DEPARTMENT OF THE ARMY
UNITED STATES ARMY CRIMINAL INVESTIGATION COMMAND
48TH MILITARY POLICE DETACHMENT (FWD)(-)
11TH MILITARY POLICE BATTALION (CID)(FWD)
BAGHDAD CENTRAL CONFINEMENT FACILITY
ABU GHRAIB, IRAQ APO AE 09342

CIRFR-PIT 29 JULY 2005

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION – FINAL/SSI - 0059-05-CID789 -39259 - ~~5H9~~B/5H6

1. DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 4 APR 2005, 1817 - 24 APR 2005, 2125; BAGHDAD CENTRAL CONFINEMENT FACILITY (BCCF); GRID: 38S MB 130 840; ABU GHRAIB, IRAQ (IZ)

2. DATE/TIME REPORTED: 4 APR 05, 1823

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

4. SUBJECT: 1. NONE; HOMICIDE (JUSTIFIABLE)

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

6. INVESTIGATIVE SUMMARY:

THIS IS AN "OPERATION IRAQI FREEDOM" INVESTIGATION.

This investigation was initiated when CPL (b)(6), (b)(7)(C) Patient Administration Department, Task Force Medical 115th Field Hospital, Abu Ghraib, IZ, notified this office of a detainee death.

Investigation disclosed that ISN 171687 died as result of a gunshot wound to the right hip and flank during an altercation with US coalition forces. Therefore his death was combat related and a justifiable homicide.

STATUTES:

N/A

EXHIBITS/SUBSTANTIATION:

ATTACHED:

1. Agent's Investigation Report (AIR) of SA (b)(6), (b)(7)(C) 21 Jul 05, detailing the initial notification, medical and law enforcement coordinations and information report.

2. Compact Disk 050059.789 containing images of (b)(6), (b)(7)(C)

3. Medical records pertaining to (b)(6), (b)(7)(C)

4. Capture paperwork pertaining to (b)(6), (b)(7)(C)

5. Dossier and Detainee Personnel Report of (b)(6), (b)(7)(C)

6. AIR of SA (b)(6), (b)(7)(C) 15 Apr 05, detailing medical coordinations.

7. Medical records pertaining to (b)(6), (b)(7)(C)

8. Certificate of Death of (b)(6), (b)(7)(C)

9. AIR of SA (b)(6), (b)(7)(C) 3 May 05, detailing (b)(6), (b)(7)(C) autopsy.

10. Compact Disk ME 05-383 containing images of (b)(6), (b)(7)(C) (USACRC and file copy only).

11. Fingerprints of (b)(6), (b)(7)(C)

12. Final Autopsy Report #ME 05-383, 24 May 05, pertaining to (b)(6), (b)(7)(C)

13. Evidence/Property Custody Document, DA Form 4137, Voucher Number (VO) 510-05.

NOT ATTACHED:

Retained in the evidence depository, 11th MP BN (CID), Camp Victory, Iraq.

14. Plastic cup containing one piece of shrapnel, VO 510-05.

The originals of Exhibits 1, 2, 6, 9 and 10 were forwarded with the USACRC copy of this report. The originals of Exhibits 3-5, 7 and 8 are retained in the files of the Task Force 134, Camp Victory, Iraq. The originals of Exhibits 11 and 12 are retained in the files of AFIP, Rockville, MD 20850. The original of Exhibit 13 is retained in the files of the Evidence Depository, 11th MP BN (CID), Camp Victory, IZ.

STATUS: This is a Final Report. Commander's Report of Action Taken (DA Form 4833) is not required.

Report Prepared By:

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

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

Report Approved By:

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

Special Agent in Charge

DISTRIBUTION:

1 - Director, USACRC, (ATTN: CICR-CR), 6010 6th Street, Fort Belvoir, VA 22060-5506 (original)
1 - Thru: CDR, 11th MP BN (CID) (FWD) (email only)
Thru: CDR, 3rd MP Group (CID) (email only)
To: CDR, HQUSACIDC (email only)
1 - Chief, Investigative Operations Division, USACIDC (email only)
1 - CID Current Operations, USACIDC (email only)
1 - Deputy Chief of Staff of Operations, USACIDC (email only)
1 - AFIP, Attn: OAFME, Rockville, MD (email only)
1 - CDR, BCCF (email only)
1 - PMO, BCCF (email only)
1 - SJA, BCCF (email only)
1 - File

AGENT'S INVESTIGATIVE REPORT

CID Regulation 195-1

ROI NUMBER 0059-2005-CID789-39259

DETAILS:

About 1823, 4 Apr 05, this office was notified by CPL (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) Patient Administration (PAD), 115th Field Hospital (115th FH), Baghdad Central Confinement Facility (BCCF), Abu Ghraib, Iraq (AGI), a detainee died. CPL (b)(6), (b)(7)(C) identified the detainee as Internment Serial Number (ISN) (b)(6), (b)(7)(C) NFI.

About 1925, 4 Apr 05, SA (b)(6), (b)(7)(C) this office, photographed ISN (b)(6), (b)(7)(C) body. (See Compact Disk 050059.789)

About 1930, 4 Apr 05, the undersigned obtained a copy of ISN (b)(6), (b)(7)(C) medical file from CPL (b)(6), (b)(7)(C) The medical record contained daily medical logs, the Hospital Report of Death detailing the detainee's time of death at 1817, 4 Apr 05, and the detainee's Certificate of Death, 4 Apr 05, detailing the detainee's Cause of Death as a Gunshot Wound to Right Flank. (See Medical File, Hospital Report of Death, and Certificate of Death of ISN (b)(6), (b)(7)(C)

About 1945, 4 Apr 05, the undersigned obtained a copy of ISN (b)(6), (b)(7)(C) capture paperwork from SGT (b)(6), (b)(7)(C) 306th Military Police Battalion (306th MP Bn), BCCF, AGI, who related no further paperwork came with the detainee. The capture paperwork contained a Detention Checklist; a Coalition Provisional Authority Forces Apprehension Form; Sworn Statements of SPC (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) and SPC (b)(6), (b)(7)(C) both of the 617 MP Co, Iraq, NFI; and a Receipt for Inmate or Detained Person. (See Capture Paperwork of ISN (b)(6), (b)(7)(C)

AGENT'S COMMENT: A review of the detainee's capture paperwork and medical paperwork revealed the detainee was seriously injured at the time of the capture and does not appear to have ever been conscious enough to provide his name or any other biographical information. Further, SPC (b)(6), (b)(7)(C) Sworn Statement was written by SGT (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) NFI, for SPC (b)(6), (b)(7)(C) and SPC (b)(6), (b)(7)(C) did not sign the statement.

About 2108, 4 Apr 05, the undersigned coordinated with SSG (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) In-processing Holding Area (IHA), 306th MP Bn, BCCF, AGI, who provided a copy of ISN (b)(6), (b)(7)(C) dossier and Detainee Personnel Report. (See Dossier and Detainee Personnel Report)

TYPED NAME, SEQUENCE NUMBER	ORGANIZATION
SA (b)(6), (b)(7)(C), (b)(7)(F)	48th MP Det (CID)(FWD)(-), BCCF, AGI, APO AE 09342
SIGNATURE (b)(6), (b)(7)(C)	DATE 21 Jul 05 / EXHIBIT

CID FORM 94-E

(Automated)

AGENT'S INVESTIGATIVE REPORT
CID Regulation 195-1

ROI NUMBER 0059-2005-CID789-39259

DETAILS:

About 1300, 20 Apr 05, this office received the Final Information report from the 48th MP Det (CID)(FWD), Camp Victory, Iraq, detailing receipt of medical records pertaining to ISN (b)(6), (b)(7)(C) while at the 86th Combat Support Hospital (86th CSH), Baghdad, Iraq. (See AIR of SA (b)(6), (b)(7)(C) and medical records from the 86th CSH)

About 1625, 2 Jul 05, the undersigned obtained a copy of the Certificate of Death pertaining to ISN 171687 from SSG (b)(6), (b)(7)(C) The Certificate of Death listed the Cause of Death as a gunshot wound. (See Certificate of Death)

About 1000, 9 Jul 05, this office received an information report from the Aberdeen Proving Grounds RA pertaining to detainee (b)(6), (b)(7)(C) autopsy. (See AIR of SA (b)(6), (b)(7)(C) fingerprints and CD ME 05-383)

About 1749, 21 Jul 05, SA (b)(6), (b)(7)(C) this office, received a copy of detainee (b)(6), (b)(7)(C) final autopsy report from the Office of the Armed Forces Medical Examiner (OAFME), Armed Forces Institute of Pathology (AIFP), 1413 research blvd., bldg. 102, Rockville, MD 20850, which listed the manner of death as homicide and the cause of death as complications of a single projectile injury, reported to have been a gunshot, to the right hip and flank. (See Autopsy Report) ///LAST ENTRY///

TYPED	ORGANIZATION
SA (b)(6), (b)(7)(C), (b)(7)(F)	48th MP Det (CID)(FWD)(-), BCCF, AGI, APO AE 09342
SIGNATURE (b)(6), (b)(7)(C)	DATE 21 Jul 05 / EXHIBIT

0059-05-CID789-39259

COMPACT DISC 050059.789
(PHOTOGRAPHIC IMAGES)

0059-05-CID789-39259

COMPACT DISC 050059.789
(PHOTOGRAPHIC IMAGES)
(DECEASED DETAINEE)

EXHIBIT 2

EXHIBIT 2

0068-05-CID789-39259

PHOTOGRAPH PACKET

NUMBER	DESCRIPTION OF PHOTOGRAPHS
1	Photograph depicting upper torso of 171934
2	Photograph depicting face ID view of 171964

EXHIBIT

Exhibits 3

Page(s) 11 THRU 102 referred to:

CDR USAMEDCOM
ATTN: FOIA Office, STOP 76
1216 Stanley RD 2D FL
FT. Sam Houston, TX 78234-5049

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 H[illegible]AL

Instructions - Medical Officer in attendance will:

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

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

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

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

(b)(6) A14F

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

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) 05

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

UNKNOWN

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* GUNSHOT WOUND TO RIGHT FLANK	16 DAYS
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) UNKNOWN	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a. UNKNOWN	
	b.	

9. DATE: (b)(6) 05

10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE: (b)(6)

11. (b)(6)

SECTION B - ADMINISTRATIVE ACTIO[illegible]

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

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)*: ☐ YES ☒ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

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

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

11 3

0059 05 CID789-3925

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

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prenoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
(b)(6)	K78	Detainee	(b)(6)

	NATION *(e.g., United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe
UNKNOWN, UNKNOWN M O DETAINEE INPROCESSING	Iraq		[X] MALE Masculin [ ] FEMALE Féminin

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

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

MEDICAL STATEMENT Declaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)			INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [1] Maladie ou condition directement responsable de la mort		GUNSHOT WOUND TO RIGHT FLANK	16 DAYS
ANTECEDENT CAUSES Symptômes précurseurs de la mort	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	UNKNOWN	
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire	UNKNOWN	
OTHER SIGNIFICANT CONDITIONS [2] Autres conditions significatives [2]		UNKNOWN	

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

DATE OF DEATH *(Hour, day, month, year)* Le jour, le mois, l'a	PLACE OF DEATH Lieu de décès
(b)(6) 05 (b)(6)	ABU GHRAIB, IRAQ

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

NAME OF ... médicin militaire ou du médicin sanitaire	TITLE OR DEGREE Titre ou diplôme
(b)(6)	

GRADE Grade	INSTALLATION OR ADDRESS Installation ou adresse
(b)(6)	(b)(6) 115th FIELD HOSPITAL ABU GHRAIB PRISON
DATE Date (b)(6) 05	SIGNATURE Signature

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

DD FORM 2064, APR 1977 REPLACES DA FORM 3565, 1 JAN 1972 AND DA FORM 3565-R(PAS), 28 SEP 1975, WHICH ARE OBSOLETE. ... A V1.00

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

DISPOSITION OF REMAINS			
NAME OF MORTICIAN PREPARING REMAINS	GRADE	LICENSE NUMBER AND STATE	OTHER
INSTALLATION OR ADDRESS	DATE	SIGNATURE	
NAME OF CEMETERY OR CREMATORY	LOCATION OF CEMETERY OR CREMATORY		
TYPE OF DISPOSITION ☐ BURIAL ☐ CREMATION ☐ REMOVAL *(Specify)*		DATE OF DISPOSITION	

REGISTRATION OF VITAL STATISTICS			
REGISTRY *(Town and Country)*	DATE REGISTERED	FILE NUMBER	
		STATE	OTHER
NAME OF FUNERAL DIRECTOR	ADDRESS		
SIGNATURE OF AUTHORIZED INDIVIDUAL			

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

ICU FLOW SHEET

OTSG APPROVED (Date)

EKG STRIPS

VASCULAR ACCESS

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

(Continue on reverse)

(b)(6)

DEPARTMENT/SERVICE/CLINIC: ICU / 6

DATE: (b)(6) 05

Name —last,

(b)(6)

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

6

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

DA FORM 4700, MAY 78

USAPPC V

0059 05 CID789-39259

DATE		DIAGNOSIS									HOSPITAL DAY							
Time	07:30	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22	
NIBP/PRE TRANS FUSION ABP	95/35	99/36	160/35	80/31	103/35	95/34	102/44	59/28		49/27	48/27							
Pulse	105	104	99	92	100	101	103	102	100	103	102							
Respirations	24	24	27	27	17	25	23	28	31	30	31							
Temperature	98.8	99.4	98.2	98	98	98	101	99	100	98	99							
SaO2	5%	5%	5%	5%	5%	5%	5%	100	100	100%	100							
%O2	94%	94%	99%	97%	99%	97%	97%	98%	99%	99%	98							
O_2 Delivery	MV		MV	MV	MV	MV	MV	MV	MV	MV	MV							
CVP																		
NIBP	80/34			85/25	91/39	91/40	97/40	97/38		91/35	91/35							
				Finish 1st Unit PRBC and Begin 2nd Board			Finish 2nd Unit PRBC											
Pain Scale	?																	
Pain Med	?																	
Pt Position	recumbent																	

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV																		
IVPB	287				-	150	150	100	400	1000								
Phenylephrine	/	/	/	22	37	37	45	60	201	150	150	150						
Fentanyl	10	10	10	10	10	10	10	10	80	10	~~off~~	~~off~~						
Blood				400				400	800	/								
Versed	5	5	5	5	5	5	5	5	40	5	off							
~~PO LASIX~~	37.5	37.5	37.5	D/C					150									
Other Dopamine	9	9	9	D/C					27									
TOTAL								16	98									
~~LASIX 37.5 37.5 37.5 D/C~~ see above									150									

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

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

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

Exhibit 3

POST OPERATIVE DAY	PHYSICIAN

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP								
Pulse								
Respirations								
Temperature								
SaO2								
%O2								
O_2 Delivery								
CVP								
Pain Scale								
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT	7659.5	
OUTPUT	3529	
DIFFERENCE	4130.5	

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV										
IVBP										
PO										
Other										
TOTAL										

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

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

Name	Signature	Init

SYSTEM	DAYS	NIGHTS
NEURO	April 4, 04	
Level of consciousness	Pham Sedation	
Extremities: Movement	UTA	
Strength	UTA	
PAIN ASSESSMENT	NO S/Sx	
CARDIOVASCULAR		
Rhthym/Lead	S1 S2 ; NSR	
Heart Sounds	S1 S2	
Skin	Pink	
Edema	Generalized edema	
JVD/ Capillary refill	Ø < 3sec	
Pulses: Radial	+ +	
Posterior Tibial		
Dorsalis Pedis	++ ++	
RESPIRATORY		
Breath Sounds	Coarse	
Oxygen Delivery	Mech Vent	
Suctioning/Sputum	CONSTANTLY / Bloody Sputum	
ETT/Trach tube	ETT	
Size: Placement:	26cm/8.0	
Cough:	~~0~~	
Treatments:	↑ TV to 800	
GASTROINTESTINAL		
Bowel Sounds	Absent	
Abdomen	DISTENDED	
Date of last BM	03 Apr 05	
NG tube: Placement	L NARE	
Suction	Intermittent	
Drainage	Bloody	
GENITORUINARY		
Urine: Color	Amber (scant)	
Void/Foley	Foley	
INTEGUMENTARY		
Integrety	Abdominal Wound (L) Hip	
Dressings	(R) CHEST	
Dressing Condition	CDI	
Drains/Tubes	JP to LIS; Pleuravacs	
Drainage	Bloody	
Signature	(b)(6)	

M[illegible]ICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **ICU FLOW SHEET**

OTSG APPROVED (Date)

EKG STRIPS

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(L)SC TLCC	31 MAR 05				
(R) radial A line					

(b)(6)

(Continue on reverse)

ARTMENT/SERVICE/CLINIC: ICU

DATE: 03 APR 05

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

(b)(6)

UNKNOWN, UNKNOWN
0 DETAINEE
INPROCESSING

#6

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

DA FORM 4700, MAY 78

USAPPC 18

10-L-0126 ACLU DD III (CID ROI) 2804

Exhibit 3

DATE	DIAGNOSIS									HOSPITAL DAY							
Time	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22
NIBP/ ABP	120/56	118/55	113/55	111/50	101/44	103/45	98/44	100/45		107/47	104/44	107/55	146/65	148/64	147/63	105/45	101/38
Pulse	122	121	120	113	114	116	112	113		107	109	111	94	95	101	116	119
Respirations	16	16	16	16	16	16	16	16		16	16	16	16	16	17	24	25
Temperature	102.9													102	—	—	—
SaO2	96%	96%	97%	97%	97%	97%	97	98		98%	98%	97%	99%	99	99	99	98
%O2	40%	40%	40%	40%	40%	40%	40%	40%		40%	40%	40%	40%	40%	40	40	40
O_2 Delivery	VENT	VENT	VENT	VENT	VENT	VENT								VENT →			
CVP																	
Pain Scale																	
Pain Med																	
Pt Position																	

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV						50	350		400	400		450						850
IVPB														100	30		50	180
DOPAMINE	9	9	9	9	9	9	9	9	72	9	9	9	9	9	9	9	9	144
LASIX	30	30	30	30	30	30	30	30	240	30	30	30	30	30	30	30	30	480
LIPIDS	14	14	14	14	14	14	14	14	112	14	14	14	14	14	14	14	14	224
VERSED	5	5	5	5	5	5	5	5	40	5	5	5	5	5	5	5	5	80
POTENT	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	10	10	160
Other TPN	90	90	90	90	90	90	90	90	720	90	90	90	90	90	90	90	90	1440
TOTAL																		

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output Hour/Total				34					34				60/94		125/219			219
NG output																		
Emesis															F		1000	1000
Stool													300		400			700
Chest tube #1/ #2																		
Jackson Pratt #1/ #2					1000			300	1300				300/1600		200/1800		200/2000	2000
SUCTION																	1000	1000
TOTAL																		

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

Continues

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

BED# 6 0059 05 CID789-392

POST OPERATIVE DAY	PHYSICIAN

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP	92/36	89/36	89/36	81/31	91/36	90/35	98/46	90/39
Pulse	117	116	115	113	107	107	106	106
Respirations	18	16	24	20	29	29	21	20
Temperature					101.0		99.8	101
SaO2	99%	99%	99	99	100	100	100	100
%O2	55%	55%	55	55	100%	100%	100%	50%
O_2 Delivery	VENT →				VENT →			
CVP								
Pain Scale								
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT	4958.1	7659.5
OUTPUT	6377	3529
DIFFERENCE	-1418.9	4130.5

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
	bolus				follow					
IV	1000				1000				2000	2850
IVBP		200				350 PRN		250	800	980
DOPAMINE	9	9	9	9	9	9	9	9	72	216
LASIX	30	30	30	37.5	37.5	37.5	37.5	37.5	277.5	757.5
LIPIDS	14	14	14	14	14	14	14	14	112	336
VERSED	5	5	5	5	5	5	5	5	40	120
POTENT	10	10	10	10	10	10	10	10	80	240
Other TPN	90	90	90	90	90	90	90	90	720	2160
TOTAL										7659.5

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total		0/219						30	30	249
NG output				1000					1000	2000
Emesis										
Stool				large						700
Chest tube #1/ #2									130	130
Jackson Pratt #1/ #2								50	50	450
TOTAL										3529

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

Name	Signature	Init
(b)(6)		

SYSTEM	DAYS	NIGHTS
NEURO	03 APR 05 7:30	@ 2000
Level of consciousness	SEDATED	Pharm. Sedated
Extremities: Movement	Ø	Ø
Strength	Ø	Ø
PAIN ASSESSMENT	FENT. DRIP	Fentanyl drip
CARDIOVASCULAR		
Rhthym/Lead	ST	ST
Heart Sounds	S_1 S_2	S_1 S_2
Skin	W & D	W & D
Edema	GENERALIZED	+ 2 non pitting All over
JVD/ Capillary refill	Ø / < 3 SEC	Ø / < 3 Secs
Pulses: Radial	+ +	+2 (B)
Posterior Tibial		
Dorsalis Pedis	+ +	+2 (B)
RESPIRATORY		
Breath Sounds	COARSE	COARSE ON INSP & EXP
Oxygen Delivery	VENT	VENT
Suctioning/Sputum	OCASIONALY	PRN
ETT/Trach tube	ETT	ETT
Size: Placement:	26 cm/8.0	26cm / 8.0
Cough:	+	Ø
Treatments:	SUCTION	SUCTION
GASTROINTESTINAL		
Bowel Sounds	HYPERACTIVE	ACTIVE
Abdomen	DISTENDED	DISTENDED
Date of last BM	02. APR. 05	03 APR 05
NG tube: Placement	(L) NARE	(L) NARE
Suction		CLAMPED
Drainage		Ø RESIDUAL
GENITORUINARY		
Urine: Color	AMBER	AMBER
Void/Foley	FOLEY	FOLEY
INTEGUMENTARY		
Integrety	ABD WOUND, (L) HIP, (R) CHEST	NO Δ
Dressings	ABD, (L) HIP, (R) CHEST	
Dressing Condition	CDI	Δ'd this shift: CDI
Drains/Tubes	JPX2, PLEURE-VAC	NO Δ
Drainage	SEROSANGUINOUS	
Signature	(b)(6)	(b)(6)

...DICAL RECORD-SUPPLEMENTAL MEDICAL DAT

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

REPORT TITLE: ICU FLOWSHEET

OTSG APPROVED (Date)

NURSING NOTES

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(L) SCTLCC	31 MAR05	ASSES			patent x3
(R) radial Aline		ASSES			patent

(Continue on reverse)

(b)(6)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 02APR05

– last

(b)(6)

UNKNOWN, UNKNOWN
M 0 DETAINEE
INPROCESSING

BED# 6

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPP 22

10-L-0126 ACLU DD III (CID ROI) 2808 Exhibit 3

DATE	DIAGNOSIS																	
Time	07	08	09	10	11	12	13	14		15	16		18	19	20	21	22	
NIBP/ ABP	140/69	137/68	135/68	118/57	119/59	135/67	135/66	138/68		140/69	137/71	141/72	143/67	106/68			131/55	
Pulse	103	101	106	107	107	107	109	112		109	101	104	98	98			114	
Respirations	16	16	16	16	16	16	16	16		16	16	16	16	16			17	
Temperature	99.1						101.8							100.4			100.2	
SaO2	98%	98%	98%	98%	98%	98	98	97		97%	97%	99%	99%	100			99	
%O2	40%	40%	40%	40%	40%					40%	40%	40%	40%					
O_2 Delivery	VENT.	VENT	VENT	VENT	VENT					vent.								
CVP																		
Pain Scale																		
Pain Med																		
Pt Position																		

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV						100		50	150								50	200
IVPBLASIX	25	25	25	37.5	37.5	37.5	37.5	37.5	262.5	37.5	37.5	37.5	37.5	38	38	38	38	564.6
TPN	90	90	90	90	90	90	90	90	720	90	90	90	90	90	90	90	90	1440
VERSED	5	5	5	5	5	5	5	5	40	5	5	5	5	5	5	5	5	80
FENTANYL	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	10	10	160
LIPIDS	14	14	14	14	14	14	14	14	112	14	14	14	14	14	14	14	14	224
PODOPAMINE	8.9	8.9	8.9	8.9	8.9	8.9	8.9	8.9	71.2	8.9	8.9	8.9	8.9	8.9	8.9	8.9	8.9	142.4
OTHEROSMOLYTE	10	10	10	20	20	20	20	20	130	20	20	20	20	20	20	20	20	290
TOTAL									1565.7									

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output Hour/Total		26	22/48			80/128	15/143		143	60	54/114	11/125	62/187					
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2	70/								70									
Jackson Pratt #1/ #2	110/100	210/100	150/150					1000	1820				1100/1920				1520	3420
									50									
									1963									
TOTAL									2033									

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

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

(6)

POST OPERATIVE DAY 1								
TIME	23	24	01	02	03	04	05	06
NIBP/ ABP		151/79		[illegible]		113/47		106/42
Pulse		81		104		121		121
Respirations		17		19		19		29
Temperature		101.8		101.8				103.7
SaO2		99		98%		97		97
%O2				40%		40%		40%
O_2 Delivery				aerol		V		V
CVP								
Pain Scale								
Pain Med								
Pt Position								

TIME	23	24	01	02	03	04	05	06	Total 8 hr
IV		100						150	450
IVBP LASIX	28	28	28	28	28	28	28	28	268.5
TPN	90	90	90	90	90	90	90	90	2160
VERSED	5	5	5	5	5	5	5	5	120
FENTANYL	10	10	10	10	10	10	10	10	240
LIPIDS	14	14	14	14	14	14	14	14	336
PO DOPAMINE	8.9	8.9	8.9	8.9	8.9	8.9	8.9	8.9	213.6
Other OSMOLITE	10	10	10	10	HOLD				330
TOTAL									4958.1

TIME	23	24	01	02	03	04	05	06	Total 8 hr
Urine output Hour/Total	/	/	/	80/367	/	50/417	/	40/457	457
NG output									
Emesis									
Stool									
Chest tube #1/ #2	/	/	/	/	/	/	/	/	/
Jackson Pratt (#1) (#2)	/	/	/	/	/	1080/4420	/	1500/5920	5920
TOTAL									6377

24-hour totals	Yesterday	Today
INPUT	4509.6	4958.1
OUTPUT	5045	6377
DIFFERENCE	-535.4	-1418.9

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

Name	Signature	Init
(b)(6)		

0107 09-29259

SYSTEM	DAYS	NIGHTS
NEURO	02 APR 05 08:00	0300
Level of consciousness	SEDATED	P3
Extremities: Movement	⊖	⊖
Strength	⊖	⊖
PAIN ASSESSMENT	FENT. DRIP	Fentanyl drip
CARDIOVASCULAR		
Rhthym/Lead	ST	ST
Heart Sounds	$S_1 S_2$	$S_1 S_2$
Skin	W&D	CW&D
Edema	GENERALIZED ALL BODY	Generalized
JVD/ Capillary refill	⊖ JVD / < 3 SEC	⊖ JVD / < 3
Pulses: Radial	+ +	+ +
Posterior Tibial		
Dorsalis Pedis	+ +	+ +
RESPIRATORY		
Breath Sounds	COARSE	Coarse
Oxygen Delivery	VENT	Vent
Suctioning/Sputum	PRN	PRN
ETT/Trach tube	ETT	ETT
Size: Placement:	8.0 / 25cm	8.0 / 25cm
Cough:	YES	+
Treatments:	SUCTION	Suction
GASTROINTESTINAL		
Bowel Sounds	ACTIVE X4	hyperactive
Abdomen	DISTENDED	distended
Date of last BM	01.04.2005	Bloody carbonaceous
NG tube: Placement	(L) NARE	(L) nare
Suction	OSMOLYTE	OSMO dced
Drainage	10 cc/hr	—
GENITORUINARY		
Urine: Color	YELLOW	Yellow / Dark
Void/Foley	FOLEY	Foley
INTEGUMENTARY		
Integrety	ABD WOUND; (L) HIP; (R) CHEST	=)
Dressings	ABD WOUND; (L) HIP (R) CHEST	=)
Dressing Condition	CDI	Prepare dsg @ pt side
Drains/Tubes	2 JP; PLEURE-VAC	2 JPs, Pleurovac CTX
Drainage	SEROUS (b)(6)	Serosanguinous Thigh pt
Signature	(b)(6)	

