RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(3)-1

Procedure: C-SPINE (2)
Requested by: (b)(6)-2
Ward/Clinic: WARD 5 FWD STBD (b)(3)-1

DIAGNOSTIC RADIOLOGY (b)(3)-1
Exam Date: 12 Apr 2003@0827
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
ADDITIONAL VIEW

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Three views were obtained. The vertebrae and alignment are normal. There is no evidence of fracture, subluxation, or other acute abnormality.

IMPRESSION: Normal Cervical Spine

Transcription Date/Time: 12 Apr 2003@1310

Interpreted by: (b)(6)-2 CDR,MC,USN
Supervised by:

Approved by: (b)(6)-2, CDR,MC,USN 12 Apr 2003@1849
Supervised by:

(b)(6)-4 (b)(6)-4

Reg #: (b)(6)-4
SF519-B

10 Apr 2003 / MALE
Loc: CASREC MAIN
Spon: (b)(6)-4
Unit:

FOREIGN CIVILIAN
H: W:
Room-Bed:
Rank: D:
RR:

Personal Data - Privacy Act 4 (PL 93-579) Printed date: 01 May 2003@1557
Page: 1

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(3)-1

Procedure: CHEST, AP (PORTABLE)
Requested by: (b)(6)-2
Ward/Clinic: CASREC MAIN

DIAGNOSTIC RADIOLOGY (b)(3)-1
Exam Date: 10 Apr 2003@1317
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
R/O INFILTRATES

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

AP Portable view of chest shows motion artifact and low lung volumes. Apparaent increase lung in density is probably due to film technique.Repeat exam is recommended.

Transcription Date/Time: 10 Apr 2003@1404

Interpreted by: (b)(6)-2 CDR,MC,USN
Supervised by:

Approved by: (b)(6)-2 CDR,MC,USN 10 Apr 2003@1407
Supervised by:

(b)(6)-4

Reg #: (b)(6)-4

SF519-B

(b)(6)-4

10 Apr 2003 / MALE
Loc: CASREC MAIN
Spon: (b)(6)-4
Unit:

FOREIGN CIVILIAN
H: W:
Room-Bed:
Rank: D:
RR:

RADIOLOGIC EXAMINATION REPORT

FMP/SSN: (b)(6)-4

(b)(6)-4

(b)(3)-1

COMPUTED TOMOGRAPHY
Exam Date: 21 Apr 2003@1720
Status: TRANSCRIBED
Exam #: (b)(6)-4
Pregnant:

CT, ABD/PELVIS W/CONTRAST
by: (b)(6)-2 (b)(3)-1
ic: WARD 4 FWD STBD

r Order:
ON VS INTESTINAL LEAK VS REACCUMULATION OF BILOMA. PLEASE CONSIDER
OUS DRAINAGE OF ANY COLLECTIONS. HAS DRAINS IN RIGHT GUTTER AND
.C SPACE

nment:

ode: SEE RADIOLOGIST'S REPORT

JE: Axial CT images of abdomen and pelvis were acquired at 10mm
tion. Intravenous and oral contrast were administered.

S: The current examination is compared to a similar study from 16
003. There is right basilar atelectasis and a right pleural effusion.
s re-accumulation of a large fluid collection over the dome of the
A drain is in a subhepatic location with marked decrease in the size
fluid collection it is draining. There is also a drain in the right
. Also smaller are several fluid collections in the mid-abdomen and
. A collection beneath the anterior abdominal wall has also decreased
e. The gallbladder is relatively decompressed with surrounding fluid
but less than on the previous study. The gallbladder and all of the
collections have enhancing walls, unchanged from the prior study. The
and spleen are normal in attenuation. Pancreas has a stable
ance. The adrenal glands and kidneys are normal in appearance. The
/s enhance symmetrically and there is no evidence of hydronephrosis.
noted is a 3cm lobulated mass in the cecum which measures -59HU and
represent a lipoma. Small mesenteric and para-aortic lymph nodes are
nged and do not meet CT criteria for pathologic enlargement. Fluid is
ing the right colon. Midline abdominal incision from recent
ploration. No extravasation of gastrointestinal contrast media.

