DEPARTMENT OF THE ARMY
U.S. ARMY CRIMINAL INVESTIGATION COMMAND
Camp Bucca CID Office
CAMP BUCCA CID OFFICE, 3D MILITARY POLICE GROUP (CID), Camp Bucca, Umm Qasr, Iraq, APO AE, Iraq

14 Aug 2007

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - FINAL (C)/SSI - 0024-2007-CID579-24072 - 5H9B

DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 21 JUN 2007, 2055 - 21 JUN 2007, 2107; EMERGENCY ROOM, THEATER INTERNMENT FACILITY (TIF), CAMP BUCCA, APO AE 09375, IRAQ

DATE/TIME REPORTED: 21 JUN 2007, 2130

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

SUBJECT:
1. UNKNOWN, ; [UNDETERMINED MANNER OF DEATH] (NFI)

VICTIM:
1. KHUDAYIR, WALID (DECEASED); IRAQ; 31 DEC 1976; BAGHDAD, IRAQ; MALE; OTHER; INTERNMENT SERIAL NUMBER (ISN) (b)(2),(b)(6),(b)(7)(THEATER INTERNMENT FACILITY (TIF) HOSPITAL, CAMP BUCCA, APO AE 09375, IZ; XZ ; [UNDETERMINED MANNER OF DEATH]

INVESTIGATIVE SUMMARY:

"This is an Operation Iraqi Freedom Investigation"

b(2), b(6), b(7)(C)

About 2130, 21 Jun 07, this office was notified by Dr. (CPT) (b)(6),(b)(7)(C) attending physician, 31st Combat Support Hospital (CSH), Theater Internment Facility (TIF), Camp Bucca, of a detainee who died while being transported via US Army Air Ambulance from the medical facility at Camp Cropper, Iraq, to the TIF Hospital, Camp Bucca, Iraq.

Investigation revealed that on 26 May 07, Detainee KHUDAYIR was admitted to the 31st CSH, International Zone (IZ), Baghdad, Iraq for injuries sustained during combat actions against U. S. Forces, Coalition Forces, and the Iraqi Army. On 21 Jun 07, Detainee KHUDAYIR was transferred to the TIF Hospital, Camp Bucca for further medical treatment. During transport to Camp Bucca, Detainee KHUDAYIR went into cardiac arrest, at which time, medical personnel began Cardiopulmonary Resuscitation (CPR). At 2107, 21 Jun 07, Dr. Beckwith pronounced Detainee KHUDAYIR dead.

On 28 Jun 07, CPT (b)(6),(b)(7)(C) Staff Judge Advocate (SJA), Operational Law Attorney, Camp Striker, conducted a legal review surrounding the circumstances of Detainee KHUDAYIR's injuries. CPT (b)(6),(b)(7)(C) opined there were no Rules of Engagement guidelines violated.

An autopsy will not be conducted. On 23 Jul 07, the remains of Detainee KHUDAYIR were released to the Ministry of Health, Iraq.

STATUTES:

N/A

EXHIBITS/SUBSTANTIATION:

Attached:

1. Agent's Investigation Report (AIR) of SA (b)(6),(b)(7)(C) 4 Jul 07.

2. Photographic Packet (Victim).

3. CD containing original images associated with Exhibit 2. (USACRC, USACIDC, and file copy only)

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

4. Hospital Report of Death, 21 Jun 07, pertaining to Detainee KHUDAYIR.

5. Medical Records pertaining to Detainee KHUDAYIR, various dates.

6. Capture Documents pertaining to Detainee KHUDAYIR, various dates.

7. Memorandum For Record, 28 Jun 07, pertaining to the legal review conducted surrounding the injuries sustained by Detainee KHUDAYIR.

Not Attached:

None.

The original of Exhibits 1 thru 3 are attached to the USACRC copy of this report. The original of Exhibits 4 and 5 are retained in the files of the Patient Administration Division, TIF Hospital, Camp Bucca, Iraq. The original of Exhibit 6 is retained in the files of Headquarters and Headquarters Battery, 2/15 Field Artillery, 2nd Brigade Combat Team, 10th Mountain Division, Camp Striker, Iraq. The original of Exhibit 7 is retained in the files of the Staff Judge Advocate, 2nd Brigade Combat Team, 10th Mountain Division, Camp Striker, Iraq.

STATUS: This is a Final (C) report. This investigation was terminated in accordance with CIDR 195-1, Section V, para 4-10 a (5) in that the supported SJA is of the opinion that additional investigation would produce only cumulative and unneeded evidence, and that the identification of additional subjects or offenses is unlikely. Leads Remaining: Autopsy of Detainee KHUDAYIR remains. Commander's Report of Disciplinary or Administrative Action (DA 4833) is not required.

Report Prepared By:

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

Special Agent

Report Approved By:

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

Special Agent in Charge

DISTRIBUTION:
1-Dir, USACRC, Ft Belvoir, VA
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1-Forensic Science Officer
1-CAMP BUCCA CID OFFICE, 280th MP DET (CID), UMM QASR, IRAQ, APO AE 09375
1-STAFF JUDGE ADVOCATE, CAMP BUCCA, UMM QASR, IRAQ, APO AE 09375
1-FILE

AGENT'S INVESTIGATION REPORT *CID Regulation 195-1* [redacted]	ROI NUMBER 0024-07-CID579-24072 PAGE 1 OF 1 PAGES

BASIS FOR INVESTIGATION: About 2130, 21 Jun 07, this office was notified by Dr. (CPT) b(6), b(7)(C) b(6), b(7)(C) attending physician, 31st Combat Support Hospital (CSH), Theater Internment Facility (TIF), Camp Bucca, of a detainee who died while being transported via air ambulance from the medical facility at Camp Cropper, Iraq to the TIF Hospital at Camp Bucca.

About 2155, 21 Jun 07, SA b(6), b(7)(C) this office, interviewed Dr. (CPT) b(6), b(7)(C) who stated he was in the TIF Hospital Emergency Room (ER) when Detainee Walid KHUDAYIR, Internment Serial Number (ISN): b(6), b(7)(C) arrived from Camp Cropper. Dr. b(6), b(7)(C) stated Detainee KHUDAYIR had suffered cardiac arrest and died en route to Camp Bucca from Camp Cropper where he was being treated for injuries sustained during combat actions against U.S, Coalition Forces, and the Iraqi Army since 26 May 07. Detainee KHUDAYIR was unresponsive with signs of lividity when he arrived. Death was confirmed by Auscultation, monitored A Systole, and Ultrasound. Dr. b(6), b(7)(C) pronounced Detainee Walid KHUDAYIR dead at 2107, 21 Jun 07.

About 2200, 21 Jun 07, SA b(6), b(7)(C) exposed digital photographs of the remains of Detainee KHUDAYIR, while in the ER, TIF Hospital, Camp Bucca, using a Nikon Coolpix 995 digital camera. (See Photographic Packet for details)

About 1400, 22 Jun 07, SA b(6), b(7)(C) obtained the medical records of Detainee KHUDAYIR from the Patient Administration Division (PAD), TIF Hospital, Camp Bucca. A review of the medical records revealed they contained the Hospital Report of Death and all medical records dating back to 26 May 07, while Detainee KHUDAYIR was receiving treatment at the Camp Cropper medical facility. The Hospital Report of Death listed the cause of death due to consequences of multiple trauma likely pulmonary embolisms, multiple trauma, and multi-system organ failure. (See Hospital Report of Death and Patient Medical Records for details)

About 1400, 24 Jun 07, SA b(6), b(7)(C) received various documents pertaining to the capture of Detainee KHUDAYIR from SA b(6), b(7)(C) Camp Cropper CID Office. These documents include a Coalition Apprehension Form, Sworn Statement of 1Lt b(6), b(7)(C) HHB, 2-15th FA, Sworn Statement of SSG b(6), b(7)(C) HHB, 2-15th FA and a Sworn Statement of Mr. (b)(6), (b)(7)(C) which was translated into English. (See various capture documents for details)

About 1900, 4 Jul 07, this office received legal review from CPT b(6), b(7)(C) Staff Judge Advocate (SJA), Camp Striker, pertaining to the death of Detainee KHUDAYIR. (See Legal Review of Death of Detainee KHUDAYIR for details)

//LAST ENTRY//

TYPED AGENT'S NAME AND SEQUENCE NUMBER SA (b)(6), (b)(7)(C), (b)(7)(F)	ORGANIZATION 280th MP Detachment(CID), Camp Bucca, APO AE 09375	
b(6), b(7)(C)	DATE 4 Jul 07	EXHIBIT

HOSPITAL REPORT OF DEATH

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

NAME AND LOCATION OF HOSPITAL: 31st CSH Camp Bucca, Iraq APO AE 09375

Instructions - Medical Officer in attendance will:

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

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

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

0024 07 CID579 24072

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*
ALI, WALEED
DOB: 01 JAN 1976
DETAINEE

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

2. TIME OF DEATH *(Hour-day-month-year)*
(b)(6) 2007

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

4. RELIGION
UNKNOWN

5. CHAPLAIN NOTIFIED
☐ YES ☒ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH
NONE

CAUSE OF DEATH

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

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. (b)(6) NDANCE
(b)(6) 07	(b)(6)	

SECTION B - ADMINISTRATIVE ACTION

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

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☐ NO	21. AUTOPSY ORDERED BY *(Signature)*
22. PROVISIONAL PATHOLOGICAL FINDINGS	
23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY / 25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
26. DATE	27. TYPED NAME AND GRADE OF REGISTRAR / 28. SIGNATURE OF REGISTRAR

DA FORM 3894, OCT 72 REPLACES DA FORM 3-25-7, [illegible] WILL BE USED. USAPA V2.01

FOUO

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES 0024 07 CID579 24072
2Jun07 1245	Nurses Transfer Note: Pt pending transfer to Bucca at 1600. Pt states understanding of reason for Discharge. Pt prepared for Discharge

(b)(6)

(b)(6)

FOUO

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

10-L-0126 ACLU DDII CID ROI 21177

ACLU-RDI 5546 p.7

000043

EXHIBIT 5

0024 07 CID579 24072

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20Jun07 0830	Pt resting in bed. NAD pt drowsy. Vss elevated. Pt communicating (indistinct) one letter words and use of sign language. eyes closed. assessment simple bill flowsheet for details. will continue to monitor. (b)(6)
21Jun07 0000	Pt resting in bed on right side. NAD VSS. no other changes in physical assessment. will continue to monitor. (b)(6)
21Jun07 0600	Pt on regular diet: breakfast not needed. Pt brushed own teeth. minimal assistance given. on left side. WBC 18.9 HH 11.9, 37.0. continue oxygen via mask. antibiotic no other changes in physical assessment. (b)(6)
21Jun07 0925	Nurses Note: Assumed care of pt at 0700. Pt had bout of vomiting after breakfast at 0730. Pt desated to 88% after emesis. O_2 titrated up to 4 L NC to maintain sats above 95%. will continue to monitor. (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		
	Cropper			
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	

PROGRESS NOTES
Medical Record

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

USAPA V1.00

EXHIBIT 5

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
20Jun07 1115	Nurses Note: Pt OOB to chair 12.10. Will continue to monitor (b)(6)
20Jun07 1330	Rehab Note S: Seenby Rehab Service for ROM to (R) and (L) Upper and lower extremities. Pain 3/10 to LUE. Foley in place. Ward pt upon O: Treatment provided: A/PROM to (R) and (L) Shoulder ext/flex, shoulder Abd/add, Elbow ext/flex, forearm sup/pron, wrist ext/flex, Digit ext/flex. (upper extremities). (Lower Extremities): Hip abd/add, Hip ext/flex, Knee ext/flex, Ankle dorsiflexion/plantarflexion, Hip rotation. A: ↑ ROM, ↑ muscle Strength. P: Continue plan of Care. ↑ sto (b)(6) upheld off SP
20Jun07 1345	Nurses Note: Report Given to (b)(6) Pt resting quietly c no c/o pain. V.S.S. (b)(6)
20Jun07 1400	Report received from (b)(6) Pt assessed while in wheelchair. Awake, cooperative. Denies pain, appears tired. ~~MAE x 4 spontaneously and on command.~~ Generalized weakness, requiring assistance to transfer into and out-of bed. ST @ 134 c ectopy. Pulses palpable @ +2 bilaterally. Generalized

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

(over)

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.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
(Cont.)			0024 07 CID579 24072

DATE	NOTES

20Jun07@1400 edema; dependent edema, pitting in both feet. Capillary refill < 3 sec. Skin is warm, dry, pink and appropriate for ethnicity. Lungs Clear in anterior lobes, bibasilar fine crackles Ⓡ > Ⓛ side. Occas. nonproductive cough. Breathing is even, mildly tachypneic, R= 25. Bowel sounds Ⓟ x 4 quadrants. Denies nausea. Abdomen soft, nontender except to deep palpation, obese. Colostomy RUQ of abdomen c formed stool - light brown in small-moderate amt. Foley catheter to gravity draining clear, dark yellow urine in sufficient quantity. O2 @ 1 LPM via NC where SaO2 @ 100%. Midline abdominal wound, LUQ of abdomen wound have dressings connected to Wound-Vac c pink tan drainage in small amt. Ⓡ elbow c dressing dry & intact. Ⓟ upper back c several small areas of excoriation that is healing, scabs in place. No breakdown on other areas of shoulders or back. Ⓟ FA PIV (20ga) site S redness or swelling → dsg C/D/I. Both heels c areas that have dark tan callouses/areas that are tender. Keeping heels off bed c blankets when pt in bed. (b)(6)

20Jun07@1500 Pt. given bath while in chair. Removed old sutures from Ⓛ lateral chest wall (old chest tube site). Scabs on posterior head, cleaned c soap/H2O and Bacitracin ointment. Foley care provided. Clean bed linen and gown provided, transferred to bed c assistance from two nurses. Weak, unsteady gait, and high fall risk. Bedrails up and locked x2. (b)(6)

20Jun07@1730 Raised HOB to 25-30° to position pt. to eat. Consumed only 10% of meal. Able to drink 8oz. of Mango juice c some coughing but tolerating p.o. fluids better. Denies any pain- (b)(6)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19Jun07@1510	Reassessed pt. and has no significant changes since earlies exam. Vital signs stable, ST@ 107 ☒ ectopy. ☒ FA PIV site remains patent; no redness or inflammation noted. —(b)(6)
19Jun07@1730	Repositioned onto back, ↑ HOB to 30°. Denies pain. —(b)(6)
19Jun07@1815	Assisted pt. to eat evening meal. Consumed 20% of meal. Became nauseated, and vomited meal. Cleaned pt., shall consult (b)(6) —(b)(6)
19Jun07@1855	(b)(6) ordered and R.N. gave Reglan 10mg, IV@1870 hrs followed by Zofran 8mg, IV@1825 hrs. HOB @ 30°, moved up in bed. —(b)(6)
19Jun07@1900	Report given to nurse assuming care of pt. —(b)(6)
19 Jun07@ 1900	(b)(6) Pt recieved from ☒ @ 1900 Pt in stable condition, VSS BP 140/77 HR 125 elevated, RR-22, Temp-97.2 O2-99% 2L NC 206 ☒ FA 1/2 NS 5 ml/hr Pt on left side, Pt resting no pain ✓ during assessment Pt seems very ~~tired~~ tired and sleepy will cont to monitor during shift —(b)(6)
19 June 07	Pt asked for hair-cut via Interpreter ask for hair to be short all over similar to ~~from~~ for example ☒ Back

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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10-L-0126 ACLU DDII CID ROI 21181
EXHIBIT 5
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0024 07 CID579 24072