10-L-0126 ACLU DD III (CID ROI) 2811

Exhibit 25 3

0059 05 CID789-39259

ICAL RECORD-SUPPLEMENTAL MEDICAL DAT

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

REPORT TITLE: ICU FLOWSHEET

OTSG APPROVED (Date)

NURSING NOTES

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(L) CTLCC	(b)(6) 31 MAR05	Asses			patent x 3
(R) radial A Line	?	Asses			patent

(Continue on reverse)

(b)(6)

(b)(6)

DEPARTMENT/SERVICE/CLINIC: (b)(6) ICU

DATE: 01APR05

(First, middle, grade/rate) — (last)

6 UNKNOWN, UNKN... M O DETAINEE INPROCESSING

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

DA FORM 4700, MAY 78

USAPP 26

10-L-0126 ACLU DD III (CID ROI) 2812 Exhibit 3

DATE	DIAGNOSIS																
Time	07	08	09	10	11	12	13	14		15	16		18	19	20	21	22
NIBP/ ABP	122/70	124/61	147/67	128/65	127/67	137/56	142/73	160/71		152/74	143/69	158/66	144/72	144/70	148/60	155/70	161/70
Pulse	104	105	107	105	116	118	110	104		108	109	120	110	100	96	97	95
Respirations	16	16	16	16	16	16	16	16		15	16	16	16	16	16	16	16
Temperature		101.0		101.6		101.7		101.5				100.8		100.9	—	—	1006
SaO2	98%	98%	98%	99%	97%	98	99	100		99	95%	100%	95%	100%	99%	100%	100%
%O2	50%	50%	50%	50%	60%	50%	50%	60%						40%	40%	40%	40%
O_2 Delivery	VENT							Vent									
CVP																	
Pain Scale																	
Pain Med																	
Pt Position																	

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV		500				10			500									500
IVPB						100		50	150	350			100				50	650
DOPAMINE	8.9	8.9	8.9	8.9	8.9	8.9	8.9	8.9	71.2	8.9	8.9	8.9	8.9	8.9	8.9	8.9	8.9	142.4
OSMOLYTE	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	10	10	160
VERSED	5	5	5	5	5	5	5	5	40	5	5	5	5	5	5	5	5	80
FENTANYL	10	10	10	10	10	10	10	10	80	80	80	80	80	10	10	10	10	160
PO TPN	90	90	90	90	90	90	90	90	720	90	90	90	90	90	90	90	90	1440
Other LIPIDS	14	14	14	14	14	14	14	14	112	14	14	14	14	14	14	14	14	224
TOTAL LAST 8									1753.2					25	25	25	25	100

→ 3456.4

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output Hour/Total		30			50/80		75/155		155		75/230				60/290		70/360	360
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2																		
Jackson Pratt #1/ #2	50/40	50/50	70/70	100/90	100/100	100/100	120/110	110/110	1390	110/110	210/150	110/140	100/100	110/110	40/80	160/260	100/25	3305
TOTAL									1545									3665

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

Continuous

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

POST OPERATIVE DAY							PHYSICIAN	
TIME	23	24	01	02	03	04	05	06
NIBP/ ABP	152/69	144/69	144/70	150/70	159/71	158/71	147/69	172/72
Pulse	94	93	90	92	89	89	92	
Respirations	16	16	16	16	16	16	16	16
Temperature	—	—			—	—	99.8	100
SaO2	100	100	100	100	100	100	100	100
%O2	40%	40%	.4	.4	40%	40%	40%	40%
O_2 Delivery	Vent	✓	✓	✓	✓	✓	✓	✓
CVP								
Pain Scale								
Pain Med								
Pt Position								

Vent @ 2000 SIMV, 760 V_T, 16 RR, 5 PEEP, 10 Pres. Supt, 40% FiO_2

TIME	23	24	01	02	03	04	05	06	Total 24 hr
IV		K							
IVBP		100						150	900
DOPAMINE	8.9	8.9	8.9	8.9	8.9	8.9	8.9	8.9	213.6
OSMOLYTE	10	10	10	10	10	10	10	10	240
VERSED	5	5	5	5	5	5	5	5	120
FENTANYL	10	10	10	10	10	10	10	10	240
PO TPN	90	90	90	90	90	90	90	90	2160
Other LIPIDS	14	14	14	14	14	14	14	14	336
TOTAL LASIX	25	25	25	25	25	25	25	25	300

3456.4 → 4509.6

TIME	23	24	01	02	03	04	05	06	Total 24 hr
Urine output Hour/Total	40/40	/	/	60/466	/	/	60/526	50/576	576
NG output									
Emesis									
Stool									
Chest tube #1/ #2	/	/	/	/	/	/	/	/	/
Jackson Pratt #1/ #2	20/20	100/80	100/100	100/100	100/50	80/100	120/120	200/250	~~1740~~ 4745
TOTAL 3665									

(b)(6)

24-hour totals	Yesterday	Today
INPUT		4509.6
OUTPUT		~~5045~~ ~~2316~~
DIFFERENCE		~~2193.6~~ −535.4

Legend

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

Name	Signature	Init
(b)(6)		

SYSTEM	DAYS	NIGHTS
NEURO	01 APR 05 07:30	@ 2000
Level of consciousness	SEDATED	Pharm. Sedated
Extremities: Movement	MAE	P.S
Strength	SEDATED	PS
PAIN ASSESSMENT	FENTANYL DRIP	Fentanyl drip
CARDIOVASCULAR		
Rhthym/Lead	ST	ST
Heart Sounds	$S_1 S_2$	$S_1 S_2$
Skin	W&D	W&D
Edema	GENERALIZED	+ 3 non pitting to total body
JVD/ Capillary refill	ø / < 3 SEC	ø JVD / < 3 SECS
Pulses: Radial	+ +	+ 3 (B)
Posterior Tibial		
Dorsalis Pedis	+ +	+3 (B)
RESPIRATORY		
Breath Sounds	NORMAL SOUND	~~ACTIVE x 4 QUADS~~ COARSE SOUNDS (B) ON EXP
Oxygen Delivery	VENT	VENT: SIMV
Suctioning/Sputum	OCASIONALY	YES
ETT/Trach tube	ETT	ETT
Size: Placement:	8.0	8.0 ; 25cm @ holder
Cough:	25 ℓ	yes
Treatments:		suction
GASTROINTESTINAL		
Bowel Sounds	ACTIVE	ACTIVE X 4 QUADS
Abdomen	ND, NT	DISTENDED
Date of last BM	?	UNKNOWN
NG tube: Placement	(L) NARE	(L) NARE
Suction	OSMOLYTE	OSMOLYTE
Drainage	10 cc ℓ hr	10cc @ hr
GENITORUINARY		
Urine: Color	AMBER YELLOW	YELLOW-ORANGE
Void/Foley	FOLEY	FOLEY
INTEGUMENTARY		
Integrety	ABD WOUND; (L) HIP; (R) CHEST	SAME NO Δ
Dressings	ABD MIDL; (L) HIP; (R) CHEST	
Dressing Condition	CDI	CDI
Drains/Tubes	2 JP; PLEURE-VAC	SAME NO Δ
Drainage	YELLOW SERUM	(b)(6)
Signature	(b)(6)	

0039 09 CID789-5925

ICAL RECORD-SUPPLEMENTAL MEDICAL DAT

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

REPORT TITLE: ICU FLOWSHEET

OTSG APPROVED (Date)

NURSING NOTES

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(R) SC TLC	?		(b)(6)		
(L) Femoral Aline	?		(b)(6)	(b)(6)	
(C) SC TLC	31 March 05				

(Continue on reverse)

PREPARE (b)(6)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 31 March 05

PATIENT (b)(6) (name - last, first, mi)

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

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

DA FORM 4700, MAY 78

USAPPA 30

DATE	DIAGNOSIS											HOSPITAL DAY					
Time	07	08	09	10	11	12	13	14	15	16	18	19	20	21	22		
NIBP/ ABP			116/71	120/72	124/70	124/85	120/66	118/70	120/68	114/80	120/74	110/63	124/71	114/70	104/100		
Pulse			120	119	124	125	125	124	125	127	118	115	118	114	112		
Respirations			19	18	19	19	16	17	18	18	18	18	22	18	19		
Temperature			101.9				102.5					102.5					
SaO2			99	99	99	98	98	97	97	96	97	98	98	98	98		
%O2		vent	50%	50%	50%	40%	40%	40%	40%	40%	40%	.4	.4	.4	.4		
O_2 Delivery																	
CVP																	
Pain Scale			0		0		0		0		0		PS				
Pain Med		Fentanyl	0	44									9+1				
Pt Position			B	B	B	C	L	B		B	R	B	B		S		

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV TPN			90	90	90	90	90	90	540	90	90	90	90	90	90	90	90	
IVPB						100	100	50	250					100				
Versed			~~105~~	~~105~~	5	5	5	5	30	5	5	5	5	5	5	5	5	
Fentanyl			10	10	10	10	10	10	60	10	10	10	10	10	10	10	10	
c.pus			14	14	14	14	14	14	84	14	14	14	14	14	14	14	14	112
blood											380							
PO																		
Other																		
TOTAL																		2016

W0017 05 000178

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output Hour/Total				10	10	10	10	10	50	10	8		33	32	20		35	112
NG output								250	250									
Emesis																		
Stool																		
Chest tube #1/ #2															60			
Jackson Pratt #1/ #2				100	110/95		100/100		505	110/100	100/100		100/110	110/110	25/50		125/75	1105
TOTAL								806										1217

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

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

FIC

POST OPERATIVE DAY 01 02 03 04 05 06	PHYSICIAN
	0059 05 CID 89-39259

TIME	23	~~24~~	~~01~~	~~02~~	03	~~04~~	~~05~~	~~06~~
NIBP/ ABP	109/64	120/68	124/70	126/71	115/63	114/68	124/71	
Pulse	109	112	116	120	121	109	113	
Respirations	18	17	21	20		16	19	
Temperature				102²				
SaO2	98	98	98	97	98	99	99	
%O2	.4	.4	.4	.4	.5	.5	.5	
O_2 Delivery	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
CVP								
Pain Scale	PS	PS	→	→	→	→	→	
Pain Med	gtt	gtt	→	→	→	→	→	
Pt Position	S	S	→	→	→	→	→	

TIME	23	~~24~~ 01	~~01~~ 02	~~02~~ 03	~~03~~ 04	~~04~~ 05	~~05~~ 06	06	Total 8 hr
IV TPN	90	90	90	90	90	90	90		630
IVBP	50	100							150
Versed	5	5	5	5	5	5	5		35
Fentanyl	10	10	10	10	10	10	10		70
Lipids	14	14	14	14	14	14	14		98
PO									
Other									
TOTAL									983

TIME	23	~~24~~ 01	~~01~~ 02	~~02~~ 03	~~03~~ 04	~~04~~ 05	~~05~~ 06	~~06~~	Total 8 hr
Urine output Hour/Total	16	14	12	12	16	10	10		90
NG output									
Emesis									
Stool									
Chest tube #1/ #2									
Jackson Pratt #1/ #2	50/50	75/75	75/50	75/50	50/25	75/25	75/0		700
TOTAL									790

24-hour totals	Yesterday	Today
INPUT		2999
OUTPUT		2812
DIFFERENCE		+187

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

UNKNOWN, UNKNOWN
M 0 DETAINEE
INPROCESSING

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

Name	Signature	Init
(b)(6)		

FAX pg 3

SYSTEM	DAYS	NIGHTS
NEURO	08[00] 31 March 05	2000
Level of consciousness	NO respons	PS
Extremities: Movement	Ø Movement	PS
Strength	Ø	PS
PAIN ASSESSMENT	UTA	Fentanyl gtt
CARDIOVASCULAR		
Rhthym/Lead	ST II	ST
Heart Sounds	S1S2 Ø murmur	S1S2
Skin	Hot, Dry	H & D
Edema	Generalized, Pitting	=
JVD/ Capillary refill	Ø / < 3 sec	Ø / <3
Pulses: Radial	(R) +2 (L) +1	++ ++
Posterior Tibial	+2 +2	
Dorsalis Pedis	+2 +2	++ ++
RESPIRATORY		
Breath Sounds	Clear in all fields	CTA Ø
Oxygen Delivery	Vent	Vent
Suctioning/Sputum	occasionally	PRN
ETT/Trach tube	ETT	ETT
Size: Placement:	8.0 23cm Lips	8.0 25 @ lips
Cough:	Ø	Ø
Treatments:	Ø	Ø
GASTROINTESTINAL		
Bowel Sounds	Hypoactive x 4 quad	hypoactive x4
Abdomen	soft - open wound	soft open wound
Date of last BM	31 March 05	=
NG tube: Placement	@ nare	@ nare
Suction	LIS	LIS Ø
Drainage	Green/Bile	Ø
GENITORUINARY		
Urine: Color	Dark	Dark
Void/Foley	Foley	Foley
INTEGUMENTARY		
Integrety	Open Abdo wound, Sacrum decub	=
Dressings	Stage III, (R) Shoulder stage II.	=
	(L) thigh Deep wound - wet to dry packed	=
Dressing Condition	wet - dry & reinf	=
Drains/Tubes	2 x JP Tubes	=
Drainage	Serosanguinous	=
Signature	(b)(6)	

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
(b)(6) 04 @ 1820	Pt passed away after all resusatative attempts to revive him. See previous notes. Physician, DON and PAD informed. Pt body left as is prior to death pending further investigation by CID (b)(6)

NOT USED

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)

ICU Bed #6

(b)(6)

KALAF YASSIM HUSSEIN, [illegible]
M O DETAINEE

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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Exhibit 34 3

Exhibit 3

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

MEDICINE

(b)(6) 05 DEATH NOTE

(b)(6)

PT W/ GSW TO (R) FLANK RESULTING IN DUODENAL INJURY, LACERATIONS OF SUPERIOR MESENTERIC ARTERY & VEIN, AND LARGE RETROPERITONEAL HEMATOMA WAS ADMITTED ON (b)(6) 05. HE WAS INJURED ON 19 MAR 2005 & TREATED FOR HIS ABOVE INJURIES AT IBN SINA HOSPITAL IN BAGHDAD.

TODAY, DESPITE MECHANICAL VENTILATION, IV ANTIBIOTICS, IV VASOPRESSORS, TPN, & MULTIPLE BLOOD TRANSFUSIONS, HE DEVELOPED WORSENING RENAL & HEPATIC FAILURE LEADING TO COAGULOPATHY & PLATELET DYSFUNCTION MANIFESTED BY BLEEDING FROM NOSE, MOUTH, ~~RECTUM~~ RECTUM, AS WELL AS FROM HIS (R) FLANK WOUND. THIS PROCESS WAS DEEMED TO BE IRREVERSIBLE. HE SUBSEQUENTLY DEVELOPED HYPOTENSION DESPITE HIGH DOSE PHENYLEPHRINE. POOR PERFUSION THEN LEAD TO GLOBAL MYOCARDIAL ISCHEMIA & BRADYCARDIA, TERMINATING IN ASYSTOLE. HIS PUPILS WERE FIXED, HE HAD NO HEART TONES OR SPONTANEOUS RESPIRATIONS. HE WAS PRONOUNCED DEAD ON (b)(6) 05 AT (b)(6)

THE HOSPITAL COMMANDER AND TOC WERE IMMEDIATELY NOTIFIED.

CERTIFICATE OF DEATH & HOSPITAL REPORT OF DEATH ~~WERE~~ WERE COMPLETED

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME	
	LAST	FIRST
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	

(b)(6)

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.

~~SABAH, ABDULLAH NOORI~~

(b)(6)

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
(b)(6)			

NOTES

(b)(6)

(b)(6)

(b)(6)

0059 05 CID789-39259

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
(b)(6)	Surgery
	Temp 101.8 HR 106 BP 90/59
	760/5500 U.O. minimal
	① Neuro - sedated
	② Resp - hyperventilating. Increase TV to 600cc
	③ CV - BP ↓. May be sepsis related
	Start neo gtt. Hct 17. 2u pRBC
7/27/11	given. Patient appears to be in DIC.
	May have to start blood products
	④ FEN Anuric. K beginning to increase
	should improve w correction of
	acidosis. D/C TPN
	⑤ GI - Bowel function controlled by
	ileus. LFT's beginning to rise c/w
	MSOF.
	⑥ ID - febrile on Unasyn - C&S pending
	⑦ Disp - Appears to be in anuric
	renal failure w/ DIC & other manifestations
	at MSOF. Unlikely to survive.
	(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; Date of Birth; Rank/Grade)

(b)(6)

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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10-L-0126 ACLU DD III (CID ROI) 2824

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Exhibit 3

E 1915-23

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(b)(6) 04 @ 1615	Pt's B/P dropped to 71/30 and physician notified. Pt Bolus 1L N/s. Calcium IV given, Bicarb given x2 Phenylephrine given and titrated to 2mcg/kg/min Pt also post-blood transfusion. Versed stopped. Fentanyl stopped as per M.Ds order. Despite all that has been done, pt continues to bleed from mouth, nose, anus, and wound drainage. Currently pt on simv (Mech Vent) and Phenylephrine. Pt Continue to be hypotensive despite fluid challenge and Cardiotonic medications. (b)(6)

STANDARD FORM 509 (REV. 5/1999) BACK
39A V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
03APR05@2200	Moderated amount of frank blood noted coming from pt's mouth. RT suctioned. (b)(6) notified. Heparin ordered for B/P support. Will continue to monitor. (b)(6)
03 April 05 2210	Called TO Bedside Reason of Profuse oral Bleeding & Hypotension and Tachycardia & Pt Re Intubated for Sx Operation O: BP 90/40 124 Sat 91% Profuse oral Bleeding Lungs: BCTA A/P: Operational Case & (b)(6) Surgically possible at this time Plan: 1) Will try Conservative resuscitative measures - Albumin Bolus - Fluid Bolus - D/C Heparin - will monitor results TO and modify (b)(6)
April 4, 05 @ 0730	Pts pretransfusion v/s noted. Pt on Mech Vent FIO2 50% Sat 94% B/P 94/45 approx. pulse 100s. Resp 20. Lipids and TPN, dopamine and levox transfusing. B/P noted through A-line. Chest tube c/d/i place. Scant urine output since 0600. Scant serous output from chest tube. Generalized non pitting edema. Abdominal dressing intact and abdomen distended. Lung sounds Coarse in all bases — pt suctioned frequently. Frothy bloody sputum noted around M.V tube. Pt appears to be bleeding Orally. See lab results. CXR Raw done this am. (b)(6)

Exhibit 3

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
02-APR-2005 1200	Patient stool at 10:00 same like yesterday. Send sample at lab for c.diff. Change JP and put on intermittent suction. Drain from 10:15 until 13:00 1000 cc. Result from lab test is positive. (b)(6)
2 Apr 2100	Found pt in pool of blood along R flank. Investigating cause of bleeding found venous bld from wound in R hip. Pressure applied to area (b)(6) notified Pressure dsg applied; reinforced (b)(6) Tm 103 HR 120 BP 113/55 0000/600
3 Apr 01	Surgery
	(1) Neuro - Sedated
	(2) CV - HR stable HCT low. transf 3u pRBC
13 / 23 (930)	
7.3/40/90	(3) Resp - oxygenating & ventilating well.
13	(4) FEN: Oliguric renal failure on hemo
142/112/55	gtt at 30mg/h & dopamine. BUN/creatinine
4.1/22	continue to increase. No dialysis option
AK	in theatre. Lytes ok.
GOS GPT	(5) GI: Doubled JP D in chest. Suspect
Bi 148	anastomotic breakdown & fistula. Drains ~~should~~ may
Amy 116	control leak. Keep NPO. Consider re-exploration
Hp	(6) ID persistently febrile. CBS (P). on ABx

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | (b)(6) | ID NUMBER

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)

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

PROGRESS NOTES
Medical Record

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

DATE	NOTES
1 APR 05 12:00	Patient don't urinate after 100 mg bolus x1 at 9:30. Until 11:30 patient urinate 50cc. Give another bolus at 11:45 at 200 mg Lasix [illegible] (b)(6)
	Befor Lasix give patient 500cc bolus NS.
1 APR 05 12:10	Transfuse 1 Blood unit. Give patient 50 mg Benadryl and [illegible] (b)(6)
	650 mg on NGT for PRN.
APR 05 15:30	Chang patient shets. Stool with old blood marks. Make a
	hema-screen test. Result is positive. Inform (b)(6) (b)(6)
1 APR 05 18:30	Empty JP – nr 2 twice in 30'. After first empty
	JP start fill with serum with blood. Inform Dr. (b)(6) (b)(6)
2 April	Surgeon
POD	Tm 100° HR 106 BP 135/65
vented	4500/5100 U.O. 20-50cc/h
fentanyl	(1) Neuro – sedate
lipid	(2) Resp – oxygenating & vent adequate
dopamine	minimal CT output [illegible]
lasix	(3) CV HD stable [illegible] tachycardia HCT [illegible]
vasopressin	on renal dose
~~[illegible]~~ Heparin	(4) R/N – worsening renal failure on dopa/lasix [illegible]
7.31/45/	lytes ok. ↑ lasix
132 / 113	(5) ID – Afebrile WBC [illegible] C&S (P) [illegible]
135 / 113 (132 4.4)	(6) GI – Increase [illegible]. P+ JPS [illegible]
3.3 / 133	well [illegible]
LFT ok	

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

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

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

(b)(6)

UNKNOWN UNKNOWN
M O DETAINEE
INPROCESSING

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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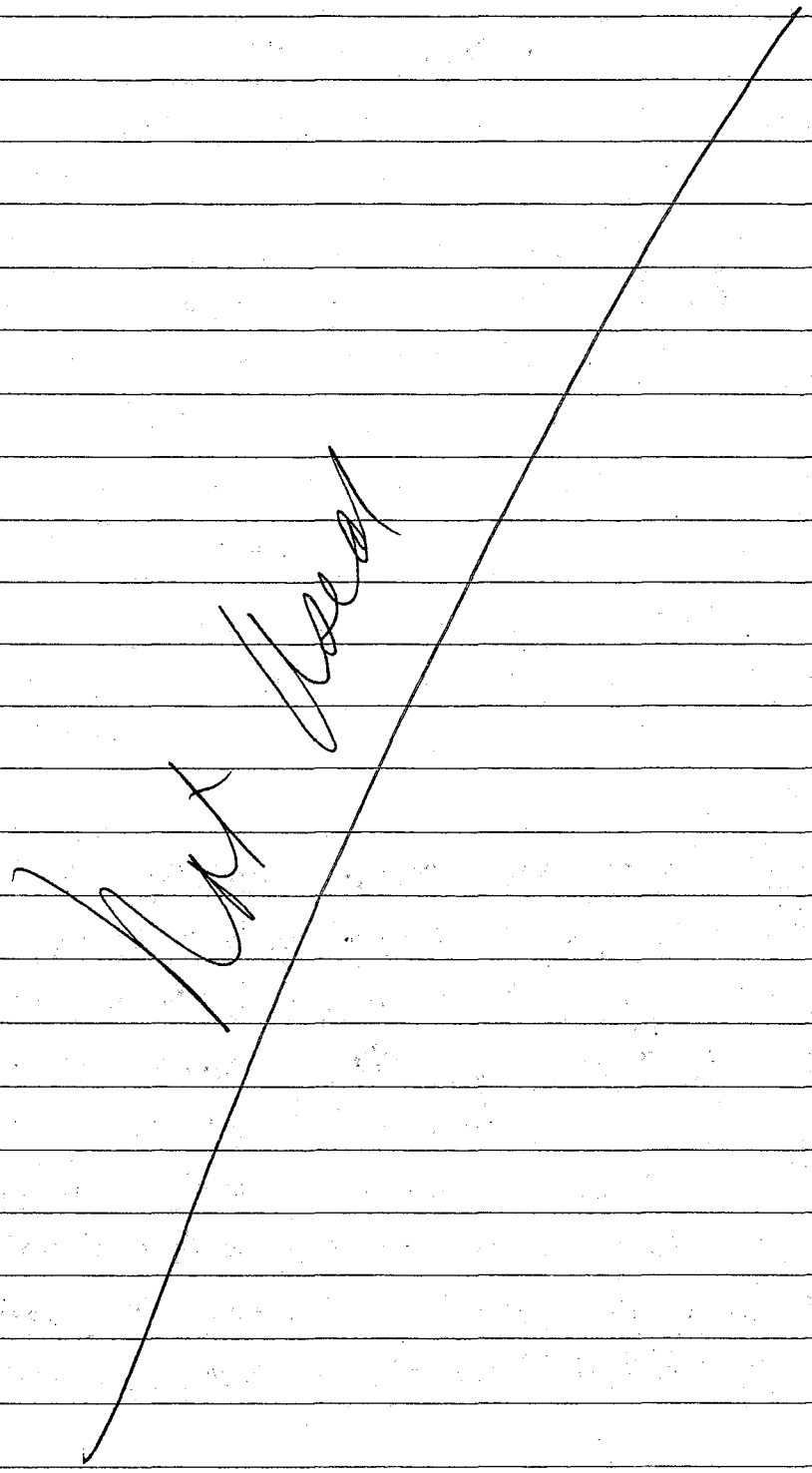
Exhibit 42

Exhibit 3

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES



DATE	NOTES Tm102 HR107 BPM7/ ~~99% on 50% 700x16 5~~ 3700/2800
1 Apr. '05	Surgery
	① Neuro-sedation
Versed	② Resp - oxygenating & vent well
fentanyl	CXR clear.
Unasyn	③ CV. ↓ HR sl hypertensive
Zantac	HCT 20.7. will transfuse 1 u pRBC
TPN	to optimize DO2 & renal fx -
lipids	④ FEN: 10-20 cc U.O/hr Dep.ty 40 mg IV
SQ heparin	lytes ok, but watch for hyperkalemia.
Dopamine 3	on TPN & trophic G-T feeds.
	continue renal dopamine. will try
	100 mg & 200 mg lasix. Pharmacy does
1.3/44/116/4	not have Zaroxylin at Bucca
44/115 (63) (3.6)	⑤ G-T on trophic feeds @ 10cc hr
4.3/21 92	will increase to 20cc/hr. Bilirubin ↑.
Alk 76	⑥ ID febrile on Unasyn. WBC 12.6
GGT 57	No obvious source. Fever curve may
GPT 100	be sl ↓ today. Lines all changed
Bili (6.1)	yesterday ✓ CZI
12.6 > (32) < (23)	

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)

