ativan 1-3 mg IVP Q2-3 hr prn	(b)(6)
1 Jun 06		Tylenol 975mg PR Q6° prn Fever >101	

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LAW ENFORCEMENT SENSITIVE

DA FORM 4678, 1 FEB 79

EXHIBIT

USAPA V1.01

209

(b)(6)

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (CNS)

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

Mo. Jun Yr. 06

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6
1 Jun 06	(b)(6)	Levaquin 500 mg IV QD	10	(b)(6)					
1 Jun 06		DIflucan 400 mg IV QD	12						
1 Jun 06		TF Optimental @ 40 ml/hr	07						
			19						
1 Jun 06		Sucralfate per NGT TID	06						
			14						
			22						
1 Jun 06		Flush Debhoff ℰ 200 ml	06						
		Free H2O TID	14						
			22						
2 Jun 06		Δ NF to D5½NS @ 75 ml/hr	07						
			19						
2 Jun 06		ΔTF: Suplena @ 50 cc/hr	07						
		for 12 hrs on + 12 hrs off	19						
2 June 06		D5 @ 75 cc/hr	07						
~~2 June~~			19						
2 June		Hold TF but cont water	04						
		bolus QID ℰ ↓ to 100 cc	10						
			16						
			22						
~~3 June 06~~		Lasix 20mg IV QAM	06						
4 June 06									
4 June 06		Suplena @ 30 ml/hr to	07						
	------	clobhoff	19						
05 June 06	(b)(6)	Levophed (Norepinephrine)	07						
		2 mcg/min titrate to	19						
	------	MAP >70							

D/C 2 June 06 2000

D/C 2 June 06 2000

D/C 2 June 06 2000

05 June 06 1400

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS:

GSW to ABD

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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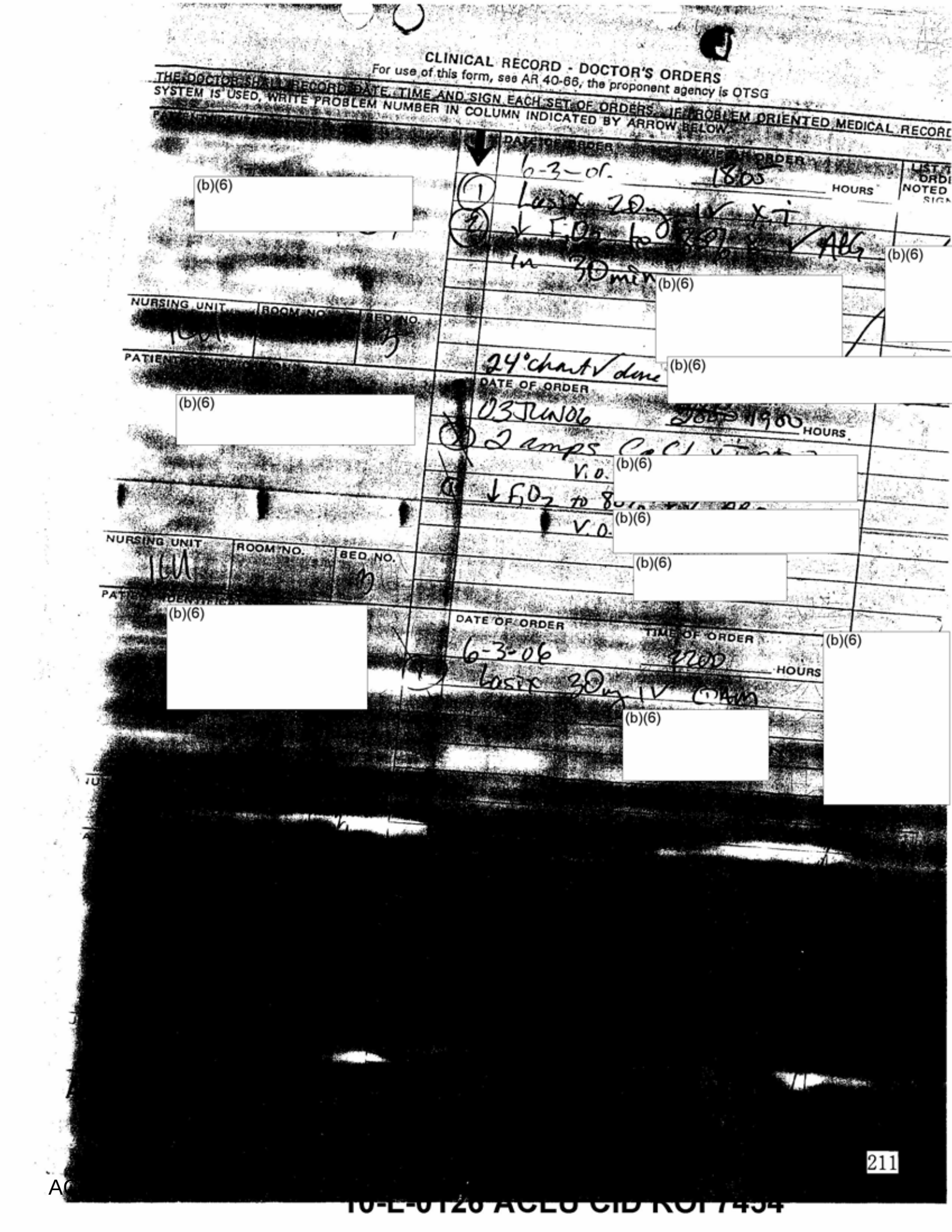
DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 72 WILL BE USED UNTIL EXHAUSTED.

USAPA

(b)(6)


CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG
THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.
DATE OF ORDER
TIME OF ORDER
HOURS
LIST ORDERS NOTED
SIGN
NURSING UNIT
ROOM NO.
BED NO.
PATIENT IDENTIFICATION
6-3-06
1 Lasix 20mg IV x 1
2 ↓ F.O2 to 80% ✓ ABG in 30 min
24° chart ✓ done
03JUN06
2 amps CaCl
V.O.
↓ FO2 to 80%
V.O.
6-3-06
Lasix 30mg IV ONCE
(b)(6)
211
AC
10-L-0126 ACLU CID ROI 7454

NSN 7540-01-075-3786

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

LOG NUMBER	TREATMENT FACILITY
RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* | TIME

TRANSPORTATION TO FACILITY

SEX

AGE

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME					
BP					
PULSE					
RESP					
TEMP					
WT					

LAB ORDERS

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

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED TO

WHEN

I have read and understand these instructions.