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(b)(6), pt given haircut and bathed – linen changed and oral care done pt in wheelchair for about 40 mins then back to bed will cont to monitor (b)(6)
20 Jun 07 0712	Nurses note. Assumed care of pt at 0645. Report recieved from (b)(6). Pt resting quietly in bed & NAD c/o pain will continue to monitor. (b)(6)
0904.	Nurses note: Pt tolerated 50% of breakfast & nurse. will continue to monitor.
	(b)(6)
20 JUN 07	IMPN
0945	S: No complaints ✕ headache; Vomited yesterday. Appetite good
	O: Tmax = 100.2 (Axy) 137/82 96-115 14-18 Sats 94-97 (2L)
	① alert; NAD ④ card- soft; NT; no S3; Nec in place.
	② Heart- RRR ⑤ Ext ⑥ edema- ⑦ Integ
	③ Resp. CTA
	Labs: 21.7 > 11.6 < 429 151 | 113 < 32 (108) / 4.6 | 26 (2.4) CXR ↑ improved, Still c RLL consolidation
	A/P: ① S/P GSW ⇒ Immunizations for splenectomy when stable
	② Pulmonary - Clinically, pt aspirated. Still has O2 requirement. Cont Ceftriaxone, Flagyl
	③ GI - R/O No abd discomfort or pulpations. Stable.
	④ ARF - Resolving. Pt may have mild CRI.
	⑤ Rehab - Myopathy ongoing. Cont PT/OT.
	⑥ Nausea - Start Reglan (b)(6)

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MEDICAL RECORD | PROGRESS NOTES 0024 07 CID579 2407

DATE	NOTES
19Jun07@0730	Report received from (b)(6) Pt. assessed, aware, has mild discomfort c repositioning. Pupils 4mm and brisk to light. Moves all extremities, able to overcome gravity and resistance, but has generalized weakness, LE > UE. Speech is clear, tongue midline. ST@ 110 c ectopy. Generalized edema @ lt, hands and feet @ 2+ but improving. Capillary refill < 3 sec. lungs CTA bilaterally. O_2 @ 2LPM via NC where SaO_2 @ 99%. Breathing is even, nonlabored; R=20-24. Nonproductive cough occassionally. Bowel sounds in upper quadrants, distant in lower quadrants. Abdomen soft, distended, obese, mildly tender on palpation. RUQ colostomy c small amt. of dark brown, formed stool; stoma is pink c uneven symmetry around skin surface. Foley catheter to gravity draining clear, yellow urine in sufficient quantity. (L) FA PIV (20 ga) s redness or inflammation → dressing CIDI. (R) upper back c improving small areas of excoriation - dressing dry + intact. (R) Elbow dressing CIDI. Midline abdominal incision and LUQ abdomen wounds c Wound-vac in place draining pink/tan-colored drainage in small quantity. (b)(6)
19Jun07@0800	ROM c arms/hands and legs/feet using flexion/extension/rotation clockwise + counterclockwise x10 reps. Pt. tolerated well, denies pain on reassessment. Given a small peeled/cut orange and 4oz (120mL) of milk and 4oz (120mL) of H_2O s difficulty swallowing.

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

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

(over →)

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.

PROGRESS NOTES
Medical Record

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EXHIBIT 5

0024 07 CIC579 24072

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Cont.)
19Jun07@0800	Given fluids c Thickener stirred/mixed to minimize aspiration risk. Pt. did well and did not cough or gag when drinking fluids. HOB was placed @ 35-40° prior to assisting c meal. (b)(6)
19Jun07@0845	Washed pt.'s face, shaved per pt.'s permission. No nicks or cuts noted. Tolerated well s discomfort. Reclined HOB to 25° for comfort. (b)(6) here to see pt. earlier, no new orders. (b)(6)
19Jun07@1015	ROM exercises as per earlier description. Pt. assisted to sit, dangle @ bedside x 3-4 minutes. Able to stand c moderate assistance and pivot to sit in wheelchair. Pt. tolerated well, transfer s incident. (E) upper back wound → abrasions dry and forming scabs, very superficial - epidermal layer, s drainage. Changed wound-vac cartridge per machine message. Only 50 mL of drainage from 0600-1000 hrs → pink/tan-colored fluid. Placed on O_2 @ 1LPM via NC where SaO_2 @ 96%. Breathing is even, nonlabored. Assisted pt. to put on disposable short pants to cover genitalia while ambulating or sitting. (b)(6)
19Jun07@1115	Pt. has clear breath sounds in all fields, (b)(6) has slightly diminished breath sounds. RRT @ bedside to encourage use of incentive spirometer. IS @ 750mL x 10 reps per (b)(6)
19Jun07@1200	Washed pt.'s hair while sitting in wheelchair. Washed face and lips per pt.'s request. No change in assessment since this A.M. Vss, ST @ 123 s ectopy. Good U.O. via foley > 100 mL/hr. Denies pain. (b)(6)
19Jun07@1300	Pt. vomited moderate amt. of milk/corn/water onto self and floor. Cleared pt and offered H_2O to rinse mouth. Denies further nausea. (b)(6)
19Jun07@1320	Assisted pt. to return to bed. Moderate amt. of lifting to get into bed, appears fatigued. Fell asleep within minutes, raised HOB to 20° for comfort. Tolerated transfer s difficulty. (b)(6)

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 JUN 07 0833	IMPN S: No complaints. (A) thirst, Notes cramp (B) lower abd. pain ± spasm O: T_{MAX} = 100.2 (AX) yesterday @ noon P= 102-125 BP= 113-130 / 70-85 R= 18-24 SAT: 97-99% I/O = +1145 (po- 180) (1) alert, NAD (2) Heart - RRR (3) Lungs ↓ BS @ (L) lat (4) abd - soft; NT; Ø masses. Nau in place (5) Ext - Hands ± 2+ edema; Ø LE edema (6) Musc - ↑ ROM of (B) UE ⇒ especially flexion Still unable to fully flex (A) foot Labs: 22.4 / 10.2 / 38 — 156 / 114 / 36 — 4.0 / 23 / 2.02 LFTs WNL CXR - none today

A/P: (1) SIP GSW ⇒ (L) diaphragmatic injury, partial gastrectomy, splenectomy, transverse colectomy ± colostomy. Immunizations this week when apparent infection resolved.

(2) Pulmonary - Clinically, pt aspirated. CXR may be normal in aspiration, but fever, ↑WBC, ↑ O_2 requirement argues for pulmonary process. Cont Ceftriaxone / Flagyl. √ CXR tomorrow. Aspiration precautions

(3) GI - Clinical peritonitis resolving. Cont Flagyl

(4) (Cont)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

(b)(6)

0024 07 CID579 24072

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Cont)
	(4) ARF - Continue to improved. Cr = 2.2 today. Re-adjust med dose
	(5) Myopathy - Resolving. √ Methyle-8 Tomorrow
	(6) Rehab Cont PT/OT. (b)(6)
19 June 07	Rehab Services
1200	S: Seen by Rehab services this AM for ADL training. Up to chair per nursing staff. Pain 2/10 to abdominal wound. Wound vac in place O: ADLs - eating setup. ROM exercise - hand, fingers, and elbow, shoulder 10 reps ā min A. Currently wearing Edema glove for edema. Transfers ō mod A. Chair<>bed. A: ↑ ADLs, ↑ endurance ↑ mobility. Pl Continue plan of care. ↑ mobility, ↑ ambulation. (b)(6)

EXHIBIT 5

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MEDICAL RECORD | **PROGRESS NOTES**

0024 07 CID579 24072

DATE	NOTES
18SUN07 1245	Nurses Note: Pt c/o pain to abdomen at 1200. Given Morphine 4mg I.V. by CRT Herrick processed 1240 Pt states no pain present. will continue to monitor. Sp (b)(6)
18 Jun 07 1430 Pt Note	Pt on 2L NC, sats 99%, BS scat rales b/lat. Pt given tx of Alb/Atr via Cam/Neb HR 123/125/125 BP 136/84 | 138/80 | 133/82 RR 22/23/22 Sats 99/100/99. Ab A to BS after tx No adverse reactions (b)(6)
18SUN07 1810	Nurses Note: Pt placed back in bed at 1500. Pt tolerated greater 50% of lunch Pt received dinner tray. Pt tolerated 3 hours OOB & ambulated pt fatigue. will continue to monitor (b)(6)
18JUN07 1900	Received report from previous nurse. Pt. currently sitting ↑ in bed eating an orange C no difficulty. VSS. Will monitor and assess. Will report Δs as they occur. (b)(6)
1925	Assessment completed. See ICU flowsheet. (b)(6)
2300	~~Dressing to (R) elbow removed. Pressure looks much better than~~ several days ago. Currently ~ Quarter size C inside yellow colored purulent tissue surrounded by red beefy-looking

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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IW #7.

10-L-0126 ACLU DDII CID ROI 21187

ACLU-RDI 5546 p.17

0024 EXHIBIT 5

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18JUN07 (continued from front)	tissue. No necrotic tissue noted. Very small amount serous drainage on dressing. Covered c̄ Telfa and tape. Pt. tolerated s̄ difficulty. ——— (b)(6)
18 Jun 07 2230	Pt on 2L NC Sat 99. Pt received alb/atro neb tx. Tolerated tx well w/o adverse reactions. 105 130/78 19 98, 103 18 BO, 107 19 E 97. Pulls 500ml insp. vol [illegible]. Will cont. to BS CTA monitor pt wean off O2. (b)(6)
2345	Pt. requested (pointed out) Ensure & cereal to eat. RN mixed them together + added Thick & Easy for pudding consistency. Pt. ate 5-8 bites by feeding self c̄ Ⓡ arm using spoon. No crushing, no signs of aspiration noted. HOB was ↑ 75°. (b)(6)
19JUN 0020	Colostomy emptied. 40cc soft, non-liquid tan stool out. Pt. ~~reassessed~~ emic (b)(6) reassessed and no acute Δ's noted from previous assessment. Pt. turned Q2' to prevent bed sores. VSS ——— (b)(6)
19Jun07 0640	Pt received alb/atro neb. Tolerated tx well w/o adverse reactions. 99 137/82 18 97 91 131/82 15 100. BS CTA. [illegible] 500 ml. Pt [illegible] NC 2L Sats 99. (b)(6)
~~0405~~	~~Pt. reassessed c̄ no acute Δs noted. Sleeping quietly. VSS,~~ afebrile. ——— (b)(6)
0500	Bath/po care completed. Pt able to wash face himself c̄ minimal assistance. Linens Δ'd. ~30cc soft tan stool out colostomy. Labs drawn & sent to lab (b)(6)

0024 07 C1D579 24072

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MEDICAL RECORD	PROGRESS NOTES

DATE

NOTES

18Jun07 0950

PM note

S: Pt has no complaints. He denies any pain.

O: 139-154/76-93 P 103-123, 15-32RR, 96-100% on 1½ L NC.

Gen: NAD. Resting comfortably. Answers questions appropriately. I/O 2455/5650 (-3195)

HEENT: TMs wnl. Nares wnl. Throat: Ø erythema. Ø Exudates.

Neck: ØLAD

Heart: RRR

Lungs: ⊕ Bibasilar rales R>L

Abd: Soft, NT, (+)BS. Wound: Ø erythema, Ø Pus.

Ext: UE 2+ edema (hands to FA) B/L.

Neuro: Pt can move all extremities.

Labs: 21.0↘ 31.7 / 10.9 / 34.0 < 407

157 / 4.6 | 115 / 24 | 43 / 2.5 < 100 (+2.7)

AST 48 ALT 36 T5'li: 0.6 AP 99

Bld Cx (14Jun07) → NGTD (17Jun07) → ⊕

CXR (17Jun07) ↓ lung volumes ↑ ⊕ basilar air space opacity. No definitive new opacities or pleural effusions

A/p ① S/P GSW, immunizations when stable

② Pulm: CXR on 17Jun07 c/w chronic atelectasis.

Nurse to have pt use IS q hr. Pt c suspicion for aspiration, ceftriaxone started.

③ CV: stable

④ GID: Pt on Flagyle D#17 for peritonitis

⑤ Renal: ARF continues to improve. Cont to monitor electrolytes, On ½ NS.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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10-L-0126 ACLU DDII CID ROI 21189

ACLU-RDI 5546 p.19

ICU #3

000055 EXHIBIT 5

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
		L	C 1 579 24072

DATE	NOTES
	FP Note cont
18Jun07 0950	⑥ TO: Pt's WBC ↑. Pt developed fever (102F) last night, was started back on levofloxacin. There was suspicion for asp pneumonia. Levofloxacin d/c'd and pt started on ceftriaxone. Source of infection: GI vs Lungs vs Urine. Would V/Q, but pt received levofloxacin and ceftriaxone. Ceftriaxone covers E.coli, Cont Ceftriaxone for now. Also on Flagyl. ⑦ Rehab: Cont PT/OT. No THIN LIQUIDS ⇒ Pt at risk for aspiration. (b)(6)
18Jun07 1230	Rehab Services Progress S: Seen by OT/PT service for transfer training and ADLs. Pain 2/10 to abdomen. Currently c wound vac and IVs
Transfer	O: Transfers c mod A bed to ~~sit to~~ sit → stand: mod A
Eating	for chair transfer. Up to chair for eating - Set-up/supervision required. A: ↑ ADL and ↑ transfers P: Continue plan of care. (b)(6)
18Jun07 1240	Nurses Note: Pt reassessed. No changes from previous assessment. Pt OOB to chair at 1200. Pt able to feed self c minimal assistance. Pt tolerating regular diet c thickened liquids well. Will continue to monitor. (b)(6)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17Jun07 1530	Nurses Note: Pt washed c̄ soap and water at 1430. Central line DC'ed. 20g @ FA. Peripheral IV started. will continue to monitor. Tem (b)(6)
17Jun07 1830	Nurses note: Pt T 102.4 ~~los Onne~~ Dr myhand page then 650mg Tylenol given PO. Blood cultures drawn x2. CXR done. will continue to monitor.
	(b)(6)
17 Jun 07 2135 RN note	Pt rec'd 1400 Alb/Atrovent tx BP 142/83 / 142/83 / 142/83, HR 127/127/127, RR 18/19/17, SpO2 96/97/100, BS CTA/n.d./n.d. Pt tol tx well c̄ NARN. (b)(6)
17 Jun 07 21	Pt rec'd Alb/Atrovent via Am, BP 161/82 / 161/82 / 161/82, HR 118/120/110 RR 26/24/26, SpO2 97/99/100, BS CTA/CTA/CTA, Pt tol tx well c̄ NARN
17Jun07 2000	Pt resting in bed A&O x3 VSS no complaints of pain. Levofloxacin discontinued. Ceftriaxone 2gm IV initiated for q day. assessment complete See flowsheet for further information. will continue to monitor (b)(6)
18 Jun 07 0000	Pt resting in bed. laying on right side. Tolerated thickened mango juice and 35% of regular tray

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)

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PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
			0024 07 CIV579 24072

DATE	NOTES 0024
	will continue to monitor. (b)(6)
18 Jun 07 0315	Pt resting in bed eyes closed. Pt tolerated 85% of regular tray last night. moderate assistance given to upper extremities to put utensils in mouth. no occlusive dsg to LT open back removed. breakdown left open to air. remains approximately 6cm x 4 inches. redness. no other changes in physical assessment. (b)(6) (b)(6)
18 Jun 07 0600	R elbow dsg changed. yellow eschar to 3cm diameter. edges breakdown. dry dressing covering. Pt given bed bath, oral care done shaven. placed on right side. wound canister changed. lab work critical value. WBC 31.7 and chloride 115. continued abx therapy. morphine passive range of motion done to BUE BLE. patient comfortable. no other changes from previous assessment. (b)(6) (b)(6)
18 Jun 07 0615	Pt recd 4D Alb/Atrovent via Am. BP 145/76 / 145/76 / 145/76, HR 120/125/128, RR 20/19/20, SpO2 97/100/97, BS. CTA/CTA/CTA. Pt tol tx well. NARN. (b)(6)
18 Jun 07 0750	Nurses Note: Assumed care of Pt at 0730. Report received from (b)(6) Pt resting in bed. will continue to monitor (b)(6)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 JUN 07	Addendum
1741	Called for T > 101 (T = 102). Restoled levaflox.
	√ Blood cult x2 and CXR (b)(6)
17 JUN 07	Addendum
2000	CXR ?? suspicion for aspiration
	DIC levaflox
	Start Ceftriaxone. Pt on floor (b)(6)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES 0024 0% C1 57, 24772
17 Jun 07	IMPN
1444	S: Feels OK, No complaints.
	O: T=100.5 P= 87-135 R= 21-33 BP= 136-143 / 82-86 SAT= 96-100%
	① Alert, NAD
	② Heart - RRR ⑥ Neuro - able to flex arm against gravity but not resistance ⇒ 3/5
	③ Resp - CTA ↓ BS @ L base
	④ Abd - Soft, NT, No Δ @ VAC site
	⑤ Ext - 2+ edema @ B Pods, & foot edem, R elbow heal.
	labs: 21.0 / 11.6 / 404 — 157 / 53 / 2.7
	A/P: ① S/p GSW; immunizations for splenectomy next week
	② Pulmonary - Stable; ✓ CXR in AM
	③ GI - CT c/w pericolic. Cont levaquin (D10) and Flagyl (D11) for 14 total days. ok D/C, afebrile dose today
	④ ARF - Cr continues to improve ⇒ 2.7 today
	⑤ Myopathy - Resolving. ✓ Methyte-8 in AM
	⑥ Rehab - Cont PT/OT. Pureed diet; No thin liquids. (Pt consistently control ⇒ aspiration risk)
	(b)(6) (b)(6)
	Addendum ⇒ Levaquin not given since 11 Jun, will hold. Cont Flagyl

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
Mom's temp letter	LAST	FIRST	(b)(6) MI	
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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.