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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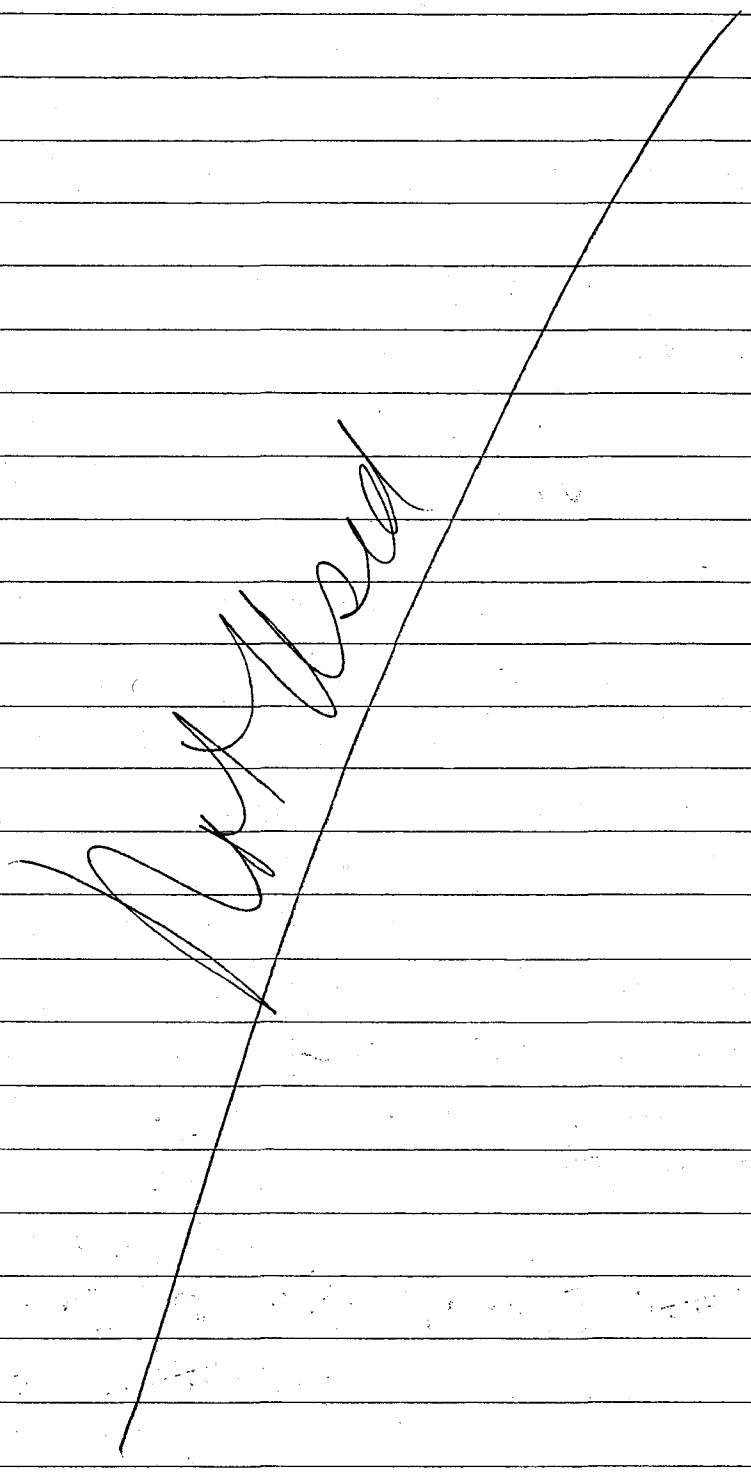
Exhibit 3

Exhibit 3

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES



DATE	NOTES
08[00]	Pt in via Medevac. See flow sheet for vital signs + assessment. Attached to C Monitor ST ∅ murmur heard. Intub with 8.0 ETT tube taped at 23cm at the lip. Bilateral breath sounds. Attached to ox vent. Pt had liquid bowel movement. 2 JP tubes draining large amounts of serous sanguinous fluid. Pleurvac charged, ∅ air leak at present time — (b)(6)
09[00]	Dressing changed by Surgery, wet today with Kerlex. Pt remains non-responsive on vent + paralyzed. ABG respiratory acidosis, Dr (b)(6) increased vent changed to compensate. UNU 918, Waiting on pending lab results. — (b)(6)
11[00]	ABG: finally normalizing. TO have 2 U PRBC, Type + Xmatch sent to lab.
12[00]	Pt urine output ↓ 10cc for past 2 hours. Surgery informed 1 bottle of Albumin hung. Pt remains unresponsive at present time. Fr ↓ and JP tube still draining large amounts of serous sanguinous fluid (b)(6)
13[00]	Blood started on pt see flow sheet for vital signs + assessment.
17[ST]	BP 120/70 P 124 T 102.
16[00]	2nd unit of blood started. Pt now on Dopamine due to ↓ urine output. New foley cath inserted 16FR. Blood cultures + urine sent to lab. New triple lumen line inserted, cleared for use by Xray. dsg CDI. (N)SL removed — (b)(6)
18[00]	Pt not putting hardly any urine. Surgeon notified Lasix given + if no effect another 40mg to be given — (b)(6)

STANDARD FORM 509 (RE) 46[999] BACK
USAPA V1.00

10-L-0126 ACLU DD III (CID ROI) 2832 Exhibit 3

Exhibit 3

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
31 MAR	Surgery
TDN	(1) Neuro - sedated on fentanyl/versed
unasyn	(2) Resp - Oxygenating well. Hypoventilating
lovenox	↑ tidal volumes CXR ok
versed	(3) CV - HD stable. not on any
	vasoactive drips. HCT 26. Transfuse
	b optimize O2
	(4) FEN - minimal U.O. creatinine 2.4.
	transfuse pRBC.
	(5) GI - S/P SMV ligation pylorus exclusion,
7.26/50/116	duodenum repair & gastrojejunostomy.
49	Patient has no feeding tube. with
2.4 / 62	open abdomen - wish mesh closure
ALK 83	looks very clean. Start BID dressing
GOT 82	Start hyperal tube feeds.
GPT 37	(6) ID WBC 13.5 on Unasyn.
Bili 5.6	Rt subclavian 3-lumen & Rt fem A-line
137 / 6.7 / 26	

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)

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

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)

(b)(6)

86th Combat Support Hospital
Ibn Sina Hospital
Baghdad, Iraq

(b)(6)

DATE OF DICATATION: 26 March, 2005

Discharge Summary/Aeromedical Evacuation Summary

NAME (b)(6)
SSN:
DOB:
STATUS: Insurgent
SERVICE/COUNTRY: Iraq
UNIT/EMPLOYER:

(b)(6)

Date of Admission: 19 March 2005
Date of Discharge/Transfer: 25 March 2005

NARRATIVE SUMMARY OF HISTORY OF PRESENT ILLNESS & HOSPITAL COURSE

Pt is a Iraqi insurgent who suffered a penetrating right flank wound. He arrived in the 86th CSH emergency room awake but in severe distress. He had systolic blood pressures in the 80's. He was taken emergently to the operating room where he was found to have a very large retroperitoneal hematoma in zones 1,2, and 3. We cross clamped his aorta at the esophageal hiatus and mobilized the right colon and the small bowel completely. His right kidney was examined and was normal. He had a complete injury to his SMV which was ligated. He had a 50% injury to the 3rd portion of his duodenum, and another less than 25% injury about 2 centimeters distal also in the 3rd/4th portion. He also had several large peripancreatic arterial bleeders and some early branches of the SMA. These were all ligated or stick tied. The pt was hemodynamically labile and required 26 u PRBC's, 10 U FFP, 20 u Cryoprecipitate, and 8000 cc of crystalloid. His total aortic cross clamp time was 30 min. He was becoming acidotic, coagulopathic, and hypothermic. Once all surgical bleeding was controlled, we elected to perform a damage control operation. A Malecot tube was placed in the larger duodenal injury, his smaller duodenal injury was whip stitched closed, and he was packed and his abdomen was left open. He was taken to the ICU where he remained hemodynamically labile with a stable Hct. He only required 2 u PRBC's that evening. 24 hours later, we returned to the operating room. The packs were removed and there was no bleeding. His larger duodenal injury was repaired in 2 layers, and the smaller one in a single layer. We stapled off his pylorus with a TA stapeler, but not divided. I then performed a hand sewn gastrojejunostomy in a retrocolic manner, isoperistaltic. # 10 JP x 2 were placed next to the duodenal repair. His bowel was completely viable, but edematous as would be expected by ligating the SMV. We were unable to close the abdomen, so a IV bag was placed over the bowel, followed by a damp blue towel, followed by JP's x 2, followed by a Ioband drape. That day, he continued to be hemodynamically labile but completely fluid responsive and not requiring any blood transfusions. Over the course of 24 hours, his blood pressure stabilized and his urine output improved. Over the next several days, he has done quite well. He did have a acute desaturation which was felt to be due to a right sided pleural effusion, so a right sided chest tube was placed. A bronchoscopy revealed the true etiology to be a mucous plug and his pulmonary function reached pre-event levels. Overall, he has done quite well. The future plan would be to either close his abdomen primarily when his edema resolves or close it with vicryl mesh followed by a skin graft and future reconstruction. Theoretically, his pylorus should open up and the gastrojejunostomy close in a few weeks. He is currently on TPN and does not have a j-tube. I felt that due to his significant bowel edema at the 2nd operation, it would not be prudent. His para-duodenal JP's are only putting out clear serous fluid. He is obviously at hight risk for a duodenal fistula, but hopefully, this will not occur. His vent settings are SIMV 18, FiO2 40%, PEEP 5, PS 10, TV 700. He did have a bump in his Creatinine to 2.3, but this is down to 1.8. Hg is stable without need for further blood transfusions. Of note is that his pancreas is fine on exploration.

DISCHARGE DIAGNOSES:

1) Duodenal injury zone 3/4
2) SMV ligation

(b)(6)

86th Combat Support Hospital
Ibn Sina Hospital
Baghdad, Iraq

(b)(6)

PROCEDURES DURING ADMISSION

1) Damage control surgery 3/19/2005
2) Primary duodenal repair, duodenal diverticulization via stapling off the pylorus without division followed by a gastrojejunostomy. 3/20/2005
3)

FINDINGS/LABS/RADIOLOGY

Sodium (137-145 mmol/L), Potassium (3.6-5.0 mmol/L), Chloride (98-107 mmol/L)
HCO3 (22-30 mmol/L), BUN (9-20 mmol/L), Cr (0.7-1.5 mg/dL), Glucose (70-105 mg/dL)
Calcium (8.4-10.2 mg/dL) Amylase (50-130 U/L) Lipase (40-375 U/L)
AlkPhos (38-126 U/L), AST (17-59 U/L), ALT (21-72 U/L), TB (0.2-1.3 mg/dL) GGTP (15-73 U/L)

WBC HGB HCT PLT LY%
UA Sp Gr pH Blood - , WBC – , Nitrate - , Urobign , Ketones -

MEDICATIONS ON TRANSFER/DISCHARGE

1) Versed gtt, Fentanyl gtt, Unasyn day 5, Zantac, TPN, Heparin SQ
2)

CONDITION: Good and Stable for Transfer

Plan/Recommendations:

1) This patient should have evaluation by a general surgeon regarding the issues mentioned in the narrative summary.
2) Please contact me if you have questions regarding his care here at the 86th CSH

(b)(6)

Exhibit 49 3

CLINICAL RECORD

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

Mo. 03 Yr. 05

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31 Apr 2 3 4 5 6 7 8
31MAR	(b)(6)	Versed 5 mg/hr	07	(b)(6)
			19	(b)(6)
31MAR		Fentanyl @ 200mcg/hr	07	(b)(6)
			19	(b)(6)
31MAR		Unasyn 3g IV Q6°	06	✓ (b)(6)
			12	(b)(6)
			18	(b)(6)
			24	(b)(6)
31MAR		Zantac 50 mg IV Q8°	06	✓ (b)(6)
			14	(b)(6)
			22	(b)(6)
31MAR		TPN (Standard Clinimix) c	07	(b)(6)
		Thiamine 100 mg IV, Folate	✓	
		1mg IV & MVI IV @	19	(b)(6)
		90 cc/hr through distal	✓	
		port of TLC		
31MAR		Lipids @ 14l°	07	(b)(6)
			19	↓ (b)(6)
31MAR		Lovenox 30mg SQ BID	08	
			20	
31MAR		Heparin 5000units SQ Q12hrs	07	✓ (b)(6) D/C 03APR05
			19	(b)(6)

ALLERGIES: ☐ YES ☐ NO
Unknown

PRIMARY DIAGNOSIS:
GSW ® Flank → Duodenal injury, Laceration of Superior Mesenteric Artery & Vein, Retroperitoneal Hematoma

ADDITIONAL PAGES IN USE: ☑ YES ☐ NO
PAGE NO. 1

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

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

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

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

8 1:1:73

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. APR Yr. 2005
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
31 Mar (b)(6)	Lasix 20mg IVx1 now	31 Mar	1825	1820	(b)(6)
31 Mar	Lasix 40mg IVx1 now	31 Mar	1845	1848	
1 APR	NS 500 cc Bolus IV NOW	1 APR	08:45	08:45	
1 APR	TRANSFUSE 1 UNIT BLOOD	1 APR	ASAP		
1 APR	LASIX 100 mg IVX1 NOW	1 APR	0930	09:30	
1 APR	HCTZ 50 mg VIA NTG NOW	1 APR	14:00	14:00	
2 APR	100 cc 25% ALBUMIN	2 APR	ASAP	21:45	
3 Apr	Transfuse 3 Units PRBCs	3 Apr	ASAP	DONE	
3 Apr	Albumin 50gm IV x1 (100cc 25% Albumin IV)	~~3 Apr 2230~~	2230	done	
3 Apr	NS 500 cc Bolus	3 Apr	2230	DONE	
4 APR	Transfuse 2 units FFP	04 APR	ASAP	~~Done~~	
4 Apr	NS 500cc Bolus	04 APR	ASAP	0300	
4 APR	Transfuse 2u PRBCs	04 APR	ASAP	Done	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
3 month	(b)(6)	Tylenol 650mg PO/PR	31 MAR 2000
.....	.....	NG tube Q4hrly PRN	1 APR 0320 Going NG (b)(6)
.....	.....	(b)(6)	(b) (6) (b) (6)
.....	.....		
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.....	.....		

USAPA V1.00

Bed #6

0059 05 CID/89-39259

CLINICAL RECORD

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

Mo. 04 Yr. 05

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	1	2	3	4	5	6	7	8
31 March	(b)(6)	Dopamine 3mcg/kg/min	07	(b)(6)								
		@ 4.8mcg/kg/min	14	(b)(6)								
1 APR		LASIX 200mg IV Q8°	08	/	/							
			16	/	(b)(6)							
			24	/								
1 APR		LASIX @ 30mg/hr	07	/	/	(b)(6)						
			19	/	(b)(6)							
3 APR		FLAGYL 500mg IVPB										
		Q 6°	06	/	/	/	/	(b)(6)				
			12	/	/	/	/	(b)(6)				
			18	/	/	/	(b)(6)					
			24	/	/	/	(b)(6)					
4 Apr		Start Neo gtt @	07	/	/	/	/	(b)(6)				
	.....	0.25 mg/kg/min & titrate	19	/	/	/	/					
	.....	for SBP >100 MAP>60										
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	.....											

ALLERGIES: ☐ YES ☐ NO
Unknown

PRIMARY DIAGNOSIS:
GSW (R) Flank → Duodenal Injury
Laceration of Superior Mesenteric Artery & Vein, Retroperitoneal Hematoma

ADDITIONAL PAGES IN USE: ☑ YES ☐ NO
PAGE NO. 2

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

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

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

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DA FORM 4870, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. APR Yr. 2005
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED														
.....	.....																
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USAPA V1.00

0059 05 CID789-39259

CLINICAL RECORD

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

Mo. 03 Yr. 05

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED (31 Apr 1 2 3 4 5 6 7 8)
31MAR	(b)(6)	Vitals: Per Unit	07	(b)(6)
		Routine	19	(b)(6)
31MAR		Activity: Bed rest	07	(b)(6)
			19	(b)(6)
31MAR		Nursing: NGT to LIS	07	(b)(6)
		Foley to gravity, A-line	19	(b)(6)
		to transducer		
31MAR		Diet: NPO	B	(b)(6)
			L	(b)(6)
			D	(b)(6)
31MAR		Respiratory: SIMV 8	07	(b)(6)
		F_iO_2 50 VT ~~1050~~ 800	19	(b)(6)
		PEEP 5/ PS 10. Increase		
		~~Tidal~~ Volume to 800cc		
31MAR		Chest tube to Pleur Evac	07	(b)(6)
			19	(b)(6)
31 Mar		Dressing Change w/Kerlix	08	(b)(6)
		wet to dry BID	20	(b)(6)
31 Mar		Osmolyte 10cc/hr	08	(b)(6) D/C 02APR05
			19	(b)(6)
31 Mar		CXR QAM	06	(b)(6)
31 Mar		CBC, BMP, Ca, Mag, Phos	06	(b)(6)
		LFT QAM		

ALLERGIES: ☐ YES ☐ NO
Unknown

PRIMARY DIAGNOSIS:
GSW (R) Flank → Duodenal injury Laceration of Superior Mesenteric Artery & Vein; Retroperitoneal Hematoma

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 1

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — 54 JSAPA V1.00

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Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 03 Yr 05	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
31 MA	(b)(6)	Admit to ICU; condition: VSI	31MAR	ASAP	⊖	
31MAR		Labs: ABG, Chem 12, Liver panel, CBC,			0930	(b)(6)
		Coags, UA, Amylase, Lipase upon admit	31MAR	ASAP	0930	
31MA		Ca+, Mg+, PO4 levels	31MAR	ASAP	0930	
31MA		Transfuse 2 units PRBC	31Mar	ASAP	11 Cu	
31Ma		Blood cultures x2	31Mar	ASAP	1300	
31Ma		Urine Culture	31Mar	ASAP	1300	
02APR		STOOL FO C.Diff	02APR	ASAP	10:00	
3Apr		X+C for 3 U PRBCs	3Apr	ASAP	1115	
3Apr		DIC Panel	3Apr	ASAP	Done	
04APR		Coag Panel p transfusion	04APR	p transfusion	ASAP	
	.....					
	.....					
	.....					
	.....					
	.....					

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

0059 05 CID789-3925

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

VERIFY BY INITIALING			INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION		
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED	
				02 03 4	
02 APR	(b)(6)	JP on suction	07	(b)(6)	
			19	(b)(6)	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

(b)(6)

PA

UNKNOWN, UNKNOWN
M 0 DETAINEE
INPROCESSING

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

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DA 1 OCT 78 4077 10-L-0126 ACLU DD III (CID ROI) 2842 PAGE 1 3

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)					Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	

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

CLINICAL RECORD - DOCTOR'S ORD[illegible]

For use of this form, see AR 40-66, the proponent age[illegible] 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)	2 apr 2/1845 1 100ml 25% albumin IV as fast as possible VO	
NURSING UNIT (b)(6) BED NO.		
PATIENT IDENT[illegible]	DATE OF ORDER / TIME OF ORDER / HOURS	
NURSING UNIT BED NO.	3 Apr 1 1 transfuse 3u pRBC (b)(6) 3 apr 05 2100 VO	
PATIENT IDENT	DATE OF ORDER / TIME OF ORDER / HOURS	
NURSING UNIT ROOM NO. BED NO.	3 Apr 1 1 Flagyl 500 mg IVPB q6h	
PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER / HOURS	
(b)(6) INPROCESSING DETAINEE	3 April 05 2230 1) Albumin 50 gms IV. X1 2) (100cc 25% Albumin IV) 3) d/c Osmolite 4) d/c Heparin 5) NS 500cc Bolus 6) D/C Foley	(b)(6) OBAPROS @ 2300
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: 2002-488-041

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
1 Apr 05	____ HOURS	
* 12six 200mg IVP q8° ✓		
NOTED 01 APR 05		

(b)(6)

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

DATE OF ORDER	TIME OF ORDER
1 Apr 05	____ HOURS
NOTED 01 APR 05 (b)(6)	F① Start 12six gtt at 20mg/hr ✓

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
24th CH	@0510	02 APR 05

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
2 Apr 05	____ HOURS
* ① Put pulls to 20cm wall Suction	
NOTED 02 APR 05 (b)(6) * ② Send stool for C. Diff	
* ③ Increase 12six gtt to 30mg/hr	
* ④ ~~Increase osmolyte~~ Increase osmolyte to 20cc/hr	

NURSING UNIT	ROOM NO.	BED NO.

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

(b)(6)

DATE OF ORDER	TIME OF ORDER

(b)(6)

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: 2002-488-041

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	01 APR 05	0839 HOURS	
	NS 500cc Bolus IV Now. ✓		
	(b)(6)		

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER
	1 April 05	HOURS
NOTED 01 APR 05	* 125i x 100 mg IVP x1 ✓	
	* Monitor Vitals, ✓	
	(b)(6)	

PATIENT IDENTIFICATION

(b)(6)

M O DETAINEE
INPROCESSING

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER
	01. APR. 05	11:45 HOURS
NOTED 01.4.2005	* (1) Lasix 200 mg IV x 1 Vo doctor	
	(2) 50 mg Benadryl ;) Vo doctor	
	(3) 650 mg Tylenol)	
	(b)(6)	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER
	01 APR 05	1400. HOURS
NOTED 01.04.200	* (1) HCTZ 50mg via NGT Now ✓	
	(b)(6)	

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

Exhibit 2
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*U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

0059 05 CID 89-392

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

SABAH

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 31 Mar TIME OF ORDER ____ HOURS

LIST TIM ORDER NOTED A SIGN

(6) DC Lovenox

(2) Start Heparin 5000u SQ q 12

(3) Transfuse 2u PRBC

(4) Start BID dressing chang w/ Kerlex wet to dry

(5) Start usmolyte at 100c/h

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

(6) CxR q am ____ HOURS

(7) CBC BPM Calcium Mg PhOS LFT q am.

(b)(6)

NOTE

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF

31 March 01 ____ HOURS

Start Dopamine @ 3mcg/kg/min.

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 31 March TIME OF ORDER ____ HOURS

Lasix 20mg IVPush

Lasix 40mg IVPush

INPROCESSING
NO DETAINEE
MANDATORY OVERNOON

(b)(6)

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | B

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

Exhibit 3

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

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

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

PATIENT IDENTIFICATION

SABAH, ABDULLAH NOORI

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	31 MAR 05	0730 HOURS	
1	ADMIT TO ICU		
2	DX: GSW TO (R) FLANK → DUODENAL INJURY		
	LACERATION OF SUPERIOR MESENTERIC ARTERY & VEIN		
	RETROPERITONEAL HEMATOMA.		
3	CONDITION: VSI		
4	VITALS: PER UNIT ROUTINE		
5	ALL: UNKNOWN		
	PATIENT IDENTIFICATION		
	DATE OF ORDER	TIME OF ORDER	
6	ACTIVITY: BEDREST	HOURS	noted by [illegible] (b)(6)
7	NURSING: NGT TO LIS		
	FOLEY TO GRAVITY		
	A-LINE TO TRANSDUCER		
8	DIET: NPO		
9	MEDS: ~~VERSED~~ 5MG/HR.		
	FENTANYL 200 MCG/HR.		
	PATIENT IDENTIFICATION		
	DATE OF ORDER	TIME OF ORDER	
10	RESPIRATORY: SIMV 8 FiO_2 .50 V_T 650		PEEP 5/PS
	CHEST TUBE TO PLEUR EVAC	HOURS	
11	MEDS: ~~UNASYN~~ 3G IV Q6°		
	ZANTAC 50MG IV Q8		
12	TPN (STANDARD CLINIMIX) & THIAMINE 100MG IV		
	FOLATE 1MG IV & MVIT IV @ 90CC/HR		
	THROUGH DISTAL PORT OF TLC.		
	NURSING UNIT	ROOM NO.	BED NO.
13	LIPIDS @ 14CC/HR.		
14	LOVENOX 30MG SQ BID.		
	PATIENT IDENTIFICATION		
	DATE OF ORDER	TIME OF ORDER	
15	LABS:	HOURS	
1	ABG, CHEM 12, LIVER PANEL, CBC, COAGS,		
	UA, AMYLASE, LIPASE; UPON ADMISSION.		
2	Ca^{++}, Mg^{++}, PO_4 = LEVELS.		
	31 MAR 05 @ 0903		
	NURSING UNIT	ROOM NO.	BED NO.
1	↑ SIMV TO 18		
2	✓ ABG in 30'.		

(b)(6)

INPROCESSING
NO DETAINEE

(b)(6)

(b)(6)

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

Exhibit 62_3

0059 05 CID789-39259

LABORATORY RESULTS FORM

(b)(6)

Physician: (b)(6) Drawn by:

Ward: ICU Bed: 6

X Female
X STAT
X Routine

Specimen Date and Time: 4 APR 05 1510

Reported by (b)(6)

Date and Tim 4 Apr 03

Chemistry (I-STAT) / Green Top / Syringe

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

X	TEST	RESULT		REF. RANGE
	Na			138-145 mmol/L
	K			3.3-4.9 mmol/L
	Cl			98-109 mmol/L
X	pH	7.229	L	7.35-7.45
X	PCO2	50.9	H	35-45 mmHg
X	PO2	134	H	80-100 mmHg
	TCO2	23		18-33 mmol/L
X	HCO3	21.3	L	22-26 mmol/L
	sO2	98		95-99%
X	BEecf	-6	L	(-2) - (+3)
	AGap			8-16 mmol/L
	iCa			1.12-1.32 mmol/L
	BUN			7-22 mg/dL
	Glu			73-118 mg/dL
	Creat			0.6-1.3 mg/dL
	Hct			37.0-52.0%
	Hgb			12.0-18.0 g/dL
	Lactate			0.90-1.70 mmol/L

Urinalysis

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

Urine Microscopic

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

Other lab request:

Chemistry (Piccolo Analyzer) / Green Top

Chem 12 / Met Lytes / BMP / Liver / Lipid / Renal

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		138-145 mmol/L
	Phosphorous		2.2-4.5 mg/dL
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Rapid Tests

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
Wet Mount		Negative
KOH		Negative

Hematology / Purple Top

CBC / Malaria / H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Se
Thick		No Plasmodium Se

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S / Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

Panel includes: Culture, Gram St... cell ... Cont. WBC Diff, Meningitis test (CSF only)

A140059 05 CID789-39259

(b)(6)

LATORY RESULTS FORM

H O DETAINEE

(b)(6)

PCCF

Physician (b)(6)
Drawn by

Ward: ICU
Bed: 6

Female
X STAT
Routine

Specimen Date and Time: 4/4/05 @1405

Reported by: (b)(6)

Date and Time 4 Apr 150

Chemistry (i-STAT) / Green Top / Syringe — Bld Gas | Bld Gas w/ lytes | Glu | Crea

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

Urinalysis

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

Urine Microscopic

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

Other lab request:

Chemistry (Piccolo Analyzer) / Green Top — Chem 12 | Met Lyte | BMP | Liver | Lipid | Renal

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		138-145 mmol/L
	Phosphorous		2.2-4.5 mg/dL
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Rapid Tests

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Drug Scr.		Negative
	HCG		Negative
	H.pylori IgG		Negative
	ETOH/Alc.		Negative
	Strep A		Negative
	Chlamydia		Negative
	Flu A&B		Negative
	C. difficile (stool)		Negative
	O&P (stool)		No Ova / Parasite
	OccBld		Negative
	Wet Mount		Negative
	KOH		Negative

Hematology / Purple Top — CBC | Malaria | H/H

X	TEST	RESULT	REF. RANGE
	WBC	21.0 (H)	4.8-10.8 x10(3)/u
	RBC	2.30 (L)	4.2-6.1 x10(6)/u
	Hgb	7.0 (L)	12.0-18.0 g/dL
	Hct	21.8 (L)	M: 42.0-52.0%
			F: 37-47%
	MCV	91.4	80.0-99.0 fl
	MCH	29.2	27.0-31.0 pg
	MCHC	32.0	33.0-37.0 g/dL
	Plt	803 (H)	130-400 x10(3)/u
	LY%	8.5 (L)	20.0-44.0%
	LY#	1.8	0.7-4.3 x10(3)/u

Differential

Segs(50-70%)	69	Mono(4-10%)	1
Bands(1-10%)	5	Eos(0-4%)	0
Lymph(20-44%)	7	Baso(0-2%)	
Atyp Ly	2	Immature cells	

RBC Abn Morph:

Plt Abn Morph: 720/0IF
Large Platelets 1+

WBC Abn Morph:

Malaria / Purple Top

	Thin		No Plasmodium Se
	Thick		No Plasmodium Se

Sed Rate / Purple Top

	Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

	PT	19.1 (H)	11.0-14.0 sec
	APTT	82.8 (H)	21.0-50.0 sec
	INR	1.9 (H)	0.5-1.5/therap 2-3
	D Dimer		Negative

Cardiac Panel/Purple Top

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

Hemoglobin S / Purple Top

	Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

Panel Includes: Culture, Gram St 64 Cell
Cell/WBC Count & Meningitis test (CSF only

10-L-0126 ACLU DD III (CID ROI) 2850

Exhibit 3

Town Field Hospital

LABORATORY RESULTS FORM

Physician: (b)(6) | Ward: | Bed: | Drawn by: | Female | STAT | Routine | Specimen Date and Time: 4 MAR 05 | (b)(6) | Date and Time: Apr 1528

Chemistry (i-STAT) / Green Top / Syringe

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

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.249	7.35-7.45
	PCO2	54.0	35-45 mmHg
	PO2	59 (L)	80-100 mmHg
	TCO2		18-33 mmol/L
	HCO3	23.9	22-26 mmol/L
	sO2	85 (L)	95-99%
	BEecf	-3 (L)	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

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

Urine Microscopic

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

Other lab request:

Chemistry (Analyzer) / Green Top

Chem | CMP | Liver | Lipid | Renal

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	>180	7-22 mg/dL
	Ca	7.6 (L)	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL	107	98-109 mmol/L
	TCO2	23	18-33 mmol/L
	Creat	7.0 (H)	0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu	127 (H)	73-118 mg/dL
	K	4.6	3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	153 (H)	138-145 mmol/L
	Phosphorous		2.2-4.5 mg/dL
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Rapid Tests

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
Wet Mount		Negative
KOH		Negative

Hematology / Purple Top

CBC | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium See
Thick		No Plasmodium See

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S / Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

Panel Includes: Culture, Gram Stain, Cell Count, Diff, Glucose, Protein, Xanthochromia test (CSF only)

115th Field Hospital — LABORATORY RESULTS FORM

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

Physician: (b)(6) | Ward: ICU | Bed: 6 | STAT / X Routine | Specimen Date and Time: 04APR05 Order | Reported by: (b)(6) | Date and Time: 4 Apr 06 1

Hemoglobin A1c / Purple Top

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

Urine Microalbumin/Creatinine Urine Cup

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

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

C Reactive Protein / Red Top

Note: Duplicate tests are performed on same. If result is pos, titrations will be performed for a rising titer result.