PATIENT'S SIGNATURE

EMERGENCY CARE AND TREATMENT *(Patient)*

HH:MM	BPM	%	mmHg			RP
18:16	147	93	14 /	9	10	OF
18:14	147	93	14 /	8	11	OF
18:12	148	93	15 /	8	10	OF
18:10	147	93	15 /	10	11	OF
18:08	147	93	14 /	8	10	OF
18:06	146	93	15 /	7	10	OF
18:04	147	92	14 /	10	10	OF
18:02	147	92	14 /	7	10	OF
18:00	147	92	15 /	6	10	OF
17:58	148	92	15 /	6	10	OF
17:56	148	91	14 /	9	10	OF
17:54	146	89	15 /	6	10	OF
17:52	145	89	14 /	6	10	OF
17:50	146	89	15 /	6	10	OF
17:48	141	88	14 /	6	10	OF
17:46	143	92	13 /	4	8	OF
17:44	[illegible]	93	13 /	4	8	OF
17:42	140	95	13 /	4	8	OF
17:40	137	93	15 /	7	11	OF
17:38	138	88	14 /	7	10	OF
17:36	138	91	12 /	7	10	OF
17:34	139	85	13 /	5	9	OF
17:32	140	88	16 /	6	12	OF
17:30	144	91	16 /	6	11	OF
17:28	144	[illegible]	15 /	5	11	OF
17:26	146	SNSR	12 /	7	9	OF
17:24	146	96	15 /	8	11	OF
17:22	146	96	14 /	5	10	OF
17:20	146	96	14 /	7	11	OF
17:18	146	96	13 /	10	10	OF
17:16	[illegible]	97	13 /	10	10	OF
17:14	[illegible]	97	13 /	9	10	OF
17:12	146	97	15 /	10	11	OF
17:10	144	97	13 /	9	10	OF
17:08	146	97	14 /	6	10	OF
17:06	[illegible]	98	15 /	7	10	OF
17:04	146	98	14 /	6	10	OF
17:02	145	98	14 /	6	10	OF
17:00	145	96	14 /	5	10	OF
16:58	144	96	14 /	6	10	OF
16:56	143	96	14 /	5	10	OF
16:54	143	96	14 /	5	10	OF
16:52	143	96	14 /	5	10	OF
16:50	141	96	14 /	5	10	OF
16:48	141	98	14 /	5	10	OF
16:46	142	100	16 /	7	11	OF
16:44	144	98	17 /	6	13	OF
16:42	120	98	12 /	2	9	OF
16:40	138	98	15 /	7	11	OF
16:38	140	96	16 /	8	11	OF
16:36	143	89	17 /	9	12	OF
16:34	144	85	15 /	8	12	OF
16:32	140	84	16 /	6	11	OF
16:30	[illegible]	[illegible]	17 /	8	13	OF
16:28	[illegible]	[illegible]	16 /	8	12	OF
16:26	[illegible]	[illegible]	17 /	8	13	OF
16:24	[illegible]	SNSR	16 /	7	11	OF
16:22	[illegible]	[illegible]	18 /	9	13	OF
16:20	[illegible]	[illegible]	19 /	9	14	OF
16:18	[illegible]	[illegible]	15 /	5	11	OF
16:16	[illegible]	[illegible]	16 /	4	11	OF
16:14	[illegible]	[illegible]	16 /	7	12	OF
16:12	[illegible]	[illegible]	19 /	8	15	OF
16:10	[illegible]	[illegible]	18 /	8	14	OF
16:08	144	[illegible]	18 /	9	14	OF
16:06	[illegible]	[illegible]	26 /	10	17	OF
16:04	146	[illegible]	19 /	9	15	OF
16:02	143	[illegible]	16 /	7	12	OF
16:00	138	[illegible]	12 /	3	8	OF
15:58	89	[illegible]	18 /	9	14	OF
15:56	50	[illegible]	21 /	11	16	OF
15:54	96	[illegible]	17 /	4	12	OF
15:52	138	[illegible]	18 /	5	12	OF
15:50	125	[illegible]	19 /	9	14	OF
15:48	134	92	14 /	8	11	OF
15:46	138	96	14 /	9	11	OF
15:44	138	93	12 /	9	13	OF

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LAW ENFORCEMENT SENSITIVE

EXHIBIT
213

HH:MM	BPM	%	mmHg	RP
18:16	147	93	14 / 9 (10)	OF
18:14	147	93	14 / 8 (11)	OF
18:12	148	93	15 / 8 (10)	OF
18:10	147	93	15 / 10 (11)	OF
18:08	147	93	14 / 8 (10)	OF
18:06	146	93	15 / 7 (10)	OF
18:04	147	92	14 / 10 (10)	OF
18:02	147	92	14 / 7 (10)	OF
18:00	147	92	15 / 6 (10)	OF
17:58	148	92	15 / 6 (10)	OF
17:56	148	91	14 / 9 (10)	OF
17:54	146	89	15 / 6 (10)	OF
17:52	145	89	14 / 6 (10)	OF
17:50	146	89	15 / 6 (10)	OF
17:48	141	88	14 / 6 (10)	OF
17:46	143	92	13 / 4 (8)	OF
17:44	[redacted]	93	13 / 4 (8)	OF
17:42	140	95	13 / 4 (8)	OF
17:40	137	93	15 / 7 (11)	OF
17:38	138	88	14 / 7 (10)	OF
17:36	138	91	12 / 7 (10)	OF
17:34	139	85	13 / 5 (9)	OF
17:32	140	88	16 / 6 (12)	OF
17:30	144	91	16 / 6 (11)	OF
17:28	144	[redacted]	15 / 5 (11)	OF
17:26	146	[redacted]	12 / 7 (9)	OF
17:24	146	96	15 / 8 (11)	OF
17:22	146	96	14 / 5 (10)	OF
17:20	146	96	14 / 7 (11)	OF
17:18	146	96	13 / 10 (10)	OF
17:16	[redacted]	97	13 / 10 (10)	OF
17:14	[redacted]	97	13 / 9 (10)	OF
17:12	146	97	15 / 10 (11)	OF
17:10	144	97	13 / 9 (10)	OF
17:08	146	97	14 / 6 (10)	OF
17:06	[redacted]	98	15 / 7 (10)	OF
17:04	146	98	14 / 6 (10)	OF
17:02	145	98	14 / 6 (10)	OF
17:00	145	96	14 / 5 (10)	OF
16:58	144	96	14 / 6 (10)	OF
16:56	143	96	14 / 5 (10)	OF
16:54	143	96	14 / 5 (10)	OF
16:52	143	96	14 / 5 (10)	OF
16:50	141	96	14 / 5 (10)	OF
16:48	141	98	14 / 5 (10)	OF
16:46	142	100	16 / 7 (11)	OF
16:44	144	98	17 / 6 (13)	OF
16:42	120	98	12 / 2 (9)	OF
16:40	138	98	15 / 7 (11)	OF
16:38	140	96	16 / 8 (11)	OF
16:36	143	89	17 / 9 (12)	OF
16:34	144	85	15 / 8 (12)	OF
16:32	140	84	16 / 6 (11)	OF
16:30	[redacted]	[redacted]	17 / 8 (13)	OF
16:28	[redacted]	[redacted]	16 / 8 (12)	OF
16:26	[redacted]	[redacted]	17 / 8 (13)	OF
16:24	[redacted]	[redacted]	16 / 7 (11)	OF
16:22	[redacted]	[redacted]	18 / 9 (13)	OF
16:20	[redacted]	[redacted]	19 / 9 (14)	OF
16:18	[redacted]	[redacted]	15 / 5 (11)	OF
16:16	[redacted]	[redacted]	16 / 4 (11)	OF
16:14	[redacted]	[redacted]	16 / 7 (12)	OF
16:12	[redacted]	[redacted]	19 / 8 (15)	OF
16:10	[redacted]	[redacted]	18 / 8 (14)	OF
16:08	144	[redacted]	18 / 9 (14)	OF
16:06	[redacted]	[redacted]	26 / 10 (17)	OF
16:04	146	[redacted]	19 / 9 (15)	OF
16:02	143	[redacted]	16 / 7 (12)	OF
16:00	138	[redacted]	12 / 3 (8)	OF
15:58	89	[redacted]	18 / 9 (14)	OF
15:56	58	[redacted]	21 / 11 (16)	OF
15:54	96	[redacted]	17 / 4 (12)	OF
15:52	138	[redacted]	18 / 5 (12)	OF
15:50	125	[redacted]	19 / 9 (14)	OF
15:48	134	97	14 / 8 (11)	OF
15:46	138	96	14 / 9 (11)	OF
15:44	138	96	14 / 9 (11)	OF
15:42	122	96	14 / 8 (12)	OF