(b)(6)

PROGRESS NOTES
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10-L-0126 ACLU DDII CID ROI 21194

000060 EXHIBIT 5

0024 07 C-10579 24072

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17Jun07 0920.	Nurses Note: Assumed care of pt at 0645 Report recieved from (b)(6) Pt resting quietly at present. Pt consumed about 30% of breakfast and choked upon consumption of anything liquids. tolerates thickened liquids and solid foods c complication. will continue to monitor (b)(6)
17Jun07 1048	Nurses Note: Pt has been educated on reason why he will no longer be having clear liquids and that he will be given regular food and thickened liquids as to prevent aspiration. Pt ROM performed on all extremities. Pt (R) UE Able to lift hand to chin. (L) UE can be lifted to chest. (L) LE and (R) LE can wiggle toes but has been unable to lift either from bed. will continue to monitor. (b)(6)
17Jun07 1446	Nurses Note: Pt T: 100.5. Dr Mychard notified. (b)(6) states to monitor and possible CXR in AM. Pt C/O to Chair at 1450, Bed changed. will continue to monitor. (b)(6)

0024 07 CI 579 24072

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
16 JUN 07 1900	Pt received from (b)(6) in calm collected manner, VSS (b)(6)
16 JUN 07 2100	Pt has a hard time swallowing liquids and will occassionally cough up fluids, Pt head of bed elevated to prevent aspiration. Will continue to monitor. (b)(6)
16 JUN 07 2400	Pt resting w/ no S/S of distress. Will continue to monitor. (b)(6)
17 Jun 07 0620	Pt received alb/atrov neb tx. Tolerated tx well w/o adverse reactions. 100 149/82 19 99, 119 149/82 23, RT.
RT note	BS diminished lobes & clear all other lobes. Pt improving on therapy. With new insp. vol of 1500mls (b)(6)
16 JUN 07 0650	Pt given bed bath, linen changed, dressings assessed and changed, oral care done. Elevated head of bed with. Continue to monitor. (b)(6)
16 Jun 07 0815	Pt is an iraqi & c GSW to chest, Pt is alert but not able to talk, Pt is on RA & SpO_2 96%. Pt has good rise & Fall of chest. Pt has no sign of Resp. distress. Pt is on a AIB/Atrovent Neb. Vitals BP 139/75, HR 114, SpO_2 90, RR 20. ↑ O_2 to keep SpO_2 >95%. Will continue to monitor. (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.

PROGRESS NOTES
Medical Record

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RCU #3

10-L-0126 ACLU DDII CID ROI 21196

EXHIBIT 5

0024 07 CID579 24072

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
14Jun07 1130	Nurses Notes: Assumed care of pt at 0645. Report recieved from (b)(6) Pt resting quietly in bed. Fentanyl DC'd at 0930. Pt has no c/o pain at this time. Will continue to monito (b)(6)
16 June07 1230	Rehab Note OT/PT S: Seen by OT service for transfer, ROM, ADLs this AM. Pain 3/10 to abdomen. Currently has wound vac to abdomen. O: Transfer c max A ~~sit~~ supine → sit → stand. Stand balance static: poor. ADLs - eating: min A. Grooming: mod A Treatment provided: ROM to extremity, ADL training, transfer training A: ↑ transfers, ↑ ADLs. P: Continue plan of (b)(6) (b)(6)
16Jun07 1900	Pt received abd/ates neb tx. Tolerated tx well w/o adverse reaction. 112/99, 120/24/99 Pt JP's are clear all bbls. (b)(6)
16Jun07 1635	Nurses Note: Pt was out of bed to chair for 2 hours. ~~From~~ Pt tolerated Puree diet consuming 30% of meal. Will continue to monitor (b)(6)

RELATIONSHIP TO SP

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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(b)(6)

PROGRESS NOTES
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ACLU-RDI 5546 p.27

000063

EXHIBIT 5

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15Jun07 1823	Nurses Note: Pt O2 sats dropped to 89% on Room Air at 1800. Pt encouraged to cough and deep breath. Pt maintained at 89% level. Pt placed on 2L N/C Sats improved to 94%. will continue to monitor.
	(b)(6)
15Jun07 1900	Nurses Note: Report given to (b)(6), (b)(6)
~~16Jun07 2230~~	~~Pt received albuterol neb. Pt tolerated tx well, w/o adverse reactions.~~ (b)(6) (b)(6) ~~BS cont. CTA~~
16Jun07 2230	Pt received albuterol neb. Tolerated tx well w/o adverse reactions BS dim w/ scattered rhonchi. P2 149/87 10 84 P03 149/87 24 98. (b)(6)

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DATE	NOTES 0024 07 CID 579 24072
RT Note 16 Jun 07 0010	Pt given tx of Alb/Atr via aerosol mask/neb. Pt currently on 2L NC sats 98%, At has Scat rales Bilat. HR 97/100/98 BP 128/72 / 126/70 / 224/70 RR 32/27/23 Sats 98/100/100 No Δ to pt bs after tx No adverse reactions. (b)(6)
16 JUN 07 0030	Pt. sleeping in NAD. VSS. Temp 98.4. Pt. reassured @ this time. No As from error RR previous assessment noted (b)(6)
0430	CXR completed. CBC & CMP drawn & sent to lap. ABG not drawn because pt. no longer on vent & currently Sat 100% on 2L/NC. Lungs remain CTA @ diminished bases. BS active x4Q. Small amt. brown liquid to colostomy bag. No acute As in assmnt. (b)(6)
0530	Pt. bath & po care completed. Linens D'd. ROM done. Lab called @ critical results: BUN 64, Cr error PR Cl 119. (b)(6)
0600 16 Jun RT note	Pt now on RA, sats 98% & scat rales bilat, pt given Alb/Atr via AM/NEB HR 91/96/93 BP 144/82 / 143/80 / 143/82 RR 17/18/19 Sats 98/100/98. No Δ to pt's BS, no adverse reactions to tx (b)(6)
0605	Attempted to get pt. to wash his face. Showed pt. what to do & he slowly washed his hands up his abdomen up (Continued →)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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10-L-0126 ACLU DDII CID ROI 21199

EXHIBIT 5

0024 07 CID579 24072

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 Jun 07 0605 (continued from front)	up his chest + to his face. Pt. has poor fine motor movement but was able to move the towel over his face + put his arms back down. (b)(6)
16 Jun 07 0830	Nutrition Note: PT's condition continues to improve. Still NPO, attempting to try Thickener c/ liquid, D/C IV Tube Feed as of the past 72hrs. Continue to monitor as condition stabalizes. (b)(6)
16 Jun 07 0930	IMPN S: Feels OK, Hungry; c/o chest; no pain, specifically, no abd discomfort O: T_{MAX} 99.6 P 98 BP 143/90 R 218 Sat 98-100% I/O: -2385 (2L N.C.) ① Abt, NAD ② Heart - RRR ⑤ Ext - 2+ edema b/l ③ Lungs - CTA (good airflow (B)) (R) elbow dsnt changed c/w 2d ago ④ Abd - NABS unchanged, No Tenderness ⑥ Ins - (R) Sc triple lumen Labs: 20.3 198/46.9 157/64 3.9 CXR-7 NO Δ. see below A/P: ① S/P GSW's, immunization for splenectomy next visit ② Pulmonary - Stable on R/A, D/C AM CXR ③ GI ⇒ Prior CT c/w peritonitis, improved on last CT. Will give full course Abx, clear liquid ⇒ solid. D/C improvem (D 20) Cont unasyn (D10) ⇒ Flagyl (D10), Will ↑ dose as Cr improves. Monitor carefully. ④ ARF - Resolving ⑤ Myopathy - resolving, D/C fentanyl. (b)(6) ⑥ Rehab - PT/OT. Advance diet to pureed

STANDARD FORM 509 (REV. 5-1999) BACK
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(b)(6)

(b)(6)

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EXHIBIT 5

0024 07 CIL579 24072

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 June 07	Rehab Services
1300	S: Seen by Rehab Services for evaluation this AM. See other / SF 513 for plan of care. (b)(6)
15 Jun 07 RT NOTE 1815	Pt on 3L NC sats 100%. BS are scat rales bilat. Pt given tx of Alb/Atr via aerosol mask/neb HR 118/119/118 BP 148/80 / 149/90 / 148/80 RR 23/25/24. Sats 99/100/100 No Δ to bs no adverse reactions to tx. (b)(6)
15 JUN 07 1900	Received report from previous RN. Pt. sitting ↑ in bed in NAD. VSS, denies pain @ this time. Will monitor closely (b)(6)
1930	Assessment completed, see ICU flowsheet. Pt. requested H2O. Gave pt. small sips H2O per medicine cup. HOB 90°, pt. coughed a little $\bar{c}$ drinking but much less cough than last pm. Will request to give pt. pudding or something thicker than H2O in a.m. (b)(6)
2010	Interpreter at bedside. Pt. requesting a "cup of H2O" instead of small sips. RN explained that he is a high risk for ~~aspiration + that we will do small sips until his throat~~ muscles are stronger to prevent aspiration + further illness. Pt. verbalized understanding but is very frustrated. Also stated "I'm starving. I haven't had food in a week." RN explained reason for not being able to eat + that we will feed him as soon as his body is healthy enough to tolerate it. Gave pt. a few more small sips of H2O $\bar{c}$ multiple episodes of non-productive coughing. (b)(6)

EXHIBIT 5

0021 AUTHORIZED FOR LOCAL REPRODUCTION 4072

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
15 Jun 07	IMPN
0921	S: No complaints
	O: Tmax 101.6 yest AM 86 151/87 17 98-100% sat
	I/O -2045
	① Alert, NAD
	② Heart - RRR ⑤ Ext - ∅ c,c ⑥ 2+ edema @ arms/legs
	③ Lungs ↓BS on Ⓛ
	④ Abd - ~~~ in place, soft, NT
	Labs: 20.4 > 9.9 < 512 157/4.8 103/19 (72) (3.1)
	A/P: ① S/p GSW, immunization for splenectomy when stable.
	② Pulmonary - Stable on NC O2; Cont IS
	③ GI - Cont current Abx, esp. c WBC @ 20K,
	④ ARF - resolving Cr = 3.1 today. (b)(6)
	⑤ Rehab - PT/OT, ↑PO ~~~ (b)(6) (b)(6)
	tolerated. Myopathy resolving
RT Note 1210 15 Jun	Pt on 3L NC Sats 99%, BS are clear. Given Alb/Atr via
	neb/aerosol mask HR 96/89/89 BP 144/72 / 144/72 / 144/72 RR 20/21/20
	Sats 99/100/100, No Δ to Pt's BS and no adverse reactions
	to tx (b)(6)

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

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

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

(b)(6)

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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0126 ACLU DDII CID ROI 21202

(b)(6)

TRM#3

000068

EXHIBIT 5

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MEDICAL RECORD — PROGRESS NOTES — PAGE 24 07 CID579 24072

DATE	NOTES
14Jun07@1900	Report given to nurse assuming care of pt. (b)(6)
1935	assessment completed. See CICU flowsheet. Pt. resting comfortably in NAD. Denies pain/difficulty breathing per interpreter (b)(6)
2030	Pt. verbally requested water. Put HOB↑ 45°, gave pt. sips of water. Pt. had severe coughing episode + HR ↑ 100's. Non-productive cough. Auscultation lungs + remain CTA all lobes c̄ dim. bases. sats 99% on 3L/NC. (b)(6)
15 Jun 07 0005	Pt rec'd 1600 Alb/Atrovent nebs via Am. BP 159/89 / 159/89 / 159/89,
RT Note	RR 20/14/20, HR 94/97/100, SpO_2 97/100/100. BS ↓ in 2 lobes.
	Pt tol tx well c̄ N ARN. (b)(6)
15 Jun 07 0005	Pt rec'd 2000 Alb/Atrovent Nebs via Am. BP 164/90 / 164/90 / 164/90,
RT Note	HR 92/95/95, RR 20/18/18, SpO_2 97/98/100, BS ↓ bases.
	Pt tol tx well c̄ N ARN. (b)(6)
15 Jun 07 0005	Pt rec'd 2400 tx Alb/Atrovent Nebs via Am. BP
RT Note	167/54 / 167/54 / 167/54, RR 18/14/19, HR 91/100/93. BS ↓ in bases.
	Pt tol tx well c̄ N ARN (b)(6)
14JUN@ 2210 (Late entry)	Pt. again requested H2O. Sat pt. ↑@ 90° c̄ assistance x 1. Pt. took sips of H2O through straw but drinks very quickly + coughs a lot ~~& sputum out but pt. able to clear airway.~~ Lungs auscultated and remain clear all lobes c̄ diminished bases. Pt. needs a thickener or something other than

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

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

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

PROGRESS NOTES
Medical Record

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

(b)(6)

000060

EXHIBIT 5

0024 07 C1 579 24072

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(continued from front)	water because risk of aspiration is high (b)(6)
5 JUN 07 0000	Pt. reassessed. Denies pain. VSS c occassional tachy to 101, RR 12-22. Temp 98.2 orally. Consistently 98-100% on 3L/NC. No acute Δs noted from previous assessment. Heels remain elevated off bed & pt. turned q2° to prevent decubitus ulcers. No sores to sacral/coccygeal areas. (b)(6)
0430	CBC, CMP drawn & sent to lab. ABG not drawn because no longer on vent. Will ask MD in a.m if still needs ABG. Pt. bathed & linens Δ'd. Pt. continues to have no signs of pressure sores to coccyx & sacral area. Dressings to ⓛ back remain intact. No (b)(6) acute Δs noted on reassessment of pt.
0530	Pt. again asking for water. HOB↑90°, gave pt. small sips out of medicine cup instead of using straw. Pt. did much better this time. Minimal coughing, ↔ ↑in HR or RR this time. Only gave 30cc water. (b)(6)
0535	CXR completed. VSS. Temp = 98.5. Pt. sleeping. Continuing to turn q2°. (b)(6)
15 Jun 07 0540 RJNolc	Pt rec'd 0400 Alb/Atrovent neb via Am. BP 153/97 / 153/97 / 153/97, HR 110/114/114, RR 20/21/22, SPO2 97/97/100, BS ~~[illegible]~~ (b)(6)
	Pt tol tx c NARN; (b)(6)
0645	Report given to oncoming RN.