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

CSF Glucose - Sterile Tube

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

Special Chemistries / Urine Cup

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

Additional Tests

For the tests below, cooridnate with lab OIC or NCOIC

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

Special Chemistries / Tiger Top (SST)

X	TEST	RESULT	REF. RANGE
	Alcohol		<10 mg/dL Negative
			50-400 mg/dL Toxic
			>400 mg/dl Poss. Fatal
	Cholinesterase		M: 5.90-12.22 U/mL
			F: 4.65-10.44 U/mL
	Iron		M: 49-181 ug/dL
			F: 37-170 ug/dL
	Lipase		23-300 U/L
X	Phosphorous 99 H		2.2-4.5 mg/dL
X	Magnesium 2.7 H		1.6-2.3 mg/dL
	Uric Acid		M: 3.5-8.5 mg/dL
			F: 2.5-6.2 mg/dL
	Lactate Dehydrogenase		313-618 U/L
	HIV		Negative
	PSA Tot		Age Range(ng/ml)
			40-49 0.0-2.5 ng/ml
			50-59 0.0-3.5 ng/ml
			60-69 0.0-4.5 ng/ml
			70-79 0.0-6.5 ng/ml
	HCG Quant		M: <3mIU/ mL
			Cyclic F: <4 mIU/ mL
			MenoP F: <13 mIU/ mL
			Preg F: >20 mIU/ mL
	Bu		0.0 - 1.1 mg/dl
	Bc		0.0 - 0.3 mg/dl

Therap. Drug Monitoring

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

Thyroid Panel / Red or Tiger Top

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

Add. Thyroid Tests / Red or Tiger Top

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

Hepatis B / Red or Tiger Top

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

Exhibit 3

0059 05 CID 789-39259

(b)(6)

RBC, HGB, HCT 0500
BCH CA 0600

LABORATORY RESULTS FORM

x male
Female

Physician (b)(6)
Drawn by

Ward: ICU
Bed: 6

STAT
x Routine

Specimen Date and Time: 04APR05@0600

(b)(6)

Date and Time 0554 04AP

Chemistry (i-STAT) / Green Top / Syringe: Bld Gas | Bld Gas w/ Lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
L	pH	7.206	7.35-7.45
H	PCO2	52.3	35-45 mmHg
H	PO2	311	80-100 mmHg
	TCO2	24	18-33 mmol/L
	HCO3	22.7	22-26 mmol/L
	sO2	100	95-99%
	BEecf	-5	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

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

Urine Microscopic

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

Chemistry (Piccolo Analyzer) / Green Top: Chem-12 | Mag | Lipid | Hepatic

X	TEST	RESULT	REF. RANGE
L	ALB	1.8	3.3-5.5 g/dL
	ALP	124	26-184 U/L
H	ALT	255	10-47 U/L
H	AMY	488	14-110 U/L
H	AST	420	11-38 U/L
H	Tbil	5.2	0.2-1.6 mg/dL
H	BUN	70	7-22 mg/dL
x	Ca L	6.8	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL	106	98-109 mmol/L
	TCO2	24	18-33 mmol/L
H	Creat	6.0	0.6-1.3 mg/dL
H	GGT	125	5-65 U/L
H	Glu	182	73-118 mg/dL
H	K	5.2	3.3-4.9 mmol/L
L	TProtein	5.2	6.4-8.1 g/dL
H	Na	161	~~138~~ 128-145 mmol/L
	Phosphorous		2.2-4.5 mg/dL
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Rapid Tests

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite

Hematology / Purple Top: CBC | Malaria | H/H

X	TEST	RESULT	REF. RANGE
H	WBC	14.7	4.8-10.8 x10(3)/u
L	RBC	1.84	4.2-6.1 x10(6)/ul
L	Hgb	5.7	12.0-18.0 g/dL
L	Hct	17.0	M: 42.0-52.0%
			F: 37-47%
	MCV	92.5	80.0-99.0 fl
	MCH	30.9	27.0-31.0 pg
	MCHC	33.4	33.0-37.0 g/dL
H	Plt	765	130-400 x10(3)/uL
L	LY%	9.5	20.0-44.0%
	LY#	1.4	0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S / Purple Top

Hemoglobin S	Negative

Wet Mount		Negative
RPR		Negative

Panel Includes: Culture, Gram Stain, Cell Count, Protein, Glucose test (CSF only)

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EXHIBIT

Task Force Med 115
Abu Ghraib, Iraq

Microbiology Laboratory Report

Accession #	W032
Collection Date	4/3/2005
Patient Name	(b)(6)
SSN or ID	
Sample Type	Abscess, Swab
Sample Site	Refro peritoneal
Patient Location	ICU
Provider	(b)(6)
Result Type	Preliminary 1
[X] Gram's Stain	Many RBC's; Few WBC's; No organism seen
[ ] Acid-fast Stain	
[ ] KOH Prep	
[X] Culture	
[ ] Acinetobacter Screen	
[ ] MRSA Screen	
Qty isolate #1	
Isolate #1	
Qty isolate #2	
Isolate #2	
Qty isolate #3	
Isolate #3	
Comments	
Report Date	4/3/2005
Tech	(b)(6)
Reviewed By	

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

0059 05 CID/89-2925

Microbiology Laboratory Report

Accession #	B062
Collection Date	3/31/2005
Patient Name	(b)(6)
SSN or ID	
Sample Type	Blood
Sample Site	A-Line; Femoral
Patient Location	ICU
Provider	(b)(6)
# bottles	2
Result Type	Preliminary 1 AMENDED
Gram's Stain	Gram-negative rods; gram-positive rods
Verbal Report	(b)(6) 4/1/2005 @ 1615 hrs
Culture	
Isolate #1	Gram-negative rods
Isolate #2	Gram-positive rods
Isolate #3	
Comments	
Report Date	4/3/2005
Tech	(b)(6)
Reviewed By	

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

Exhibit 3

Microbiology Laboratory Report

Accession #	B061
Collection Date	3/31/2005
Patient Name	(b)(6)
SSN or ID	
Sample Type	Blood
Sample Site	Central Line
Patient Location	ICU
Provider	(b)(6)
# bottles	2
Result Type	Preliminary 1
Gram's Stain	Gram-negative rods; gram-positive rods
Verbal Report	
Culture	
Isolate #1	Gram-negative rods
Isolate #2	Gram-positive rods
Isolate #3	
Comments	
Report Date	4/3/2005
Tech	(b)(6)
Reviewed By	

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

0059 05 CID789-59259

115th Field Hospital

LABORATORY RESULTS FORM

LAST, FIRST, MI:

X Male
Female (b)(6)

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

STAT
X Routine

Specimen Date and Time: 03APR06@0450

Reported by: (b)(6)

Date and Time: 3 Apr 06

Signs and Symptoms:

Hemoglobin A1c / Purple Top

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

Urine Microalbumin/Creatinine Urine Cup

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

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

C Reative Protein / Red Top

Note: Qualitative Screen performed on serum. If results positive, will be reported as a semi-quantitative result.

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

CSF Glucose - Sterile Tube

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

Special Chemistries / Urine Cup

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

Additional Tests

For the tests below, cooridnate with lab OIC or NCOIC

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

Special Chemistries / Tiger Top (SST)

X	TEST	RESULT	REF. RANGE
	Alcohol		<10 mg/dL Negative
			50-400 mg/dL Toxic
			>400 mg/dl Poss. Fatal
	Cholinesterase		M: 5.90-12.22 U/mL
			F: 4.65-10.44 U/mL
	Iron		M: 49-181 ug/dL
			F: 37-170 ug/dL
	Lipase		23-300 U/L
X	Phosphorous	6.9 H	2.2-4.5 mg/dL
X	Magnesium	2.5 H	1.6-2.3 mg/dL
	Uric Acid		M: 3.5-8.5 mg/dL
			F: 2.5-6.2 mg/dL
	Lactate Dehydrogenase		313-618 U/L
	HIV		Negative
	PSA Tot		Age Range(ng/ml)
			40-49 0.0-2.5 ng/ml
			50-59 0.0-3.5 ng/ml
			60-69 0.0-4.5 ng/ml
			70-79 0.0-6.5 ng/ml
	HCG Quant		M: <3mIU/ mL
			Cyclic F: <4 mIU/ mL
			MenoP F: <13 mIU/ mL
			Preg F: >20 mIU/ mL
	Bu		0.0 - 1.1 mg/dl
	Bc		0.0 - 0.3 mg/dl

Therap. Drug Monitoring

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

Thyroid Panel / Red or Tiger Top

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

Add. Thyroid Tests / Red or Tiger To

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

Hepat's B / Red or Tiger Top

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

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115th Field Ho[illegible]tal | (b)(6) | 0059 05 CID 789-39259 | LABORATORY RESULTS FORM

(b)(6) | (b)(6) | 0707

Physician Drawn b | Ward: ICU Bed: 6 | STAT / Routine X | Specimen Date and Time: 03APR05 0450 | Reported by (b)(6) | Date and Tim 03APR

Chemistry (I-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ Lytes | Glu | Crea

X	TEST	RESULT		REF. RANGE
	Na			138-145 mmol/L
	K			3.3-4.9 mmol/L
	Cl			98-109 mmol/L
X	pH	7.323	L	7.35-7.45
X	PCO2	48.1	H	35-45 mmHg
	PO2	90		80-100 mmHg
	TCO2	26		18-33 mmol/L
	HCO3	25.0		22-26 mmol/L
	sO2	96		95-99%
	BEecf	-1		(-2) - (+3)
	AGap			8-16 mmol/L
	iCa			1.12-1.32 mmol/L
	BUN			7-22 mg/dL
	Glu			73-118 mg/dL
	Creat			0.6-1.3 mg/dL
	Hct			37.0-52.0%
	Hgb			12.0-18.0 g/dL
	Lactate			0.90-1.70 mmol/L

Urinalysis

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

Urine Microscopic

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

Other lab request:

Chemistry (Piccolo Analyzer) / Green Top

Chem 12 | Met Pres | BMP | Liver | Lipid | Renal

X	TEST	RESULT	REF. RANGE
L	ALB	1.4	3.3-5.5 g/dL
	ALP	83	26-184 U/L
H	ALT	84	10-47 U/L
H	AMY	116	14-110 U/L
H	AST	152	11-38 U/L
H	Tbil	4.8	0.2-1.6 mg/dL
H	BUN	135	7-22 mg/dL
X	Ca	8.1	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
H	CL	112	98-109 mmol/L
	TCO2	22	18-33 mmol/L
H	Creat	5.5	0.6-1.3 mg/dL
H	GGT	67	5-65 U/L
H	Glu	149	73-118 mg/dL
	K	4.1	3.3-4.9 mmol/L
L	TProtein	5.5	6.4-8.1 g/dL
H	Na	148	138-145 mmol/L
	Phosphorous		2.2-4.5 mg/dL
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Rapid Tests

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
Wet Mount		Negative
KOH		Negative

Hematology / Purple Top

CBC | Malaria | H/H

X	TEST	RESULT	REF. RANG
H	WBC	13.1	4.8-10.8 x10(3
L	RBC	2.50	4.2-6.1 x10(6)
L	Hgb	7.5	12.0-18.0 g/d
L	Hct	22.8	M: 42.0-52.0
			F: 37-47%
	MCV	91.5	80.0-99.0 fl
	MCH	29.9	27.0-31.0 pg
L	MCHC	32.7	33.0-37.0 g/dl
H	Plt	930	150-400 x10(3)/
L	LY%	7.5	20.0-44.0%
	LY#	1.0	0.7-4.3 x10(3)/u

Differential

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

RBC Abn Morph:

Plt Abn Morph: >20/02F
2nd RELEASED

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Se
Thick		No Plasmodium Se

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

PT	13.8		11.0-14.0 sec
H APTT	44.7	71.1	21.0-50.0 sec
INR	1.4		0.5-1.5/therap 2-3
D Dimer			Negative

Cardiac Panel/Purple Top

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

Hemoglobin S / Purple Top

Hemoglobin S	Negative

Body Fluid Panel - Sterile Cont.

Panel includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis tes 72:SF only)

10-L-0126 ACLU DD III (CID ROI) 2858 3

115th Field Hospital

LABORATORY RESULTS FORM

(b)(6)

(b)(6)

Physician: (b)(6) Ward: CU

Drawn by: Bed: 6

STAT

Routine

Specimen Date and Time: 0 4 3 0

(b)(6)

Date and Ti 2Apr 10

Chemistry (i-STAT) / Green Top / Syringe: Bld Gas, Bld Gas w/ lytes, Glu, Crea				Chemistry (Piccolo Analyzer) / Green Top: Chem 12, Metabs, BMP, Liver, Lipid, Renal				Hematology / Purple Top: CBC, Malaria, H/H			
X	TEST	RESULT	REF. RANGE	X	TEST	RESULT	REF. RANGE	X	TEST	RESULT	REF. RANG
	Na		138-145 mmol/L		ALB		3.3-5.5 g/dL		WBC		4.8-10.8 x10(3
	K		3.3-4.9 mmol/L		ALP		26-184 U/L		RBC		4.2-6.1 x10(6)
	Cl		98-109 mmol/L		ALT		10-47 U/L		Hgb		12.0-18.0 g/
	pH		7.35-7.45		AMY		14-110 U/L		Hct		M: 42.0-52.0
	PCO2		35-45 mmHg		AST		11-38 U/L				F: 37-47%
	PO2		80-100 mmHg		Tbil		0.2-1.6 mg/dL		MCV		80.0-99.0 fl
	TCO2		18-33 mmol/L		BUN		7-22 mg/dL		MCH		27.0-31.0 pg
	HCO3		22-26 mmol/L		Ca		8.0-10.3 mg/dL		MCHC		33.0-37.0 g/d
	sO2		95-99%		Chol		100-200 mg/dL		Plt		130-400 x10(3)/
	BEecf		(-2) - (+3)		CK		M: 39-380 U/L		LY%		20.0-44.0%
	AGap		8-16 mmol/L				F: 30-190 U/L		LY#		0.7-4.3 x10(3)/
	iCa		1.12-1.32 mmol/L		CL		98-109 mmol/L		Differential		
	BUN		7-22 mg/dL		TCO2		18-33 mmol/L	Segs(50-70%)			Mono(4-10%)
	Glu		73-118 mg/dL		Creat		0.6-1.3 mg/dL	Bands(1-10%)			Eos(0-4%)
	Creat		0.6-1.3 mg/dL		GGT		5-65 U/L	Lymph(20-44%)			Baso(0-2%)
	Hct		37.0-52.0%		Glu		73-118 mg/dL	Atyp Ly			Immature cells
	Hgb		12.0-18.0 g/dL		K		3.3-4.9 mmol/L	RBC Abn Morph:			
	Lactate		0.90-1.70 mmol/L		TProtein		6.4-8.1 g/dL				
Urinalysis					Na		138-145 mmol/L	Plt Abn Morph:			
	Color		Straw/Yellow		Phosphorous		2.2-4.5 mg/dL				
	Clarity		Clear		HDL Chol		30-75 mg/dL	WBC Abn Morph:			
	Glucose		Negative		LDL Chol		50-130 mg/dL				
	Bilirubin		Negative		Triglycerides		60-150 mg/dL	Malaria / Purple Top			
	Ketone		Negative		VLDL		≤30 mg/dL		Thin		No Plasmodium See
	SG		1.010-1.025		Chol/HDL Ratio		≤4.5		Thick		No Plasmodium See
	Blood		Negative	Rapid Tests				Sed Rate / Purple Top			
	pH		5.0-8.0		Mono		Negative		Sed Rate		1hr = 0-20 mm
	Protein		Negative-Trace		RPR		Negative	Coagulation (Blue Top - Sodium Citrate)			
	Urobili		0.1-1.0 Ehrlich U/dL		HIV		Negative		PT		7.0-14.0 sec
	Nitrite		Negative		Drug Scr.		Negative		APTT		21.0-50.0 sec
	Leuko		Negative		HCG		Negative		INR		0.5-1.5/therap 2-3
Urine Microscopic					H.pylori IgG		Negative		D Dimer		Negative
	WBC		Epi		ETOH/Alc.		Negative	Cardiac Panel/Purple Top			
	RBC		Mucus		Strep A		Negative		Myoglobin		0-107 ng/mL
	Bacteria		Yeast		Chlamydia		Negative		CK-MB		0-4.3 ng/mL
	Casts:		Spermatozoa		Flu A&B		Negative		Troponin		0.0-0.4 ng/mL
	Crystals:		Amorph Sed	X	C. difficile (stool)	POS	Negative	Hemoglobin S / Purple Top			
	Other:				O&P (stool)		No Ova / Parasite		Hemoglobin S		Negative
					OccBld		Negative	Body Fluid Panel - Sterile Cont.			
Other lab request:					Wet Mount		Negative	Panel includes: Culture, Gram Stain, Cell Count, WBC Diff., Meningitis test (CSF only)			
					KOH		Negative				

For C. difficile

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1 of 3

0059 05 CID789-3925

115th Field Hos[illegible]al
Baghdad Central Detention [illegible]ility Hospital

LA[illegible]RATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.

X Male / Female

SSN or ISN: (b)(6)

Signs and Symptoms:

Physician: (b)(6) Ward: 10A
Drawn by: Bed: 6

STAT / X Routine

Specimen Date and Time: 02APR05 @ 0500

Reported by: (b)(6)

Date and Time: 2Apr 07

Chemistry (i-STAT) / Green Top / Syringe

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

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
X	pH	7.309 L	7.35-7.45
X	PCO2	48.8 H	35-45 mmHg
	PO2		80-100 mmHg
	TCO2	26	18-33 mmol/L
	HCO3	24.5	22-26 mmol/L
	sO2		95-99%
	BEecf	-2	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

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

Urine Microscopic

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

Chemistry (Piccolo Analyzer) / Green Top

Chem 12 | Met Lytes | BMP | Liver | Lipid | Panel

X	TEST	RESULT		REF. RANGE
X	ALB	1.2	L	3.3-5.5 g/dL
	ALP	80		26-184 U/L
X	ALT	49	H	10-47 U/L
	AMY	72		14-110 U/L
X	AST	92	H	11-38 U/L
X	Tbil	4.2	H	0.2-1.6 mg/dL
X	BUN	102	H	7-22 mg/dL
X	Ca	8.6		8.0-10.3 mg/dL
	Chol			100-200 mg/dL
	CK			M: 39-380 U/L
				F: 30-190 U/L
X	CL	113	H	98-109 mmol/L
	TCO2	27		18-33 mmol/L
X	Creat	4.4	H	0.6-1.3 mg/dL
	GGT	34		5-65 U/L
X	Glu	138	H	73-118 mg/dL
	K	3.8		3.3-4.9 mmol/L
X	TProtein	6.2	L	6.4-8.1 g/dL
X	Na	152	H	138-145 mmol/L
X	Phosphorous	6.2	H	2.2-4.5 mg/dL
	HDL Chol			30-75 mg/dL
	LDL Chol			50-130 mg/dL
	Triglycerides			60-160 mg/dL
	VLDL			≤30 mg/dL
	Chol/HDL Ratio			≤4.5

Rapid Tests

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative

Hematology / Purple Top

CBC / Malaria / ETH

X	TEST	RESULT		REF. RANGE
X	WBC	13.2	H	4.8-10.8 x10(3)/u
X	RBC	3.23	L	4.2-6.1 x10(6)/uL
X	Hgb	9.6	L	12.0-18.0 g/dL
X	Hct	29.7	L	M: 42.0-52.0%
				F: 37-47%
	MCV	91.7		80.0-99.0 fl
	MCH	29.6		27.0-31.0 pg
X	MCHC	32.3	L	33.0-37.0 g/dL
X	Plt	93	L	130-400 x10(3)/uL
X	LY%	8.1	L	20.0-44.0%
	LY#	1.1		0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S / Purple Top

Hemoglobin S	Negative

Critical Results given to (b)(6)

Exhibit 743

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.		X Male / Female	SSN or ISN: (b)(6)	Signs and Symptoms:
Physician: (b)(6) / Drawn by:	Ward: ICU / Bed: 6	STAT / X Routine.	Specimen Date and Time: 02APR05 @ 0500	Reported by: (b)(6) / Date and Time: 2 Apr 0728

Hemoglobin A1C / Purple Top

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

Urine Microalbumin/Creatinine Urine Cup

Note: Will not perform on urine samples with a protein value of 30 mg/dL or higher or grossly bloody specimens.

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

C Reactive Protein / Red Top

[illegible] result.

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

CSF Glucose - Sterile Tube

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

Additional Tests

For the tests below, cooridnate with lab OIC or NCOIC

X	TEST	RESULT	REF. RANGE
	TIBC		
	Ammonia		
	Lactate		

Special Chemistries / Tiger Top (SST)

X	TEST	RESULT	REF. RANGE
	Alcohol		<10 mg/dL
			50-400 mg/dL Toxic
			>400 mg/dl Poss. Fatal
	Cholinesterase		M: 5.90-12.22 U/mL
			F: 4.65-10.44 U/mL
	Iron		M: 49-181 ug/dL
			F: 37-170 ug/dL
	Lipase		23-300 U/L
X	Magnesium	2.8 H	1.6-2.3 mg/dL
	Uric Acid		M: 3.5-8.5 mg/dL
			F: 2.5-6.2 mg/dL
	Lactate Dehydrogenase		
			313-618 U/L

Therap. Drug Monitoring

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

Special Chemistries / Urine Cup

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

75

Task Force Med 115
Abu Ghraib, Iraq

Microbiology Laboratory Report

Accession #	U021
Collection Date	3/31/2005
Patient Name	(b)(6)
SSN or ID	(b)(6)
Sample Type	Urine
Sample Site	Catheterized
Patient Location	ICU
Provider	(b)(6)
Result Type	FINAL
☐ Gram's Stain	
☒ Culture	No growth after 24 hours
Qty isolate #1	
Isolate #1	
Qty isolate #2	
Isolate #2	
Qty isolate #3	
Isolate #3	
Comments	
Report Date	4/1/2005
Tech	(b)(6)
Reviewed By	(b)(6)

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

Exhibit 3

Task Force Med 115
Abu Ghraib, Iraq

Microbiology Laboratory Report

Accession #	B062
Collection Date	3/31/2005
Patient Name	(b)(6)
SSN or ID	(b)(6)
Sample Type	Blood
Sample Site	A-Line; Femoral
Patient Location	ICU
Provider	(b)(6)
# bottles	2
Result Type	Preliminary 1
Gram's Stain	Gram-negative rods; Yeast
Verbal Report	
Culture	
Isolate #1	Gram-negative rods
Isolate #2	Yeast
Isolate #3	
Comments	
Report Date	4/1/2005
Tech	(b)(6)
Reviewed By	

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

0059 05 CID 05-2623

MEDICAL RECORD | **BLOOD OR BLOOD COMPONENT TRANSFUSION**

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool of ____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ____

VOLUME REQUESTED (If applicable): 1 UNIT ML

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

DATE REQUESTED: 01 APR 05

DATE AND HOUR REQUIRED: 01 APR 05 ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify):

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

REMARKS:

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

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW (L) FLANK

I have collected a blood specimen on the belo named patient, verified the name and ID No. the patient and verified the specimen tube label be correct. (b)(6)

SIGNATURE: (b)(6)

DATE VERIFIED: 01 APR 05

TIME VERIFIED: 10:30

SECTION II – PRE-TRANSFUSION TESTING

Exp: 07 Apr 2005

UNIT NO.: (b)(6)

TRANSFUSION NO.: 1

PATIENT NO.: (b)(6)

DONOR		RECIPIENT	
ABO	A	ABO	A
Rh	pos	Rh	pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

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

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

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE 01 Apr 05

REMARKS: No Antibody screen performed Immediate Spin crossmatch only (b)(6)

(b)(6)

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT (Hour): 1155 U | ON (Date): 01 Apr 05

IDENTIFICATION:

I have examined the Blood Component container label and this form and I

(b)(6)

(b)(6)

2nd VERIFIER (Signature): (b)(6)

PRE-TRANSFUSION

TEMP. 102.8 | PULSE 145 | BP 150/80

DATE OF TRANSFUSION: 2005.01.04 | TIME STARTED: 12:45

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME COMPLETED	INTERRUPTED
ML	01.04.2005 13:30	

REACTION: [X] NONE [ ] SUSPECTED

If reaction is suspected -- IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO [ ] YES (Specify) ____

SIGNATURE OF PERSO (b)(6)

(b)(6)

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

SEX: M | WARD: ICU

(b)(6)

(b)(6)

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

78

115th Field Hos[illegible]l — Baghdad Central Detention [illegible]cility Hospit

(b)(6)

0039 05 CID789-5925

A[illegible]RATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.