**********ATTENTION**********
* THIS REPORT IS PENDING APPROVAL BY RADIOLOGY AND *
* SHOULD NOT BE INTERPRETED AS THE FINAL REPORT. *
****

(b)(6)-4

(b)(6)-4

10 Apr 2003 / MALE
Loc: CASREC MAIN
Spon: (b)(6)-4
Unit:

FOREIGN NATIONAL - POW/INTERN
H: W:
Room-Bed:
Rank: D:
RR:

(b)(6)-4

19-B

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

IMPRESSION:

1. Interval placement of two drains, as above with decreasing size of all fluid collections except the collection over the dome of the liver which has increased in size; this collection is amenable to percutaneous drainage.

2. 3cm fat-containing cecal mass, as described above;

3. No evidence of extravasation of contast;

4. Post-operative changes.

Discussed with Dr. (b)(6)-2

Transcription Date/Time: 21 Apr 2003@2107

Interpreted by: (b)(6)-2 CDR,MC,USN
Supervised by:

Approved by:
Supervised by:

**********ATTENTION**********
* THIS REPORT IS PENDING APPROVAL BY RADIOLOGY AND *
* SHOULD NOT BE INTERPRETED AS THE FINAL REPORT. *
****

(b)(6)-4 (b)(6)-4 FOREIGN NATIONAL - POW/INTERN

10 Apr 2003 / MALE H: W:

Reg #: (b)(6)-4 Loc: CASREC MAIN Room-Bed:

Spon: (b)(6)-4 Rank: D:

SF519-B Unit: RR:

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(3)-1

Procedure: CT, ABD/PELVIS W/CONTRAST
Requested by: (b)(6)-2
Ward/Clinic: WARD 4 FWD STBD (b)(3)-1

COMPUTED TOMOGRAPHY
Exam Date: 21 Apr 2003@1640
Status: COMPLETE
Exam # (b)(6)-4
Pregnant:

Reason for Order:
OBSTRUTION VS INTESTINAL LEAK VS REACCUMULATION OF BILOMA. PLEASE CONSIDER PERCUTANEOUS DRAINAGE OF ANY COLLECTIONS. HAS DRAINS IN RIGHT GUTTER AND SUBHEPATIC SPACE

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

AAS cf AAS of 4/15/03.

Chest: Right hemidiaphragm again elevated. A sliver of left sided subdiaphragmatic free air is noted on the current film. Question recent prior surgery? Otherwise consider other causes of free intraabdominal air such as perforation. Bibasilar atelectasis and low lung volumes.

Drain over the right flank, new. Air collections scattered throughout the small bowel and gasless colon consistent with ileus but not suggesting obstrucion at this point. Oval densities over the left UQ most likely pill frags in the bowel.

Study otherwise negative.

Transcription Date/Time: 21 Apr 2003@1640

Interpreted by: (b)(6)-2 CAPT,MC,USN
Supervised by:

Approved by: (b)(6)-2 CAPT,MC,USN 21 Apr 2003@1648
Supervised by:

Amended Result Code: ABNORMALITY, ATTN. NEEDED

(b)(6)-4 (b)(6)-4 FOREIGN NATIONAL - POW/INTERN

Reg #: (b)(6)-4 10 Apr 2003 / MALE H: W:
Loc: CASREC MAIN Room-Bed:
Spon: (b)(6)-4 Rank: D:
SF519-B Unit: RR:

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

Amended:
Though this exam was for CT of the abdomen/pelvis, the Acute Abdominal Series exam # (b)(6)-4 was inadvertantly dictated onto this CT report instead of the CT. The CT will be reported on a separate dictation after being re-ordered.