STANDARD FORM 509 (REV. 5/1989) BACK
SAPA V1.00

000070
EXHIBIT 5

0024 03 $10574 24072

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	IMPN NOTES
14JUN07	S: Hungry eat thirsty. No pain O: T≡ 100^3 93 15-24 156/92 ~~P~~ SAT = 100% (B) (1) Alert, NAD I/O = -56 (2) Heart - RRR (3) Lungs - ↓BS @ (B) lower (4) Abd - soft, NT, (+)BS; Vac present (R) colostomy (5) Ext - 2+ edema (6) Ant line, (L) groin - D/C'd Labs: 21.2 / 10.1 / 508 — 155 / 72 / 3.3 (+) (L) shift CXR - ↑ feat sig, pacl small (B) effusion CT (A/P) - ↓ monitor study; stable pancreatic fluid A/P: (1) S/P GSW ≡ splenectomy, incarcerated ileo stable (2) Pulmonary - on 3L NC O_2. Sat IS (3) GI - CT w/ edema WBC ≡ left shift persists. Sat unspecified, levaflox, flagyl. attempt to transition pt for oral intake (4) ARF - Cr ↓ to 3.3. Metabolic acidosis better. No Na
~~14JUN07@1500~~ RAH	(b)(6)
~~14JUN07@1500~~	~~Assisted to sit up ≡ HOB @ 30°. Given sips of H2O ≡ tolerated. Aspirates occassionally and coughs frequently. Pt to sit up ≡ bed @ 30° or greater, tuck chin when swallowing using a straw to minimize risk of aspiration. VSS, ST @ 101 ≡ ectopy. No acute changes in assessment since earlier exam. Denies pain or discomfort.~~
14JUN07@1700	Asleep, breathing is even and nonlabored. O_2 @ 3LPM via NC where SpO2 @ 98%. Denies pain on assessment. Flushed unused ports of TNC (medial and distal) ≡ NS = 10mL. Both patent

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 Jan 07 0820	Pt recd up Alb/Atrovent via Aerosol mask. BP 172/95 / 172/95 / 170/90, HR 84/
RT Note	99/89, RR 24/28/25, SpO_2 98/97/97 BS Rhonchi to / no Δ / no Δ.
	Pt tol tx well c NARN.
14 Jan 07 1150	Pt is an IRAQI ♂ c GSW to chest, Pt is alert & an
RT Note	O/m NC. Pt has ø complaint of breathing no ↑ wob noted.
initial	Pt has a productive cough & able to mobilize secretions.
	BS are rhonchi to. Pt is on Q4 Alb/Atrovent nebs.
	BP 174/93, HR 84, RR 24, SpO_2 97%. Pt has no sign of Resp. distress.
	Pt tol. tx well. Will continue to monitor Pt & wean
	O_2. (b)(6)
14 Jan 07 1220	Pt recd q4 Alb/Atrovent Nebs via AM. BP 148/74 / 148/74 / 148/74,
RT Note	RR 22/20/22, HR 104/104/104, SpO_2 98/100/97. BS Rhonchi/
	no Δ / no Δ. Pt to tx well c NARN. (b)(6)
14 Jan 07 @ 1300	Removed old ⓟ upper back dressing. Six 0.5–1cm areas where blisters formed from allergic rxn to foam tape. Covered c telfa non-adherent pads and held in place dry clear, plastic op-sites. Removed old ⓟ lateral chest wall – left open-to-air c scab over old wound, that is dry and intact. Removed NG tube from ⓟ nare per (b)(6) (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.	

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
14 JUN 0725	Pt on alb/atro q4 neb tx. tolerates tx well. HR for tx has been in the 80s. RR 20-26. Encouraged pt to use IS. Has improved greatly now around 750 ml of inspired vol. Pt BS are dim in lower lobes w/ scattered rhonchi in all other lobes. Currently pt on 2L NC sats 97. Will cont to monitor pt. Wean off O_2 and cont w/ IS. (b)(6)
(b)(6)	
14 JUN 0740	Report received from previous nurse. Pt. assessed - awake, pupils 4mm and brisk to light. Oriented to name, place. Reoriented to time via interpreter, explained to pt. about oral contrast given via NGT, CT scan for abdomen/pelvis and purpose. NSR @ 88 c ectopy, pulses @ 2+, generalized edema @ 2+. Skin warm & fair. Both hands @ 3+ and appear very edematous. (R) femoral art line c redness or inflammation c good waveform (R) SC TLC c redness or swelling, CVP = 11 per distal port. lungs CTA in anterior lobes, slightly diminished in bases. O_2 @ 2 LPM via NC where SpO_2 @ 100%. pO_2 per ABG = 72. ↑ O_2 to 3 LPM via NC per (b)(6). Med-neb-tx in progress per RRT. Oral contrast ~650 ml via NGT - placement verified c air bolus/auscultation. C.T. scheduled for 0830 this A.M. Bowel sounds (+) in upper quadrants, absent

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

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

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

(b)(6)

REGISTER NO. | WARD NO.: ICU

(b)(6)

PROGRESS NOTES
Medical Record

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

000073
EXHIBIT 5

0024 07 [illegible] 2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES 0024 07 CID579 24072
	(cont.)
14Jun07@0740	in lower quadrants. Abdomen soft, distended, obese and
	nontender. RUQ colostomy c̄ small amt. of brown, liquid stool.
	Midline abdominal incision and LUQ of abdomen - dressing
	attached to wound-vac c̄ pink-tinged fluid present. Foley
	to gravity draining clear, yellow urine in adequate quantity.
	Ⓛ upper back, Ⓛ lateral CW c̄ dressings intact. Ⓡ elbow
	c̄ dressing covering stage II wound - C/D/I. Both heels c̄
	stage I-II breakdown covered c̄ foam dressing in place,
	heels elevated off bed. (b)(6)
14Jun07@0800	T°= 101.6/Ax, skin is very warm. Removed blanket from
	pt. Blood cultures drawn via Ⓡ SC TLC x 1 set. Shall
	give Tylenol p̄ return from C.T. scan. Given contrast
	over 1hr, 15 min. (b)(6)
14Jun07@0945	(b)(6) @ bedside earlier to see pt., wrote an order and R.N.
	removed Ⓡ femoral arterial line. Removed sutures, direct pressure
	held x 8 minutes until hemostasis achieved, cleaned groin c̄ Chlor-
	hexedine 2%, dried c̄ sterile 4x4, applied 2x2 gauze c̄ sterile
	opsite x 2. No hematoma or induration @ Ⓡ femoral site. (b)(6)
14Jun07@1030	~~Shaved pt's face, brushed teeth. Washed hands,~~ changed
	RUQ colostomy bag. Total of 580mL of liquid brown stool
	obtained over two and one-half hours. Stoma appears pink,
	even c̄ skin surface. Pt. has reddened bumps on chest, shoulders
	and abdomen. Bacitracin applied to reddened areas. (b)(6)
14Jun07@1130	(b)(6) made rounds. Changed midline and LUQ abdominal
	dressing and wound-vac. Wounds appear pink, mild bleeding
	c̄ area proximal to umbilicus that is tan-colored ≈ 3cm in
	diameter. Pt. tolerated procedure well s̄ pain on reassessment.

STANDARD FORM 509 [illegible] BACK

10-L-0126 ACLU DDII CID ROI 212 (b)(6)

000044

EXHIBIT. 5

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER 0021 07 [illegible] 579 24772

DATE	NOTES
13 Jun 07	(2145) Report received and pt care assumed at 1900 hrs. Pt sitting up in bed, quiet, looking around. Denies pain. See ICU flowsheet for completed ICU assessment. Fentanyl gtt infusing @ 50 mcg/hr – concentration and rate verified. (R) ~~radial~~ femoral arterial line zeroed & good waveform noted on monitor. VSS. Pt in NAD. Will continue to monitor and report changes as they occur — (b)(6)
14 Jun 07	(0030) Pt reassessed. Ø S's to report. Pt resting quietly & c/o pain/discomfort. (R) femoral arterial line zeroed. good waveform noted on monitor. Monitoring — (b)(6) (0430) Pt reassessed @ 0400. Ø S's to primary assessment @ that time. Dressings to central line/A-line S'd using aseptic technique. A-line zeroed and waveform reported on monitor remained WNL. Bedbath given & oral hygiene completed. Comfeel dressings to bilat heels applied to Stage I-II pressure ulcers. Dressing to old chest tube site in (L) lateral chest changed. Pt due to go to CT Scan this am. P.O. contrast @ bedside – approx 300 ml ~~instilled~~ in (L) NGT, but pt immediately vomitted all over himself. P.O. contrast held. Bed linens changed. Report given to oncoming shift. — (b)(6)

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MEDICAL RECORD — PROGRESS NOTES 0024 07 CID579 24072

DATE	NOTES (cont)
13 ~~JUN~~ 07 1633	Labs: 21.0 (7.9) 561 153/4.1/122 (19) (75) 4.0 AG=12 CK (733) CXR → No sig A
	A/P: ① S/p GSW to abd
	② Pulmonary – extubated yesterday. SO2 wnl c RR 18-20 all day today. 1 ~~Duo~~ breath given to assist in respiratory attempt to compensate for mild metabolic acidosis of renal failure. On 2L O2 via N.C.
	③ GI – SOne tea pt stability, activity today c PRBC Transfusion, will obtain ~~CBC~~ CT (b) tomorrow. Cont imipen, levoflox, flagyl.
	④ ARF – Slowly improving
	⑤ Rehab. PT/OT consults; SO2 exhibit. care
	(b)(6)
13Jun07@1700	Second unit of PRBCs transfused over three hrs c signs or symptoms of a reaction. Vss, slow grade fever intermittently, T°=99% ~~Ax~~ 100.5/Ax. (b)(6)
~~13Jun07@1900~~	~~Report given to nurse assuming care of pt.~~ (b)(6)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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10-L-0126 ACLU DDII CID ROI 21210

ACLU-RDI 5546 p.40

000076

EXHIBIT 5

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
		0024 07	CTO579 24072

DATE	NOTES
13Jun07@0950	Changed bed linen and pads underneath. No skin breakdown on coccyx or buttocks noted. (b)(6)
13Jun07@1020	Blood type, demographics verified c second R.N. Vital signs recorded, first unit of PRBCs initiated @ 1015 hrs to run over 3-4 hrs. Pt. was premedicated @ 0830 hrs c Tylenol 650mg. and Benadryl 25mg via NG tube. (b)(6) (b)(6)
13Jun07@1100	No signs or symptoms of blood transfusion reaction. (b)(6)
13Jun07@1130	Repositioned onto back. Oral suction, mouth care provided. No acute changes in assessment. O_2 @ 1 LPM via NC where SpO_2 @ 98%. Breathing is even, nonlabored, R=18-20. (b)(6)
13Jun07@1301	(b)(6) here to see pt., no new orders. (b)(6)
13Jun07@1400	First unit of PRBCs completed @ 1334 hrs. Premedicated c Tylenol 650mg and Benadryl 25mg via NG Tube @ 1345 hrs. Second unit of PRBCs started @ 1355 hrs p vital signs recorded and pt. verification procedures. (b)(6)
13Jun07@1515	Reassessment reveals ↓ SpO_2 to 96% on room air. Breathing is even, nonlabored, R=20. (b)(6) ordered and R.N. obtained blood via art-line for ABG. (b)(6)

13 Jun 07 1625

IMPN

S: No complaints, Pain controlled. Breathing is OK

O: T_m = 100.6 P= 88 BP= 129/85 R: 19-24 I/O = @ 1945

① abd, NNP ⑤ Ext - Ø c.c. SAT= 96-100%

② Heart - RRR ⑥ 2+ edema, ⑦ allow c 3 cm pressure ulcer.

③ Lungs - ↓ BS on ⑥

④ abd - soft, NT ⑥ Skin - ⑧ sc triple lumen ⑧ femoral art line

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

13Jun07@0730 Report received from previous nurse. Pt. assessment completed (see flowsheet). Awake, denies pain. Able to move arms, and feet. Generalized weakness, handgrips (3/5 strength), feet (3/5 strength). ST@104 ē ectopy. Pulses @ +2 bilaterally, +1 in PT bilaterally. Generalized edema @ 1-2+, more prominent in hands and feet. Lungs clear in anterior lobes, diminished in dibasilar lobes. O2 @ 1LPM via NC where SpO2 @ 98-100%. Breathing is even, nonlabored. BS ⊕x 2 in upper quadrants, very distant/hypoactive in lower quadrants. Abdomen soft, distended, obese and nontender per pt. Foley cath to gravity draining clear, yellow urine ≥100 mL/hr. ⓇSCTHC, Ⓡ femoral art-line ē redness or inflammation. All ports on THC patent. Dressings CDIT @ ⓇSC, Ⓡ femoral sites. Dressing to Ⓓ upper back, Ⓓ lateral CW are dry and intact. Midline abdominal and WOC wounds ē wound-vac drsg dry + intact. NGT via Ⓛ nare clamped, placement verified ē air bolus / auscultation and aspiration of dark green fluid.

(b)(6)

13Jun07@0830 Oral care provided, teeth brushed. Suctioned mouth p irrigating ē H2O x 4.

(b)(6)

13Jun07@0915 Repositioned onto Ⓡ side p changing dressing on Ⓑ upper back, Telfa pads applied p cleansing four small skin tears from previous skin reaction to tape. Skin is reddened. Applied clear-opsites. Cover →)

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

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

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

PROGRESS NOTES
Medical Record

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

0021 07 C10529 24072

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(continued from front) 13 Jun 07 @ 0200	and large Op-site. Pt's arm elevated on pillow to prevent further breakdown. Pt. also has extremely large area of irritation + small areas of skin tear/skin breakdown to left back. Wounds covered c Carra Gauze + opsite. Lungs c minimal rhonchii throughout. Weaned ↓ to 4L/NC c Sats 100%, RR 20. VSS. BS active x 4Q. No acute changes. (b)(6)
0530	Received notification from lab of critical values: Chloride 122, BUN 75. Will notify MD upon arrival. ABG as follows: pH 7.34, CO_2 30, HCO_3 16, pO_2 89. Other labs: WBC 21, Hgb 7.9, Hct 25.1, Na 153, Cr 4 (b)(6)
13 June 07 0915	Nutrition F/U. Pt's BUN ~~&~~ improving slowly as is creatinine (88 & 3.9) if held to prevent aspiration) p extubation. P- Continue to follow. (b)(6)

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MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES 0024 07 CID579 24072

12 Jun 2050 RT Note: Pt was extubated @1030 this ~~morning~~ and has O^2 of 31% currently on a venti-mask. pt BS are dim ō scat rales t/o and is maintaining sats of 100%. Pt was given tx of Alb/Atr via neb/aerosol mask HR 86/83/87, BP 157/86 / 158/85 / 155/83, RR 21/22/20, Sats 100/100/100 no Δ to pt bs, and no adverse reactions to tx. (b)(6)

12JUN07 2100: Pt. is calm and in NAD. Assessment completed. See flowsheet. Denies pain @ this time. VSS, T=100.6. Will monitor. (b)(6)

12 Jun 07 RT Note 0030: Pt given Alb/Atr via aerosol mask, pt has scat rales bilat on 4L NC Sats 100% HR 97/99/97 BP 157/87 / 160/83 / 161/84 RR 20/21/20 Sats 100/100/99, No Δ on BS after tx. No adverse reactions to tx. (b)(6)

12 Jun 07 RT Note 0430: Pt given Alb/Atr via aerosol mask pt was on 4L NC sats 100% pt's bs are scat rales bilat. HR 112/117/118 BP 156/82 / 152/83 / 157/81 RR 120/20/20 Sats 100/100/100. No Δ to BS after tx reduced O_2 to 2L NC. No Adverse reactions (b)(6)

13JUN07 0200 (Late Entry): Bath completed + linens Δ'd. Small dressing to ® elbow ~~dated~~ ERR noted to have some drainage. Removed dressing + found ~~Stage III pressure sore ō erythema, light green colored~~ drainage, ~1 inch Area of white pus and small area of black necrotic tissue. Covered wound ō Cama Gauze

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

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

Continued →

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)