Male / Female

SSN or ISN: (b)(6) (b)(6)

Signs and Symptoms:

0634

Physician (b)(6) Drawn by

Ward: ICU Bed: 6

STAT / X Routine

Specimen Date and Time: 1APR05 ~~0805~~0005

(b)(6)

Date and Time 01 APR

Chemistry (i-STAT) / Green Top / Syringe: Bld Gas, Bld Gas w/ lytes, Glu, Crea				Chemistry (Piccolo Analyzer) / Green Top: Chem 12, Met Vital, BMP, Liver, Lipid, Renal				Hematology / Purple Top: CBC, Malaria, H/H			
X	TEST	RESULT	REF. RANGE	X	TEST	RESULT	REF. RANGE	X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L	L	ALB	1.1	3.3-5.5 g/dL	H	WBC	12.6	4.8-10.8 x10(3)/u
	K		3.3-4.9 mmol/L		ALP	76	26-184 U/L	L	RBC	3.13	4.2-6.1 x10(6)/uL
	Cl		98-109 mmol/L		ALT	37	10-47 U/L	L	Hgb	9.4	12.0-18.0 g/dL
L	pH	7.309	7.35-7.45	H	AMY	104	14-110 U/L	L	Hct	28.7	M: 42.0-52.0%
	PCO2	44.5	35-45 mmHg	H	AST	100	11-38 U/L				F: 37-47%
H	PO2	116	80-100 mmHg	H	Tbil	6.1	0.2-1.6 mg/dL		MCV	91.7	80.0-99.0 fl
	TCO2	24	18-33 mmol/L	H	BUN	68	7-22 mg/dL		MCH	30.1	27.0-31.0 pg
	HCO3	22.4	22-26 mmol/L	L	Ca	7.8	8.0-10.3 mg/dL	L	MCHC	32.8	33.0-37.0 g/dL
	sO2	98	95-99%		Chol		100-200 mg/dL	H	Plt	822	130-400 x10(3)/uL
L	BEecf	-4	(-2) - (+3)		CK		M: 39-380 U/L		LY%	8.6	20.0-44.0%
	AGap		8-16 mmol/L				F: 30-190 U/L		LY#	1.1	0.7-4.3 x10(3)/uL
	iCa		1.12-1.32 mmol/L	H	CL	115	98-109 mmol/L		Differential		
	BUN		7-22 mg/dL		TCO2	21	18-33 mmol/L	Segs(50-70%)			Mono(4-10%)
	Glu		73-118 mg/dL	H	Creat	3.6	0.6-1.3 mg/dL	Bands(1-10%)			Eos(0-4%)
	Creat		0.6-1.3 mg/dL		GGT	31	5-65 U/L	Lymph(20-44%)			Baso(0-2%)
	Hct		37.0-52.0%		Glu	82	73-118 mg/dL	Atyp Ly			Immature cells
	Hgb		12.0-18.0 g/dL		K	4.3	3.3-4.9 mmol/L		RBC Abn Morph:		
	Lactate		0.90-1.70 mmol/L	L	TProtein	5.5	6.4-8.1 g/dL				
	Urinalysis				Na	144	~~138~~ 145 mmol/L		Plt Abn Morph: INCREASED		
	Color		Straw/Yellow		Phosphorous		2.2-4.5 mg/dL			>20/02 F	
	Clarity		Clear		HDL Chol		30-75 mg/dL		WBC Abn Morph:		
	Glucose		Negative		LDL Chol		50-130 mg/dL				
	Bilirubin		Negative		Triglycerides		60-160 mg/dL		Malaria / Purple Top		
	Ketone		Negative		VLDL		≤30 mg/dL		Thin		No Plasmodium Seen
	SG		1.010-1.025		Chol/HDL Ratio		≤4.5		Thick		No Plasmodium Seen
	Blood		Negative		Rapid Tests				Sed Rate / Purple Top		
	pH		5.0-8.0		Mono		Negative		Sed Rate		1hr = 0-20 mm
	Protein		Negative-Trace		RPR		Negative		Coagulation (Blue Top - Sodium Citrate)		
	Urobili		0.1-1.0 Ehrlich U/dL		HIV		Negative		PT		7.0-14.0 sec
	Nitrite		Negative		Drug Scr.		Negative		APTT		21.0-50.0 sec
	Leuko		Negative		HCG		Negative		INR		0.5-1.5/therap 2-3
	Urine Microscopic				H.pylori IgG		Negative		D Dimer		Negative
	WBC		Epi		ETOH/Alc.		Negative		Cardiac Panel/Purple Top		
	RBC		Mucus		Strep A		Negative		Myoglobin		0-107 ng/mL
	Bacteria		Yeast		Chlamydia		Negative		CK-MB		0-4.3 ng/mL
	Casts:		Spermatozoa		Flu A&B		Negative		Troponin		0.0-0.4 ng/mL
	Crystals:		Amorph Sed		C. difficile (stool)		Negative		Hemoglobin S / Purple Top		
	Other:				O&P (stool)		No Ova / Parasite		Hemoglobin S		Negative
					OccBld		Negative				

Exhibit 793

0059-05-CID789-3925

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

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.

Male / Female

SSN or ISN: (b)(6) (b)(6)

Signs and Symptoms:

Physician Drawn by: (b)(6)

Ward: ICU
Bed: 6

STAT / X Routine

Specimen Date and Time: 1APR05 0500

Reported by:

Date and Time

Chemistry (i-STAT) / Green Top / Syringe — Bld Gas, Bld Gas w/ lytes, Glu, Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
L	pH	7.309	7.35-7.45
	PCO2	44.5	35-45 mmHg
H	PO2	116	80-100 mmHg
	TCO2	24	18-33 mmol/L
	HCO3	22.4	22-26 mmol/L
	sO2	98	95-99%
L	BEecf	-4	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

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

Urine Microscopic

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

Chemistry (Piccolo Analyzer) / Green Top — Chem 12, Metabolic, BMP, Liver, Lipid, Renal

X	TEST	RESULT	REF. RANGE
L	ALB	1.1	3.3-5.5 g/dL
	ALP	76	26-184 U/L
	ALT	37	10-47 U/L
H	AMY	104	14-110 U/L
H	AST	100	11-38 U/L
H	Tbil	6.1	0.2-1.6 mg/dL
H	BUN	68	7-22 mg/dL
L	Ca	7.8	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
H	CL	115	98-109 mmol/L
	TCO2	21	18-33 mmol/L
H	Creat	3.6	0.6-1.3 mg/dL
	GGT	31	5-65 U/L
	Glu	82	73-118 mg/dL
	K	4.3	3.3-4.9 mmol/L
L	TProtein	5.5	6.4-8.1 g/dL
	Na	144	138-145 mmol/L
	Phosphorous		2.2-4.5 mg/dL
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Rapid Tests

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative

Hematology / Purple Top — CBC, Malaria, Diff

X	TEST	RESULT	REF. RANGE
H	WBC	12.6	4.8-10.8 x10(3)/u
L	RBC	3.13	4.2-6.1 x10(6)/uL
L	Hgb	9.4	12.0-18.0 g/dL
L	Hct	28.7	M: 42.0-52.0%
			F: 37-47%
	MCV	91.7	80.0-99.0 fl
	MCH	30.1	27.0-31.0 pg
L	MCHC	32.8	33.0-37.0 g/dL
H	Plt	822	130-400 x10(3)/uL
	LY%	8.6	20.0-44.0%
	LY#	1.1	0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S / Purple Top

Hemoglobin S	Negative

Exhibit 803

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool of ____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ____

VOLUME REQUESTED (If applicable): 1 unit ML

REMARKS:

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

DATE REQUESTED: 31MAR05

DATE AND HOUR REQUIRED: 31MAR05/ ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify):

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW (L) flank

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)

DATE VERIFIED: 31 MAR 05

TIME VERIFIED: 1005

SECTION II – PRE-TRANSFUSION TESTING

Exp 02 Apr 05

UNIT NO.: (b)(6)

TRANSFUSION NO.: 2

PATIENT NO.: (b)(6)

DONOR: ABO A, Rh POS

RECIPIENT: ABO A, Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	compatable

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

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

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 31 Mar 05

REMARKS: No antibody screen performed
Immediate spin crossmatch only

(b)(6)

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT (Hour): 15:56

ON (Date): 31 Mar 05

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature): (b)(6)

2nd VERIFIER (Signature): (b)(6)

PRE-TRANSFUSION
TEMP. 102.5 PULSE 125 BP 118/88

DATE OF TRANSFUSION: 31 March 05

TIME STARTED: 1610

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME DATE COMPLETED	INTERRUPTED
Unit ML	1730 31 Mar 05	

REACTION
- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO
- [ ] YES (Specify) ____

SIGNATURE: (b)(6)

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

SEX: M

WARD: ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

Exhibit 3

CID 89-39259

MEDICAL RECORD | **BLOOD OR BLOOD COMPONENT TRANSFUSION**

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [X] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)*: 1 unit ML

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

DATE REQUESTED: 31 MAR 05

DATE AND HOUR REQUIRED: 31 MAR 05 / ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

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

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW (L) flank

I have collected a blood specimen on the belo named patient, verified the name and ID No. the patient and verified the specimen tube label be correct.

SIGNATURE OF VERIFIER: (b)(6)

DATE VERIFIED: 31 MAR 05

TIME VERIFIED: 1005

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

Exp 07 Apr 05

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)

TRANSFUSION NO.: 1

PATIENT NO.: (b)(6)

DONOR: ABO A, Rh pos

RECIPIENT: ABO A, Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	compatable

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

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

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 31 Mar 05

REMARKS: No Antibody screen performed
Immediate spin crossmatch only

(b)(6)

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)*: 1327 ON *(Date)*: 31 Mar 05

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

(b)(6)

(b)(6)

(b)(6)

PRE-TRANSFUSION

TEMP. 102.5 PULSE 125 BP 120/65

DATE OF TRANSFUSION: 31 March 05

TIME STARTED: 1340

POST-TRANSFUSION DATA

AMOUNT GIVEN: ALL ML

TIME DATE COMPLETED: 1550

INTERRUPTED

REACTION
- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)

UNKNOWN, UNKNOWN
H O DETAINEE
INPROCESSING

SEX: M

WARD: ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

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Exhibit 3

0039 03 CID/89-39259

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	Male	SSN or ISN: (b)(6) (b)(6)	Signs and Symptoms:
	Female		
Physician: (b)(6) Ward: ICU	STAT	Specimen Date and Time:	Reported by: (b)(6) Date and Time:
Drawn by: Bed: 6	X Routine	1 APR 05 0500	1 Apr @ 0637

Hemoglobin A1c / Purple Top

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

Urine Microablumin/Creatinine Urine Cup

Note: Will not be ran on urine samples with a protein value of 30 mg/dL or higher or on visibly bloody specimens

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

C-Reactive Protein / Red Top

Note: Qualitative Screen performed on sample. If result is pos, titrations will be performed for a semi-quantitative result

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

CSF Glucose - Sterile Tube

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

Special Chemistries / Urine Cup

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

Additional Tests

For the tests below, cooridnate with lab OIC or NCOIC

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

Special Chemistries / Tiger Top (SST)

X	TEST	RESULT	REF. RANGE
	Alcohol		<10 mg/dL Negative
			50-400 mg/dL Toxic
			>400 mg/dl Poss. Fatal
	Cholinesterase		M: 5.90-12.22 U/mL
			F: 4.65-10.44 U/mL
	Iron		M: 49-181 ug/dL
			F: 37-170 ug/dL
	Lipase	TC	23-300 U/L
H	Phosphorous	~~2.8~~ 6.4	2.2-4.5 mg/dL
H	Magnesium	2.8	1.6-2.3 mg/dL
	Uric Acid		M: 3.5-8.5 mg/dL
			F: 2.5-6.2 mg/dL
	Lactate Dehydrogenase		
			313-618 U/L
	HIV		Negative
	PSA Tot		Age Range(ng/ml)
			40-49 0.0-2.5 ng/ml
			50-59 0.0-3.5 ng/ml
			60-69 0.0-4.5 ng/ml
			70-79 0.0-6.5 ng/ml
	HCG Quant		M: <3mIU/ mL
			Cyclic F: <4 mIU/ mL
			MenoP F: <13 mIU/ mL
			Preg F: >20 mIU/ mL
	Bu		0.0 - 1.1 mg/dl
	Bc		0.0 - 0.3 mg/dl

Therap. Drug Monitoring

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

Thyroid Panel / Red or Tiger Top

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

Add. Thyroid Tests / Red or Tiger Top

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

Hepatis B / Red or Tiger Top

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

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Exhibit

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

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

Physician: (b)(6) | Ward: ICU | X STAT / Routine | Specimen Date and Time: 31 March 1103 | Reported by: (b)(6) | Date and Time: 31.03.2005

Chemistry (i-STAT) / Green Top / Syringe

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

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.309 L	7.35-7.45
	PCO2	45.5 H	35-45 mmHg
	PO2	142 H	80-100 mmHg
	TCO2	24	18-33 mmol/L
	HCO3	22.8	22-26 mmol/L
	sO2	99	95-99%
	BEecf	-3	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

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

Urine Microscopic

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

Chemistry (Piccolo Analyzer) / Green Top

Chem 12 | MetLyte | BMP | Liver | Lipid | Renal

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		138-145 mmol/L
	Phosphorous		2.2-4.5 mg/dL
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Rapid Tests

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		

Hematology / Purple Top

CBC | Malaria | H/H

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S / Purple Top

Hemoglobin S	Negative

Exhibit 3

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

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

Physician: (b)(6) | Ward: ICU | Bed: 6 | STAT / X Routine | Specimen Date and Time: 31MAR05 | Reported by: (b)(6) | Date and Time: 31MAR 1(

Chemistry (STAT) / Green Top - Syringe: Bld Gas | Bld Gas w/ tyles | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
*	pH	7.187	7.35-7.45
*	PCO2	66.2	35-45 mmHg
	PO2	374	80-100 mmHg
	TCO2	27	18-33 mmol/L
	HCO3	26.1	22-26 mmol/L
	sO2	100	95-99%
	BEecf	-3	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	0.86	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color	yellow	Straw/Yellow
Clarity	hazy	Clear
Glucose	Neg	Negative
Bilirubin	Large	Negative
Ketone	Neg	Negative
SG	1.020	1.010-1.025
Blood	Large	Negative
pH	5.0	5.0-8.0
Protein	300	Negative-Trace
Urobili	0.2	0.1-1.0 Ehrlich U/dL
Nitrite	Pos	Negative
Leuko	Neg	Negative

Urine Microscopic

WBC		Epi	5-10
RBC	5-10	Mucus	
Bacteria		Yeast	
Casts:		Spermatozoa	
Crystals:		Amorph Sed	4+
Other:			

Chemistry (Piccolo Analyzer) / Green Top: Chem12 | Metabolics | LFP | Lipid | Urate | Renal

X	TEST	RESULT	REF. RANGE
*	ALB	<1.0	L 3.3-5.5 g/dL
	ALP	83	26-184 U/L
	ALT	32	10-47 U/L
X	AMY	158	H 14-110 U/L
	AST	77	H 11-38 U/L
	Tbil	5.6	H 0.2-1.6 mg/dL
	BUN	49	H 7-22 mg/dL
X	Ca	7.6	L 8.0-10.3 mg/dL
	Chol	98	L 100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	Cl		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat	1.4	H 0.6-1.3 mg/dL
	GGT	23	5-65 U/L
	Glu	62	L 73-118 mg/dL
X	K	4.0	3.3-4.9 mmol/L
	TProtein	5.1	L 6.4-8.1 g/dL
	Na		138-145 mmol/L
X	Phosphorous	6.7 (H)	2.2-4.5 mg/dL
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Rapid Tests

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite

Hematology / Purple Top: CBC | Malaria | HgbS

X	TEST	RESULT	REF. RANGE
	WBC	13.5	H 4.8-10.8 x10(3)/
	RBC	2.90	L 4.2-6.1 x10(6)/u
	Hgb	8.4	L 12.0-18.0 g/dL
	Hct	26.8	L M: 42.0-52.0%
			F: 37-47%
	MCV	92.6	80.0-99.0 fl
	MCH	29.2	27.0-31.0 pg
	MCHC	31.5	L 33.0-37.0 g/dL
	Plt	683	H 130-400 x10(3)/ul
	LY%	9.9	L 20.0-44.0%
	LY#	1.3	0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Special Citrate)

	PT	12.5	7.0-14.0 sec
*	APTT	130.3	21.0-50.0 sec
	INR	1.2	0.5-1.5/therap 2-3
	D Dimer		Negative

Cardiac Panel / Purple Top

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

Hemoglobin S / Purple Top

Hemoglobin S	Negative

Ictotest: (+)

PH panic value 7.187 ! pco2 panic value 66.2, APTT = 130.3, INR = <1.1 85

10-L-0126 ACLU DD III (CID ROI) 2871

Exhibit 3

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)	X Male / Female	SSN or ISN: (b)(6)	Signs and Symptoms:
Physician: (b)(6) Drawn by:	Ward: ICU Bed: 6	STAT / X Routine.	Specimen Date and Time: 31 MAR05
Reported by: (b)(6)	Date and Time: 31 MAR 05		

Hemoglobin A1c / Purple Top

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

Urine Microalbumin/Creatinine Urine Cup
Note: Will not be ran on urine samples with a protein value of 30 mg/dl or higher or on visibly bloody specimens.

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

C Reactive Protein / Red Top
Note: Qualitative Screen performed on serum. If result is pos. the test will be performed for a semi-quantitative test.

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

CSF Glucose - Sterile Tube

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

Additional Tests
For the tests below, cooridnate with lab OIC or NCOIC

X	TEST	RESULT	REF. RANGE
	TIBC		
	Ammonia		
	Lactate		

Special Chemistries / Tiger Top (SST)

X	TEST	RESULT	REF. RANGE
	Alcohol		<10 mg/dL
			50-400 mg/dL Toxic
			>400 mg/dl Poss. Fatal
	Cholinesterase		M: 5.90-12.22 U/mL
			F: 4.65-10.44 U/mL
	Iron		M: 49-181 ug/dL
			F: 37-170 ug/dL
X	Lipase	432 (H)	23-300 U/L
X	Magnesium	2.5	1.6-2.3 mg/dL
	Uric Acid		M: 3.5-8.5 mg/dL
			F: 2.5-6.2 mg/dL
	Lactate Dehydrogenase		
			313-618 U/L

Therap. Drug Monitoring

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

Special Chemistries / Urine Cup

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

115th Field Hospital
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.		SSN or ISN:	Signs and Symptoms:
(b)(6)	X Male / Female	(b)(6)	
Physician: (b)(6) Drawn by:	Ward: 14 Bed: 6	X STAT / Routine	Specimen Date and Time: 31 MAR 0935	Reported by: (b)(6)	Date and Time 31-03-2005

Chemistry (i-STAT) / Green Top / Syringe
Bld Gas | Bld Gas w/ Lytes | Glu | Crea

X	TEST	RESULT		REF. RANGE
	Na			138-145 mmol/L
	K			3.3-4.9 mmol/L
	Cl			98-109 mmol/L
	pH	7.265	L	7.35-7.45
	PCO2	50.5	H	35-45 mmHg
	PO2	116	H	80-100 mmHg
	TCO2	24		18-33 mmol/L
	HCO3	22.9		22-26 mmol/L
	sO2	98		95-99%
	BEecf	-4	L	(-2) - (+3)
	AGap			8-16 mmol/L
	iCa			1.12-1.32 mmol/L
	BUN			7-22 mg/dL
	Glu			73-118 mg/dL
	Creat			0.6-1.3 mg/dL
	Hct			37.0-52.0%
	Hgb			12.0-18.0 g/dL
	Lactate			0.90-1.70 mmol/L

Urinalysis

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

Urine Microscopic

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

Chemistry (Piccolo Analyzer) / Green Top
Chem 12 | Methyls | BMP | Liver | Lipid | Fecal

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		138-145 mmol/L
	Phosphorous		2.2-4.5 mg/dL
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Rapid Tests

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative

Hematology / Purple Top
CBC | Malaria | H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/u
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		M: 42.0-52.0%
			F: 37-47%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		20.0-44.0%
	LY#		0.7-4.9 x10(3)/uL

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel/Purple Top

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

Hemoglobin S / Purple Top

Hemoglobin S	Negative

87

10-L-0126 ACLU DD III (CID ROI) 2873

115th Field Hol al
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

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

Physician: (b)(6) | Ward: Icu | X STAT / Routine | Specimen Date and Time: 31MAR05 | Reported by: (b)(6) | Date and Tim: 31.03.2005, 9

Drawn by: | Bed: 6

Chemistry (ESLAT) / Green Top / Syringe
Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
*	pH	7.187	7.35-7.45
*	PCO2	66.2	35-45 mmHg
	PO2	374	80-100 mmHg
	TCO2	27	18-33 mmol/L
	HCO3	26.1	22-26 mmol/L
	sO2	100	95-99%
	BEecf	-3	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	0.86	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Chemistry (Piccolo Analyzer) / Green Top
Others: Mg/Phos | AMP | Iron | Uric | Recal

X	TEST	RESULT	REF. RANGE
*	ALB	<1.0	L 3.3-5.5 g/dL
	ALP	83	26-184 U/L
	ALT	32	10-47 U/L
X	AMY	158	H 14-110 U/L
	AST	77	H 11-38 U/L
	Tbil	5.6	H 0.2-1.6 mg/dL
	BUN	49	H 7-22 mg/dL
X	Ca	7.6	L 8.0-10.3 mg/dL
	Chol	98	L 100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat	1.4	H 0.6-1.3 mg/dL
	GGT	23	5-65 U/L
	Glu	62	L 73-118 mg/dL
	K		3.3-4.9 mmol/L
	TProtein	5.1	L 6.4-8.1 g/dL
	Na		138-145 mmol/L
X	Phosphorous		2.2-4.5 mg/dL
	HDL Chol		30-75 mg/dL
	LDL Chol		60-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Hematology / Purple Top
CBC | Manual Diff

X	TEST	RESULT	REF. RANGE
	WBC	13.5	H 4.8-10.8 x10(3)/u
	RBC	2.90	L 4.2-6.1 x10(6)/ul
	Hgb	8.4	L 12.0-18.0 g/dL
	Hct	26.8	L M: 42.0-52.0%
			F: 37-47%
	MCV	92.6	80.0-99.0 fl
	MCH	29.2	27.0-31.0 pg
	MCHC	31.5	L 33.0-37.0 g/dL
	Plt	683	H 130-400 x10(3)/ul
	LY%	9.9	L 20.0-44.0%
	LY#	1.3	0.7-4.3 x10(3)/uL

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Urinalysis

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

Urine Microscopic

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

Rapid Tests

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

	PT	12.5	7.0-14.0 sec
*	APTT	130.3	21.0-50.0 sec
	INR	1.2	0.5-1.5/therap 2-3
	D Dimer		Negative

Cardiac Panel/Purple Top

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

Hemoglobin S / Purple Top

Hemoglobin S	Negative

PH panic value 7.187 ! pco2 panic value 66.2, APTT = 130.3, ALB 88 = <1.0

Exhibit 3

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

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST MI: (b)(6)

☑ Male ☐ Female

SSN or ISN: (b)(6)

Signs and Symptoms:

Physician: (b)(6)
Drawn by:

Ward: ICU
Bed: 6

☐ STAT ☑ Routine

Specimen Date and Time: 31MAR05/

Reported by: (b)(6)

Date and Tim: 31Mar05 09(

Chemistry (i-STAT) / Green Top / Syringe — Bld Gas, Bld Gas w/ Lytes, Glu, Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH *	7.187	7.35-7.45
	PCO2 *	66.2	35-45 mmHg
	PO2	374	80-100 mmHg
	TCO2	27	18-33 mmol/L
	HCO3	26.1	22-26 mmol/L
	sO2	100	95-99%
	BEecf	-3	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	0.86	1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

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

Urine Microscopic

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

Chemistry (Paccle Analyzer / Green Top) — Creatine, Met Gluc, SMP, Liver, Lipid, Renal

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-184 U/L
	ALT		10-47 U/L
X	AMY		14-110 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
X	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L
			F: 30-190 U/L
	CL		98-109 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.3 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.9 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		138-145 mmol/L
X	Phosphorous		2.2-4.5 mg/dL
	HDL Chol		30-75 mg/dL
	LDL Chol		50-130 mg/dL
	Triglycerides		60-160 mg/dL
	VLDL		≤30 mg/dL
	Chol/HDL Ratio		≤4.5

Rapid Tests

Mono		Negative
RPR		Negative
HIV		Negative
Drug Scr.		Negative
HCG		Negative
H.pylori IgG		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite

Hematology / Purple Top — CBC / Manual / Diff

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

Differential

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

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium Citrate)

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

Cardiac Panel / Purple Top

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

Hemoglobin S / Purple Top

Hemoglobin S	Negative

PH panic value 7.187 ! pCO2 panic value / 66.2

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Exhibit 3

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool of ____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ____

VOLUME REQUESTED (If applicable): 1 unit ML

REMARKS: EXP IS APR 05

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

DATE REQUESTED: ASAP

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: P GSW

I have collected a blood specimen on the belo named patient, verified the name and ID No. the patient and verified the specimen tube label be correct.

SIGNATURE OF VERIFIER: PRIOR CLOT

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)

TRANSFUSION NO. 16

PATIENT NO. (b)(6)

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N A	COMPATIBLE

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

(b)(6)

DONOR: ABO O Rh POS

RECIPIENT: ABO A Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 04 APR 05

REMARKS: NO ANTI BODY SCREEN PERFORMED
IMMEDIATE SPIN CROSSMATCH ONLY

SECTION III – RECORD OF TRANSFUSION

(b)(6)

AT (Hour) 1045 ON (Date) 4 APR 05

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature) (b)(6)

2nd VERIFIER (Signature) (b)(6)

PRE-TRANSFUSION

TEMP. 98 PULSE 100 BP 103/35

DATE OF TRANSFUSION 4/4/05 TIME STARTED 1100

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME DATE COMPLETED	INTERRUPTED
ALL ML	1255 4 APR 05	

REACTION
- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [ ] NO
- [X] YES (Specify) ____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

(b)(6)

UNKNOWN, UNKNOWN
H O DETAINEE
INPROCESSING

SEX: M

WARD: ICU #6

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool of ____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ____

VOLUME REQUESTED (If applicable): 1 unit ML

REMARKS: EX ISAF105

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

DATE REQUESTED: ASAP

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P GSW

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: Prior dot

DATE VERIFIED

TIME VERIFIED

(b)(6)

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)

TRANSFUSION NO. 9

PATIENT NO. (b)(6)

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	COMPATIBLE

PREVIOUS RECORD CHECK: [✓] RECORD [ ] NO RECORD

(b)(6)

DONOR	RECIPIENT
ABO O	ABO A
Rh POS	Rh POS

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE 04 APR 05

REMARKS:
NO ANTIBODY SCREEN PERFORMED
2MMEDIATE SPIN CROSSMATCH ONLY

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT (Hour) 0715 | ON (Date) 4Apr04

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature): (b)(6)

2nd VERIFIER (Signature): (b)(6)

PRE-TRANSFUSION
TEMP. 98 PULSE 105 BP 95/33

DATE OF TRANSFUSION: 4/4/05 | TIME STARTED: 1100

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME	DATE COMPLETED	INTERRUPTED
400 ML	1000	4/4/05	

REACTION [✓] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [ ] NO [ ] YES (Specify) ____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

SEX M | WARD ICU #6

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

Exhibit 3

CID 89-392

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [ ] RED BLOOD CELLS
- [X] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) _____

VOLUME REQUESTED (If applicable) _____ ML

REMARKS: EXP: 03 SEP 05 APROS

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

DATE REQUESTED: 3 April 05

DATE AND HOUR REQUIRED: 1100

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

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

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

DIAGNOSIS OR OPERATIVE PROCEDURE: DIC

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)

TRANSFUSION NO. 8

PATIENT NO. (b)(6)

	DONOR	RECIPIENT
ABO	A	A
Rh	POS	POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	N/A

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

SIGNATURE OF PERSON PERFORMING TEST (b)(6)

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 7 APR 05

REMARKS: FRESH FROZEN PLASMA
NO ANTIBODY SCREEN PERFORMED

SECTION III – RECORD OF TRANSFUSION

(b)(6)

AT (Hour) 0606 ON (Date) 04APR05

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature) (b)(6)

2nd VERIFIER (Signature) (b)(6)

TEMP. 101.0 PULSE 106 BP 91/44

DATE OF TRANSFUSION 04APR05 TIME STARTED 0615

PATIENT IDENTIFICATION - USE EMBOSSER (For typed or written entries give NAME - Last, first, middle; rank/rate; hospital number and name of facility.)