Transcribed Date/time: 21 Apr 2003@1715

Interpreted by: (b)(6)-2 CAPT,MC,USN
Supervised by:

Approved by: (b)(6)-2 CAPT,MC,USN 21 Apr 2003@1719
Supervised by:

(b)(6)-4

Reg #: (b)(6)-4

SF519-B

(b)(6)-4
10 Apr 2003 / MALE
Loc: CASREC MAIN
Spon: (b)(6)-4
Unit:

FOREIGN NATIONAL - POW/INTERN
H: W:
Room-Bed:
Rank: D:
RR:

(b)(3)-1

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

PATIENT LAB INQUIRY

For: 14 Apr 03 - 17 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/7d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

16 Apr 03 @ 2129 (Coll) SERUM

Order comment: PRE-OP

NA+	136	L	(137-145)	mmol/L
K	3.9		(3.6-5.0)	mmol/L
CL-	100		(97-107)	mmol/L
CO2	33	H	(22-31)	mmol/L
BUN	5	L	(9-21)	mg/dL
GLUCOSE	122	H	(76-110)	mg/dL
CREAT	0.6	L	(0.8-1.5)	mg/dL
CA	8.5	L	(8.8-10.4)	mg/dL
PHOSPHORUS	4.9	H	(2.5-4.5)	mg/dL
URIC ACID	4.6		(3.3-8.4)	mg/dL
PROTEIN TOTAL	6.3		(6.3-8.3)	g/dL
ALBUMIN	2.7	L	(3.5-5.0)	g/dL
AST	28		(15-46)	U/L
ALT	37		(11-66)	U/L
LDH	694	H	(313-618)	U/L
ALK PHOS	287	H	(70-250)	U/L
TBILI	0.6	L	(1.0-10.5)	mg/dL
GGT	104	H	(8-78)	U/L
CK	42		(0-203)	U/L
MG	2.0		(1.7-2.2)	mg/dL

Interpretations:

16 Apr 03 @ 2129 (Coll) BLOOD

Order comment: PRE-OP

WBC	13.4	H	(4.8-10.8)	K/UL
RBC	4.6	L	(4.7-6.1)	1X10 6/UL
HGB	12.5	L	(14.0-18.0)	g/dL
HCT	37.8	L	(42-52)	%
MCV	83.1		(80-94)	fL
MCH	27.5		(27-32)	pg
MCHC	33.1		(31-37)	g/dL
RDW	15.9	H	(12-14)	%
PLT CNT	827	H	(150-450)	1x10 3/UL

Result Comment: NOTIFIED ENS (b)(6)-2 @ 2229 (b)(6)-2

MPV	7.9		(7.4-10.4)	FL
NEUT/100 WBC	46.7			%
NEUT%	6.3			1x10 3/UL
LYMPHS/100 WBC	38.3			%
LY#	5.1			1x10 3/UL
MONO/100 WBC	15.0			%

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 14 Apr 03 - 17 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/7d Reg #: (b)(6)-4
Ph: Military Unit: UNKNOWN

16 Apr 03 @ 2129 (Coll)				BLOOD
MO#	2.0			1x10 3/UL
BAS#	<0.2			1x10 3/UL
16 Apr 03 @ 1617 (Coll)				BODY FLUID
WBC	135			MM3
RBC	1225			MM3
COLOR	BROWN			MM3
APPEARANCE	CLOUDY			
MN CELL	23			
PMN CELLS	77			MM3
16 Apr 03 @ 1354 (Coll)				SERUM
PROTEIN TOTAL	3.2	L	(6.3-8.3)	g/dL
Order comment: ascites fluid				
ALBUMIN	1.1	L	(3.5-5.0)	g/dL
Order comment: ascites				
TBILI	12.6	H	(1.0-10.5)	mg/dL
15 Apr 03 @ 1515 (Coll)				STOOL(FECES)

STOOL CU: Final Report

Bacteriology Result:
no salmonella or shigella noted

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

ANTIBIOTIC: ~~0~~
TIME GIVIEN:
OTHER:
lowered 550 mg fr..y

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281   ALLERGIES

OPERATION PERFORMED	AGENTS AND TECHNICS OF ANESTHESIA
Flex Colonoscopy	Conscious Sedation