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 214 (b)(

15:34	80	[redacted]	15 /	6	11	OF
15:32	56	[redacted]	16 /	8	12	OF
15:30	55	[redacted]	19 /	8	14	OF
15:28	145	[redacted]	20 /	8	15	OF
15:26	136	89	14 /	1	10	OF
15:24	138	95	15 /	7	11	OF
15:22	137	94	14 /	5	10	OF
15:20	136	93	16 /	6	12	OF
15:18	146	87	17 /	9	13	OF
15:16	140	[redacted]	18 /	6	12	OF
15:14	150	[redacted]	18 /	7	13	OF
15:12	148	[redacted]	18 /	7	14	OF
15:10	141	[redacted]	16 /	1	10	OF
15:08	137	91	14 /	3	9	OF
15:06	129	98	14 /	4	10	OF
15:04	129	97	17 /	13	13	OF
15:02	117	[redacted]	28 /	16	23	OF
15:00	136	[redacted]	36 /	21	28	OF
14:58	128	85	22 /	7	15	OF
14:56	128	93	19 /	7	15	OF
14:54	136	97	19 /	8	14	OF
14:52	134	98	19 /	8	14	OF
14:50	136	98	21 /	8	15	OF
14:48	136	97	20 /	7	15	OF
14:46	136	96	19 /	6	14	OF
14:44	136	97	19 /	6	15	OF
14:42	135	97	19 /	7	14	OF
14:40	135	98	17 /	4	14	OF
14:38	135	97	18 /	6	13	OF
14:36	134	97	18 /	6	14	OF
14:34	134	97	17 /	4	13	OF
14:32	132	97	18 /	3	13	OF
14:30	132	98	17 /	5	13	OF
14:28	131	98	18 /	4	13	OF
14:26	131	98	17 /	3	13	OF
14:24	131	98	17 /	3	13	OF
14:22	131	98	17 /	3	13	OF
14:20	131	97	18 /	5	13	OF
14:18	130	97	17 /	5	13	OF
14:16	128	98	17 /	6	13	OF
14:14	128	98	18 /	6	13	OF
14:12	127	99	19 /	5	13	OF
14:10	128	99	18 /	4	13	OF
14:08	126	99	17 /	4	13	OF
14:06	127	99	18 /	6	13	OF
14:04	127	99	18 /	5	13	OF
14:02	127	99	18 /	4	12	OF
14:00	126	99	17 /	4	12	OF
13:58	126	99	18 /	5	12	OF
13:56	125	99	17 /	2	13	OF
13:54	125	99	18 /	6	13	OF
13:52	126	99	18 /	4	14	OF
13:50	124	100	17 /	3	14	OF
13:48	122	100	18 /	4	13	OF
13:46	121	SNOW	17 /	4	13	OF
13:44	119	100	22 /	9	18	OF
13:42	115	98	25 /	14	20	OF
13:40	117	97	15 /	6	11	OF
13:38	118	98	15 /	6	10	OF
13:36	116	99	14 /	6	10	OF
13:34	114	99	14 /	5	10	OF
13:32	114	100	10 /	0	8	OF
13:30	112	100	10 /	2	8	OF
13:28	105	100	11 /	5	8	OF
13:26	111	100	9 /	0	7	OF
13:24	106	100	12 /	1	7	OF
13:22	105	100	11 /	2	7	OF
13:20	106	100	9 /	3	7	OF
13:18	107	100	10 /	3	8	OF

ADULT

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LAW ENFORCEMENT SENSITIVE

EXHIBIT (b)(6)
215

15:36	144	[illegible]	16 /	7	11	OF
15:34	80	[illegible]	15 /	6	11	OF
15:32	56	[illegible]	16 /	8	12	OF
15:30	55	[illegible]	19 /	8	14	OF
15:28	145	[illegible]	20 /	8	15	OF
15:26	136	89	14 /	1	10	OF
15:24	138	95	15 /	7	11	OF
15:22	137	94	14 /	5	10	OF
15:20	136	93	16 /	6	12	OF
15:18	146	87	17 /	9	13	OF
15:16	149	[illegible]	18 /	6	12	OF
15:14	150	[illegible]	18 /	7	13	OF
15:12	148	[illegible]	18 /	7	14	OF
15:10	141	[illegible]	16 /	1	10	OF
15:08	137	91	14 /	3	9	OF
15:06	129	98	14 /	4	10	OF
15:04	129	97	17 /	13	13	OF
15:02	117	[illegible]	28 /	16	23	OF
15:00	136	[illegible]	36 /	21	28	OF
14:58	128	85	22 /	7	15	OF
14:56	128	93	19 /	7	15	OF
14:54	136	97	19 /	8	14	OF
14:52	134	98	19 /	8	14	OF
14:50	136	98	21 /	8	15	OF
14:48	136	97	20 /	7	15	OF
14:46	136	96	19 /	6	14	OF
14:44	136	97	19 /	6	15	OF
14:42	135	97	19 /	7	14	OF
14:40	135	98	17 /	4	14	OF
14:38	135	97	18 /	6	13	OF
14:36	134	97	18 /	6	14	OF
14:34	134	97	17 /	4	13	OF
14:32	132	97	18 /	3	13	OF
14:30	132	98	17 /	5	13	OF
14:28	131	98	18 /	4	13	OF
14:26	131	98	17 /	3	13	OF
14:24	131	98	17 /	3	13	OF
14:22	131	98	17 /	3	13	OF
14:20	131	97	18 /	5	13	OF
14:18	130	97	17 /	5	13	OF
14:16	128	98	17 /	6	13	OF
14:14	128	98	18 /	6	13	OF
14:12	127	99	19 /	5	13	OF
14:10	128	99	18 /	4	13	OF
14:08	126	99	17 /	4	13	OF
14:06	127	99	18 /	6	13	OF
14:04	127	99	18 /	5	13	OF
14:02	127	99	18 /	4	12	OF
14:00	126	99	17 /	4	12	OF
13:58	126	99	18 /	5	12	OF
13:56	125	99	17 /	2	13	OF
13:54	125	99	18 /	6	13	OF
13:52	126	99	18 /	4	14	OF
13:50	124	100	17 /	3	14	OF
13:48	122	100	18 /	4	13	OF
13:46	121	SNOW	17 /	4	13	OF
13:44	119	100	22 /	9	18	OF
13:42	115	98	25 /	14	20	OF
13:40	117	97	15 /	6	11	OF
13:38	118	98	15 /	6	10	OF
13:36	116	99	14 /	6	10	OF
13:34	114	99	14 /	5	10	OF
13:32	114	100	10 /	0	8	OF
13:30	112	100	10 /	2	8	OF
13:28	105	100	11 /	5	8	OF
13:26	111	100	9 /	0	7	OF
13:24	106	100	12 /	1	7	OF
13:22	105	100	11 /	2	7	OF
13:20	106	100	9 /	3	7	OF
13:18	107	100	10 /	3	8	OF