TCU 8206

(b)(6)

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME COMPLETED	DATE COMPLETED	INTERRUPTED
287 ML	0647	04APR04	NO

REACTION [X] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER _____

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO [ ] YES (Specify) _____

SIGNATURE OF PERSON NOTING ABOVE (b)(6)

SEX M WARD TCU

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

10-L-0126 ACLU DD III (CID ROI) 2878

92 Exhibit 3

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- ☐ RED BLOOD CELLS
- ☒ FRESH FROZEN PLASMA
- ☐ PLATELETS *(Pool of _____ units)*
- ☐ CRYOPRECIPITATE *(Pool of _____ units)*
- ☐ Rh IMMUNE GLOBULIN
- ☐ OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 1 UNIT ML

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

DATE REQUESTED: 3 April 05

DATE AND HOUR REQUIRED: NOW

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? ___

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

DIAGNOSIS OR OPERATIVE PROCEDURE: DIC

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER:

DATE VERIFIED:

TIME VERIFIED:

EXP 0338 05APR05

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)

TRANSFUSION NO.: 7

PATIENT NO.: (b)(6)

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	N/A

PREVIOUS RECORD CHECK: ☒ RECORD ☐ NO RECORD

(b)(6)

DONOR	RECIPIENT
ABO A	ABO A
Rh POS	Rh POS

☒ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE 04 APR 05

REMARKS: FFP (FRESH FROZEN PLASMA) NO ANTIBODY SCREEN PERFORMED

(b)(6)

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)*: 0338 **ON** *(Date)*: 04 APR 05

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: (b)(6)

2nd VERIFIER *(Signature)*: (b)(6)

PRE-TRANSFUSION

TEMP. 99.8 (Axillary) PULSE 107 BP 89/36

DATE OF TRANSFUSION: 04APR05

TIME STARTED: 0355

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME DATE COMPLETED	INTERRUPTED
350 ML	0430 04APR05	NO

REACTION ☒ NONE ☐ SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- ☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
- ☐ OTHER _____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- ☒ NO ☐ YES *(Specify)* _____

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

SEX: M **WARD**: ICU

ICU Bed 6

(b)(6)

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

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10-L-0126 ACLU DD III (CID ROI) 2879 Exhibit 3

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

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

DATE REQUESTED: 3 Apr 05

DATE AND HOUR REQUIRED: 1300 3 Apr

VOLUME REQUESTED *(If applicable)*: 1 Unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? ____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: Anemia

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF (b)(6)

DATE VERIFIED: 3 APR 2005

TIME VERIFIED: 11:00

Sept. (b)(6)

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)

TRANSFUSION NO. 3

PATIENT NO. (b)(6)

(b)(6)

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	COMP

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD (b)(6)

DONOR	RECIPIENT
ABO O	ABO O (new) A
Rh POS	Rh POS

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 3 Apr 05

REMARKS: No antibody screen performed (b)(6)

(b)(6)

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)

AT *(Hour)* 1654 ON *(Date)* 3 Apr 05

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* (b)(6)

2nd VERIFIER *(Signature)* (b)(6)

PRE-TRANSFUSION TEMP. 100.0 PULSE 95 BP 132/61

DATE OF TRANSFUSION 03.04.2005 TIME STARTED 17:10

PATIENT IDENTIFICATION - USE EMBOSSER *(For NAME - last, first, middle; rank/rate; hospital number)* (b)(6)

(b)(6)

UNKNOWN, UNKNOWN
M 0 DETAINEE
INPROCESSING

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME COMPLETED	DATE COMPLETED	INTERRUPTED
ML	18:45	03.APR.2005	

REACTION [X] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER _____

OTHER DIFFICULTIES *(Equipment, clot)*
- [X] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABO (b)(6)

SEX M WARD ICU 6

BLOOD OR BLOOD COMPONENT TRANSFUSION STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

10-L-0126 ACLU DD III (CID ROI) 2880

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Exhibit 3

MEDICAL RECORD | **BLOOD OR BLOOD COMPONENT TRANSFUSION**

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)*: 1 UNIT ML

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

DATE REQUESTED: 3 Apr 05

DATE AND HOUR REQUIRED: 1300 3 Apr

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

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

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

DIAGNOSIS OR OPERATIVE PROCEDURE: Anemia

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF [illegible]: (b)(6)

DATE VERIFIED: 03 APR 2005

TIME VERIFIED: 11:00

REMARKS:

Sgt F. (b)(6)

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)

TRANSFUSION NO.: 1

PATIENT NO.: (b)(6)

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	COMP

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

(b)(6)

DONOR	RECIPIENT
ABO O	ABO A
Rh pos	Rh pos

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE 3Apr05

REMARKS: 16 antibody screen performed Immediate spin crossmatch only

(b)(6)

SECTION III – RECORD OF TRANSFUSI

(b)(6)

PRE-TRANSFUSION DATA

(b)(6)

AT *(Hour)* 1314 | ON *(Date)* 3Apr05

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: (b)(6)

2nd VERIFIER *(Signature)*: (b)(6)

(b)(6)

PRE-TRANSFUSION

TEMP. 99.9 | PULSE 112 | BP 104/55

DATE OF TRANSFUSION: 03.04.2005 | TIME STARTED: 13:30

AMOUNT GIVEN: 1 Unit ML | TIME DATE COMPLETED: 1500 2 Apr 05 | INTERRUPTED

REACTION
- [X] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF [illegible]: (b)(6)

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)

UNKNOWN, UNKNOWN
N O DETAINEE
INPROCESSING

SEX: M | WARD: ICU 6

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

0059 03 CID 89-3925

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ____ units)*
- [ ] CRYOPRECIPITATE *(Pool of ____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ____

VOLUME REQUESTED *(If applicable)*: 1 Unit ML

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

DATE REQUESTED: 3 Apr 05

DATE AND HOUR REQUIRED: 1300 3 Apr 05

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

REMARKS:

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

DIAGNOSIS OR OPERATIVE PROCEDURE: Anemia

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

(b)(6)

SIGNATURE OF VERIFIER: (b)(6)

DATE VERIFIED: 03 APR 2005

TIME VERIFIED: 11:00

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

Seq #: (b)(6)

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)

TRANSFUSION NO.: 2

PATIENT NO.: (b)(6)

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	COMP

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

(b)(6)

DONOR	RECIPIENT
ABO O	ABO A
Rh pos	Rh pos

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE 3 Apr 05

REMARKS: No antibody screen performed

(b)(6)

(b)(6)

(b)(6)

SECTION III – RECORD OF TRANSFUSION

TRANSFUSION DATA (Signature)

AT *(Hour)*: 1514 **ON** *(Date)*: 3 Apr 05

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the c(b)(6)cipient matches item by item. The recipient is t(b)(6)s Blood Component Transfusion Form and on th(b)(6)

1st VERIFIER *(Signature)*: (b)(6)

2nd VERIFIER *(Signature)*: (b)(6)

PRE-TRANSFUSION

TEMP. 99.8 PULSE 114 BP 110/65

DATE OF TRANSFUSION: 03 APR 2005 **TIME STARTED**: (b)(6)

POST-TRANSFUSION DATA

AMOUNT GIVEN: ____ ML

TIME DATE COMPLETED: 03 APR 2005 17:00 **INTERRUPTED**

REACTION [ ] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[ ] NO [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - last, first, middle; rank or grade; hospital number and name of facility.)*

0 DETAINEE
INPROCESSING

SEX: M **WARD**: IZ 6

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

10-L-0126 ACLU DD III (CID ROI) 2882

96 Exhibit 3

NSN 7540-00-634-4162 519-218

PATIENT IDENTIFICATION (For typed or written entries: Name — last, first, middle, Medical Facility)	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
(b)(6) UNKNOWN, UNKNOWN M 0 DETAINEE INPROCESSING Bed #6	(b)(6)			ICU	

EXAMINATION REQUESTED (Use SF 519-B for multiple exams)
CXR

REQUESTED BY	TELEPHONE NO.
(b)(6)	

LOCATION OF MEDICAL RECORDS	FILM NO.	DATE REQUESTED	PREGNANT
ICU		04APR05	☐ YES ☒ NO

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)
intubated & chest tube

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

RADIOLOGIC REPORT
New infiltrate (R) medial lung.

(b)(6)

SIGNATURE	LOCATION OF RADIOLOGIC FACILITY

1 – MEDICAL RECORD

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

NSN 7540-00-634-4162 519-218

PATIENT IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
(b)(6)		M		ICU	

EXAMINATION REQUESTED (Use SF 519-B for multiple exams)

CXR

REQUESTED BY	TELEPHONE NO.
(b)(6)	

LOCATION OF MEDICAL RECORDS	FILM NO.	DATE REQUESTED	PREGNANT
ICU Bed #6		03APR05	☐ YES ☒ NO

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

intubated

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

RADIOLOGIC REPORT

prox port (L) pl drain just inside (L) chest wall

improvement (L) pl eff.

(b)(6)

SIGNATURE	LOCATION OF RADIOLOGIC FACILITY

MEDICAL RECORD

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

Exhibit 98

NSN 7540-00-634-4162 519-218

PATIENT IDENTIFICATION (For typed or writ[illegible]ntries give:)	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
(b)(6)				ICU #6	

UNKNOWN, UNKNOWN
H O DETAINEE
INPROCESSING

EXAMINATION REQUESTED (Use SF 519-B for multiple exams)
CXR

REQUESTED BY (b)(6) | TELEPHONE NO.

LOCATION OF MEDICAL RECORDS	FILM NO.	DATE REQUESTED	PREGNANT
ICU BED #6		02APR05	☐ YES ☒ NO

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)
INTUBATED, Chest tube

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

RADIOLOGIC REPORT
NGT tip & well seen s/w stable chest w/ (L) lung base contusion / atx.

(b)(6)

SIGNATURE | LOCATION OF RADIOLOGIC FACILITY

MEDICAL RECORD ♻ RADIOLOGIC CONSULTATION REQUEST/REPORT

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

NSN 7540-00-634-4162 519-218

PATIENT IDENTIFICATION (For typed or written entries give: Name)
(b)(6)
UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING
pod 4

AGE: M. | SEX | SSN (Sponsor) | WARD/CLINIC: ICU. /6. | REGISTER NO.

EXAMINATION REQUESTED (Use SF 519-B for multiple exams)
CxR.

REQUESTED BY: (b)(6) | TELEPHONE NO.

LOCATION OF MEDICAL RECORDS | FILM NO. | DATE REQUESTED: 01 APR 2006. | PREGNANT: ☐ YES ☐ NO

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)
iatu Patrol

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

RADIOLOGIC REPORT
Tubes / lns unremarkable except NGT tip not seen
No sig Δ B/B atx, (L) pulmonary contusion / atx

(b)(6)

SIGNATURE | LOCATION OF RADIOLOGIC FACILITY

MEDICAL RECORD ♻ RADIOLOGIC CONSULTATION REQUEST/REPORT

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

NSN 7540-00-634-4162 519-218

PATIENT IDENT (Name — last, first, middle)	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
(b)(6) UNKNOWN, UNI AN M O DETAINEE INPROCESSING				ICU	

EXAMINATION REQUESTED (Use SF 519-B for multiple exams)
Port CXR

REQUESTED BY	TELEPHONE NO.
(b)(6)	

LOCATION OF MEDICAL RECORDS	FILM NO.	DATE REQUESTED	PREGNANT
		3 MAR 05	☐ YES ☐ NO

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)
S/P central line placement

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

RADIOLOGIC REPORT
(R) SC CC tip in SVC
(L) baseline atx.

(b)(6)

LOCATION OF RADIOLOGIC FACILITY

RECORD

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

10-L-0126 ACLU DD III (CID ROI) 2887

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NSN 7540-00-634-4162 519-218

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

(b)(6)

AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
			ICU	Bed 6

EXAMINATION REQUESTED *(Use SF 519-B for multiple exams)*

PCXR

REQUESTED BY	TELEPHONE NO.
(b)(6)	

LOCATION OF MEDICAL RECORDS	FILM NO.	DATE REQUESTED	PREGNANT
		31 Mar 05	☐ YES ☐ NO

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

CT Placement

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
31 Mar 05		

RADIOLOGIC REPORT

Ett tip @ level clavids

NGT tip not well seen.

c/w unremarkable CXR.

(b)(6)

SIGNATURE	LOCATION OF RADIOLOGIC FACILITY

DICAL RECORD **RADIOLOGIC CONSULTATION REQUEST/REPORT** **STANDARD FORM 519-A** (REV. 8-83)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

DEPARTMENT OF THE ARMY 0059 05 CID78

256 BCT
APO AE 09303
Staff Action
TIGERS!

S:

SUBJECT: Detainees

REASON FOR ACTION: Detention Checklist

FACTS OR DISCUSSION:

Required Forms and Evidence (complete prior to detention at BIF)

- CPA Apprehension Form or DA From 2748 - EPW Capture Tag (Parts A-C)
- DA Form 4137 / USIR 503-3 - Evidence/Property Custody Document
- DA Form 4002 - Evidence Property Tag
- DA Form 2823 (2) - Sworn Statements (Unit Soldiers) or USIR 503-2 in Arabic for detainees or Arabic witnesses
- SF 600 - Medical Exam Form
- DD Form 2708 - Receipt for Inmate/Detained Person

- Photographs of scene and / or detainees in front of evidence, i.e. weapons (take whenever possible, if no camera present sketch or notate possible evidentiary details).
- Targeting packet, if applicable.

CONCLUSION: I have received and reviewed the enclosed detention packet.

ACTION OFFICER/PHONE: BDE S2X (b)(6), (b)(7)(C) [redacted]	NAME OF BDE S-2X: MAJ (b)(6), (b)(7)(C) [redacted]

Section	Name	Initials	Date
BN S2			
BN CDR/XO			
BDE S2X	MAJ (b)(6), (b)(7)(C) [redacted]		
SJA			
BDE DBC/XO	COL (b)(6), (b)(7)(C) [redacted]		
BDE CDR	BG (b)(6), (b)(7)(C) [redacted]		

COMMENTS:

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

Offense against Civilian(s) [check one] If "Other" then describe: 0059 05 CID 789-39259

- [ ] 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)
- [X] Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- [ ] Maiming (I.P.C. 412)
- [ ] Simple Assault (I.P.C. 415)
- [ ] 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:

- [ ] Violation of Curfew
- [ ] Illegal Possession of Weapon
- [X] 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: 617 MP CO			Location Grid:
Date of Incident: (D/M/Y) 320-04 to	Time of Incident: hrs to hrs	Date of Report: (D/M/Y)	Time of Report: hrs

Detainee #			Key Connected Person: [ ] Victim [ ] Witness		
Last Name:			Last Name:		
First Name:	Given Name:		First Name:	Given Name:	
Hair Color:	Scars/Tattoos/Deformities:		Hair Color:	Scars/Tattoos/Deformities:	
Eye-Color:	Weight: lb	Height: in	Eye-Color:	Weight: lb	Height: in
Address:			Address:		
Place of Birth:			Place of Birth:		
Ethn/Tribe/ Sect:	Sex: [ ] M [ ] F	Phone#: DOB D/M/Y: [ ] Mobile [ ] Regular	Ethn/Tribe/ Sect:	Sex: [ ] M [ ] F	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)

Make:	Color:	License No.:	Owner:
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:	Owner:

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

Detaining Soldier's Name (Print): Last, First MI	Supervising Officer's Name (Print): Last, First MI
Signature:	Signature:
Email: Unit Phone: (b)(6), (b)(7)(C) Date: / /	Email: Unit Phone: Date: / 104/

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

0059 05 CID789-3925

Why was this person detained?

For Attacking a convoy of the Coalition Forces on MSR [(b)(2)] the date was 3-20-05

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

[(b)(6), (b)(7)(C)]

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

Who was with this person?

What weapons was this person carrying?

AK 47
RPG
RPK

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information:

Exhibit 4

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 PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately
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
MSR (b)(2)	2005/March/20	1600	

5. LAST NAME, FIRST NAME, MIDDLE NAME	6. SSN	7. GRADE/STATUS
(b)(6), (b)(7)(C)	(b)(6), (b)(7)(C)	E4

8. ORGANIZATION OR ADDRESS
617 MP Co

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

Ravin 4-2 was shadowing a convoy on Msr (b)(2) We were going down the N Bound Ln. Whin the convoy came under fire by AK47, RPG, and RPK. Whin the firing started we went around the Right side to laydown fire for the Convoy so thay could get pass the AO. There was many AIF along the side of the (b)(2) We made a right turn on a road to flank thim (b)(6), (b)(7)(C) burn that ran beside CAIFS and there was more AIF on both side of the Side Road. Thin we layed down fire on both side of the side road. We killed lots of AIF and took five EPW's Three 617th MP were shot as well. // End of Statment // Nothing to follow //

10. EXHIBIT	(b)(6), (b)(7)(C) N MAKING STATEMENT	PAGE 1 OF _____ PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "S[redacted]KEN 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.

USE THIS PAGE IF NEEDED. IF THIS PAGE IS NOT NEEDED, PLEASE PROCEED TO FINAL PAGE OF THIS FORM.

STATEMENT OF _____ TAKEN AT _____ DATED 0059 05 CID789-3925

9. STATEMENT *(Continued)*

INITIALS OF PERSON MAKING STATEMENT | PAGE OF PAGES

STATEMENT OF (b)(6), (b)(7)(C) TAKEN AT 1600 DATED 20 March 2008

9. STATEMENT *(Continued)*

Nothing to follow

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_____. 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 INFLU(b)(6), (b)(7)(C)

_____
(Signature of Person Making Statement)

WITNESSES:

_____

_____

_____
ORGANIZATION OR ADDRESS

_____

_____

_____
ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this_____ day of _____, _____

at _____

_____
(Signature of Person Administering Oath)

_____
(Typed Name of Person Administering Oath)

_____
(Authority To Administer Oaths)

INITIALS OF PERSON MAKING ST(b)(6), (b)(7)(C) PAGE OF PAGES

0059 05 CID789-39259

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 PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately identified.
ROUTINE USES: Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE: Disclosure of your social security number is voluntary.

1. LOCATION	2. DATE (YYYYMMDD)	3. TIME	4. FILE NUMBER
CHS	2005 0720	1651	

5. LAST NAME, FIRST NAME	6. SSN	7. GRADE/STATUS
(b)(6), (b)(7)(C)	(b)(6), (b)(7)(C)	1E-4/BAC

8. ORGANIZATION OR ADDRESS
617th MPCO

9. I, (b)(6), (b)(7)(C), WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH: we were escorting a convoy, came on the radio that they were taking fire. Our patrol was approaching on the left side of the convoy. Witnessed the convoy receiving fire from the 3 o'clock side. I then laid fire I Feared P. I. P. The clothes were of local nationals, common clothes. Continued down the side of the main while laying supressive fire. We were the trail vehicle, there was a road that went to the right off the MSR, MSR was unknown at this time. I then ~~heard~~ saw about twenty ~~insurg~~ gunmen, along with other gunmen spread out along the trail. I laid supressive fire towards the gunmen. Several gunmen sought cover through out the fields. About that time Maple and SGT (b)(6), (b)(7)(C) dismounted, and moved towards the none contact side. (b)(6), (b)(7)(C) were laying supressive fire when SPC (b)(6), (b)(7)(C) got hit, At the same time I was hit by a round going through the .50 cal Ammo can and the m4 de 64 hitting me in the goggles. At that time I got Mike, a medic, knew about me and (b)(6), (b)(7)(C) I then resumed fire, while SPC (b)(6), (b)(7)(C) worked on SPC (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) were receiving fire from the 12 the 9 and the 3 o'clock, then SGT (b)(6), (b)(7)(C) got hit then help SGT (b)(6), (b)(7)(C) also assisted (b)(6), (b)(7)(C) we laid ~~laid~~ laid more supressive fire. I was firing with all weapons 9mm, SAW, and .50 cal. As I was reloading I heard fire with my 9mm. We then loaded (b)(6), (b)(7)(C) and SGT (b)(6), (b)(7)(C) loaded ~~them~~ into Another unknown Patrol and are the next down the road ~~with~~ with me and Another Soldier set up the (b)(6), (b)(7)(C) then we then taken to CHS. This was dicted to SGT (b)(6), (b)(7)(C) ~~was~~ then we taken

///- End of Statement

Dictated by (b)(6), (b)(7)(C) SGT

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF ____ PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ____ TAKEN AT ____ DATED ____"

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

DA FORM 2823, DEC 1998 — DA FORM 2823, JUL 72, IS OBSOLETE — USA 1.00

Exhibit 4

USE THIS PAGE IF NEEDED. IF THIS PAGE IS NOT NEEDED, PLEASE PROCEED TO FINAL PAGE OF THIS FORM.

STATEMENT OF _____ TAKEN AT _____ DATED _____

9. STATEMENT *(Continued)*

INITIALS OF PERSON MAKING STATEMENT _____ PAGE OF PAGES

STATEMENT OF _____ TAKEN AT _____ DATED 05 CID 789-3925

9. STATEMENT *(Continued)*

AFFIDAVIT

I, _____, HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE____. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

_____
(Signature of Person Making Statement)

WITNESSES:

Subscribed and sworn to before me, a person authorized by law to administer oaths, this_____ day of _____, _____ at _____

_____
ORGANIZATION OR ADDRESS

_____
(Signature of Person Administering Oath)

_____
(Typed Name of Person Administering Oath)

_____
ORGANIZATION OR ADDRESS.

_____
(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT	PAGE OF PAGES

PAGE 3, DA FORM 2823, DEC 1998 USAPA V1.0C

Exhibit 4

RECEIPT FOR INMATE OR DETAINED PERSON

1. RECEIVED FROM *(Unit or Agency and Station)* 617th MP Co. 156 [redacted] (b)(6), (b)(7)(C)	2. TIME	3. DATE *(YYYYMMDD)* 20050320
4. INMATE NAME *(Last, First, Middle)* pvt #1 1654, 1655, [redacted], 1659, 1660, 1657	5. SSN	6. GRADE
7. ORGANIZATION	8. STATION	

9. OFFENSE

10. PERSONAL PROPERTY

11. REMARKS

12. NAME AND TITLE OF PERSON RECEIVING ABOVE INDIVIDUAL Sgt [redacted] (b)(6), (b)(7)(C)	13. SSN 8255	14. GRADE E-5
15. RECEIV[redacted]ATION DC CO 1-151 FA (86th CSH)	16. SIGNATURE Sgt [redacted] (b)(6), (b)(7)(C)	

DD FORM 2708, NOV 1999 USAPA V1

10-L-0126 ACLU DD III (CID ROI) 2898

Pvt # 1657

Pvt

0059 05 CID 789-39259

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AGENT'S INVESTIGATION REPORT	ROI NUMBER 0089-05-CID259
CID Regulation 195-1	PAGE 1 OF 1 PAGES

DETAILS

BASIS FOR INVESTIGATION: About 0900, 08 Apr 05, SA [redacted] received a Request For Assistance (0059-05-CID259-39259) from 48th Military Police Detachment (CID) (FWD) (-), Baghdad Central Confinement Facility (BCCF), Abu Ghraib, Iraq, to obtain medical records of Detainee [redacted] patient number [redacted] from the 86th Combat Support Hospital (CSH), International Zone (IZ), Baghdad, Iraq, as well as locate and interview MAJ (Dr.) [redacted] 745th Forward Surgical Team (FST), 44th Medical Command (MEDCOM), IZ, Baghdad, Iraq.

About 1000, 14 Apr 05, SA [redacted] coordinated with MAJ [redacted] Patient Administration Division (PAD), 86th CSH, 44th MEDCOM, IZ, Baghdad, Iraq, who provided copies of all medical records pertaining to Detainee 171687, patient 1657.

About 1040, 14 Apr 05, SA [redacted] interviewed MAJ (Dr.) [redacted] who stated he had treated [redacted] the day he had come into the 86th CSH. MAJ (Dr.) [redacted] related [redacted] had a serious injury to his right flank, described as being the lower right part of the back. He described it as being a hole large enough to insert a fist into the back. MAJ (Dr.) [redacted] believed the wound was some type of fragmentation wound but could not say with 100 percent certainty. MAJ (Dr.) [redacted] said about 10 minutes after [redacted] was seen in the emergency room he was transported to the operating room for "damage control surgery". [redacted] underwent 3-5 of these types of surgeries before being transported to BCCF, Abu Ghraib, Iraq, approximately a week after arriving. MAJ (Dr.) [redacted] stated [redacted] was transported in serious condition with an open abdomen but believed due to the seriousness of the injury that [redacted] might eventually die from his wounds.

//LAST ITEM//

TYPED NAME, GRADE, AND UNIT	SIGNATURE	
SA [redacted] UMBER 48th MP Det (CID) (FWD)	[redacted]	15 Apr 05

CID FORM 94-E
1 OCT 95

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE
PROTECTIVE MARKING IS EXCLUDED FROM
AUTOMATIC TERMINATION (Para 13, AR 340-16)
FOUO Data is Entered

EXHIBIT 6

Exhibit 6

Exhibits 7

Page(s) 117 THRU 121 referred to:

CDR USAMEDCOM
ATTN: FOIA Office, STOP 76
1216 Stanley RD 2D FL
FT. Sam Houston, TX 78234-5049

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

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER
(b)(6)	(b)(6)	Detainee	(b)(6)
ORGANIZATION UNKNOWN, UNKNOWN M O DETAINEE INPROCESSING	NATION *(e.g., United States)* Pays Iraq	DATE OF BIRTH Date de naissance	SEX Sexe ☒ MALE Masculin ☐ FEMALE Féminin

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

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

MEDICAL STATEMENT Declaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [1] Maladie ou condition directement responsable de la mort. [1]	GUNSHOT WOUND TO RIGHT FEMUR	16 DAYS
ANTECEDENT CAUSES Symptômes précurseurs de la mort	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire: UNKNOWN	
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire: UNKNOWN	
OTHER SIGNIFICANT CONDITIONS [2] Autres conditions significatives [2]	UNKNOWN	

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☐ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort ouscitées par des causes extérieures
☐ NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
☐ ACCIDENT Mort accidentelle		
☐ SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
☐ HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident d'Avion ☐ YES Oui ☐ NO Non

DATE OF DEATH *(Hour, day, month, year)* Date de décès (Heure, le jour, le mois, l'année)	PLACE OF DEATH Lieu de décès
(b)(6) 05 (b)(6)	ABU GHRAIB, IRAQ

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

NAME OF MEDICAL OFFICER Nom du médicin militaire ou du médicin sanitaire	TITLE OR DEGREE Titre ou diplômé
(b)(6)	
GRADE Grade (b)(6)	INSTALLATION OR ADDRESS Installation ou adresse (b)(6) 115th FIELD HOSPITAL ABU GHRAIB PRISON
DATE Date (b)(6) 05	SIGNATURE Signature

[1] State disease, injury or complication which caused death, but not mode of dying, such as cardiac arrest, heart failure, shock or hemorrhage. (b)(6)
[2] State conditions contributing to the death, but not related to the disease or condition causing death.
[1] Préciser la nature de la maladie, de la blessure ou de la complication ... le mourir, telle qu'un arrêt du coeur, etc.
[2] Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.

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DD FORM 2064, APR 1977 REPLACES DA FORM 3565, 1 JAN 1972 AND DA FORM 3565-R(PA3), 26 SEP 1975, WHICH ARE OBSOLETE. USAPA V1.00

0059 05 CID789-5925

HOSPITAL REPORT OF DEATH

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

NAME AND LOCATION OF HOSPITAL

Instructions - Medical Officer in attendance will:

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

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

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

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

(b)(6)

UNKNOWN, UNKNOWN
M O DETAINEE
INPROCESSING

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) 05

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
UNKNOWN

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* GUNSHOT WOUND TO RIGHT FLANK	16 DAYS
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) UNKNOWN	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a. UNKNOWN	
	b.	

9. DATE (b)(6) 05

10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE (b)(6)

(b)(6)

SECTION B - ADMINISTRATIVE AC

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

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)*
☐ YES ☒ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

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

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

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0037 03 CID/89-2925

Personal Effects And Money

Internment Serial Number
(b)(6)

Property Tag	Description	Qty	Dispostition

The Above List Of Items Is Correct _____

Signature Of Detainee

Brief Details Of Death/Burial By Person Who Cared For The DeceasedDuring Illness Or During Last Moments (Doctor, Nurse, Minister of Religion, Fellow Internee). Death/Cremation Details.