HOUR(S) 14W 15 30 45 ... 15 30 45 15 30 45

TEMPS: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Spiral Level:

EKG to monitor on ☐ Rhythm SR-ST

BP art

BP cuff

Pulse = •

% Sat:

RESP. RATE

NUMBERS FOR REMARKS (1) (2) (3) (4) (5) (6)

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10		Arrival	1454
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	800			
RECOVERY ROOM	300			
TOTAL	1100			

BLOOD LOSS IN OR: ~~0~~ CC

WARD PRE-OP BP 136/80 mmHg

TUBES: ☐ N/G ☐ FOLEY

18g IV IN (L) FA c̄ 300 cc OF LR AT 300 cc/hr AOW

IV IN (L) FA c̄ 1000 cc 18g OF LR AT KVO cc/hr TOW

ART. LINE IN

T-TUBES, HEMOVAC IN

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY DATE 4/15 HRS 1448	TO WARD 4FS DATE 4/15 HRS 1545

DRESSINGS: LOCATIONS abd

STATUS: CD; I	STATUS: CDI

ENDOTRACHEAL TUBE – ORAL OR NASAL

☐ YES ☐ NO	☐ YES ☒ NO

AIRWAY / BREATH SOUNDS

☒ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY	STATUS: CLEAR

	MOR	PACU	URINARY OUTPUT			DRAINAGE	
TIME	AOW	1545					
CC	0	75					
TOTAL		75					
SP, GR							
S/A							

REMARKS *(AS NUMBERED)* AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by (b)(6)-2

PMH: anorexia s/p BSW to abdominal lump?

Neuro: Awake

Pain Yes/No Action: abdominal

CV: S1 S2 ⊕   IV: patent

Other: ... ↓ low portion. Side ... ↑ x 2

(CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☒ NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT ______ HRS
SENSATION PRESENT AT ______ HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)			A	D
Able to move 4 extremities voluntarily or on command 2; Able to move 2 extremities voluntarily or on command 1; Able to move 0 extremities voluntarily or on command 0		Activity	2	2
Able to deep breathe and cough freely 2; Dyspnea or limited breathing 1; Apneic 0		Respiration	2	2
BP±20% of preanesthetic level 2; BP±20-50% of preanesthetic level 1; BP±50% of preanesthetic level 0		Circulation	2	2
Fully awake 2; Arousable on calling 1; Not responding 0		Consciousness	2	2
Pink 2; Pale, dusky, blotchy, jaundiced, other 1; Cyanotic 0		Color	2	2
		TOTALS	10	

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS
AOW (b)(6)-2 (b)(6)-2
TOW (b)(6)-2 (b)(6)-2

NAVMED 6320/16 (BACK)

HOUR(S)	15	30	45		15	30	45		15	30	45		15	30	45		15
TEMPS: 220																	
200																	
180																	
160																	
140																	
120																	
100																	
80																	
60																	
40																	
20																	
RESP. RATE →																	
NUMBERS FOR REMARKS																	

Spinal Level:

EKG Rhythm

BP ⊥/T art

BP v/Λ cuff

Pulse = •

% Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE

REMARKS *(AS NUMBERED)* AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) O2 NC for O2 sat 92-94%. [illegible] pt. (3) [illegible] in to speak to pt - give instruction about (L) site / passing [illegible] pt (4) Pt requesting Soda to help him burp. BS (+) all quads. Abdomen distended. Tight but not hard. (b)(6)-2
(5) O2 NC off pt. (6) Pt meets PACU discharge criteria - report called to Enf (b)(6)-2 4FS (b)(6)-2

TOW Note: Neuro: A&O x3

Pain: Yes/(No) Action:

Pulmonary: LUNGS CLEAR TO AUSCULTATION

CV: S1 S2

EKG Rhythm: NSR

IV: PATENT & INTACT

Skin/Wound: NO DRNG. SITE OVER ABD

Drainage Yes/(No) Color:

Edema Yes/(No)

GI: STOMACH DISTENDED NORMAL BOWEL SOUNDS

GU: Foley Yes/(No)

Color of urine: -0-

Due to void: [illegible] @ 15 [illegible]

Instructions/Interventions in PACU: Pt TOLD of TOW. TOLD TO ASK FOR ASSISTANCE IN AMBULATION.