DULT

0089 06 CID 789 78

Blood vitals

NIBP TREND — 05/31/06

From 1112 - 1605

TIME HH:MM	HR/PR BPM	SpO2 %	SYS / DIA - MAP mmHg	
16:30	116	100	117 / 48	×
16:00	114	100	113 / 46	×
15:30	116	98	109 / 52	×
15:00	118	99	110 / 49	×
14:31	97	98	116 / 52	×
14:01	115	95	129 / 65	×
13:31	110	100	130 / 64	
13:01	109	96	114 / 66	
12:30	102	100	116 / 65	
12:00	107	100	115 / 65	
11:30	111	100	109 / 58	×
11:00	107	100	107 / 54	×
10:51	105	100	109 / 53	
10:30	101	100	SEARCH	
10:00	109	98	112 / 62	
09:30	106	98	100 / 55	
09:17	107	98	103 / 55	
09:00	109	97	99 / 55	
08:61	109	98	96 / 53	

Temps -

ADULT

1112 - 99.5

1200 - 99.8

1315 - 100.0

1400 - 100.2

1605 - 100.3

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EXHIBIT 217 (b)

0089 06 CID 789 78469

APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

	Offense against Civilian(s) [check one]: If "other" then describe:		
	Arson (I.P.C. 342)		Burglary or Housebreaking (I.P.C. 428)
	Solicitation of Fornication/Prostitution (I.P.C. 399)		Extortion/Communicating Threats (I.P.C. 430)
	Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)		Theft (I.P.C. 439)
	Murder (I.P.C. 405)		Destruction of Property (I.P.C. 477)
	Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)		Obstructing a Public Highway/Place (I.P.C. 487)
	Maiming (I.P.C. 412)		Discharging Firearm/Explosive in City/Town/Village (I.P.C. 495)
	Simple Assault (I.P.C. 415)		Riot or Breach of Peace (I.P.C. 496(3))
	Kidnapping (I.P.C. 421)		Other:

X	**Offense against Coalition Forces [check one]:** If "other" then describe:		If "Entering a Known IED site"
	Violation of Curfew		Trespass on Military Installation or Facility
	Illegal Possession of Weapon		Photographing/Surveilling Military Installation or Facility
X	Assault/Attack on Coalition Forces		Obstructing Performance of Military Mission
	Theft of Coalition Force Property		Other:

Apprehending Unit: India, 3/3, RCT 7, I MEF		**Location Grid:** 38SKC	
Date of Incident: (D/M/Y) 14/5/2006	**Time of Incident:** 1430	**Date of Report: (D/M/Y)** 15/5/2006	**Time of Report:** 1845

Detainee # b(6), b(7)(C)			**Other Connected Person:** ☐ Victim ☐ Witness		
First Name:	**Given Name:**		**Last Name:**		
Last Name:			**First Name:** -	**Given Name:** -	
Hair Color: Black	**Scars/Tattoos/Deformities:** none		**Hair Color:** -	**Scars/Tattoos/Deformities:** -	
Eye-Color: Brown	**Weight:** lb	**Height:** in	**Eye-Color:** -	**Weight:** - lb	**Height:** - in
Address: Haditha			**Address:** -		
Place of Birth: unknown			**Place of Birth:** -		
Ethn/Tribe/ Sect: unknown	**Sex:** X M ☐ F	**Phone#:** unknown **DOB D/M/Y:** unknown	☐ Mobile ☐ Regular	**Ethn/Tribe/ Sect:** -	**Sex:** ☐ M ☐ F **Phone#:** - **DOB D/M/Y:** - ☐ Mobile ☐ Regular
☐ Passport ☐ Dr. license ☐ Other (specify)				☐ Passport ☐ Dr. license ☐ Other (specify)	
Document #: -				**Document #:** -	

Total Number of Persons Involved 2 (list names/identifying info on reverse under "Additional Helpful Information")

X **Vehicle Information**	**Vehicle Number** 1 of 1 **Vehicle(s)**		**Owner:** -
Make:	**Color:**	**VIN:** -	
Model: Tractor	**Type:** -	**Plate No.:** -	**Number of People in Vehicle:** -
Year:	**Names of People in Vehicle:** -		
Contraband/Weapons in Vehicle: -			

☐ Property/Contraband ☐ Weapon		**Photo Taken of Suspect with Weapon/Contraband:**	
Type: -	**Model:** -		**Color/Caliber:** -
Serial No.: -	**Quantity:** -	**Make:** -	**Receipt Provided to Owner:** n
Other Details: -	**Where Found:** -		**Owner:** -

Name of Assisting Interpreter: none	**Email, Phone, or Contact Info:**

Detaining Soldier's Name (Print): Timothy Grajco		**Supervising Officer's Name (Print):** John A. Stihnett	
Last, First MI		Last, First MI	
Signature:		**Signature:**	
Email:		**Email:**	
Unit Phone: 3614-808	**Date:** 14/05/2006	**Unit Phone:** 3614-808	**Date:** 14/05/2006

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EXHIBIT 218

0089 06 CID 789 78469

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained?

He was seen digging in a known IED site

Who witnessed this person being detained or the reasons for detention? Give names, contact numbers, addresses.

Sgt b(6), b(7)(C)
LCp

How was this person traveling (car, bus, on foot)?

on tractor

Who was with this person?

no one

What weapons was this person carrying?

none

What contraband was this person carrying?

none

What other weapons were seized?

none

What other information did you get from this person?

none

Additional Helpful Information: 3/3 is rotating out of Iraq on or about 10 Oct 06. Unit can be reached in Hawail at (808) 257-1599

The following two individuals were detained together:

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EXHIBIT 219

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is PMG.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 (SSN).
PRINCIPAL PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately identified.
ROUTINE USES: Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE: Disclosure of your social security number is voluntary.