DETAINEE DIED DUE TO GUNSHOT WOUND TO RIGHT FLANK

Exhibit 7

Encl 5

0059 05 CID789-3925

RECORD OF IDENTIFICATION PROCESSING
(Effects and Physical Data)

DATE: (b)(6) 05

LAST NAME - FIRST NAME - MIDDLE INITIAL *(Or unknown number)*	GRADE	SERVICE NO. SSAN	CIL CASE NUMBER *(If applicable)*
BTB: Unidentified	N/D	(b)(6)	N/A

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

RECEIVED FROM
Abu Ghahb, Iraq

OFFICIAL IDENTIFICATION FOUND WITH REMAINS *(Include personal effects aiding identification)*
1 ea Medical Identification Tag
----------Nothing Follows----------

IMPRINT OF IDENTIFICATION TAG
None Found

ITEMS OF CLOTHING AND EQUIPMENT FOUND WITH REMAINS *(Indicate type, color, size, markings, service, etc. If laundry marks are indistinct, follow procedures outlined in TM10-286)*
1 ea Towel, orange in color
----------Nothing Follows----------

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

PHYSICAL DESCRIPTION

ESTIMATED HEIGHT	MUSCULARITY	COLOR OF HAIR	RACE OR NATIVITY
76"	Large	Black	Mongoloid

TATTOOS, SCARS OR MARKS ON BODY
Medical tubing on the mouth, penis, left shoulder, right side of the abdomen and left side of chest.
Medical gauge patch on the left side of the chest and right side of the abdomen.
Lacerations on the left side of the abdomen.
Abrasions on the right shoulder, right wrist and left knee.

EVIDENCE OF HEALED FRACTURES AND BONE MALFORMATIONS
N/D

WOUNDS OR INJURIES
Burns on the right ankle and left ankle.

I HAVE PERSONALLY VIEWED THE REMAINS OF THIS DECEASED AND ALL RESULTING INFORMATION HAS BEEN RECORDED TO THE BEST OF MY KNOWLEDGE.

NAME, GRADE, AND ORGANIZATION
(b)(6)

(b)(6)

DD FORM 890, JAN 58 PREVIOUS EDITION OF THIS FORM IS

0059 05 CID789-39259

Certificate of Death For use of this form, see AR 190-8, the Proponent agency is DCSOPS	Internment Serial Number (b)(6)
From: HQ V TNAAAPO AE 09342 ABU GHRAIB BAGHDAD	To:

Name(Last, First, MI) UNK,UNK	Grade	Service Number
Nationality IZ-Iraq	Power Served IZ-Iraq	Place of Capture/Internment and Date 2005 (b)(6)

Name, Relationship, Address of Next of Kin APO AE 09342 ABU GHRAIB BAGHDAD	Father's First Name Place Of Birth: Date Of Birth:

Place of Death ABU GHRAIB,	Date Of Death 2005 (b)(6)	Cause Of Death GUNSHOT WOUND
Place Of Burial	Date Of Burial 2005 (b)(6)	Identification Of Grave

Personal Effects: Please See Attached Page

Brief Details Of Death And Burial: Please See Attached Page

Do Not Write In This Space Seal of the Office of The Provost Marshal General)APO AE 09342 ABU GHRAIB BAGHDAD	Date 2005 (b)(6) Signature of Commanding Officer (b)(6) Signature (b)(6) Address Abu Ghraib Signature (b)(6) Address Abu Ghraib

Exhibit

0059 05 CID789-39259

DEPARTMENT OF THE ARMY
UNITED STATES ARMY CRIMINAL INVESTIGATION COMMAND
48th MILITARY POLICE DETACHMENT (CID)(FWD)
3RD MILITARY POLICE GROUP (CID)
CAMP VICTORY, BAGHDAD, IRAQ
APO AE 09342

CIMPR-FR 13 Apr 05

MEMORANDUM FOR Maj. [redacted] 86th Combat Support Hospital Patient Administration Division, International Zone, Baghdad, Iraq (IZ)

SUBJECT: Request for Medical Records

1. This office is conducting an investigation pertaining to the death of a detainee whose name is UNKNOWN, Interment Serial Number (ISN) [redacted] Preliminary investigation revealed ISN [redacted] was treated at the 86th Combat Support Hospital (CSH) on 20 Mar 05 for gunshot wounds received in an attack with coalition forces earlier the same day. A review of the detainee file shows ISN [redacted] was assigned as patient number [redacted]

2. This office is also conducting an investigation pertaining to the death of PFC [redacted], 211th Brigade Combat Team, IZ and the injuries sustained by a yet unidentified soldier. Preliminary investigation revealed PFC [redacted] and this Unknown soldier were both treated at the 86th CSH on 6 and 7 April 05 for severe burns.

3. Request your office provide copies of all medical records pertaining to the receipt, treatment and discharge of ISN [redacted] patient number [redacted] PFC [redacted] and this Unknown Soldier.

4. Point of contact for this memorandum is the undersigned or SA [redacted] at DSN [redacted]

[redacted]
CW2, MP
Special Agent in Charge

Exhibits 7 and 8

Page(s) 123 THRU 146 referred to:

CDR USAMEDCOM
ATTN: FOIA Office, STOP 76
1216 Stanley RD 2D FL
FT. Sam Houston, TX 78234-5049

INPATIENT TREATMENT RECORD COVER SHEET
For use of this form, see AR 40-400; the proponent agency is TSG

0059 05 CID789-39259

1. REGISTER NUMBER	2. NAME (Last, First, MI)	GRADE	ADMISSION REMARKS
(b)(6)	DOE, JOHN		

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M						

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)	SECURITY INTEREST	ICU2

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
		(b)(6)			BC

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIR-ER	1400	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	TAR	(b)(6) 05

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		(b)(6) 05	(b)(6)

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
1193-86TH CSH/TFN IBN SINA, BAGHDAD, IRAQ		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY
GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES
DX: GSW to R flank ICD-9-CM 879.5
PROCEDURES: Damage control surgery, Primary duodenal repair, duodenal diverticulization via stapling off the pylorus without division followed by gastrojejunostomy

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	11	11

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	11	11

SIGNATURE OF ATTENDING MEDICAL OFFICER
(b)(6)

SIGNATURE OF RAD OR MEDICAL RECORDS OFFICER
(b)(6)

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

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INPATIENT TREATMENT RECORD COVER SHEET

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

0859 05 CID789-392

1. REGISTER NUMBER	2. NAME (Last, First, MI)						3. GRADE	ADMISSION REMARKS
(b)(6)	DOE, JOHN							
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS		10. PREVIOUS ADMISSION	
M								
11. FMP	12. SSN		13. ORGANIZATION				14. WARD	
99	(b)(6)		SECURITY INTEREST				ICU2	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP			20. TYPE CASE	
		(b)(6)					BC	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIR-ER	1400	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	TAR	(b)(6) 05

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		(b)(6) 05	(b)(6)

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
1193-86TH CSH/TFN IBN SINA, BAGHDAD, IRAQ		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to R flank ICD-9-CM 879.5

PROCEDURES: Damage control surgery, Primary duodenal repair, duodenal diverticulization via stapling off the pylorus without division followed by gastrojejunostomy

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	11	11

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	11	11

SIGNATURE OF ATTENDING MEDICAL OFFICER: (b)(6)

SIGNATURE OF HAD OR MEDICAL RECORDS OFFICER: (b)(6)

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

Exh 124 7

(b)(6)

86th Combat Support Hospital
Ibn Sina Hospital
Baghdad, Iraq

(b)(6)

DATE OF DICATATION: 25 March, 2005

Discharge Summary/Aeromedical Evacuation Summary

NAME: (b)(6)
SSN:
DOB:
STATUS: Insurgent
SERVICE/COUNTRY: Iraq
UNIT/EMPLOYER:

Date of Admission: 19 March 2005
Date of Discharge/Transfer: 25 March 2005

NARRATIVE SUMMARY OF HISTORY OF PRESENT ILLNESS & HOSPITAL COURSE

Pt is a Iraqi insurgent who suffered a penetrating right flank wound. He arrived in the 86th CSH emergency room awake but in severe distress. He had systolic blood pressures in the 80's. He was taken emergently to the operating room where he was found to have a very large retroperitoneal hematoma in zones 1,2, and 3. We cross clamped his aorta at the esophageal hiatus and mobilized the right colon and the small bowel completely. His right kidney was examined and was normal. He had a complete injury to his SMV which was ligated. He had a 50% injury to the 3rd portion of his duodenum, and another less than 25% injury about 2 centimeters distal also in the 3rd/4th portion. He also had several large peripancreatic arterial bleeders and some early branches of the SMA. These were all ligated or stick tied. The pt was hemodynamically labile and required 26 u PRBC's, 10 U FFP, 20 u Cryoprecipitate, and 8000 cc of crystalloid. His total aortic cross clamp time was 30 min. He was becoming acidotic, coagulopathic, and hypothermic. Once all surgical bleeding was controlled, we elected to perform a damage control operation. A Malecot tube was placed in the larger duodenal injury, his smaller duodenal injury was whip stitched closed, and he was packed and his abdomen was left open. He was taken to the ICU where he remained hemodynamically labile with a stable Hct. He only required 2 u PRBC's that evening. 24 hours later, we returned to the operating room. The packs were removed and there was no bleeding. His larger duodenal injury was repaired in 2 layers, and the smaller one in a single layer. We stapled off his pylorus with a TA stapeler, but not divided. I then performed a hand sewn gastrojejunostomy in a retrocolic manner, isoperistaltic. # 10 JP x 2 were placed next to the duodenal repair. His bowel was completely viable, but edematous as would be expected by ligating the SMV. We were unable to close the abdomen, so a IV bag was placed over the bowel, followed by a damp blue towel, followed by JP's x 2, followed by a Ioband drape. That day, he continued to be hemodynamically labile but completely fluid responsive and not requiring any blood transfusions. Over the course of 24 hours, his blood pressure stabilized and his urine output improved. Over the next several days, he has done quite well. He did have a acute desaturation which was felt to be due to a right sided pleural effusion, so a right sided chest tube was placed. A bronchoscopy revealed the true etiology to be a mucous plug and his pulmonary function reached pre-event levels. Overall, he has done quite well. The future plan would be to either close his abdomen primarily when his edema resolves or close it with vicryl mesh followed by a skin graft and future reconstruction. Theoretically, his pylorus should open up and the gastrojejunostomy close in a few weeks. He is currently on TPN and does not have a j-tube. I felt that due to his significant bowel edema at the 2nd operation, it would not be prudent. His para-duodenal JP's are only putting out clear serous fluid. He is obviously at hight risk for a duodenal fistula, but hopefully, this will not occur. His vent settings are SIMV 18, FiO2 40%, PEEP 5, PS 10, TV 700. He did have a bump in his Creatinine to 2.3, but this is down to 1.8. Hg is stable without need for further blood transfusions. Of note is that his pancreas is fine on exploration.

DISCHARGE DIAGNOSES:

1) Duodenal injury zone 3/4
2) SMV ligation

Exhibit 7

(b)(6)

86th Combat Support Hospital
Ibn Sina Hospital
Baghdad, Iraq

(b)(6)

PROCEDURES DURING ADMISSION

1) Damage control surgery 3/19/2005
2) Primary duodenal repair, duodenal diverticulization via stapling off the pylorus without division followed by a gastrojejunostomy. 3/20/2005
3)

FINDINGS/LABS/RADIOLOGY

Sodium (137-145 mmol/L), Potassium (3.6-5.0 mmol/L), Chloride (98-107 mmol/L)
HCO3 (22-30 mmol/L), BUN (9-20 mmol/L), Cr (0.7-1.5 mg/dL), Glucose (70-105 mg/dL)
Calcium (8.4-10.2 mg/dL) Amylase (50-130 U/L) Lipase (40-375 U/L)
AlkPhos (38-126 U/L), AST (17-59 U/L), ALT (21-72 U/L), TB (0.2-1.3 mg/dL) GGTP (15-73 U/L)

WBC HGB HCT PLT LY%
UA Sp Gr pH Blood - , WBC – , Nitrate - , Urobign , Ketones -

MEDICATIONS ON TRANSFER/DISCHARGE

1) Versed gtt, Fentanyl gtt, Unasyn day 5, Zantac, TPN, Heparin SQ
2)

CONDITION: Good and Stable for Transfer

Plan/Recommendations:

1) This patient should have evaluation by a general surgeon regarding the issues mentioned in the narrative summary.
2) Please contact me if you have questions regarding his care here at the 86th CSH

(b)(6)

DATE | NOTES | 0059 05 CID 89-39251

27 MAR 0930 Assumed care of pt; report received from (b)(6) Initial assessment complete (see DA 4700) Periodic drop in sat from 97 to 92% with tachypnea 37 bpm; pt deep suctioned, ø secretions from ETT; minimal frothy white secretions from oral cavity. Will continue to monitor. VSS, pt febrile ~ temp of 102.1 on unasyn 3 gm q6°. (b)(6)

0830 Mouthcare & deep suctioning done, frothy white-blood tinged secretions from ETT; pt also had another episode of ↓ sats 93% & TPR 40; (b)(6) informed. (b)(6)

1600 No change in status (b)(6)

1700 ↓ UOP 25cc, will continue to monitor (b)(6)

1900 ↓ UOP Reported to (b)(6) order received for (b)(6)

28 MAR 05 @ 0800 Initial assessment done, see DA 4700 mouthcare done, (L) chest tube dsg Δ done. Pt deep suctioned, white mucous secretion noted. Pt stable (b)(6)

0830 Pt to OR for abd. washout (b)(6)

0980 Pt back from OR S/P abd-washout. VSS, chest tube ~~N~~ ed to water seal; suctioned — secretions - mucoid white, no distress noted (b)(6)

1500-1800 At 1500 Pt suction. Heart visibly pounding in chest, HR 130's - 140, sustained @ 140 for past 30 min. Pt febrile ~ temp of 103.1, medicated ~ tylenol for fever; fent 100 mcg

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

PART./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.
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2C
USAI

Exhibit 127 of 7

DATE	NOTES
	and versed 2mg bolus given; 500 cc bolus x2 with no improvement in heart rate, resp rate at 39. ABG, CBC, coags, blood cultures, urine culture & sputum cx sent to lab. ↓ UOP 20's noted. Available labs, ↓UOP, fever reported to (b)(6) Orders received to ↑PS to 15, & transfuse 2 units pRBC. Pt tolerated blood transfusion without SIS of reaction, heart rate decreased to 120's & Abd. more tender than before, finding reported to (b)(6) states he will come by to evaluate pt per (b)(6)
March 15	Received report from offgoing RN & assumed care of pt. See DT 47(0) for I&O, VS, & assessment. (b)(6)

NURSING NOTES
(Sign all Notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25MAR05	0720		Pt assesment completed. Pt care assumed. Pt sedated but responsive to physical stimuli Pt trached c 8.5 French ET tube 25cm @ lips. CTA Bilat Pain control adequate. Sedation adequate. Febrile c T-max of 102.5 @ beginning of shift, MD notified. Will continue to monitor Temp. UOP adequate. Ø B.M noted, absent bowel sounds. Pt moves all extranities, weak movement. Drains JP 1 & 2 output large. JP #3 & 4 output minimal. Will Continue to monitor. - (b)(6)
25MAR05	1000		Pt's central line changed to (R) subclavian TLC. Central line flushes well. Pt tolerated procedure well. Continues to be sedated. Remains febrile MD aware. Blood cultures x2, done. Will con- (b)(6) tinue to monitor. -
25Mar05		2000	Received pt c dc c/p/sW. Intubated, mechanically ventilated and sedated on versed and Fentanyl drips. Hemodynamically stable. Febrile - T 102 TPN/Lipid/Fent/Versed infusing through (R) SC TLC. Pt c open abdomen JPx2 to bulb suction on (R), x2 to wall suction in open Abd wound. F/C to drainage - amber urine. NGT to LWS. (b)(6) Continuc present care. Turn @ 2
26Mar05	0120		Pt received #1 unit PRBC, 3 difficulty. #2 unit (b)(6) initated. Infusing 3 c/s at non-

* U.S. Government Printing Office: 1995 - 404-763/20065 STANDERD FORM 510 (REV. 7-91) BACK

510-112 NSN 7540-00-634-41

MEDICAL RECORD — NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 Mar 05	0600		Pt opens eyes to painful stimulation only. Versed and Fentanyl. Pt hemodynamically stable. afebrile. Labs unchanged from am PRBC last night. To OR 1100 am. (b)(6)
26 Mar 05	1400		Nutrition Note Patient recieving TPN & Lipids 1878 calories per day. Current mix provides 51% of calories coming from FAT. Recommend increasing Clinimix (contains A to rate of 110 cc/hr to provide a better balance of Nutrients. Too much fat calories increases the risk of Sepsis. The other option is to decrease the 20% Lipids to 15 cc/hr however that will greatly decrease the calories provided for healing. (b)(6)
26 Mar 05		1845	Received report @1845 & pt arrived from OR @ 1900 (b)(6) See DA 4700 for assessment, I+O, VS

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

NURSING NOTES
Medical Record

(b)(6)

STANDARD FORM 510 (REV. 7-81) E130 sit 7

510-112 NSN 7540-00-634-41

MEDICAL RECORD — NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
23 MAR	X		0600 (b)(6) called about Pts Hemoglobin of 8.9 and Hematocrit of 26.5. No new orders given (b)(6)
24 MAR 05	0730		Assumed care of pt. @ 0700. Initial assessment done, (see DA 4700). Pt stable, no distress noted (b)(6)
	0900		Mouth care, complete bed bath done. dsg Δ's done
	1030		(L) radial A-line no longer functional, no blood return – line discontinued. new 18 G Heplock started in (R) AC. – (b)(6)
	1100		K-run infusing for potassium of 3.2 (b)(6)
	1300		Pt sxn – Ø secretions from ETT, thick white-b secretions suctioned from oral cavity. pt tolerated well (b)(6)
	1500		Chem 7 drawn & sent to lab – (b)(6)
	1600		K+ 3.8, 2nd K-run infusing as ordered No change in status (b)(6)

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

(b)(6)

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91) F131 Exhibit

510-112 NSN 7540-00-634-41

MEDICAL RECORD — NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
23 Mar 05		1425	Nursing: Pt early afternoon began to drop O2 Sat to 70%, ↑ FiO2 on Vent to 100%, ∴ No improvement. Disconnected Vent from Pt and began Bag ET Bagging @ 100% FiO2, No improvement Informed M.D. here to evaluate, ↓ BS (L) side. Order CXR-done, Based on clinical picture, M.D. placed a 36 French chest tube to (L) midaxillary area. Connected to 20cm of suction, initial 120cc of bloody secretion was removed. Another CXR done, No change, M.D. proceeded to Bronchoscopy pt. It revealed mucous plugs to (L) lung field. Secretions Lavaged plugs. Pt tolerated all procedures well. VS remain stable. Reconnected to Vent SIMV 16, FiO2 100% TV 700 PS 10 Peep 10. Continue to wean pt to prior vent setting. (b)(6)
23 Mar 05		1830	Nursing: Pt fever ↑ 102.6 F. Informed M.D. gave 650m Tylenol, PR. Continue to monitor.
24		0730	(b)(6)

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO. ICU 2

(b)(6)

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91) F132 bi f

NURSING NOTES
(Sign all Notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21 Mar 05	08		Assumed pt care this am from 9PT D pt sedated on fentanyl + versed gtt. 2 unit PRBC infusing. VSS on SIMV + TV@ 22 18 on 35% FiO2 - JP drainage x 3 to abdomen, incision x1. Assessment c.w. shift. Will continue to monitor. (b)(6)
21 Mar 05		2000	Received report on pt @ 1845 + agreed c&c. See DA 4700 for Assessment + I+O's (b)(6)
22 Mar 05	0800		Nursing: See Nursing flowsheet for shift assessment. Pt currently c stable VS. Pt became more responsive c ↑ in BP. Increase pt's fentanyl to 150 ml/hr. Plan to continue to monitor. (b)(6)
22 Mar 05		1200	Pt has no change in Assessment. Change Dsg to (R) lower flank, c wet to dry Kerlex. Had a pseudomonas smell. Had green → white edges to entrance wound. Change taken. Pt tolerated well Dsg Change. Pt BP ↑ to 160-170/60-80's, increase fentanyl to 200mcg/hr. Continue to monitor. (b)(6)
23 Mar		0600	(b)(6) called for H+H 8.9 and 26.5. No new orders given (b)(6)
23 Mar 05	0800		Nursing: See Nursing flowsheet for shift assessment. Lower pain medication to 200mcg/hr Fentanyl to manage pt's SAS from 2 to 2. Plan to monitor (b)(6)

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Exhibit

NURSING NOTES
(Sign all Notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20Mar 05		2100	PT sedated on Versed, fentanyl gtt for pain, responds to painful stimuli pupils 4mm Perrl brisk. PT has #8 OETT 23 cm @ lip secured with ETT holder to (R) side. Lungs are CTA (B). PT breaths over and unlabored Vent settings SIMV TV 700 R 20 FIO2 40 PS 10 PS Sats 100%. ABD Open + packed TPX3 1 to Suction and 2/3 to continuous suction. Malecott for duodenal drain to gravity. PT HR 120-130s ectopy, pulses palpable, Radial x2 DP x2, PT has generalized edema (1) SC Cordis and (1) Femoral Cordis for access (1) Radial A-line. (b)(6)
21Mar 05	0200		(b)(6) notified of PT temp of 103°F. PT cultured earlier in day no new orders given (b)(6)
21Mar 05	0500		(b)(6) notified of PT am labs K 6.0 Na 152 Creat 2.3 H/H 10.4/30.5 Plt 78 PTT 50.9 INR 1.43 orders given to transfuse II units PRBCs, II units FFP and TLC PK of Platelets (b)(6)
21Mar 05	0615		Changed Normal Saline to LR. Na 152 (b)(6)

* U S Government Printing Office 1995 - 404-763/20065

STANDERD FORM 510 (REV. 7-91) BACK

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3/20/05 1800	Op Note
	Pre Op Dx - ① Penetrating injury to ABD / hypotension
	Post Op Dx ① 3rd portion duodenal injury x2
	② SMV injury
	③ large retroperitoneal hematoma zone 1, 2, & 3
	Procedure ① damage control laparotomy
	② duodenotomy 24 F malecot placed
	③ ligation of SMV
	Team - (b)(6) [redacted]
	Anesth - GETA
	EBL - massive
	IVF - 26 u PRBC, 14 u FFP, 20 u cryo, 8000 cc crystalloid, 7 u platelets
	UO - 400 cc
	Dispo - intubated to ICU / open ABD
	drains ① 24 F Malecot duodenostomy
	② (R) retroperitoneal JP
	③ JP x2 outside ABD packing
	(b)(6) [redacted]

*U.S. GPO: 2000-461-707/20307

STANDARD FORM 509 (REV. 5/1999) BACK

Exhibit 7

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE** 0059 03 CID789-3

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3/21/05 1230	Op Note Pre Op Dx - Purulent injury 3rd ipsilateral x 2 Primary related laparotomy Post Op Dx ① 50% circumferential injury sm D3 agonist present in 2 layers ② Small laceration D3 closed in single layer ③ TA 4.3 mm stapler fired across the perforation ④ Retrograde cystogram Team - (b)(6) ⑤ ABX left open GBL - none IVF - 3000 cc crystalloid, 4 u FFP UO - 250 cc Airway - ETT Drains - ① #10 JP x 2 near duodenum staple line and RLQ x 2 ② #10 JP left external to Bogota bag / closed on return x 2 Disposition - Taken to ICU / intubated (b)(6)

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

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

(b)(6)

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

Exhibit 7
136

0059 05 CID789-3925

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
3/24/05	GRS
	POD# 3,4
	Intubated, Sedated;
	PE-
	Semi-Intubated, Sedated
	ABD- distended, softer;
	I-1440
	O-1240
	CT-250
	[illegible]
	Ca-7.2
	Imp - Hemodynamically stable, adequate [illegible]
	Plan - Consider ABD closure [illegible]

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

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

Exhibit 137

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3/22/05 0500	GNS POD# 1, 2
	Pt intubated, sedated.
	PE – 101° – 136/63 – 130 – 18/18 — 18/700 4070 5/10
	I – 15,455
	O – 7246 — 7.30/38.8/135/
	JP#1 – 50-70° / serous
	2 – 40-60° / serous
	3+4 – 550cc total.
	NGT – 500cc
	ABD – open, dry, ⊕ distended
	Lab – 5.8 / 8.6 / 26.1 / 115 — 145 / 127 / 23 / 3.5 / 24 — 4-3-4 Ca-6.4
	PT – 16.6/1.7
	PTT – 43.5
	Imp – Improved hemodynamics, ↑Ina, Stable Creat. ↑Na+ ↑Cl. Vent [illegible]. Stable. Improved hemodynamic status.
	Plan ① ↓IVF to D5½NS – Start TPN [illegible] ② Cont H2-blocker ③ OR [illegible]

*U.S. GPO: 2000-461-707/20307

STANDARD FORM 509 (REV. 5/1999) BACK

(b)(6)

Exhi 138- 7

0059 05 CID 89-3925

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23 MARCH 05	
	TRAUMA / CRITICAL CARE:
	• CALLED TO SEE PT RE: ↓ SaO2 80's
	• EXAM: ↓ BS ON LEFT, TRACH MIDLINE
	HEART: RRR
	• CXR: COMPLETE OPACITY OF LT LUNG FIELDS
	ETT - OR
	PROCEDURES: 1) LT CHEST TUBE = 990 ml SEROUS FLUID
	2) REPEAT CXR / HYPOXIA NOT IMPROVED
	3) BRONCHOSCOPY c COMPLETE
	OBSTRUCTION OF LT SIDED AIRWAYS
	c THICK MUCUS

(b)(6)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

Exhibit 139 7

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3/27/05 1300	ICU
	POD# 1, 6, 7
	Pt intubated, sedated
	PE: 101.7 - 127/83 - 136 - 35/18 4070 / 700
	I - 7522 / 24° ... 8 / 5/5
	O - (+) 5077
10.5 / 25.9 / 250	CT -
	RBD - ...
51 / 125 / 24 / 7 / 26 / 1.7	Imp: (1) FEN - TPN, hypernatremia ... D5½NS @ 200cc; Creat stable @ 1.7
	(2) Cardiac - stable, ... pressors
	(3) Resp - stable; ...
	(4) Renal - adequate UO - (30-50cc ... Creat stable @ 1.7
	(5) ID - Trach Cx (+), UCx (+) · Blood Cx ... for ABD ...
	Plan (1) ...
	(b)(6)

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.0C

Exh 140 - 7

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3/28/05 1030	Op Note
	Pre Op Dx – GSW ABD / duodenal injury / open ABD
	Post Op Dx – Same
	Procedure ① ABD dressing Δ
	② ABD washout
	(b)(6)
	Anesth – GETT
	IVF
	EBL – min
	Finding ① ⊘ evidence of duodenal fistula; ⊘ pus in ABD
	② ↓ purulence from 2 d ago
	Plan ① anticipate vicryl mesh closure soon
	(b)(6)

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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

(b)(6)

REGISTER NO.	WARD NO.