PROGRESS NOTES
Medical Record

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

EXHIBIT 5

MEDICAL RECORD - PATIENT RELEASE/DISCHARGE INSTRUCTIONS

0624 07 CID579 24072

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

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure or extended care/treatment, or discharge from an inpatient hospital stay. The patient/significant other will be provided a legible copy of this document.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 26 MAY 07
2. ADMITTING DIAGNOSIS: S/P GSW
3. PERTINENT DIAGNOSTIC FINDINGS:
(1) S/P GSW with Colostomy, subtotal gastrectomy, splenectomy, diaphragmatic repair
(2) Critical Illness Myopathy/Polyneuropathy
(3) S/P peritonitis/pancolitis
(4) ARF- resolved
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
(1) Above
(2) Mechanical Ventilation
(3) CT (Abd/pelvis) - Multiple
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:
(1) S/P GSW (5) Peritonitis/colitis
(2) Sepsis Cond = Stable
(3) Acute Renal failure
(4) Critical Illness Myopathy/Polyneuropathy
6. ACTIVITY:
7. DIET:
8. MEDICATIONS:
☐ See seperate list and special instructions provided.
☐ The following medications have been prescribed for home use:
Flagyl 600 mg IV q 6° Zantac 50 mg IV q 8°
Ceftriaxone 2gm IV qd MS Contin 15mg po BID
Lovenox 30mg sq BID O2 via N.C.
9. PROFILE ☐ YES ☐ NO Reglan 10mg
CONVALESCENT LEAVE: ____ DAYS ☐ N/A IV qhs and AC
INSTRUCTIONS: *(To home care providers, patient, etc.)*
Transfer to Bucca
10. DISCHARGING PROVIDER:
(b)(6) (b)(6)
(Signature) *(Printed or Stamped Name)*

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☑ OTHER Bucca
2. MODE: ☐ AMBULATORY ☐ WHEELCHAIR ☑ OTHER Bucca Bus
3. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☑ OTHER MP.
4. PATIENT EDUCATION:
Completed and patient prepared for home care. ☐ YES ☐ NO
If "No," explain:
Patient ☑ verbalizes ☐ demonstrates understanding of home care.
Printed educational materials provided: *(Specify)*
5. Clinical outcomes met and post-discharge/release referrals made?
☑ YES ☐ NO If "No," explain:
6. NUTRITION CARE INSTRUCTIONS:
7. MEDICATIONS: *(Explained by)*
☑ Nurse ☐ Physican ☐ Pharmacist ☐ Other
Printed medication literature provided? ☐ YES ☑ NO
Patient verbalizes understanding of prescribed medications? ☑ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
9. FOLLOW-UP APPOINTMENTS: *(Date/time, POC, and phone)*
10. FOR PROBLEMS OR EMERGENCY, PLEASE CONTACT:
Inpatient Ward
(Name) *(Phone)*

PATIENT IDENTIFICATION *(For typed or written entries note: Name - last, first, middle initial; grade; DOB; hospital or medical facility)*
(b)(6)

11. COMPLETED BY:
(b)(6) 26 MAY 07 1340
(Signature and Title) *(Date and Time)*
12. ACKNOWLEDGMENT OF INSTRUCTIONS:
I understand and have received a copy of these instructions.
(b)(6)
(Patient/Responsible Adult's Signature) *(Date and Time)*

DISTRIBUTION OF THIS FORM WHEN COMPLETED: (1) MTF; (2) PATIENT/FAMILY; (3) OTR; (4) OTHER

MEDCOM FORM 691-R (TEST) (MCHO) JUN 03 PREVIOUS EDITIONS ARE OBSOLETE

CLINICAL RECORD - DOCTOR'S ORDERS 0024 07 CID579 2407

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. (b)(6)

DATE OF ORDER 20 JUN 07 TIME OF ORDER 0940 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Reglan 10 mg IV AC and qhs

(2) Cepacol lozenge x 1 now, then q 6°, prn

(b)(6)

20 Jun 07 @ 1500 Orders Verified (b)(6)

PATIENT IDENTIFICATION (b)(6)

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

DATE OF ORDER 21 JUN 07 TIME OF ORDER 1114 HOURS

(1) Δ Lovenox to 30 mg sq BID

(2) Transfer to Bucca when transportation Available (b)(6)

(b)(6)

PATIENT IDENTIFICATION (b)(6)

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

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION (b)(6)

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

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2[illegible]-[illegible]/391

"USE BALL POINT PEN—PRESS FIRMLY | NO CARBON PAPER REQUIRED"

10-L-0126 ACLU DDII CID ROI 21216

ACLU-RDI 5546 p.46

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EXHIBIT 5

0024 07 CID579 24072

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER _____ HOURS	LIST TIME ORDER NOTED AND SIGN
(b)(6)						
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 20[illegible]-[illegible]

10-L-0126 ACLU DDII CID ROI 21217

"USE BALL POINT PEN—PRESS FIRMLY ! NO CARBON PAPER REQUIRED"

000083 DAIRD11 5

0024 07 CID 579 24072

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
	17 JUN 07	1958 HOURS	
(1)	D/C Levofloxacin after this dose		17 Jun 2200 (b)(6)
(2)	Ceftriaxone 2 gm IV now, then q d.	(b)(6)	

NURSING UNIT | ROOM NO. | BED NO.

24 Chart (b)(6)

PATIENT IDENTIFICATION: (b)(6)

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	19 JUN 07	0928 HOURS	19Jun07 @0940 noted (b)(6)
(1)	CXR in AM tomorrow		
(2)	Methyte 8 in AM tomorrow (methyte has CK)		
(3)	ROM q 2° while Awake, 0800 - 2000 hrs	(b)(6)	

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

PATIENT IDENTIFICATION: (b)(6)

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	19 Jun 07	1430 HOURS	
(1)	Verbal Order D/C Alb/Atrovent+Neb	(b)(6) (b)(6)	19Jun07 @ noted 1430 (b)(6)

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

Orders verified 19 Jun 07 @ 1459 (b)(6)

PATIENT IDENTIFICATION: (b)(6)

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	19 Jun 07	1817 HOURS	19Jun07 @1817 noted (b)(6)
	1) Zofran 8mg, IV - now x 1.		
	2) Reglan 10mg, IV - now x 1.		
	(V.O (b)(6)		

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

24 Chart V 0/20/07 0310 (b)(6)

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-500-291

"USE BALL POINT PEN—PRESS FIRMLY ! NO CARBON PAPER REQUIRED"

EXHIBIT 5

0000847

0028 07 CID579 24072

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 16 JUN 07 TIME OF ORDER 1011 HOURS

LIST TIME ORDER NOTED AND SIGN: 16JUN07 1110 (b)(6)

1. D/C AM CXR
2. D/C imipenem
3. Levaquin 40 mg SL q d
4. Thanks (b)(6)

ORDERS VERIFIED 16JUN 07 @ 1125 (b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 17 JUN 07 TIME OF ORDER 1540 HOURS

Note 17JUN07 1740 (b)(6)

1. D/C central line
2. CXR in AM
3. No water or other liquid without thickener (b)(6)
4. ~~D/C IV Morphine~~
4. D/C levaflox (not being given)
5. Mellyte-8 in AM

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER (2) HOURS

6. Fluid to 60 ~~mg~~ IV (b)(6) (6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 17 JUN 07 TIME OF ORDER 1738 HOURS

NOTED 17JUN07 1800HRS (b)(6)

1. CXR
2. Blood Cultures X2
3. ~~Levaquin~~ Levofloxacin 750 mg IV now, then 500 mg IV q od
4. Tylenol 650 mg po now, then 650 mg po q 8°, prn T>101. (b)(6)

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2006-0-531

"USE BALL POINT PEN—PRESS FIRMLY | NO CARBON PAPER REQUIRED"

000085

EXHIBIT 5

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 NO
14 JUN 07	1521 HOURS	(b)(6)

(1) D/C Protonix (Not Available)

(2) ZANTAC 50 mg IV q 8°.

(b)(6)

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

24° chart ✓ 6/15/07 @ 0300 R. Russell CPT/AN

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER: 15 JUN 07 TIME OF ORDER: 0705 HOURS

(1) Δ Nebs to q 4°.

noted 15 0705

(b)(6)

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

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER: 15 JUN 07 TIME OF ORDER: 0929 HOURS

(1) ROM TID please

(2) PT/OT for ROM a/s. n

noted 1100 15 JUN 07

(b)(6)

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

24° chart ✓ 6/15/07 @ 2201 (b)(6)

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER: 16 JUN 07 TIME OF ORDER: 0945 HOURS

(1) Diet; Pureed

(2) D/C fentanyl drip

(3) MS Contin 15 mg po BID

(4) Morphine sulfate 2-4 mg IV q 4° prn PAIN

(5) Δ Nebs to q 8°

16 JUN 07 1107

(b)(6)

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

ORDERS verified 6/14/07 @ 1125 (b)(6)

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2006-290-591

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

10-L-0126 ACLU DDII CID ROI 21220

ACLU-RDI 5546 p.50

000086

EXHIBIT 5

0024 07 CID579 24072

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6) NURSING UNIT / ROOM NO. / BED NO.	(1)	DATE OF ORDER: 13 Jun 07 TIME OF ORDER: 1502 HOURS ABG, please (b)(6)	13 Jun 07 @ 1505 (b)(6)
		orders verified 13 Jun 07 @ 1730 (b)(6)	
(b)(6) NURSING UNIT: ICU / ROOM NO. / BED NO. (b)(6)		DATE OF ORDER: 14 Jun 07 TIME OF ORDER: ~~0720~~ HOURS Blood cultures x 1 via (R) SC TLC. Tylenol 650mg via NGT x 1. Jor fever. CV.O. (b)(6) (b)(6) (b)(6)	
(b)(6) NURSING UNIT: ICU / ROOM NO. / BED NO. 3	(1)	DATE OF ORDER: 14 Jun 07 TIME OF ORDER: 0856 HOURS D/C femoral Arterial line (b)(6)	14 Jun 07 @ 0915 noted (b)(6)
(b)(6) NURSING UNIT: ICU / ROOM NO. / BED NO. 3		DATE OF ORDER: 14 Jun 07 TIME OF ORDER: 1300 HOURS D/C NG tube and tube feedings May give sips of H_2O c̄ HOB ≥ 30 degrees. (b)(6) (b)(6)	

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

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

0024 07 CID579 24072

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
13Jun07	1450 HOURS	(b)(6)

Fentanyl gtt Start @ 25 mcg/hr
+ Titrate to effect

(b)(6)

(b)(6)

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

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER	TIME OF ORDER	
13Jun07	1500 HOURS	(b)(6)

ABG - now x 1.

(b)(6)

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

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER	TIME OF ORDER	
13 JUN 07	1604 HOURS	13Jun07 @1605

1. O_2 to Keep SAT ≥ 98%
2. $NaHCO_3$, 1 amp, slow IV
3. ABG in AM

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

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

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER	TIME OF ORDER	
13 Jun 07	1714 HOURS	13Jun07 @1715

1. CT (Abd/Pelvis) in AM tomorrow

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

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

ORDERS verified 13 Jun 07 @ 1730 (b)(6)

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

"USE BALL POINT PEN—PRESS FIRMLY ! NO CARBON PAPER REQUIRED"

0024 07 CID579 24072

CLINICAL RECORD - DOCTOR'S ORDERS

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

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PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 12 JUN 07 TIME OF ORDER 1524 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Venti-MASK @ 50%
2. Hold tube feeds
3. ABG

(b)(6)

12 JUN 07 1700

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 12 JUN 07 TIME OF ORDER 1614 HOURS

1. 1 AMP NaHCO3 IV NOW @ the

(b)(6)

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 12 JUN 07 TIME OF ORDER 1642 HOURS

1. Albuterol / Atrovent Nebs q 4°
2. Methyle-8 IN AM
3. Thanks

(b)(6)

24° chart ✓ 6/13/07 0124

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 13 JUN 07 TIME OF ORDER 0825 HOURS

1. Type And Cross for 2u PRBC
2. Transfuse 2u PRBC, each over 3-4 hrs. Premedicate with Tylenol 650mg PO And Benadryl 25mg PO (Per NGT) prior to each unit
3. ↓IVF rate to 75 cc/hr

13 JUN 07 0835 Initiated

(b)(6)

(b)(6)

(b)(6)

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

Orders verified 13 JUN 07 1730

☆ U.S. GOVERNMENT PRINTING OFFICE: 1979-289-393

"USE BALL POINT PEN--PRESS FIRMLY I NO CARBON PAPER REQUIRED"

0024 07 CID579 24072

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
11 Jan 07	1315 HOURS	
Bacitracin ointment to Abdomen rash BID.		

(b)(6)

(b)(6)

NURSING UNIT	ROOM NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
11 Jan 07	1500 HOURS
BMP now please	

(b)(6)

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
11 Jun 07	2100 HOURS
IV Lasix 40mg [X] dose now	

(b)(6)

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER	TIME OF ORDER
12 JAN 07	1440 HRS HOURS
P/C PROPOFOL	

(b)(6)

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.

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

10-L-0126 ACLU DDII CID ROI 21224

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-300-391

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

000090

EXHIBIT 5

0024 07 CID579 24072

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	10 Jun 07	0810 HOURS	
1	Vent ∆ PS=5		10 Jun 07 0815 Noted (b)(6)

PATIENT IDENTIFICATION: (b)(6)

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

	DATE OF ORDER	TIME OF ORDER	
	10 Jun 07	1060 HOURS	(b)(6)
1	↑ IVF rate to 200 cc/hr		
2	~~BMP at 1400 hrs~~ @ Methyle-8 At 1400hrs		
3	LASIX 40 mg IV at 1800 hrs		
4	BIC UNASYN		
5	Levofloxacin 750mg IV x 1, then 500mg IV q 48 hrs		

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
		HOURS	(b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: (b)

chart V 1516 10 Jun 07 (b)(6)

PATIENT IDENTIFICATION: (b)(6)

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

	DATE OF ORDER	TIME OF ORDER	
	11 Jun 07	1214 HOURS	
	1 U/A now x 1		
	CY.D		(b)(6) x Noted (b)(6)

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-360-384

10-L-0126 ACLU DDII CID ROI 21225

ACLU-RDI 5546 p.55

"USE BALL POINT PEN--PRESS FIRMLY I NO CARBON PAPER REQUIRED"

000091

EXHIBIT 5

0024 07 CID579 24072

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: 9 Jun 07 TIME OF ORDER: 0838 HOURS

LIST TIME ORDER NOTED AND SIGN

1. $NaHCO_3$, 1 amp IV
2. Bolus pt c 500 cc ½ NS, then ↑ ½ NS maintenance rate to 200 cc/hr X 12 hrs, then ↓ to 125 cc/hr
3. Lasix 60 mg IV after 500 cc ½ NS bolus

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

4. BMP at Noon - ordered in CHCJ
5. ↓ to CPAP, F_IO_2 0.4 PEEP 5, PS 5
6. ABG at Noon - ordered in (b)(6)
7. Thanks

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

8. Restart tube feedings at 50 cc/hr

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 Jun 07 TIME OF ORDER: 2033 HOURS

1. ~~A-top~~ If RR > 24, ↓ to SIMV, TV 500, Rate 12, F_IO_2 0.4 PS 10 PEEP 5

Chart ✓ 10 Jun 07 @ 1517

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-300-391

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

0024 07 CID579 24072

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.: 8 | BED NO.: (b)(6)

DATE OF ORDER: 8 JUN 07 | TIME OF ORDER: 1204 HOURS | LIST TIME ORDER NOTED AND SIGN

① Combivent MDI, 4 puffs q 4°

~~②~~ ③

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

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

DATE OF ORDER: 8 JUN 07 | TIME OF ORDER: 1233 HOURS

① If RR > 24 or AT 1800 hrs, Δ to SIMV TV 500 Rate 12 FIO2 0.4 PS 10 PEEP 5

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

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

DATE OF ORDER: 8 JUN 07 | TIME OF ORDER: ~~0722~~ 1922 HOURS

① Δ vent RR to 8 - done

② Δ IVF maintenance to ½ NS 150 transferred to

③ Titrate propofol to moderate sedation q PM, hold q AM at 0600 hrs.