Report called to: ENS (b)(6)-2 By: (b)(6)-2 [illegible]

TOWed to: 4FS By: [illegible] (b)(6)-2 [illegible] (b)(6)-2

*U.S. Government Printing Office: 1991 — 504-109/20525 2-1

506-111 NSN 7540-00-634-4121

MEDICAL RECORD — DOCTOR'S OF (Sign all orders)

DATE AND TIME START	~~STOP~~	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
15APR03 1430			**ANESTHESIA PACU ORDERS**		
		(1)	Admit to PACU.		(b)(6)-2
		(2)	Allergies: NKDA		(b)(6)-2
		(3)	Vital signs per PACU protocol.		
		(4)	O2: ___FM @ 10LPM, ____% Blowby, ✓ NP @ 3 LPM.		(b)(6)-2
		(5)	IVF: LR at 200 cc/hr		
		(6)	On ward: 02 @ 2-3 LPM via NC: YES (NO)		
		(7)	Pain medication:		
			~~Ketorolac ___ mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)~~		
			MSO_4 2 mg IV q 6 min prn; max dose 12 mg		
			~~Fentanyl ___ mcg IV q ___ min prn; max dose ___ mcg~~		
			~~Percocet ___ tab(s) p.o. with sip of water~~		
			Other: Meperidine 25mg IV x1 PRN shivering		
		(8)	Antiemetics:		
			Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			Metoclopramide ___ mg IV x1 (0.15 mg/kg; max 10 mg)		
			~~Droperidol ___ mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other ___		
		(9)	Clear liquids as tolerated: (YES) NO		
		(10)	Notify Anesthesi (b)(3)-1 for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol. (b)(6)-2		

(rev 3/2002) (OVER)

e on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: t, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO. ~~WARD NO.~~

(b)(6)-4 (b)(6)-2 started Vicn 15Apr03

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA-ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
15APR03 1430			**ANESTHESIA PACU ORDERS -- CONTINUED**		
		11.	Discharge patient from PACU per protocol: YES NO		(b)(6)-2
		X	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.		
			FOR PACU KEEP PATIENTS ONLY		
		X	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		X	Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management		
			c. Other _____		
		✓	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
			Signature (b)(6)-2 (b)(6)-2 Beeper		
			(b)(6)-2 15Apr03		

STANDARD FORM 508 (Rev. 3-94) BAC

Pre / Post-anesthetic Summary

NNMC 6320/279 (Dec-10)

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
Colonoscopy Esophagogastroduodenoscopy	~50	~70	5'4"	1 (2) 3 4 5 E	NKDA

Chemistries

Hematology
H / H -
Platelets -
WBCs -

Coags
PT -
INR -
PTT -

Urinalysis / HCG

NPO - ✓
Teeth - own short neck prominent teeth
Airway - MP I / II / III / IV
(FROM) ___ FB O, ___ FB HM

Respiratory
Cough:
Sputum:
Asthma:
COPD:
Recent URI:
TB:
Lung Exam: CTA (b)(6)-2
CXR:

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
Exercise Tolerance:
Cardiac Exam: RRR
ECG:

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:

Misc

Other
Hepatic:
Renal:
GI:
Endo:
Heme:
EtOH:
Tobacco:

Previous Anesthetics:
29MAR03 ex lap (b)(6)-2

Current Medications:
Azithromycin 250mg PO QD

Premedication:

Family Hx:

Preoperative Diagnoses
~50y.o.♂ c Anorexia s/p GSW Abdomen. s/p ex lap
ASA II.
NPO.