1. LOCATION	2. DATE (YYYYMMDD)	3. TIME	4. FILE NUMBER
Haditha Dam THA	2006/05/15		

5. LAST NAME, FIRST NAME, MIDDLE NAME	6. SSN	7. GRADE/STATUS
b(6), b(7)(C)	b(6), b(7)(C)	E3/LCpl

8. ORGANIZATION OR ADDRESS: India, 3/3, RCT 7, I MEF

9. I, b(6), b(7)(C), WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

b(6), b(7)(C) Detainees b(6), b(7)(C) Marines - Sgt b(6), b(7)(C) LCpl b(6), b(7)(C) Sgt b(6), b(7)(C) Cpl b(6), b(7)(C)
b(6), b(7)(C)

WHAT: Digging on the side of the road at a known IED location
WHEN: 14 May 06 from 1410 until 1600
WHERE: Southern Part of South Dam Village, 500meters south of the water treatment facility
WHY: This area had previously been used as an IED site to attack Coalition Forces and these men were seen acting suspicious and digging on the side of the road.
HOW: At about 1410, while in a hide site, we observed four men on a tractor and trailer (towed behind the tractor). A man on the trailer threw a rock at one of our mounted surveillance cameras. While the tractor was driving, the trailer that the man was towing behind the tractor came off the tractor in the middle of the road. Two of the men were picked up a couple of minutes later by a taxi from the south. The two remaining men walked south and then returned a couple minutes later with a third man on a second tractor. About one minute later, a taxi arrived and dropped off a tow chain at the broken down trailer, which was then towed off the side of the road by the first tractor. The second tractor then parks just north of the broken down trailer. All of these events took place very quickly (under 10 minutes) with a lot of pre-planed coordination and appear to be a staged breakdown. b(6), b(7)(C)

b(6), b(7)(C) About two minutes later, the two men at the scene b(6), b(7)(C) pull shovels from the trailer and began digging between between the first tractor and the broken down trailer. The third man appeared to be watching the area while the two men continued to dig on the side of the road. The two men dug for about 5 minutes and then stopped, appearing confused and nervous. While they were not digging, the third man went to the first tractor and got an unknown square (6" by 6") object which he placed by the hole. Then the two men picked the shovels up and began digging again, while the third man resumed watching the area. b(6), b(7)(C)

b(6), b(7)(C) Because this was a known IED location and because these men's suspicious activity and because they appeared to be emplacing an IED, we determined this to be hostile activity with hostile intent. Based of our rules of engagement, we determined that we were cleared to engage the men. We observed the area and ensured that there were no other people in the area who might be injured by our shots. The area was clear and we knew we had positive identification of men with hostile activity and hostile intent, so we made 9 well aimed shots at the men. We hit all three of the men and they began fleeing the scene. The men managed to get away, two on foot and one on the second tractor. The time this concluded was 1434. b(6), b(7)(C)

b(6), b(7)(C) At about 1515, a patrol arrived at the hospital and went inside. Once inside, they found two of the men who had been wounded. They were informed that the third man was killed. The men were then flown to Al Asad for medical treatment and detained. b(6), b(7)(C)

10. EXHIBIT	11. INITIALS OF b(6), b(7)(C)	PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF _____ TAKEN AT _____ DATED _____"

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

DA FORM 2823, DEC 1998 DA FORM 2823, JUL 72, IS OBSOLETE USAPA V1.01

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EXHIBIT 220

STATEMENT OF b(6), b(7)(C) TAKEN AT Haditha Dam THA DATED May 15, 2006

9. STATEMENT (Continued)

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

AFFIDAVIT

1 b(6), b(7)(C) 2 . HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE . I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

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

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 15 day of May , 2006

at Haditha Dam, THA

WITNESSES:

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

INDIA, 3/3 RCT 1, 1MEF

ORGANIZATION OR ADDRESS

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

ORGANIZATION OR ADDRESS

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

(Typed Name of Person Administering Oath)

Warrant Officer, USMC

(Authority To Administer Oaths)

Article 136 (b) 4 (b) 6

INITIALS OF PERSON MAKING STATEMENT b(6), b(7)(C)

PAGE 2 OF 2 PAGES

USAPA V1.01

PAGE 3, DA FORM 2823, DEC 1998

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EXHIBIT 221

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is PMG.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 (SSN).
PRINCIPAL PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately identified.
ROUTINE USES: Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE: Disclosure of your social security number is voluntary.

1. LOCATION	2. DATE (YYYYMMDD)	3. TIME	4. FILE NUMBER
Haditha Dam THA	2006/05/15		

5. LAST NAME, FIRST NAME, MIDDLE NAME	6. SSN	7. GRADE/STATUS
b(6), b(7)(C)	b(6), b(7)(C)	E5/Sgt

8. ORGANIZATION OR ADDRESS: India, 3/3, RCT 7, 1 MEF

9. b(6), b(7)(C), WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

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

WHO: Detainees b(6), b(7)(C) b(6), b(7)(C) LCpl b(6), b(7)(C) b(6), b(7)(C), Sgt b(6), b(7)(C) b(6), b(7)(C), Cpl b(6), b(7)(C)
Marines - Sgt b(6), b(7)(C)
b(6), b(7)(C)

WHAT: Digging on the side of the road at a known IED location
WHEN: 14 May 06 from 1410 until 1600
WHERE: Southern Part of South Dam Village, 500meters south of the water treatment facility
WHY: This area had previously been used as an IED site to attack Coalition Forces and these men were seen acting suspicious and digging on the side of the road.
HOW: At about 1410, while conducting observation along River Road, we observed a tractor and trailer, filled with dirt, drive south on River Road. There were four men on the tractor and trailer. While the tractor was driving, one of the men threw a rock at a mounted observation camera placed by Coalition Forces. The trailer broke off the tractor in the middle of the road next to an existing hole on the side of the road. This hole was about 1 meter wide 2/3 of a meter deep. A taxi drove up from the south and picked up two of men from the tractor and trailer and proceeded north on River Road. The two remaining men then walked south out of our sight and returned 2-3 minutes later with a third man on a second tractor. A second taxi showed up and dropped off a chain with the three men. The men used the chain to tow the broken down trailer off the road directly between the observation camera and the hole on the side of the road. They then moved the first tractor south of where the trailer and hole in the side of the road were. All of these events took place in about 10 minutes and seemed very suspicious as if it was a pre planned breakdown. b(6), b(7)(C)

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

The original two men then began to dig in front of the trailer, where it could not be viewed by the observation camera. The third man who arrived on the second tractor acted as their lookout and observed the entire area while they were digging. The men dug for about 5 minutes and then stopped while the third man walked to the first tractor and retrieved a square object (about 6" x 6" x 6") which he then returned to the two men digging and placed beside the hole they were digging. The two men began digging again at this time. b(6), b(7)(C)