④ Lasix 60 mg IV x1

⑤ ABG

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

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

DATE OF ORDER | TIME OF ORDER: HOURS

(b)(6)

In the Chart

(b)(6)

see 07E0220

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2006-300-001

10-L-0126 ACLU DDII CID ROI 21227

ACLU-RDI 5546 p.57

"USE BALL POINT PEN--PRESS FIRMLY ! NO CARBON PAPER REQUIRED"

000093

EXHIBIT 5

0024 07 [illegible]

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.: 3 | BED NO.: 3

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
✓ ①	7 JUN 07	0843 HOURS	(b)(6)
	Δ Vent to CPAP FIO2 = 0.4 PS = 5 PEEP = 5		Noted 7 JUN 07 0851 (b)(6)

PATIENT IDENTIFICATION: (b)(6)

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

	DATE OF ORDER	TIME OF ORDER	
✓ ①	7 JUN 07	1057 HOURS	Noted 7 JUNE 1215 (b)(6)
	At 1700 hrs or earlier if RR > 24, Δ vent to SIMV, FIO2 = 0.40, RATE = 12 TV = 500 PEEP = 5		(b)(6)
	24hr chart		08 JUNE 07 @ 0340

PATIENT IDENTIFICATION: (b)(6)

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

	DATE OF ORDER	TIME OF ORDER	
①	8 JUNE	0745 HOURS	
	Δ to CPAP, FIO2 = 0.4 PS = 5 PEEP = 5		NOTED 8 JUNE 07 0743 HRS (b)(6)

PATIENT IDENTIFICATION: (b)(6)

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

	DATE OF ORDER	TIME OF ORDER	
①	8 Feb 07	0820 HOURS	
	CT, Abd/ [illegible]		NOTED 8 JUN 07 0947 HR (b)(6)

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

☆ U.S. GOVERNMENT PRINTING OFFICE 20[illegible]-[illegible]

10-L-0126 ACLU DDII CID ROI 21228

ACLU-RDI 5546 p.58 "USE BALL POINT PEN--PRESS FIRMLY / NO CARBON PAPER REQUIRED"

000094

EXHIBIT 5

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.
ICU		3

DATE OF ORDER 6 JUN 07 TIME OF ORDER 1350 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) CXR (b)(6) noted 1410 1430 (b)(6)

PATIENT IDENTIFICATION

DATE OF ORDER 6 JUN 07 TIME OF ORDER 2000 ~~1956~~ HOURS

(1) Vent Δ's, ↑ PEEP to 8

(2) Mucomyst Neb. 6mL of 10% soln X 1 now, Repeat in 8 hrs.

(3) UNASYN 3 gm IV q 24° } 1st dose
Flagyl 300mg IV q 6° } now

(4) Hold tube feedings (b)(6) (b)(6)

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER 6 JUN 07 TIME OF ORDER 2024 HOURS

(1) Δ Mucomyst Above to 3ml of 20% soln with Albuterol neb X 2 doses, 6 hrs Apart (b)(6) (b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

(b)(6) 7 JUN 07 0330

PATIENT IDENTIFICATION

DATE OF ORDER 7 June 07 TIME OF ORDER 0841 HOURS

✓ (1) Δ IVF to ½ NSTRA 150 cc/hr X 1 liter

✓ (2) LASIX 60 mg IV

✓ (3) After 1 liter of ½ NS, Δ back to NS at 150 cc/hr

✓ (4) BMP At 1500 hrs (b)(6) (b)(6)

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1983 0-391

"USE BALL POINT PEN--PRESS FIRMLY ! NO CARBON PAPER REQUIRED"

000095

EXHIBIT 5

0024 07 CID579 24072

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.
ICU		3

DATE OF ORDER: 6 Jun 07 TIME OF ORDER: 0752 HOURS — LIST TIME ORDER NOTED AND SIGN

✓(1) DIC propofol

✓(2) Δ to CPAP

FIO2 = 0.4 PS = 5 PEEP = 5 noted 10/10 0814

✓(3) ABC 1 hr later (b)(6) (b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER: 6 Jun 07 TIME OF ORDER: 1108 HOURS

✓(1) APS to 10 After ABG 08/10/14 (b)(6) (b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER: 6 Jun 07 TIME OF ORDER: 1307 HOURS

(1) Ativan 1 mg IV 6 Jun 07 @ 1300 noted

Repeat in 10 minutes if (b)(6)

No ↓ in RR (Anxiety) (b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER: 6 Jun 07 TIME OF ORDER: 1335 HOURS (b)(6)

✓(1) A vent SIMV Rate 12 TV = 500

PS = 10 PEEP = 5 FIO2 = 0.4

✓(2) Propofol drip, 15 mcg/kg/min, titrate 1345

to moderate sedation, ie, pt Asleep

✓(3) Tylenol 650 mg per NGT Now, 1350

then q 6°, prn T > 101.

✓(4) Blood culture x 1 (b)(6)

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-330-398

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

0024 07 CID579 24072

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.
ICU		3

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
5 Jun 07	0748 HOURS	
① Δ Protonix to 40mg IV qd		
② Δ to CPAP		5 JUN 07
FIO2 = 0.4 PS=5 PEEP=5		

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER	TIME OF ORDER	
5 JUN 07	1049 HOURS	
① LASIX 60 mg IV x 1		NOTED
② Plain film, thigh		5 JUN 07

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER	TIME OF ORDER	
5 JUN 07	1230 HOURS	
✓ PIC ZOSYN		NOTED
V.O. FROM (b)(6)		5 JUN 07
(b)(6)		
(b)(6)		
ORDERS VERIFIED 5 JUN 07 @ 1030 (b)(6)		

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER	TIME OF ORDER	
5 JUN 07	1640 HOURS	
① Δ to SIMV 12		NOTED
FIO2 = 0.4 TV = 500		5 JUN 07
RATE = 12 PS = 10 PEEP = 5		
O/V done 5 JUN 07 @ 2[illegible]		

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2006-320031

"USE BALL POINT PEN--PRESS FIRMLY ! NO CARBON PAPER REQUIRED"

000097

EXHIBIT 5

0024 07 GIDS79 24072

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
04Jun07	1250 HOURS	(b)(6)
↑ IVF rate to 150cc/hr of ½NS.		
Protonix 80mg IV q day		
D/C IV Zantac		

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER	TIME OF ORDER	
04Jun07	1545 HOURS	(b)(6)
(6) Change IV protonix to 80 mg IV q12hrs.		(b)(6)
(8) BMP @ 1800hrs.		

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER	TIME OF ORDER	
04Jun07	2030 HOURS	(b)(6)
(1) PS to 10 please		
(2) Δ vent to SIMV/PS10/PE TV500. at 2200hrs.		
(3) Propofol drip 15mcg/kg/min to mild sedation. Hold gtt at 0600 hrs. Please start Precedex gtt prior to vent Δs.		(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
4 Jun 07	2100 HOURS	(Transcribed by)
Clarification: When pt is placed back on SIMV, set FiO_2 to 40%.		(b)(6)
V.O (b)(6)		

NURSING UNIT	ROOM NO.	BED NO.
24 Medical	(b)(6)	

07 0035

DA FORM 1 APR 79 4256 REPLACES EDITION OF ... BE USED.

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-305-858

"USE BALL POINT PEN—PRESS FIRMLY | NO CARBON PAPER REQUIRED"

000098

EXHIBIT 5

0024 07 C 10579 24072

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.
ICU		3

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
3/7	Fentanyl drip. Start @ 25mcg IVP + titrate to sed e g	(b)(6)
	24hr chart	03 Jun 07 @ 2201

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER	TIME OF ORDER	
04 Jun 07	0730 HOURS	
CPAP, PS 10, PEEP 5 @ 40%		(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER	TIME OF ORDER	
1 4 June 07	0930 HOURS	(b)(6)
Start Suplena @ TF @ 55cc/Hr. Check TF q 4hrs & if TF residuals are 200cc or higher Hold TF 2hrs & re-check.		

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER	TIME OF ORDER	
	0933 HOURS	
1 V.O. (b)(6) INSERT NGT NOW		(b)(6)
By (b)(6)		

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1979 281-

"USE BALL POINT PEN--PRESS FIRMLY I NO CARBON PAPER REQUIRED"

000099

0024 07 CID579 24072

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
3 JUN 07	0938 HOURS	

1. NASAL Airway, Suction, PRN
2. ABG
3. Change Nebs to q 4° X 6, then q 6° (combivent)
4. D/C NGT

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

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

PATIENT IDENTIFICATION
(b)(6)

DATE OF ORDER	TIME OF ORDER	
3 JUN 07	1136 HOURS	

1. Δ to 50% venturi mask.
2. Enalapril 2.5mg IV x1

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

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

PATIENT IDENTIFICATION
(b)(6)

DATE OF ORDER	TIME OF ORDER	
3 JUN 07	1624 HOURS	

1. Propofol drip 15 mcg/kg/min titrate to mild sedation
Hold q AM At 0600 hrs, to be restarted [illegible] orders
~~iv~~.

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

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

PATIENT IDENTIFICATION
(b)(6)

DATE OF ORDER	TIME OF ORDER	
	1800 hrs HOURS	

1. V.O. (b)(6)
ABG 1hr. Post. vent Δ.
received by (b)(6)

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2006-360-001

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

0024 07 CID579 24072

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: 25 JUN 07 | TIME OF ORDER: 1803 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ~~5 mg~~ ~~Morso~~
   Acetylcysteine 3ml per Nebulizer ℥ bronchodilator @ 2000 hrs and 2400 hrs.
2. CPAP, FIO_2 = 40% PS=10, PEEP=5 AT 0830 hrs to Morning

PATIENT IDENTIFICATION: (b)(6)

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

DATE OF ORDER: 2 JUN 07 | TIME OF ORDER: 1809 HOURS

1. LASIX 40 mg IV X 1
   ℥ 2nd PRBC transfusion

2 hr duration — 03 JUNE 07 @ 0115

PATIENT IDENTIFICATION: (b)(6)

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

DATE OF ORDER: 02 JUNE 07 | TIME OF ORDER: 1930 HOURS

1. Start a Diprivan gtt @ 15 mcg/kg/min
   and titrate to light sedation.

V.O. (b)(6)

PATIENT IDENTIFICATION: (b)(6)

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

DATE OF ORDER: 3 JUN 07 | TIME OF ORDER: 0828 HOURS

1. Extubate PT
2. NRB please

(b)(6)

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

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-808-291

"USE BALL POINT PEN--PRESS FIRMLY | NO CARBON PAPER REQUIRED"

000101

EXHIBIT 5

0024 07 CID579 24072

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: ~~26~~ 2 Jun 07 TIME OF ORDER: 1046 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) ABG
(2) Venti Mask @ 50%
(3) Lasix 40 mg IV p 1st unit PRBC transfused
(4) Δ Tylenol (premeds for transfusion) to NGT
(b)(6)

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

PATIENT IDENTIFICATION
(b)(6)

DATE OF ORDER: 2 Jun 07 TIME OF ORDER: 1106 HOURS

1) O2 @ 100% via NRB now
2) Propofol 80mg, IV x 1
3) Propofol 40mg, IV x 1
4) Vecuronium 12mg, IV x 1
5) Vent: SIMV, rate = 12, VT = 600mL, PEEP +5, PS = 10, FiO2 = 100%
6) Portable Chest x-ray Stat. (V.O. (b)(6)
(b)(6)
(b)(6)

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

PATIENT IDENTIFICATION
(b)(6)

DATE OF ORDER: 2 Jun 07 TIME OF ORDER: 1250
(b)(6)

1) SIMV, rate = 12, VT = 600mL, PEEP +5, PS = 10, FiO2 = 40%
(V.O. (b)(6)

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

PATIENT IDENTIFICATION
(b)(6)

DATE OF ORDER: 2 Jun 07 TIME OF ORDER: 1300 HOURS

Portable chest xray @ 1430
ABG @ 1430.
(V.O. (b)(6) (b)(6)

1526 2 Jun 07 ... (b)(6)

2 Jun 07 @ 1530 notes
(b)(6)

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

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-300-39

10-L-0126 ACLU DDII CID ROI 21236

ACLU-RDI 5546 p.66 "USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

000102
EXHIBIT 5

0024 07 CID579 24072

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
1 JUN 07	1822 HOURS	
✓ (1) BMP		
✓ (2) D/C hydrocortisone		
1 Jun 07 @ 1830		
Noted (b)(6)		

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER	TIME OF ORDER	
1 JUN 07	1905 HOURS	Noted 1 Jun 07 (b)(6)
(1) AIVF to ½NS to run at 100 cc/hr		
(2) LASIX ~~60~~ 80 mg IV at 2200 hrs		
(3) AM Labs AT 0400 hrs tomorrow please		

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER	TIME OF ORDER	
2 JUN 07	0713 HOURS	2 Jun 07 0800 (b)(6)
✓ (1) CMP NOW and q AM; LDH NOW		
✓ (2) Albuterol Neb X T		
✓ (3) TRANSfuse 2 units PRBC, each over 3-4 hrs		
Premedicate with Tylenol 650 mg ~~po~~ PO per rectum and Benadryl 25 mg IV prior to each unit transfused		

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER	TIME OF ORDER	
2 JUN 07	0852	(b)(6)
✓ (1) Extubate pt - done		
~~(2) ↓ IVF to @~~		(b)(6)
✓ (2) ↓ IVF to TKO		2 Jun 07 @ 0925
✓ (3) ABG @ 0930 Noted KS		(b)(6)
(4) Albuterol/Atrovent (combivent) Nebs q 4° X 4, then q 6° Noted KS		(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2006 [illegible]

10-L-0126 ACLU DDII CID ROI 21237

EXHIBIT 5

ACLU-RDI 5546 p.67

"USE BALL POINT PEN--PRESS FIRMLY ! NO CARBON PAPER REQUIRED"

000103

0024 07 CID579 24072

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.
ICU		3

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
31 MAY 07	1549 HOURS	

① CPAP trial ↗ FIO2 = 40%
PS = 10 PEEP = 5 until 1730 hrs, then return to prior SIMV vent settings

Noted (b)(6)

(b)(6)

(b)(6)

24 hr done 6/1/07 @ 0620

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER 1 Jun 07 TIME OF ORDER 0930 HOURS

1) M.D. and RN to discontinue
ⓓ PCT @ bedside
2) Portable Chest X-Ray p C.T. removal

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

(b)(6)

Noted (b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER 1 Jun 07 TIME OF ORDER 1000 HOURS

Place on CPAP +5, PS=10, FIO2=0.40
ABG @ 1700 hrs.
C.V.O. (b)(6)

(b)(6)

(b)(6)

Noted

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU	1 Jun 07 @ 1830	3

DATE OF ORDER 1 JUN 07 TIME OF ORDER 1805 HOURS

① Δ back to SIMV ~~At Prevue~~ @
Rate = 15 TV = 600 FIO2 = 40%
PS = 10 PEEP = 5

② At 0600 hrs tomorrow AM, ↓
Fentanyl drip to 50 mcg/hr and
Δ to CPAP, ~~FIO2~~ FIO2 = 40%
PS = 10 PEEP = 5

(b)(6)

(b)(6)

Noted (b)(6)

DA FORM 1 APR 79 4256 REPLACES ... WHICH MAY BE USED.

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-300-304

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

0024 07 CID579 24072

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.
ICU		3

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
29 MAY 07	1912 HOURS	
(1) ↓IVF to TKO		
(2) LASIX 80mg IV X 1		
(3) BMP AT 2200 hrs		
		(b)(6)
29 May 07 @ 1935 noted		(b)(6)
24 hr chart Check Completed		(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
30 MAY 07	0900 HOURS	PHARM NOTED 30MAY07 0900
(1) Δ Hydrocortisone to 100 mg BID x 2 doses, then 100 mg q AM		
(2) Repeat BMP AT NOON		(b)(6)
		(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
30 MAY 07	1701 HOURS	
(1) ~~BMP~~ AT 2200 hrs		NOTED 30MAY07 1704 MW
(2) ABG q AM		
(3) CXR q AM		
		(b)(6)
		(b)(6)

NURSING UNIT	ROOM NO.	BED NO.