Vitals	Pre-op	DOS
BP:	136/80	
HR:	90	
Resp:	14	
Temp:	97°F	
~~EHR~~	OX 98	

Evaluator Signature (b)(6)-2 Date 15APR03

Day of Surgery
- ☑ Chart Reviewed / patient examined
- ☑ Risks / benefits / options discussed with patient
- ☑ Patient questions answered
- ☑ Patient / parent / guardian understands and accepts risks
- ☑ NPO after _____ liq., _____ clears, _____ solids

Plan: GA.

Staff MD / CRNA signature (b)(6)-2 (b)(6)-2 Date & Time 15APR03 1330

Patient identification
(b)(6)-4

Post-operative note
s/p GA for EGD + colonoscopy

☑ No apparent anesthetic complications

Signature (b)(6)-2 Date 16APR03

MEDCOM - 5984

ANESTHESIA RECOR

ANMC 4279(12/00)

Wt (kg) - 70 Ht (in) - ~54" Allergies NKDA

Procedure	Anesthe (b)(6)-2	Surgeon (b)(6)-2	OR # 3
EGD/Colonoscopy			See Page One

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA	Page 1 of 1
15APR03	1330	1360	1405	1443	1450		

Time 1400 1500 1600

O₂ L/M 3

N₂O Air L/M

Inh Halo / Iso / Sevo / Des

STP / Prop / Etomidate

Sux / Cistracurium 20

Ro / Rapa / Vec / Curonium

Lidocaine

Neostigmine / Glyco

Ephedrine / Neo

Midazolam 10

MSO₄ / Remi / Sufent / Fentanyl 250

Epid. Lido / Bupiv / Ropiv

benzocaine 20% 3 sprays 3

NS / LR 1 800

U/O

EBL

● = Pulse
○ = Spont. Resp.
Ø = Asst. Resp.
Ⓥ = Ventilator
X = MAP
Λ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

180 160 140 120 100 80 60 40

PACU / ICU

Pulse - 10

BP - 146/91

Temp - 96.3

RR - 14

SaO₂ - 100%

Comps - + / -

ECG SR SR SR ST SR

Es / Np / Or / Sk / Ax Temp

% FiO₂ 3L 3L 3L 3L 3L

% SaO₂ 100 100 100 99 100

EtCO₂

TV

PIP (cmH₂O)

Resp. Rate

Checklist - ☑ O₂ ☑ Suction ☐ Machine ☑ Consent ☑ NPO

Monitors - ☑ SaO₂ ☑ ECG ☑ FiO₂ ☑ NIBP L / R arm ☑ EtCO₂ ☐ PCS / ES ☐ PNS ☐ PIP ☐ Temp ☐ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer ☐ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath ☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R ☐ A-Line Rad / Fem L / R

Position - ☑ Pressure points padded ☑ Arms < 90°

Supine Prone Lithotomy Sitting Lateral L / R

Drawn____ Used____ Wasted____ Witns____

Drawn____ Used____ Wasted____ Witns____

IV - 20 Ga L (R) Hand Wrist FA AC EJ

☐ Tourniquet ____ mmHg Times I____ I____

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

	Total
800cc	Total
No Foley	Total
Minivda	Total

Antibiotics

Agent -

ing -

over minutes

@

NO2 3L an.
Monitors an.

To PACU Awake

Induction (Monitors On) Preoxygenated Smooth Inhalation / IV Cricoid Pressure Rapid Sequence Mask ventilation easy Y / N

Intubation - Mac / Mil ____ Grade ____ view Tube Size ____ Attempts ____ Oral / Nasal L / R w/o w/ Cuff Stylet Y / N Bil BS / EtCO₂ x 3 / CIN

Tube taped @ ____ cm @ lips / teeth / nares Trauma Y / N FOB / LW / Blind LMA # ____ DLT ____ Fr L / R

Maintenance - Smooth Cuff checked Eyes taped / lubed

Extubation - Smooth Reversed SV VSS Full T4 / Head lift / Sustained tetanus Suctioned Awake / Deep

Disposition - PACU / ICU SV VSS Awake / sleepy Extubated / intubated

Prep
- ☐ Sterile Technique
- ☐ Disposable kit
- ☐ Betadine prep x 3
- ☐ Local infiltration
- ☐ Site ____ L / R
- ☐ Attempts ____