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

Because these men were at a know IED site and were clearly displaying hostile action and hostile intent (digging an IED hole and emplacing an IED for use against Coalition Forces), we decided to engage them. Before shooting at the men, we visually checked the area and ensured that there were no other people in the area that might be injured. There were none, so we shot 9 well aimed rounds at the three men. We observed all three men being shot and and injured. The three men fled south away from us and escaped. They fled the scene at 1433. b(6), b(7)(C)

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

At approximately 1520 a patrol arrived at the hospital and found two of the three men inside. They were informed that the third man died of his wounds. The two men were detained and flown to Al Asad for further medical treatment. b(6), b(7)(C)

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT b(6), b(7)(C)	PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ____ TAKEN AT ____ DATED ____"

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

DA FORM 2823, DEC 1998 DA FORM 2823, JUL 72, IS OBSOLETE USAPA V1.01

EXHIBIT 222

STATEMENT OF b(6), b(7)(C) TAKEN AT Hadltha Dam THA DATED May 15, 2006

9. STATEMENT (Continued)

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

AFFIDAVIT

I, b(6), b(7)(C) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

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

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 15 day of May, 2006 at Hadltha Dam THA

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

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

ORGANIZATION OR ADDRESS

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

(Typed Name of Person Administering Oath)

Warrant Officer, USMC

(Authority To Administer Oaths)

Article 136 (b) 4 (b) 6

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

ORGANIZATION OR ADDRESS

INITIALS OF PERSON MAKING STATEMENT BSW

PAGE 2 OF 2 PAGES

USAPA V1.01

PAGE 3, DA FORM 2823, DEC 1998

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EXHIBIT 223

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0089-06-CID259-78469

DETAILS

About 1114, 10 Jun 06, SA [redacted] and SA [redacted] Forensic Science Officer (FSO), 10th Military Police (MP) Battalion(BN) (Airborne)(CID), Camp Victory, IZ, attended the autopsy of Detainee Ibrahim ISMAIL, Internment Serial Number (ISN) [redacted] at Mortuary Affairs (MA), Baghdad International Airport (BIAP). Dr. (COL) [redacted] Chief Deputy Medical Examiner, U.S. Air Force (USAF), Armed Forces Institute of Pathology (AFIP), Dover, MD, conducted the autopsy, and TSGT [redacted] USAF, AFIP, photographed the remains.

About 1214, 10 Jun, 06, Dr. [redacted] rendered the preliminary cause of death as homicide, and the preliminary manner as complications of a gun shot wound to the abdomen.

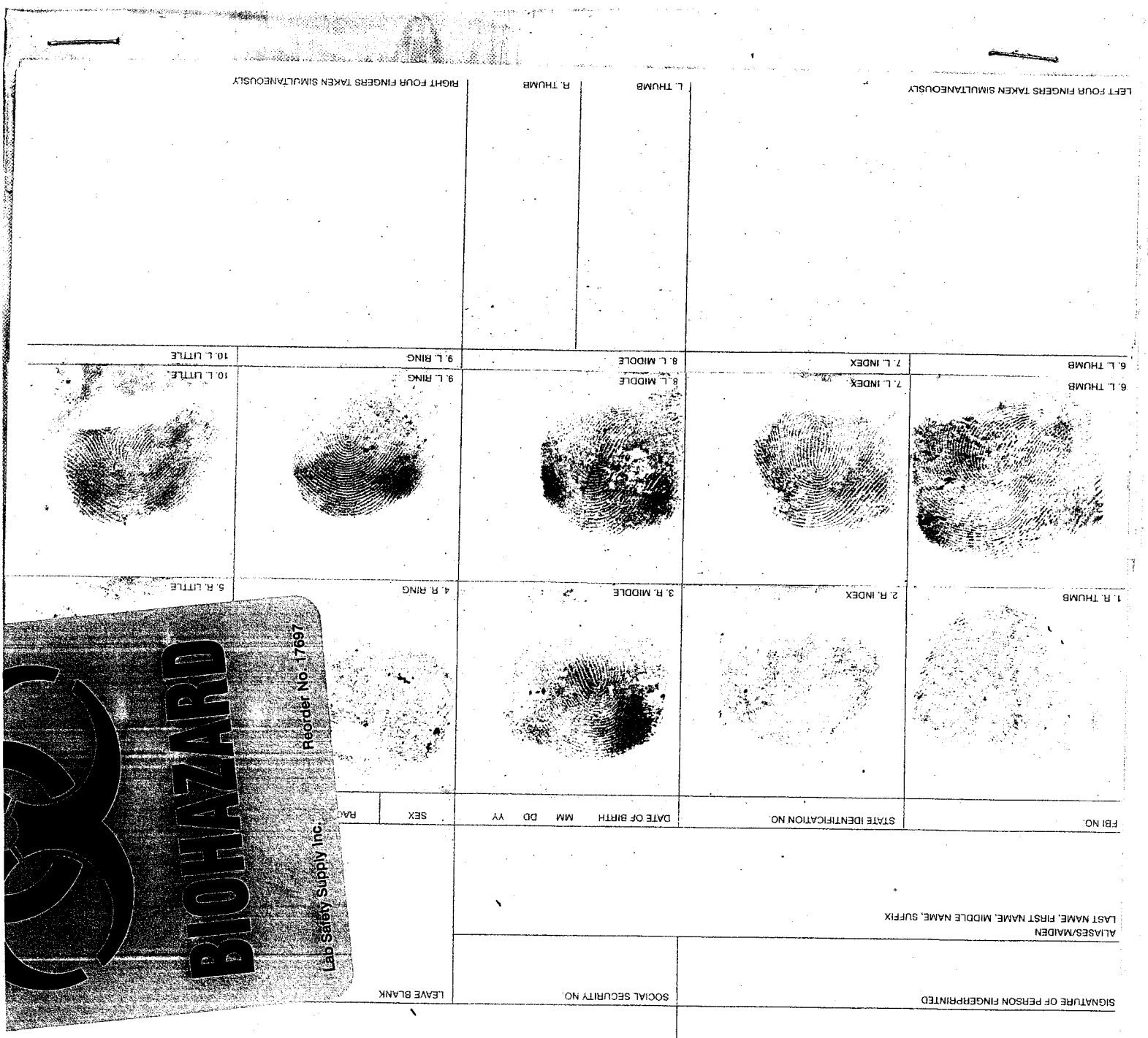
About 1220, 10 Jun 06, SA [redacted] collected the photographic CD ME 06-0490 from TSGT [redacted]

AGENT'S COMMENT: Upon Taking fingerprints of the deceased, it was observed the skin of the deceased's fingers were peeling.