24 hr chart ✓ & verified 31 May 07 @ 0030 (b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER	TIME OF ORDER	
31 MAY 07	0720 HOURS	
(1) D/C Lovenox		
(2) Δ Hydrocortisone to 50 mg IV q AM		pharm
		(b)(6)
		(b)(6)

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-309-397

10-L-0126 ACLU DDII CID ROI 21239

EXHIBIT 5

ACLU-RDI 5546 p.69

"USE BALL POINT PEN–PRESS FIRMLY | NO CARBON PAPER REQUIRED"

000105

0024 OF [illegible]

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 29 MAY07 TIME OF ORDER 0730 HOURS

CT to water seal

(b)(6)

LIST TIME ORDER NOTED AND SIGN

NOTED 29MAY07 0730HRS (b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 29 MAY ~~02~~ 07 TIME OF ORDER 0808 HOURS

(1) D/C Vecuronium

(b)(6)

NOTED 29MAY07 0808 (b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER 0915 HOURS

V.O USA DR MYHAND.

* FiO2 TO 40%

REPEAT ABG IN ONE HOUR

(b)(6)

NOTED 0915 29MAY07 (b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER 1800 HRS HOURS

VO per DR MYHAND

POST TRANSFUSION CBC AFTER 2nd UNIT PRBC FINISHED

(b)(6)

ORDERED 29MAY07 1800HRS (b)(6)

30MAY07@0550

24 chart Check Completed (b)(6)

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

EXHIBIT 5

10-L-0126 ACLU DDII CID ROI 24240

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-300-391

"USE BALL POINT PEN--PRESS FIRMLY I NO CARBON PAPER REQUIRED"

0024 07 CID 579 24072

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
28May07	1630 HOURS	

BMP @ 1800hrs (b)(6)

noted 5/28 1630

NURSING UNIT	ROOM NO.	BED NO.
24hr done	29 May07 @ 0330	

(b)(6)

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER	TIME OF ORDER
28May07	2010 HOURS

(b)(6)

Kayexalate 50mg Enema DA.
~~BMP in AM~~
BMP at 0100hrs.

(b)(6)

NURSING UNIT	ROOM NO.

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER	TIME OF ORDER
29 MAY 07	0716 HOURS

(b)(6)

1. ↓ Vent rate to 15
2. ABG in 1 hr
3. Type and Cross for 2u PRBC
* Transfuse 2u PRBC each over 3-4 hrs
Premedicate with ~~Tylenol~~ 650 mg per NGT and Benadryl 25mg ~~IV prior~~ to each unit
4. Lasix 40mg IV after 1st unit transfused
5. BMP at 1200hr

ANTEP 29May07 0730

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION: (b)(6)

(b)(6)

24hr Chart Check Completed (b)(6)

(b)(6)

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-500-394

"USE BALL POINT PEN--PRESS FIRMLY I NO CARBON PAPER REQUIRED"

10-L-0126 ACLU DDII CID ROI 21241

ACLU-RDI 5546 p.71

000107

EXHIBIT 5

CLINICAL RECORD - DOCTOR'S ORDERS 0024 07 CID 579 24072

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: 28 May 07 | TIME OF ORDER: 0114 HOURS | LIST TIME ORDER NOTED AND SIGN

✓ Kayexalate 60 mg NG

✓ Lasix 40 mg IV x 1 @ 0400

Noted 5/28/07 e

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 May 07 | TIME OF ORDER: 0441 HOURS

✓ Lasix 40 mg IV

✓ HCO3 + Amp IV

Noted 5/28 e

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

24 hr chart ✓ 28 May

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 07 @0533

(b)(6)

28 May 07 Lasix 40 mg

ABG & BMP @ 1230 hrs

Noted 5/28

(b)(6)

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 May 07 | TIME OF ORDER: 1420 HOURS

✓ Lasix 40 mg IV x 1

✓ ↓ FiO2 to 45%

(b)(6)

5/28

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

24° ✓ done 29 May 07 e 0330

(b)(6)

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

10-L-0126 ACLU DDII CID ROI 21242

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-300-391

ACLU-RDI 5546 p.72

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

006108

EXHIBIT 5

0024 07 C10579 24072

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: 27 MAY 07 TIME OF ORDER: 1915 HOURS — LIST TIME ORDER NOTED AND SIGN

(1) FS q hr x 2 ⇒ 2000 hrs and 2100 hrs

(b)(6)

Noted 5/27/07 e

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27 MAY 07 TIME OF ORDER: 1930 HOURS

Wet-dry dressing changes BID

(b)(6)

(b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27 MAY 07 TIME OF ORDER: 2100 HOURS

(1) Change meds to renal dose ⇒

Δ Imipenem to 125 mg IV q 12°

Δ Zantac 50 mg IV q day

Δ Lovenox to 30 mg sq qday

Δ Zosyn to 2.25 gm IV q 8°

Pharm/ Noted 5/27/07 e

(b)(6)

(b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27 MAY 07 TIME OF ORDER: 2106 HOURS

(1) Please give ½ AM D50. IV

(2) Cont Fingersticks. qhr for 3 hrs

(3) Lasix 40 mg IV XT Rekyla

(4) ~~Hold IV~~ ©

(4) ~~VM~~ Hold Vecuronium in AM at 0700 hrs

(b)(6)

(b)(6)

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

24 hr chart ✓ 28 may 07 EL @ 1263 AC

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-505

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

000100

EXHIBIT 5

CLINICAL RECORD - DOCTOR'S ORDERS 0024 07 C10579 24072

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
27 MAY 07	1708 HOURS	
(1) Avent rate to 20', F_IO_2=50		
(2) ABG in 30 min. noted 1730		

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

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER	TIME OF ORDER	
27 MAY 07	1529 HOURS	
(1) Taper Levophed to D/C.		

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

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER	TIME OF ORDER	
27 MAY 07	1618 HOURS	
(1) D50, 1/2 Amp IV x1		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER	TIME OF ORDER	
27 MAY 07	1858 HOURS	
(1) Lasix 20 mg IV x1 done 1915		
(2) Titrate fentanyl to adequate pain control		noted 1727 OTE
(3) Δ Vent → RR ≥ 18		
(4) BMP (for kt) at midnight		

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

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

24 hr chart ✓ 28 may 07 @ 0533 10-L-0126 ACLU (b)(6)

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-305-991

"USE BALL POINT PEN--PRESS FIRMLY I NO CARBON PAPER REQUIRED"

000110

EXHIBIT 5

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

0024 07 CID579 2407

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
27 May 07	0640 HOURS	

1 12-Lead EKG Stat.

(b)(6)

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

27 May 07 0715 Noted (b)(6)

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
27 May 07	0714 HOURS

0739
1 Lasix 10 mg IV x 1
2 ATV to 700
3 ABG 0830 2L

(b)(6)

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.

pharm

PATIENT IDENTIFICATION
(b)(6)

DATE OF ORDER	TIME OF ORDER
27 May 07	0745 HOURS

1 Advance ET tube 3 cm.
2 Repeat CXR

(b)(6)

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

PATIENT IDENTIFICATION
(b)(6)

DATE OF ORDER	TIME OF ORDER
27 May 07	0821 HOURS

1 ~~Levophed to 7~~ (R)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

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

24 hr chart ✓ 28 May 07 @ 0530

(b)(6)

10-17-0126 ACL

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-305-39

"USE BALL POINT PEN--PRESS FIRMLY I NO CARBON PAPER REQUIRED"

000111

EXHIBIT 5

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG 0024 07 CIP579 2407

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
27 MAY 07	0838 HOURS	
(1) Repeat BMP @ 1800 hrs		
(2) Bibarb, 1 AMP slow IVP = 50 meq		pharm 5/27

PATIENT IDENTIFICATION

(b)(6)

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

DATE OF ORDER	TIME OF ORDER
27 MAY 07	1044 HOURS
(1) Δ Vent to TV = 600	
(2) ABG in 30 min	

PATIENT IDENTIFICATION

(b)(6)

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

DATE OF ORDER	TIME OF ORDER
27 MAY 07	1111 HOURS
(1) NS fluid bolus, 500 cc X 1	

PATIENT IDENTIFICATION

(b)(6)

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

DATE OF ORDER	TIME OF ORDER
27 MAY 07	1231 HOURS
(1) Lasix 10 mg IV	
(2) D50 1/2 AMP IV	
(3) Insulin 6u SQ	
(4) FS 1 hr p insulin then qhr x 4	
(5) Repeat BMP @ 1800 hrs	

pharm

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

24 M chart ✓ 28 may 07

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-30

"USE BALL POINT PEN--PRESS FIRMLY I NO CARBON PAPER REQUIRED"

000112
Exhibit 5

0024 07 CID579 24072

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)

copied for pharm + transcribed 22[illegible] 26 May 07 (b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER: 26 May 06 TIME OF ORDER: 2155 HOURS — LIST TIME ORDER NOTED AND SIGN

1. may increase Levophed up 20 mcg/min
V.O. (b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER: May 26/07 TIME OF ORDER: 2200 HOURS

Epinephrine drip @ 1 mcg/min (Hold) titrate to MAP >60 (b)(6)

26 May 07 @ 2200 noted (b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER: 26 May 07 TIME OF ORDER: 2245 HOURS

1) NS Bolus 1 liter, continue per MAP > 60 1 L/hour NS IV Bolus
2) Hydrocortisone 100 mg IV Q 6 hours
3) ABG repeat
4) Draw Cortisol level

~~26 May 07 @ 2245~~ noted (b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER: 26 May 07 TIME OF ORDER: ~~2245~~ HOURS

1) Hold Epinephrine drip for now. (V.O. (b)(6)

26 May 07 @ [illegible] noted (b)(6)

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

24 hr chart ✓ 28 May 07 @ 1548 (b)(6)

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003 0-495-041

"USE BALL POINT PEN--PRESS FIRMLY I NO CARBON PAPER REQUIRED"

EXHIBIT 5

0024 07 CID579 24072

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)

Transcribed & copied for pharm

NURSING UNIT	ROOM NO.	BED NO.
ICU		3

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
26 MAY 07	2018 HOURS	

① ↓ Vent rate to 16.
② ABG @ 2000hr (b)(6)

2

PATIENT IDENTIFICATION: (b)(6)

20 may 07 @ 2?

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 26 May 07 TIME OF ORDER: 2054 HOURS

✓ start Levophed 5mcg/kg/min titrate to MAP > 60

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 26 May 07 TIME OF ORDER: 2055 HOURS

✓ Order Clarification:
1) Give Epinephrine 100 mcg, IV x 1 now.
2) Begin levophed gtt @ 5 mcg/min, titrate to MAP > 60 mmHg.

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

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 26 May 07 TIME OF ORDER: 2055 HOURS

✓ 1) D/C phenylephrine.
(V.O (b)(6)

NURSING UNIT	ROOM NO.	BED NO.
24-hr chart ✓		28 may 07 @ 0552

(b)(6)

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2[illegible]-300-391

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

EXHIBIT 5

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG 0024 07 CID579 24072

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: 26 MAY 07 TIME OF ORDER: 1532 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Phenylephrine 50 mcg IV bolus, then drip at 40 mcg/min. May titrate to max of 100 mcg/min to keep MAP ≤ 60.
2. Titrate Dopamine to DIC.
3. Vent Δ: FIO2 = .40 Rate = 24

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER ↓ TIME OF ORDER ↓ HOURS

4. ABG At 1615 hrs. done @ 1540 MM
5. NaHCO3 25 meq IV ÷

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 26 MAY 07 TIME OF ORDER: 1652 HOURS

1. NaHCO3 25 meq. IV
2. DIC Propofol® ordered prior
3. ABG @ 1800 hrs

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 26 MAY 07 TIME OF ORDER: 1900 HOURS

1. ABG @ ~~2000 hrs~~ 1945 hrs
2. phenylephrine 100 mg in 500 ml please, to run at current rate
3. Imipenem 500 mg IV q 6°.
4. Tylenol 650 mg PR q 4°, prn

transcribed copied & for pharm 24 may 07 1903

NURSING UNIT | ROOM NO. | BED NO.

24 hr chart ✓ 28 may 07 @ 0500

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2006-300-001

10-L-0126 ACLU DDII CID ROI 21249

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

0001511 5

EXHIBIT

0024 07 CID579 24672

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	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
↓	26 MAY 07	1245 HOURS	
1	Calcium Gluconate, 10% solution 10mL IV over 5-10 minutes	(b)(6)	Done (b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	26 MAY 07	1400 HOURS	
1	Δ Vent ⇒ ↑ rate to 18 ↑ FIO2 to 0.5		Done
2	Blankets	(b)(6)	D

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	26 MAY 07	1422 HOURS	
1	Repeat ABG	(b)(6)	Done D

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	26 MAY 07	1432 HOURS	
1	Dopamine 5 micrograms/kg/minute, titrate to keep MAP >60.	(b)(6)	Done RS

24 hr chart ✓ 28 may 07 @ 0622 (b)(6)

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2006-[illegible]

10-L-0126 ACLU DDII CID ROI 21250

"USE BALL POINT PEN—PRESS FIRMLY I NO CARBON PAPER REQUIRED"

000116

EXHIBIT 5

0024 07 CIC579 24072

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: 26 MAY — TIME OF ORDER: 1035 HOURS — LIST TIME ORDER NOTED AND (b)(6)

① Vecuronium bolus with 8 mg IV, then continuous infusion at 1 mcg/kg/min (estimated body weight = 80 kg)

② Dopamine - premixed bag to ICU

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 26 MAY — TIME OF ORDER: 1133 HOURS

① Vent change:
SIMV Rate = 12 FIO2 = 40%
TV = 600 PS = 10 PEEP = 5
done

② IVF = NS wide open

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 26 MAY 07 — TIME OF ORDER: 1212 HOURS

① Δ IVF rate to 150 cc/hr

② CBC and ABG @ 1300 hrs

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 26 MAY 07 — TIME OF ORDER: 1235 HOURS

① Lasix 5 mg IV x 1

(b)(6)

(b)(6)

(b)(6)

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

24 hr chart ✓ 28 may 07 @ 0437

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-300-001

TOL 0136 ACLU

"USE BALL POINT PEN--PRESS FIRMLY ! NO CARBON PAPER REQUIRED"

000117

EXHIBIT 5

MEDICAL RECORD - PROVIDER ORDERS

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

0024 07 CID5: 2007

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

DATE/ TIME	ORDERS (SIGNATURE REQUIRED FOR EACH ORDER/SET OF ORDERS. SIGNATURE MUST BE LEGIBLE; PROVIDER WILL USE SIGNATURE STAMP
25MAY07	ADMIT to: (ICW) (ICU) (Outpatient Border) (b)(6) / (b)(6)
0800	DX: s/p bsw / ex lap Condition: Stable Critical Guarded
	VITALS: (qshift on ward) (per ICU routine) ALLERGIES: (NKDA)
	ACTIVITY: bed rest Weight Bearing Status: ~~WBAT~~
	NURSING ORDERS (Apply only the checked nursing orders)
	( ) Keep heels OFF bed ( )Elevate affected extremity while in bed
	( ) Consult PT OT Reason:
	( ) Pin care BID - start POD2, or after first dressing change. 50/50 peroxide/water
	( ) Wound Vac care (75mmHG)/(125mmHG) continuous, apply extra sticker for leaks
	(X) Record drain output (qshift) Hemovac JP NGT to LIS CT to ws / suction Foley
	( )Dressing change POD (1) (2) (3) (4) (5) (Daily) (BID) (Dakins) (Wet-Dry) (Xeroform-Dry)
	( ) Labs: (CBC) (CRP) (ESR) (Coags) (ABG) (CMP) (BMP) (Now) (in AM) (qAM) (qAM*3 days)
	( ) Xrays: Lft IV & Hepatitis Panel 2° to needle stick incident (b)(6)
	DIET: (Regular) (Clear liquids) (NPO) (NPO start midnight before surgery DOS:)
	IV FLUIDS: (Heplock) (KVO-30ml/hr NS) (D5 1/2NS + 20 K @ _____/hr) (NS or LR @ 150 cc/hr)
	MEDICATIONS: (Order only the checked medications)
	( ) Percocet (1 - 2) tabs po q6hrs(pt may refuse) ( ) Morphine 2-8mg IV q1hr prn severe pain or while NPO
	( ) Colace 200 mg po BID ( ) Dulcolax 10 mg supp PR QAM BID or: _____
	(X) Zantac 150mg po BID / 50 mg IV q8 ( ) Benadryl (25 mg - 50 mg) po / iv / im q4hrs q8hrs prn itch
	(X) Lovenox 30mg SQ BID- Hold PM dose the night before surgery or insomnia
	(X) Zosyn 3.375gm IV q6hrs ( ) Unasyn 3gm IV q6hrs ( )Ancef 1gm IV q8hrs
	( ) Levofloxacin 500 mg po / iv qd ( ) Cefoxitin 1 gm IV q8hrs
	(X) Zofran (4 mg - 8 mg) IV q4hrs qday prn nausea ( )Reglan 10 mg (IV) (PO) q8hrs
	Call HO for Temp (>100.7) (101.7) HR <50 >120 SBP <90 >200
	Vent settings: simv VT 600 RR 12 F.O2 .40 PS/10/PEEP 5
	NG tube must NOT be removed. (b)(6)
Orders verified (b)(6)	Fentanyl 50-eg/hr titrate for pain relief
	Propofol 25mcg/kg/min titrate for sedation

(b)(6)

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

(b)(6)

Complete the following information on p only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight (lbs): _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.