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

NURSING NOTES
(Sign all Notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29 Mar	0045	/	Assumed care of Pt @ 0045. Pt sedated c 4mg versed + 200 mcg of fentanyl. Mech ventilated SIMV mode. Chest tube x 1 on left side to H_2O seal. D5½NS MIVF infusing @ 30 cc/hr. TPN + Lipids infusing. NGT in (L) nare to LIS. JP x 4. JP 1+2 to bulb suction JP 3+4 LIS. SCD's on. ND apparent distress noted. Pt. Possible Transfer to another facility. Will continue to monitor. And Assessment done. (b)(6)
29 Mar	1110	/	Report given to Nurse (b)(6) (b)(6)

Exhibit 142 7

Eric Jensen, MD
Major, U.S. Army, Medical Corps
Department of Surgery

86th Combat Support Hospital
Ibn Sina Hospital
Baghdad, Iraq

HOSPITAL TEL. (914) 360- 3477 E-mail: eric.robert.jensen@us.army.mil

DATE OF DICATATION: 14 April, 2005

Discharge Summary/Aeromedical Evacuation Summary

NAME: 1657
SSN:
DOB:
STATUS: Insurgent
SERVICE/COUNTRY: Iraq
UNIT/EMPLOYER:

Date of Admission: 19 March 2005
Date of Discharge/Transfer: 25 March 2005

NARRATIVE SUMMARY OF HISTORY OF PRESENT ILLNESS & HOSPITAL COURSE

Pt is a Iraqi insurgent who suffered a penetrating right flank wound. He arrived in the 86th CSH emergency room awake but in severe distress. He had systolic blood pressures in the 80's. He was taken emergently to the operating room where he was found to have a very large retroperitoneal hematoma in zones 1,2, and 3. We cross clamped his aorta at the esophageal hiatus and mobilized the right colon and the small bowel completely. His right kidney was examined and was normal. He had a complete injury to his SMV which was ligated. He had a 50% injury to the 3rd portion of his duodenum, and another less than 25% injury about 2 centimeters distal also in the 3rd/4th portion. He also had several large peripancreatic arterial bleeders and some early branches of the SMA. These were all ligated or stick tied. The pt was hemodynamically labile and required 26 u PRBC's, 10 U FFP, 20 u Cryoprecipitate, and 8000 cc of crystalloid. His total aortic cross clamp time was 30 min. He was becoming acidotic, coagulopathic, and hypothermic. Once all surgical bleeding was controlled, we elected to perform a damage control operation. A Malecot tube was placed in the larger duodenal injury, his smaller duodenal injury was whip stitched closed, and he was packed and his abdomen was left open. He was taken to the ICU where he remained hemodynamically labile with a stable Hct. He only required 2 u PRBC's that evening. 24 hours later, we returned to the operating room. The packs were removed and there was no bleeding. His larger duodenal injury was repaired in 2 layers, and the smaller one in a single layer. We stapled off his pylorus with a TA stapeler, but not divided. I then performed a hand sewn gastrojejunostomy in a retrocolic manner, isoperistaltic. # 10 JP x 2 were placed next to the duodenal repair. His bowel was completely viable, but edematous as would be expected by ligating the SMV. We were unable to close the abdomen, so a IV bag was placed over the bowel, followed by a damp blue towel, followed by JP's x 2, followed by a Ioband drape. That day, he continued to be hemodynamically labile but completely fluid responsive and not requiring any blood transfusions. Over the course of 24 hours, his blood pressure stabilized and his urine output improved. Over the next several days, he has done quite well. He did have a acute desaturation which was felt to be due to a right sided pleural effusion, so a right sided chest tube was placed. A bronchoscopy revealed the true etiology to be a mucous plug and his pulmonary function reached pre-event levels. Overall, he has done quite well. The future plan would be to either close his abdomen primarily when his edema resolves or close it with vicryl mesh followed by a skin graft and future reconstruction. Theoretically, his pylorus should open up and the gastrojejunostomy close in a few weeks. He is currently on TPN and does not have a j-tube. I felt that due to his significant bowel edema at the 2nd operation, it would not be prudent. His para-duodenal JP's are only putting out clear serous fluid. He is obviously at hight risk for a duodenal fistula, but hopefully, this will not occur. His vent settings are SIMV 18, FiO2 40%, PEEP 5, PS 10, TV 700. He did have a bump in his Creatinine to 2.3, but this is down to 1.8. Hg is stable without need for further blood transfusions. Of note is that his pancreas is fine on exploration.

He has subsequently went to the operating room on 3/26 and 3/28, with plans to go again on 3/30. His abdomen is quite soupy with the closed wound vac type dressing. However, the deeper aspects look good. We cultured gram negative rods on gram stain from the abdominal purulence. My goal is to get it cleaned up at least so I can use a vicryl mesh closure. He actually has had a few green bowel movements and still has no evidence of a duodenal fistula by his drain

Eric Jensen, MD
Major, U.S. Army, Medical Corps
Department of Surgery

86th Combat Support Hospital
Ibn Sina Hospital
Baghdad, Iraq

HOSPITAL TEL. (914) 360- 3477 E-mail: eric.robert.jensen@us.army.mil

output or when we take looks during his washouts, although we do not completely mobilize this segment. Overall, he is doing decent. He is cardiovascularly stable not on any pressors, he has a stable creatinine of 1.7, and his respiratory status is stable on vent setting of SIMV 18, PS 10/5, and FiO2 40%. He is prone to hypernatremia and this was corrected by simply increasing his free water (with the open abdomen and all his drains, he has a high fluid loss). I actually think once the vicrly mesh is placed, attempts at weaning might be possible. However, he is still in a critically ill state and he still could deteriorate. He will definitely be a long term ICU player. He remains on TPN and is on Unasyn day # 9

DISCHARGE DIAGNOSES:

1) Duodenal injury zone 3/4
2) SMV ligation

PROCEDURES DURING ADMISSION

1) Damage control surgery 3/19/2005
2) Primary duodenal repair, duodenal diverticulization via stapling off the pylorus without division followed by a gastrojejunostomy. 3/20/2005
3) Abdominal washouts and replacement of temporary abdominal closures on 3/26 and 3/28.

FINDINGS/LABS/RADIOLOGY

Sodium (137-145 mmol/L), Potassium (3.6-5.0 mmol/L), Chloride (98-107 mmol/L)
HCO3 (22-30 mmol/L), BUN (9-20 mmol/L), Cr (0.7-1.5 mg/dL), Glucose (70-105 mg/dL)
Calcium (8.4-10.2 mg/dL) Amylase (50-130 U/L) Lipase (40-375 U/L)
AlkPhos (38-126 U/L), AST (17-59 U/L), ALT (21-72 U/L), TB (0.2-1.3 mg/dL) GGTP (15-73 U/L)

WBC HGB HCT PLT LY%
UA Sp Gr pH Blood - , WBC – , Nitrate - , Uroblgn , Ketones -

MEDICATIONS ON TRANSFER/DISCHARGE

1) Versed gtt, Fentanyl gtt, Unasyn day 8, Zantac, TPN, Heparin SQ
2)

CONDITION: Good and Stable for Transfer

Plan/Recommendations:

1) This patient should have evaluation by a general surgeon regarding the issues mentioned in the narrative summary.
2) Please contact me if you have questions regarding his care here at the 86th CSH

Eric Jensen, MD, MAJ, USA, MC
General Surgery
eric.robert.jensen@us.army.mil
Ibn Sina Hospital/86th Combat Support Hospital, Baghdad, Iraq

Exh 144 7

0059 05 CID 789-3925

Certificate Of Death For use of this form, see AR 180-8, the Proponent agency is DCSOPS	Internment Serial Number US9IZ-171687CI
From: WYTNAAAPO AE 09342 ABU GHRAIB BAGHDAD	To: , ,

Name(Last, First, MI)	Grade	Service Number
UNK,UNK		

Nationality	Power Served	Place of Capture/Internment and Date
IZ-Iraq	IZ-Iraq	2005/04/03

Name, Relationship, Address of Next of Kin	Father's First Name
,APO AE 09342 ABU GHRAIB BAGHDAD	Place Of Birth: Date Of Birth:

Place of Death	Date Of Death	Cause Of Death
ABU GHRAIB,	2005/04/04	GUNSHOT WOUND
Place Of Burial	**Date Of Burial**	**Identification Of Grave**
,	2005/04/04	

Personal Effects: Please See Attached Page

Brief Details Of Death And Burial: Please See Attached Page

Do Not Write In This Space	Date 2005/04/04
(Seal of the Office of The Provost Marshal General)APO AE 09342 ABU GHRAIB BAGHDAD	Signature of Commanding Officer Witnesses: Signature Address Abu Ghraib Signature Address Abu Ghraib

Exhibit 8

Personal Effects And Money		Internment Serial Number US9IZ-171687CI	
Property Tag	Description	Qty	Dispostition

The Above List Of Items Is Correct _____

Signature Of Detainee

Brief Details Of Death/Burial By Person Who Cared For The DeceasedDuring Illness Or During Last Moments (Doctor, Nurse, Minister of Religion, Fellow Internee). Death/Cremation Details.

DETAINEE DIED DUE TO GUNSHOT WOUND TO RIGHT FLANK

AGENT'S INVESTIGATION REPORT	ROI NUMBER (0091-05-CID112) 0059-05-CID789-39259
CID Regulation 195-1	PAGE 1 OF 1 PAGE

DETAILS

About 0800, 29 Apr 05, this office was notified by SA (b)(6), (b)(7)(C) 5320, Operational Investigations, Office of the Armed Forces Medical Examiner (OAFME), Armed Forces Institute of Pathology (AFIP), 1413 Research Blvd, Building 102, Rockville, MD 20850, that the remains of an unknown Iraqi Male, Internment Serial Number (b)(6), (b)(7)(C) had arrived at Dover Air Force Base (DAFB), DE 19902, and an autopsy would be conducted later that morning.

This is an "Operation Iraqi Freedom 2004-2006" Investigation.

About 1115, 3 May 05, SA (b)(6), (b)(7)(C) attended the autopsy of the aforementioned individual (ME 05-383), which was conducted by LTC (Dr.) (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) USA, Associate Medical Examiner, OAFME, AFIP, Rockville, MD 20850. **The preliminary Cause of Death was Non Specific Projectile Injury; and the Manner of Death was listed as Homicide.** A single metal-type piece of shrapnel was identified in the right iliac crest area and was collected as evidence. Photographers from AFIP exposed digital photographs of the autopsy and prepared a compact disk containing all images exposed. A copy of the compact disk containing those images was obtained. Also obtained was a copy of a fingerprint taken by the FBI pertaining to ME 05-383. (See Compact Disk containing all autopsy digital images/FBI copy of fingerprint)

AGENT'S COMMENT: The official results of the autopsy will be documented in the Final Autopsy Report, which will be posted when completed, to the Army Knowledge Online (AKO), by SA (b)(6), (b)(7)(C) OAFME, AFIP, 1413 Research Blvd, Building 102, Rockville, MD 20850.

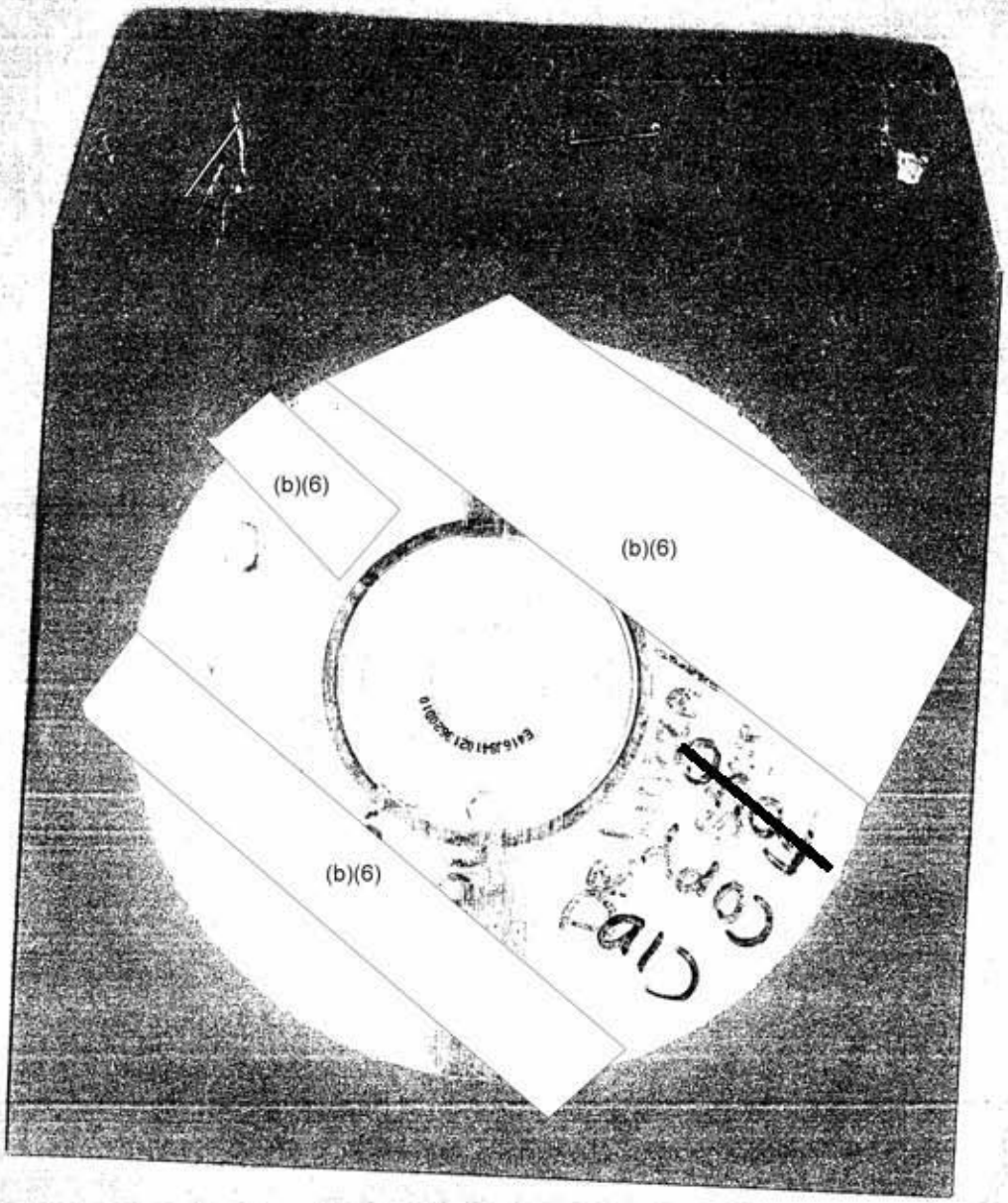
////////////////////////////////Last Entry////////////////////////////////

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA (b)(6), (b)(7)(C), (b)(7)(F)	Aberdeen Proving Ground Resident Agency Aberdeen Proving Ground, MD 21005	
(b)(6), (b)(7)(C)	DATE 3 May 05	EXHIBIT 9

EXHIBITS 10 thru 12

Pages 148 thru 156 referred to:

CDR USAMEDCOM
ATTN: FOIA OFFICE, STOP 76
1216 STANLEY RD 2D FL
FT. SAM HOUSTON, TX 78234-5049



0059 05 CID789-392

FOR OFFICIAL USE ONLY - LAW ENFORCEMENT SENSITIVE

LEAVE BLANK

TYPE OR PRINT ALL INFORMATION IN BLACK

FBI LEAVE BLAI

LAST NAME NAM FIRST NAME MIDDLE NAME

STATE USAGE

ALIASES

CONTRIBUTOR ORI (b)(6)

FBI DISASTER SQUAD

SIGNATURE OF PERSON FINGERPRINTED

DATE OF BIRTH Month

THIS DATA MAY BE COMPUTERIZED IN LOCAL, STATE AND NATIONAL FILES

DATE SIGNATURE OF OFFICIAL TAKING FINGERPRINTS

DATE ARRESTED OR RECEIVED DOA

SEX RACE HGT. WGT. EYES HAIR PLACE OF BIRT

YOUR NO. OCA

LEAVE BLANK

CHARGE

FBI NO. FBI

CLASS.

SID NO. SID

REF.

FINAL DISPOSITION

SOCIAL SECURITY NO. SOC

NCIC CLASS - PPC

CAUTION

(b)(6)

1. R. THUMB | 2. R. INDEX | 3. R. MIDDLE | 4. R. RING | 5. R. LITTLE

6. L. THUMB | 7. L. INDEX | 8. L. MIDDLE | 9. L. RING | 10. L. LITTLE

LEFT FOUR FINGERS TAKEN SIMULTANEOUSLY | L. THUMB | R. THUMB | RIGHT FOUR FINGERS TAKEN SIMULTANEOUSLY

Dover AFB Port Mortuary

ıcident : OIF

temains/Case #: (b)(6)

tecovery/TC #:

rocess Date: 03 May 05 (b)(6)

FOR OFFICIAL USE ONLY - LAW ENFORCEMENT SENSITIVE

Exhibit 149 11

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

AUTOPSY EXAMINATION REPORT

Name: US91Z-171687-CI
SSAN: N/A
Date of Birth: Unknown
Date/Time of Death (b)(6) 2005 (b)(6)
Date/Time of Autopsy: 3 MAY 2005, 1100h
Date of Report: 24 MAY 2005

Autopsy No. (b)(6)
AFIP No.: (b)(6)
Rank: N/A
Place of Death: 115 Field Hosp., Iraq
Place of Autopsy: Port Mortuary Dover

Circumstances of Death: Deceased is reported to have been a civilian who was involved in an altercation with US Forces during which he shot at them. These forces returned fire, striking the deceased in the right flank. He was brought to a CSH for initial treatment and was later transferred to the 115 Field Hospital, Abu Ghraib, Iraq, where he expired from what were noted as complications secondary to a gunshot wound to the right flank.

Authorization for Autopsy: Armed Forces Medical Examiner, per 10 U.S. Code 1471

Identification: The decedent is identified at the time of autopsy as a detainee with Internment Serial Number US9IZ-17687-CI by identification bands about the right wrist, and by a toe tag. A right index fingerprint is recorded, a DNA comparison specimen collected, and photographs of the face are taken, without currently known source for comparison.

CAUSE OF DEATH: Single projectile wound to the right hip and flank

MANNER OF DEATH: Homicide

FINAL AUTOPSY DIAGNOSES:

1.0 Single penetrating, healing, indeterminate range projectile wound to the right hip and flank

1.1 Entry on right hip 75 cm below the vertex of the skull and 22 cm to the right of the posterior midline, wound measuring 8 x 4 cm
1.1.1 Extensive wound healing with resultant obscuring of other possible wound characteristics

1.2 Path directly from right-to-left and slightly anterior

1.3 Impact on right iliac bone
1.3.1 Comminuted fractures of right iliac bone with extensive surrounding hemorrhage
1.3.2 Pulpefaction of the mid-portion of the right psoas muscle

1.4 Recovery of a single large metallic fragment from within pulpefied psoas and fragmented iliac bone in the right iliac area

1.5 Status post laparotomy with dressing of open wound
1.5.1 Insertion of two (2) abdominal cavity drains

1.6 Diffuse peritonitis with organizing peritoneal adhesions

1.7 Right lower lobe bronchopneumonia

1.8 Fatty Liver (3,000 gm liver weight)

1.9 Prominent pulmonary congestion and edema
1.9.1 Right lung weight 1,000gm, left lung 890 gm
1.9.2 Bilateral serosanguinous pleural effusions, 100 ml each

1.10 Status post therapeutic intervention
1.10.1 Left thoracotomy tube incision (2 cm, sutured)
1.10.2 Nasogastric tube
1.10.3 Orotracheal tube
1.10.4 Urinary catheter
1.10.5 Intravenous line, left upper chest

1.11 Healing decubitus ulcers (2), one each on the left buttock (2.0 cm diameter) and of the upper right back (3 x 2 cm)

2.0 Results of toxicologic analysis:

2.1 Carboxyhemoglobin saturation 9%

2.2 Acetaldehyde – trace detected in blood; quantitated in bile at 6 mg/dl
2.3 Ethanol – 29 mg/dl in blood; 77 mg/dl in bile
2.4 Cyanide – negative in blood
2.5 Midazolam – detected in liver; quantitated in blood at 0.18 mg/L
2.6 Diphenhydramine – quantitated in liver at 0.6 mg/kg

3.0 Moderate postmortem decompositional changes

ANCILLARY STUDIES

TOXICOLOGY – Blood (chest cavity), bile, gastric contents, liver, lung, spleen, kidney, brain, adipose tissue, psoas are collected.

DNA - Psoas

EVIDENCE – One (1) large metallic projectile fragment measuring 5.4 x 1.4 x 1.0 cm

TISSUES in formalin for possible future use.

PHOTOGRAPHS – Total body; head/scalp, brain in situ; wound on right hip; superficial ulcerations of back

RADIOGRAPHIC STUDIES – Total body showing comminuted fractures of the right iliac bone and two (2) metallic fragments within tissues near fragmented bone, one large and the other very small.

DISSECTED ORGANS are forwarded with body

PERSONAL EFFECTS are released to the appropriate mortuary operations representatives.

OPINION:

This young male, reported to have been an Iraqi detainee, died from the complications of a single projectile injury, reported to have been a gunshot, to the right hip and flank that was sustained during an altercation with US forces. Wound features were obscured by healing that occurred during a sixteen-day period of hospitalization. The results of toxicologic analysis reflect therapeutic administration of medications. The ethanol is likely the result of endogenous production due to postmortem decomposition. A 9% carboxyhemoglobin saturation can be seen in smokers and some city dwellers, and is not by itself indicative of abnormal exposure to carbon monoxide. The manner of death is homicide.

(b)(6)

24 MAY 2005
Date Signed

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

REPLY TO ATTENTION OF

AFIP-CME-T

TO:

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

PATIENT IDENTIFICATION

AFIP Accessions Number (b)(6) **Sequence** 00

Name UNKNOWN IRAQI DET (US91Z-171687-CI)

SSAN: **Autopsy:** (b)(6)

Toxicology Accession #: (b)(6)

Date Report Generated: May 16, 2005

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident (b)(6) 2005 **Date Received:** 5/10/2005

CARBON MONOXIDE: The carboxyhemoglobin saturation in the blood was 9% as determined by spectrophotometry with a limit of quantitation of 1%. Carboxyhemoglobin saturations of 0-3% are expected for non-smokers and 3-10% for smokers. Saturations above 10% are considered elevated and are confirmed by gas chromatography.

VOLATILES: The **BLOOD AND BILE** were examined for the presence of ethanol (cutoff of 20 mg/dL), acetaldehyde, acetone, 2-propanol, 1-propanol, t-butanol, 2-butanol, iso-butanol and 1-butanol by headspace gas chromatography. The following volatiles were detected: (concentration(s) in mg/dL)

	Acetaldehyde	Ethanol
BLOOD	Trace	29
BILE	6	77

Trace = value greater than or equal to 1mg/dL, but less than 5 mg/dL

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

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

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

REPLY TO
ATTENTION OF

REPORT OF TOXICOLOGICAL EXAMINATION (CONT – UNKNOWN, IRAQI):

Positive Benzodiazepine: Midazolam was detected in the liver by immunoassay and confirmed by gas chromatography/mass spectrometry. The blood contained 0.18 mg/L of midazolam as quantitated by gas chromatography/mass spectrometry.

Positive Antihistamine: Diphenhydramine was detected in the liver by gas chromatography and confirmed by gas chromatography/mass spectrometry. . The liver contained 0.6 mg/kg of diphenhydramine as quantitated by gas chromatography/mass spectrometry.

(b)(6)

Office of the Armed Forces Medical Examiner

(b)(6)

Office of the Armed Forces Medical Examiner

EVIDENCE/PROPERTY CUSTODY DOCUMENT

For use of this form see AR 190-45 and AR 195-5; the proponent agency is US Army Criminal Investigation Command

MPR/CID SEQUENCE NUMBER 0091-0-CID112

CRD REPORT/CID ROI NUMBE 0059-05-CID789-39259

RECEIVING ACTIVITY APG Resident Agency (CID)	LOCATION Aberdeen Proving Ground, MD 21005
NAME, GRADE AND TITLE OF PERSON FROM WHOM RECEIVED ☐ OWNER LTC (Dr.) (b)(6), (b)(7)(C) [redacted] b(6), b(7)(C) [redacted] USA, Dover, AFB. DE ☒ OTHER	ADDRESS (*Include Zip Code*) 1413 Research Boulevard, Building #102 Rockville, MD 20850
LOCATION FROM WHERE OBTAINED (OAFME #05-383) Autopsy of Unknown Iraqi Male, ISN#171687, performed by Dr (b)(6), (b)(7)(C) [redacted] at Building 116, Port Mortuary, DAFB, DE 1990219902	REASON OBTAINED: Evidence TIME/DATE OBTAINED: 1310, 3 May 05

ITEM NO.	QUANTITY	DESCRIPTION OF ARTICLES (*Include model, serial number, condition and unusual marks or scratches*)
1	1	Specimen Cup, clear in color with light blue colored lid. Cup marked "Evidence ME 05-383", containing one piece of shrapnel, metal type construction, approximately 2.5" in length x ½" in width. The shrapnel is silver and black in color. The shrapnel was removed during the autopsy. The specimen cup was sealed with red in color evidence tape and MFID with 1310, 3 may 05, (b)(6), (b)(7)(C) [redacted]
////	//////	////////////////////////////LAST ITEM////////////////////////////////

CHAIN OF CUSTODY

ITEM NO.	DATE	RELEASED BY	RECEIVED BY	PURPOSE OF CHANGE OF CUSTODY
1	3 May 05	(b)(6), (b)(7)(C) [redacted] NAME, GRADE OR TITLE DR (b)(6), (b)(7)(C) [redacted]	NAME, GRADE OR TITLE SA (b)(2), (b)(6), (b)(7)(C) [redacted]	Evaluation As Evidence
1	4 MAY 05	(b)(6), (b)(7)(C) [redacted] NAME, GRADE OR TITLE SA (b)(2), (b)(6), (b)(7)(C) [redacted]	(b)(6), (b)(7)(C) [redacted]	Released to Evidence Custodian
1	11 May 05	(b)(6), (b)(7)(C) [redacted]	SIGNATURE PP208 8493545 NAME, GRADE OR TITLE Registered mail	Forward to controlling office
		SIGNATURE NAME, GRADE OR TITLE	SIGNATURE NAME, GRADE OR TITLE	
		SIGNATURE NAME, GRADE OR TITLE	SIGNATURE NAME, GRADE OR TITLE	

DA FORM 4137
1 Jul 76

Replaces DA FORM 4137, 1 Aug 74 and DA FORM 4137-R 26 Sep 75 Which are Obsolete.

LOCATION _____ DOCUMENT NUMBER 0510-05

157

Exhibit 13

CHAIN OF CUSTODY *(Continued)*

ITEM NO.	DATE	RELEASED BY	RECEIVED BY	PURPOSE OF CHANGE OF CUSTODY
		SIGNATURE	SIGNATURE	
		NAME, GRADE OR TITLE	NAME, GRADE OR TITLE	
		SIGNATURE	SIGNATURE	
		NAME, GRADE OR TITLE	NAME, GRADE OR TITLE	
		SIGNATURE	SIGNATURE	
		NAME, GRADE OR TITLE	NAME, GRADE OR TITLE	
		SIGNATURE	SIGNATURE	
		NAME, GRADE OR TITLE	NAME, GRADE OR TITLE	
		SIGNATURE	SIGNATURE	
		NAME, GRADE OR TITLE	NAME, GRADE OR TITLE	
		SIGNATURE	SIGNATURE	
		NAME, GRADE OR TITLE	NAME, GRADE OR TITLE	
		SIGNATURE	SIGNATURE	
		NAME, GRADE OR TITLE	NAME, GRADE OR TITLE	
		SIGNATURE	SIGNATURE	
		NAME, GRADE OR TITLE	NAME, GRADE OR TITLE	

FINAL DISPOSITION ACTION

RELEASE TO OWNER OR OTHER *(Name/Unit)* ____________________

DESTROY ____________________

OTHER *(Specify)*

FINAL DISPOSITION AUTHORITY

ITEM(S) ____________ ON THIS DOCUMENT, PERTAINING TO THE INVESTIGATION INVOLVING ____________ *(Grade)*

____________________ (IS) (ARE) NO LONGER

(Name) *(Organization)*

REQUIRED AS EVIDENCE AND MAY BE DISPOSED OF AS INDICATED ABOVE. *(If article(s) must be retained, do not sign, but explain in separate correspondence.)*

____

(Typed/Printed Name, Grade, Title) *(Signature)* *(Date)*

WITNESS TO DESTRUCTION OF EVIDENCE

THE ARTICLE(S) LISTED AT ITEM NUMBER(S) ____________(WAS) (WERE) DESTROYED BY THE EVIDENCE CUSTODIAN, IN MY PRESENCE, ON THE DATE INDICATED ABOVE

____

(Typed/Printed Name, Organization) *(Signature)*