STATUS: No further investigative activity anticipated by this office.///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
(b)(6), (b)(7)(C), (b)(7)(F) [redacted]	76th MP Det (CID) (FWD) Camp Slayer, Iraq APO AE 09342
SIGNATURE	10 Jun 06
	EXHIBIT 6

1 FEB 77


LEFT FOUR FINGERS TAKEN SIMULTANEOUSLY
L. THUMB
R. THUMB
RIGHT FOUR FINGERS TAKEN SIMULTANEOUSLY
6. L. THUMB
7. L. INDEX
8. L. MIDDLE
9. L. RING
10. L. LITTLE
1. R. THUMB
2. R. INDEX
3. R. MIDDLE
4. R. RING
5. R. LITTLE
FBI NO.
STATE IDENTIFICATION NO.
DATE OF BIRTH MM DD YY
SEX
LEAVE BLANK
ALIASES/MAIDEN
LAST NAME, FIRST NAME, MIDDLE NAME, SUFFIX
SIGNATURE OF PERSON FINGERPRINTED
SOCIAL SECURITY NO.
STATE USAGE
LAST NAME, FIRST NAME, MIDDLE NAME, SUFFIX
SUBMISSION
APPROXIMATE CLASS
AMPUTATION
SCAR
NFF SECOND
STATE USAGE
(STAPLE HERE)
LEAVE BLANK
CRIMINAL
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BIOHAZARD
Reorder No. 17697
Lab Safety Supply Inc.

AGENT'S INVESTIGATIVE REPORT

CID Regulation 195-1

ROI NUMBER 0089-06-CID789-78469

Page 1 of 1 pages

BASIS FOR INVESTIGATION:

About 1610, 9 Nov 06, this office received the final Death Certificate and Autopsy Report # ME06-0490, from the Armed Forces Institute of Pathology (AFIP), Office of the Armed Forces Medical Examiner (AFME), 1413 Research Blvd., Bldg 102, Rockville, MD 20850, which listed the cause of death as complications from gunshot wound (s) to the abdomen and the manner of death as Homicide. (See Death Certificate and Autopsy Report for details)///Last Entry///

TYPED (b)(6), (b)(7)(C), (b)(7)(F) SA [redacted]	ORGANIZATION 76th MP Det (CID)(FWD)(-), CCI, APO AE 09342
SI b(6), b(7)(C) [redacted]	DATE 9 Nov 06 / EXHIBIT 9

CID FORM 94-E

(Automated)

PROTECTIVE MARKING IS EXCLUDED FROM AUTOMATIC TERMINATION (Para 13, AR 34-16)

0089 06 CID789 78469

CERTIFICATE OF DEATH *(OVERSEAS)*

Acte dé 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
BTB Ismail, Ibrahim,		Civilian	(b)(6)
ORGANIZATION Organisation	**NATION** (e.g. United States) Pays: Iraq	**DATE OF BIRTH** Date de naissance: (b)(6) 1976	**SEX** Sexe: [X] MALE [ ] FEMALE

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

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

MEDICAL STATEMENT Déclaration médicale

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

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée [X] YES Oui [ ] NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
[ ] NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
[ ] ACCIDENT Mort accidentelle		
[ ] SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste (b)(6)	
[X] HOMICIDE Homicide	(b)(6) DATE Date (b)(6) 2006	AVIATION ACCIDENT Accident à Avion [ ] YES Oui [X] NO Non

DATE OF DEATH Date de décès (le jour, le mois, l'année)	PLACE OF DEATH Lieu du décès
(b)(6) 2006	Iraq

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

NAME OF MEDICAL OFFICER Nom du médecin militaire ou du médecin sanitaire	TITLE OR DEGREE Titre ou diplôme
(b)(6)	Medical Examiner
GRADE Grade (b)(6)	**INSTALLATION OR ADDRESS** Installation ou adresse BIAP, Iraq
DATE Date (b)(6) 06	(b)(6)

[1] State disease, injury or complication which caused death
[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 maniere de mourir, telle qu'un arrêt du coeur, etc
[2] Préciser la condition qui a contribué à la mort mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort

DD FORM 1 APR 77 2064 REPLACES DA FORM 3565, 1 JAN 72 AND DA FORM 3565-R(PAS), 26 SEP 75, WHICH ARE OBSOLETE.

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

EXHIBIT 238 10

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

DISPOSITON OF REMAINS			
NAME OF MORTICIAN PREPARING REMAINS	GRADE	LICENSE NUMBER AND STATE	OTHER
INSTALLATION OR ADDRESS	DATE	SIGNATURE	
NAME OF CEMETERY OR CREMATORY	LOCATION OF CEMETERY OR CREMATORY		
TYPE OF DISPOSTION	DATE OF DISPOSTION		

REGISTRATION OF VITAL STATISTICS			
REGISTRY *(Town and Country)*	DATE REGISTERED	FILE NUMBER	
		STATE	OTHER
NAME OF FUNERAL DIRECTOR	ADDRESS		
SIGNATURE OF AUTHORIZED INDIVIDUAL			

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

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

EXHIBIT 239 10

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

FINAL AUTOPSY REPORT

Name: BTB ISMAIL, Ibrahim
SSAN: (b)(6)
Date of Birth: (b)(6) 1967 (38 years)
Date of Death (b)(6) 2006
Date of Autopsy: 10 JUN 2006, 1100 hours
Date of Report: 16 AUG 2006

Autopsy No.: (b)(6)
AFIP No.: (b)(6)
Rank: Civilian, Iraqi Detainee
Place of Death: Abu Ghraib, Iraq
Place of Autopsy: BIAB Mortuary
Baghdad, Iraq

Circumstances of Death: Mr. Ibrahim Ismail is an Iraqi detainee, who was shot in the abdomen approximately three weeks prior to his demise. The circumstances surrounding the shooting are unknown at this time. The first entry in his available medical records (b)(6) (b)(6) 06, did not address his initial admission or treatment prior to admission to Abu Ghraib Hospital. He developed Sepsis syndrome (Acinetobacter, E-coli, Enterobacter and Candida albicans), Acute Respiratory Distress Syndrome (ARDS) and multi-organ system failure, and died on (b)(6) 06.

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

Identification: Identified by transport documents.

CAUSE OF DEATH: Complications of Gunshot Wound (s) to the abdomen

MANNER OF DEATH: Homicide

EXHIBIT 240 (b)(6)

FINAL AUTOPSY DIAGNOSES:

I. Gunshot Wound (s) to the Torso:

a. No medical records or investigation reports are available at this time.

II. Evidence of Medical Intervention: Medical records starting (b)(6) 06 until (b)(6) 06, with evidence of surgical intervention and prolonged hospital care.

a. Tracheotomy tube
b. Multiple sites of chest tubes
c. Colostomy
d. IV lines
e. Midline abdominal surgical defect.

III. Identifying Marks: No tattoos are noted. Large healed scars (? Burn) are noted of the anterior surfaces of both thighs and extending from the inguinal area to just above the knees.

IV. Natural Diseases: Multi-organ failure and ARDS, consistent with complications of a GSW of the abdomen. No other natural diseases identified within the limitations of the autopsy examination.