Form Revised 4/07

10-L-0126 ACLU DDII CID ROI 21252

EXHIBIT 5

ACLU-RDI 5546 p.82

DA FORM 3881-R (PEST) (MCHO)JUN 03 PREVIOUS EDITIONS ARE OBSOLETE. MC-V2.00

000118

24 hr chart ✓ 28 May 07 (b)(6) 110310

0024-07 CID579 24072

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	IMPN
21 Jun 07	
1056	S: Feels fine
	O: Tmax 99.9 80 130/79 16-19 Sat 97-100% (3L N.C.)
	1) alert, NAD
	2) Heart - RRR 6) Neuro - 4/5 strength @ biceps
	3) lungs ↓BS @ L base Still c no movement @ R LE c foot drop
	4) abd - soft, NT, NGT in place Minimal L LE movement, improving
	5) Ext 2+ B LE edema
	RUE @ elbow c doublets, healing
	Labs:
	18.9 > 11.9 < 423 151 | 110 < 28 / 4.1 | 26 > 1.8
	A/P: 1) S/P GSW - Immunizations post splenectomy, w/c off Abx
	2) Pulmonary - Clinically, pt improved 2 d ago. He has been stable on
	3L N.C. Cont Ceftriaxone / flagyl
	3) ARF - Cr 1.8, and continues to improve
	4) Rehab. Cont PT/OT, transfer to Burn.
	(b)(6)

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

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

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

PROGRESS NOTES
Medical Record

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

10-L-0126 ACLU DDII CID ROI 21253

ACLU-RDI 5546 p.83

000119

EXHIBIT 5

Single Married Sunni b(6), b(7)(C) FOUO B Al Kut Baghdad Basit DOE Fallujah, Anbar

Coalition Apprehension Form

0224-07 CPN 24072

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)
- Solicitation of Fornication/Prostitution (I.P.C. 399)
- Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- Murder (I.P.C. 405)
- Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- Maiming (I.P.C. 412)
- Simple Assault (I.P.C. 415) b(6), b(7)(C)
- Kidnapping (I.P.C. 421)
- Burglary or Housebreaking (I.P.C. 428)
- Extortion/Communicating Threats (I.P.C. 430)
- Theft (I.P.C. 439)
- Destruction of Property (I.P.C. 477)
- Obstructing a Public Highway/Place (I.P.C. 487)
- Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- Riot or Breach of Peace (I.P.C. 495(3))
- Other

Offense against Coalition Forces [check one] If "Other" then describe: Assault (A Patrol)

- Violation of Curfew
- Illegal Possession of Weapon
- Assault/Attack on Coalition Forces
- Theft of Coalition Force Property
- Trespass on Military Installation or Facility
- Photographing/Surveilling Military Installation or Facility
- Obstructing Performance of Military Mission
- Other

Apprehending Unit:		Location Grid:	
Date of Incident: (D/M/Y) 26 / 05 / 07 to / /	Time of Incident: 0220 hrs to hrs	Date of Report: (D/M/Y) / /	Time of Report: hrs

Detainee #		Key Connected Person: ☐ Victim ☐ Witness	
Last Name: b(6), b(7)(C)		Last Name:	
First Name:	Given Name:	First Name:	Given Name:
Hair Color: Black	Scars/Tattoos/Deformities: N/A	Hair Color:	Scars/Tattoos/Deformities:
Eye-Color: Brown	Weight: Unk lb / Height: Unk in	Eye-Color:	Weight: lb / Height: in
Address: Unk		Address:	
Place of Birth: Unk		Place of Birth:	
Ethn/Tribe/ Sect: Unk	Sex: ☒ M ☐ F	Ethn/Tribe/ Sect:	Sex: ☐ M ☐ F
Phone#: DOB D/M/Y: Unk	☐ Mobile ☐ Regular	Phone#: DOB D/M/Y:	☐ Mobile ☐ Regular
☐ Passport ☐ Dr. license ☐ Other (specify) Document #:		☐ Passport ☐ Dr. license ☐ Other (specify) Document #:	

Total Number of Persons Involved ____ (list names/identifying info on reverse under "Additional Helpful Information")

☐ Vehicle Information / Vehicle Number ____ of ____ Vehicle(s) / Owner:

Make:	Color:	VIN:	
Model:	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: Yes/ No

Type:	Model:	Color/Caliber:
Serial No.:	Quantity: / Make:	Receipt Provided to Owner: Yes/ No
Other Details:	Where Found: / Place of Birth	Owner:

Name of Assisting Interpreter: Email, Phone, or Contact Info:

Detaining Soldier's Name (Print): b(6), b(7)(C)	Supervising Officer's Na (Print): b(6), b(7)(C)
Signat: b(6), b(7)(C)	Signatur: b(6), b(7)(C)
Email: b(6), b(7)(C) 2 BCT. 10MTN.army.smil.mil	Email: b(6), b(7)(C) 2 BCT. 10MTN. army. smil. mil
Unit Phone: 674-8601 Date: 26 MAY 07	Unit Phone: 674-8601 Date: 26 MAY 07

☐ Vehicle Information / Vehicle Number ____ of ____ Vehicle(s) / Owner:

LAW ENFORCEMENT SENSITIVE

0024 07 CID579 24072

Coalition Apprehension Form

Why was this person detained? He was detained for questioning at an IA Point. It was later determined that he was on the Blacklist and was had been looking for him for two months.

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

1/4/6 IA

B/2-15 FA, 2-10 MTN LT. b(6), b(7)(C) 6 Months

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying? AK-47

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

What weapons was this person carrying? AK-47

Additional Helpful Information:

LAW ENFORCEMENT SENSITIVE

EXHIBIT 6

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

0324.07 CID579 24072

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 (SSN).

PRINCIPAL: 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
MAHMUDIYAH IRAQ	20070526	1637	

5. LAST, FIRST, MIDDLE NAME	6. SSN	7. GRADE/STATUS
b(6), b(7)(C)	b(6), b(7)(C)	O-2

8. ORGANIZATION OR ADDRESS

HHB 2-15TH FA BN 2BCT 10TH MTN DIV APO AE 09322

9. I, b(6), b(7)(C) HAD A [illegible], WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

ON 26 MAY 07 AT APPROXIMATELY 0700HRS ELEMENTS FROM 1/14 IA BROUGHT TWO WOUNDED INDIVIDUALS TO FOB MAHMUDIYAH. ONE OF THE INDIVIDUALS BROUGHT THE FOB WAS b(6), b(7)(C) WHO WAS REPORTED TO HAVE BEEN SHOT BY THE IA. b(6), b(7)(C) HAD A GUNSHOT WOUND TO LEFT LATERAL THORAX APPROXIMATELY AT THE POSTERIOR AXILLARY LINE AND AN EXIT WOUND ANTERIOR THORAX (LEFT) MIDCLAVICULAR LINE. WE WERE INFORMED BY THE IA THAT b(6), b(7)(C) WAS ON THE 1/4/6 IA HAD BEEN LOOKING FOR HIM FOR THE PAST 10 MONTHS. AND THAT THE IA THE OTHER INDIVIDUAL THAT WAS BROUGHT IN WAS b(6), b(7)(C) HE WAS AN IA SOURCE THAT HAD A GUNSHOT WOUND TO HIS RIGHT KNEE. THE WOUND WAS A THROUGH AND THROUGH THAT ENTERED AND PENETRATED b(6), b(7)(C) POSTERIOR TO MEDIAL MALLEOLUS AND EXITED THE POSTERIOR THE b(6), b(7)(C) LATERAL MALLEOLUS. Working Failure's

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

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

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

10. EXHIBIT	11. INITIALS OF PERS b(6), b(7)(C) STATEMENT	PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT ____ 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 V1.00

EXHIBIT 6

0021 07 CID570 24072

STATEMENT OF b(6), b(7)(C) TAKEN AT 1637 DATED 26 MAY 05

9. STATEMENT *(Continued)*

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

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

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

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

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

(Signature of Person Making Statement)

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 26 day of May 2005 at FOB [illegible] IRAQ APO AE 39352

WITNESSES:

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

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

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

(Signature of Person Administering Oath)

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

(Typed Name of Person Administering Oath)

(Authority To Administer Oaths)

ORGANIZATION OR ADDRESS

INITIALS OF PERSON MAKING STATEMENT b(6), b(7)(C)

PAGE 2 OF 2 PAGES

EXHIBIT 236

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

0024 07 CID579 24072

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

AUTHORITY:	Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 (SSN).
PRINCIPAL	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
FOB MAHMUDIYAH	20070526	1634	

5. LAST NAME, FIRST NAME, MIDDLE NAME	6. SSN	7. GRADE/STATUS
b(6), b(7)(C)	b(6), b(7)(C)	E-6

8. ORGANIZATION OR ADDRESS
HHB, 2-15 FA, 10TH MTN DIV LI

9. I, b(6), b(7)(C), WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH.

b(6), b(7)(C) came to the Mahmudiyah AT CIRC ON 26 May 07 with a bullet wound entering on the left upper of his chest and exiting on the abdomen near to the ribs. We (the station) were informed that he was shot during IA action and that he was a bad guy and on the IA black list. We treated his wounds (a grazed bullet hole) and also gave him IVs and a chest tube we exchanged him for transport and drove him to the LZ, loaded him onto the blackhawk MEDEVAC with CPL b(6), b(7)(C) as his escort at that point had no knowledge to responsibility for him. There was also brought in a IA soldier name unknown with a gunshot wound to lateral aspect of his right ankle caught by fire and released to the IA's.

Nothing follows

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

10. EXHIBIT	11. b(6), b(7)(C) OF PERSON MAKING STATEMENT	PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT ____ 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 92, IS OBSOLETE

10-L-0126-ACLU-DDII-CID ROI 24258

EXHIBIT 6

STATEMENT OF [redacted] TAKEN AT 1634 DATED 26 May 07

9. STATEMENT *(Continued)*

[redacted]

(Signature of Person Making Statement)

(Typed Name of Person Making Statement)

AFFIDAVIT

I, [redacted], 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.

[redacted]

(Signature of Person Making Statement)

WITNESSES:

[redacted] 1LT

2-15th FA BN

2nd BCT 10th MTN DIV APO AE 09322

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 26 day of MAY, 2007 at FOB [illegible] IRAQ APO AE 09322

[redacted]

(Signature of Person Administering Oath)

[redacted] SGT, MI

(Typed Name of Person Administering Oath)

(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT [redacted]

PAGE 2 OF 2 PAGES

EXHIBIT 6

LOCAL NATIONAL NAME: b(6), b(7)(C)

TRANSLATED REPORT:

1. Which insurgency group does (b)(6), (b)(7)(C) belong to?
   - b(6), b(7)(C) belongs to Towhid Al Jihad – Al Qaeda (TWJ AQIZ)

2. Who is the Prince of the insurgent group?
   - The Prince is b(6), b(7)(C) as known as b(6), b(7)(C)

3. Who are additional members of the insurgency group?
   - b(6), b(7)(C)

4. What activities did the detainee, b(6), b(7)(C) participate in?
   1. In December 2006, b(6), b(7)(C) and his group attacked the houses belong to: b(6), b(7)(C), b(6), b(7)(C) and b(6), b(7)(C)
   2. b(6), b(7)(C) and his group killed the three local nationals, blew up their homes, and stole all of their possessions.
   3. b(6), b(7)(C) and his group make fake checkpoints behind the Karkh Oil Facility.
   4. Throughout 2004 and 2005, b(6), b(7)(C) and his group stole cars and killed civilians.
   5. b(6), b(7)(C) and his group evicted Shia people from Hyy Al Salaam district and took Shia homes in order to be used by TWJ AQIZ insurgents.
   6. In 2004, b(6), b(7)(C) is the individuals who blew up the Lutifiyah Bridge along RTE Jackson.
   7. On 17 February 2006, b(6), b(7)(C) and his group attacked the IA Checkpoints in Lutifiyah
   8. In 2006 b(6), b(7)(C) is involved in the killing of Haydar Ali Shodhon, as well as the stealing of Haydar Shodhon's kia bus.
   9. On 13 May 2007, b(6), b(7)(C) led his group in their attack of the IA Dairy Farm Checkpoint.
   10. In December 2006, b(6), b(7)(C) killed 2x Shia Females and 1x child in Hyy Al Ba'ath district of Hyy Al Salaam when the local nationals came to receive their Rushen Food Card.
   11. In 2004, b(6), b(7)(C) attacked a shop owner by the name of b(6), b(7)(C) b(6), b(7)(C)

5. Do you have another other questions?
   - No, this concludes my sworn statements.

0024 07 CID579 24072

LOCAL NATIONAL NAME: b(6), b(7)(C)

TRANSLATED REPORT:

1. Which insurgency group does b(6), b(7)(C) belong to?
   - b(6), b(7)(C) belongs to Towhid Al Jihad – Al Qaeda (TWJ AQIZ)

2. Who is the Prince of the insurgent group?
   - The Prince is b(6), b(7)(C) as known as (b)(6), (b)(7)(C)

3. Who are additional members of the insurgency group?
   - b(6), b(7)(C)

4. What activities did the detainee, b(6), b(7)(C) participate in?
   1. In December 2006, b(6), b(7)(C) and his group attacked the houses belong to: b(6), b(7)(C)
   2. b(6), b(7)(C) and his group killed the three local nationals, blew up their homes, and stole all of their possessions.
   3. b(6), b(7)(C) and his group make fake checkpoints behind the Karkh Oil Facility.
   4. Throughout 2004 and 2005, b(6), b(7)(C) and his group stole cars and killed civilians.
   5. b(6), b(7)(C) and his group evicted Shia people from Hyy Al Salaam district and took Shia homes in order to be used by TWJ AQIZ insurgents.
   6. In 2004, b(6), b(7)(C) is the individual who blew up the Lutifiyah Bridge along RTE Jackson.
   7. On 17 February 2006, b(6), b(7)(C) and his group attacked the IA Checkpoints in Lutifiyah
   8. On 13 May 2007, b(6), b(7)(C) led his group in their attack of the IA Dairy Farm Checkpoint.
   9. In December 2006, b(6), b(7)(C) killed 2x Shia Females and 1x child in Hyy Al Ba'ath district of Hyy Al Salaam, because they were Shia.

5. Do you have another other questions?
   - No, this concludes my sworn statements.

EXHIBIT 6