Blocks
- ☐ Nerve Stim ____ mA
- ☐ Trans-arterial
- ☐ Dual cuff

Regional
- ☐ Spinal / Epidural
- ☐ Touhy / Whitacre / Quincke
- ☐ Needle guage ____
- ☐ Sitting
- ☐ Lateral R / L
- ☐ LOR to Air / NS
- ☐ Paresthesia + / -
- ☐ Heme + / -
- ☐ CSF + / -
- ☐ Test dose ⊖
- ☐ CSF ⊖ swirl

Regional
- ☐ Catheter out - tip intact
- ☐ Level ____

Lines
- ☐ Seldinger Technique
- ☐ CVP manually transduced
- ☐ Cordis 9.5 / 8.5 Fr
- ☐ SLIC
- ☐ 2 / 3 - lumen

Comments / Drugs:

Patient Identification

(b)(6)-4

516-108

NSN 7540-00-634-4156

MEDICAL RECORD — Name 3 Case #2 — **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

R/O cancer

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
Dr (b)(6)-2		Ø	
ANESTHETIST	**ANESTHETIC**		TIME BEGAN: 1435
(b)(6)-2	(b)(6)-2		TIME ENDED:
CIRCULATING NURSE	**SCRUB NURSE**	TIME OPERATION BEGAN	TIME OPERATION COMPLETED
(b)(6)-2 HN (b)(6)-2	HN (b)(6)-2	1412	1450

OPERATIVE DIAGNOSES

SAT

DRAINS *(Kind and number)* — Ø

SPONGE COUNT VERIFIED — (b)(6)-2 — Com.

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

A) Bx of hepatic Flexure

1) Stool Culture for pathogens

OPERATION PERFORMED

1) Colonoscopy

2) EGD

DESCRIPTION OF OPERATION *(Type(s) of suture used, gross findings, etc.)*

Dr (b)(6)-2 - Consulted stm @ 1420

PROSTHETIC DEVICES *(Lot no.)*	DATE OF OPERATION
Ø	4/18/03

Colonoscopy to cecum normal except for circumferential ~~mass~~ fullness & suture noted in area of hepatic flexure.

EGD to 3rd portion duodenum normal, including retroflex

No complications

SIGNATURE OF SURGEON — (b)(6)-2 — DATE 15 Apr 03

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

(b)(6)-4

REGISTER/I.D. NO.

WARD NO.

Dot (b)(6)-4

OPERATION REPORT
Medical Record

*U.S. GOVERNMENT PRINTING OFFICE: 1990-259-301

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

(b)(3)-1 [redacted]

P[redacted]ative Plan Of Care & Nursing [redacted]

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☐ Yes ☐ No

Trauma# or Patient #

Diagnosis: R/O Cancer **Planned Procedure:** EGD, Colonoscopy

Date: 4/15/03 Arrival Time: 1300 Interviewer: (b)(6)-2 [redacted] [illegible]

Side: ☐ N/A ☐ Right ☐ Left Age: HT: WT:

From: ☐ CASREC ☐ ICU ☑ Ward ☐ OTHER:

Transport Via: ☑ Gurney ☐ Litter ☐ Ambulated ☐ Wheelchair ☐ Other

Patient ID: ☐ Trauma card ☐ Verbal ☑ Chart ☑ Armband ☐ Other

Blood Ordered: ☑ N/A ☐ Yes ☐ Consent ☐ T/C #Units ☐ T/H #Units Comments:

Surgical/Anesthesia Consent Verified: ☐ Procedure ☐ Consent complete, dated, signed ☐ Emergent case; no consent, MD note — N/A

Preop Labs (HCG, etc): ☑ None ☐ Yes Test/Results:

Drug/Latex Allergies: ☐ NKDA Allergy/Reaction: NKA

Present On Admission: ☐ N/A ☐ Oxygen ☑ IV Site: #1 (R) forearm 20g #2 ☐ Foley ☐ Endotracheal Tube ☐ Arterial Line Site: ☐ Drain(s) ☐ Chest Tube(s) ☐ See RN Note #