V. Evidence: None collected during autopsy.

VI. Toxicology: No testing requested. Patient was hospitalized for approximately three weeks prior to his demise.

VII. Autopsy: Performed in Iraq By (b)(6), assisted by (b)(6) and [(b)(6) Examination started at 1000 hours and concluded at 1200 hours, on 10 June 2006.

EXTERNAL EXAMINATION

The unclad body is that of a well-developed, well-nourished male whose appearance is consistent with an estimated age of 38 years. Lividity is present and fixed on the posterior surface of the body except in areas exposed to pressure. Rigor and temperature of the body are deemed of no forensic significance.

The head and neck reveal no evidence of trauma. The scalp and mustache hair is black. The irides are brownish, and the pupils are round and equal in diameter. The external auditory canals are unremarkable. The nares are patent. The lips and mouth are unremarkable on external examination. The teeth are in fair condition. The neck is unremarkable except for a tracheotomy tube inserted in the midline, and properly positioned.
The chest reveals multiple bilateral incisions (2 on each side), consistent with the site of chest tubes. The abdomen is slightly protuberant (mild obesity), with a large anterior

defect, extending from the xiphoid process to the pubic area, consistent with a non-healed exploratory laparotomy surgical incision. The abdominal defect reveals a severely adhesed internal abdominal organs. A colostomy opening and colostomy bag are noted of the right lower abdominal quadrant. A 4 x 3 ½" defect, of unknown etiology, is noted of the left mid abdomen, exposing underlying internal organs/intestines. The external genitalia are those of a normal circumcised adult male. The testes are descended and free of masses. Pubic hair is present in a normal distribution. The buttocks and anus are unremarkable. The back reveals skin slippage and two large decubitus ulcers (bed sores), but no evidence of trauma.

The upper and lower extremities are symmetric and reveal moderate edema. No evidence of trauma is noted.

Two large scars are noted of the anterior surface of both thighs, extending from the inguinal area down to the knees. No tattoos, other major scars or identifying marks are noted.

CLOTHING AND PERSONAL EFFECTS

None received.

MEDICAL INTERVENTION

The deceased spent almost three weeks under medical care. The body reveals evidence of extensive medical treatment. There are: Nasogastric tube, tracheotomy tube, multiple sites of chest tubes, a non-healed abdominal exploratory laparotomy incision, colostomy bag, and a urinary catheter.

RADIOGRAPHS

Full-body radiographs are obtained for documentation. No skeletal fractures or evidence of projectiles/foreign bodies are noted.

EVIDENCE OF INJURIES

The deceased had a history of gunshot wound, not otherwise specified. Medical history of his initial admission and the early surgical procedures are requested, but not received as of the date of this report.

INTERNAL EXAMINATION

HEAD:
The scalp and subgaleal soft tissues reveal no evidence of trauma. The skull is opened revealing intact dura mater. No intracranial hemorrhage or trauma is noted. Clear cerebrospinal fluid surrounds the 1510-gram brain, which has unremarkable gyri and sulci, but for mild cerebral edema. Coronal sections demonstrate sharp demarcation between white and grey matter, without hemorrhage or contusive injury. The ventricles are of normal size. The basal ganglia, brainstem, cerebellum, and arterial systems are free of injury or other abnormalities. The skull is unremarkable with no cranial or basal fractures. The atlanto-occipital joint is stable.

NECK:
The anterior strap muscles of the neck are homogenous and red-brown, with no lacerations or hemorrhage. The thyroid cartilage and hyoid bone are intact and unremarkable. The pharynx is unremarkable and is lined by intact mucosa. The thyroid gland is symmetric and red-brown, without cystic or nodular change. The tongue is unremarkable. The cervical spine and spinal cord are intact.

BODY CAVITIES:
The pleural and pericardial cavities are unremarkable, with no evidence of trauma or excessive fluid. The abdominal cavity reveals severe adhesions and firm fat necrosis precluding definitive evaluation. The small and large bowels are encased in a firm mass of fat necrosis and fibrous adhesions. The major abdominal organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 1780-grams and 1850-grams, respectively. The external surfaces are smooth and free of adhesions, with no apparent evidence of firearm injuries. Both lungs are extremely heavy and firm. Serial sections reveals extensive consolidation of all lobes with diffuse oozing of yellowish purulent material from the cut surfaces, consistent with pneumonia and ARDS.

CARDIOVASCULAR SYSTEM:
The pericardial sac is intact. The heart is intact and enlarged, cardiomegaly, and weighs 490-grams. The heart is otherwise essentially unremarkable. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution. Cross sections of the vessels show no luminal narrowing or abnormality. Serial sectioning of the myocardium reveals focally mottled cut surfaces, suggestive of possible recent ischemia, but with no clear indication of remote or recent infarctions. The valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.7 cm and 0.5 cm thick, respectively. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels. The aorta and major blood vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 2260-gram liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is mottled tan-brown with a nutmeg appearance. No mass lesions or other abnormalities are seen. The gallbladder contains dark green bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 230-gram spleen has a smooth, intact, red-purple capsule. The parenchyma is maroon and congested, with distinct Malpighian corpuscles and no significant abnormality.

PANCREAS:
The pancreas is severely adhesed to the small and large bowel mass and could not be definitely evaluated.

ADRENAL GLANDS:
The right and left adrenal glands are autolysed, but otherwise unremarkable. Sections through both glands reveal yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys each weigh 220-grams. The external surfaces are intact and smooth. The cut surfaces are red-tan and congested, with mottled cut surfaces and mild loss of normal cortico-medullary demarcation. The pelves are unremarkable and the ureters are normal in course and caliber. Smooth bladder mucosa overlies an intact urinary bladder wall. The bladder wall is slightly hemorrhagic from the placed catheter. 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 is lined by smooth grayish mucosa. The stomach is unremarkable. The gastric wall is intact lined by sloughing autolysed mucosa. The duodenum, small and large bowels are completely encased in a firm mass precluding definitive evaluation.

MICROSCOPIC EXAMINATION

Representative sections of all major organs are obtained and placed in formalin for storage and microscopic examination if needed in the future.

ADDITIONAL PROCEDURES

1. Full body radiographs are obtained and reveal no skeletal injuries or foreign metal fragments.
2. The dissected organs are forwarded with the body.
3. Documentary photographs of the body are obtained.
4. No body fluids or tissue samples are submitted for toxicological testing (the deceased was hospitalized for approximately three weeks prior to his demise).

OPINION

Ibrahim Ismail, a 38 year-old Iraqi civilian detainee, died from complications of a gunshot wound(s). No medical records of the initial presentation and surgical management are available for review. The available medical records reveal a down hill hospital course culminating in his demise, three weeks after his injuries, from ARDS and multi-organ failure. Toxicological testing deemed of no importance and no specimens were submitted for testing. Manner of death is homicide.

(b)(6)

(b)(6)

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