Past Medical History: ☐ None known ☐ Smoker ppd/yrs / ☐ ETOH ☐ Asthma ☐ HTN ☐ CAD ☐ GERD ☐ CBR exposure ☐ Other:

Past Surgical History: ☐ None known ☐ Yes GSW ABD List: X-Lap oversew bowel perforation

Cultural Needs Addressed: ☐ Yes ☐ No List: N/A

Pre-Op Pain: ☑ No ☐ Yes Level (0-10) Action Taken: Location/type:

Last PO Intake: (date/time) Solid: 4/14/03 Liquid: 4/14/03

In Chart: ☑ H&P ☐ Yes ☐ No ☐ EKG ☐ Yes ☐ No ☐ CXR ☐ Yes ☐ No ☐ Other:

Skin Condition: ☐ Intact ☑ Other: Sm wounds on lower Extremity s/p ABD Surgery

Limitations: ☐ N/A ☐ Auditory ☐ Language ☐ Visual ☐ Mobility ☐ Prosthesis ☐ Other: — N/A

Personal Items: ☐ None ☐ Military gear ☐ Glasses ☐ Dentures ☐ Jewelry/wallet ☐ Other — Disposition:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

Mental/Emotional Status: ☐ Alert/Oriented ☐ Disoriented ☐ Anxious ☐ Appropriate for age ☐ Other ☐ Calm ☐ Sedated ☐ Unresponsive — N/A

Comfort Measures Implemented: ☐ Clear, concise explanations ☐ Communicated patient concerns to other staff members ☐ Remain with patient during induction — N/A

Pre-op Teaching Included: ☐ N/A due to patient condition ☐ Physical layout of OR ☐ Personnel present during procedure ☐ Environment (noise, temperature, etc.) ☐ Post-op expectation (PACU, drains, etc.) — N/A

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☐ Yes ☐ No

Operative Position: ☐ Supine ☐ Prone ☐ Jackknife ☐ Lithotomy ☐ Other: ☐ Beach chair ☐ Sitting ☑ Lateral L / R

Positional Aids: ☐ Arms <90 Armboard: ☐ L ☐ R Tucked: ☐ L ☐ R ☐ Airplane ☐ Fracture Table ☐ Hand Table ☐ Stirrups ☐ Other: ☐ Axillary roll ☐ Gel Pad ☐ Leg Holder ☐ Tape ☐ Bean Bag ☐ Gel donut ☑ Pillows ABD ☐ Wilson Frame Comments:

ESU # Pad Site: Pad Lot # Site Clear at end of case? ☐ No ☐ Yes If No, see RN note # Bipolar: Max Cut Coag — N/A

DVT Prevention: SCD used ☐ No ☐ Yes Pressure: ☐ Left ☐ Right Teds: ☐ No ☐ Yes **Bair Hugger used:** ☐ No ☐ Yes Other warming techniques: — NA

Tourniquet: ☐ Arm ☐ Leg ☐ Left ☐ Right ☐ webril applied # Applied by: ↑ ↓ ↑ ↓ Total Min: Comments: — N/A

(b)(6)-4 [redacted]

(b)(6)-4 [redacted]

Comments:

(b)(3)-1 [redacted]

Potential For Infe **p** **Outcome:** Appropriate Actions Taken tc **Infection** ☐ Yes ☐ No

Wound Classification: ☐ I ☐ II ☐ III ☐ IV

Shave Prep: ☐ Shave ☐ Clipper
Area: _____ By: _____
N/A

Skin Prep:
☐ Betadine Scrub
☐ Hibiclens
☐ Duraprep
☐ Other: N/A

Solutions:
☐ Normal saline
☐ Sterile water
☐ Local _____
☐ Antibiotics _____
☐ Other: _____

Drains/Packing: ☐ None
Foley FR: _____
JP #1 Fr ___ Location: _____ #2 Fr ___ Location: _____
Hemovac: Size ___ Location _____
Chest tube: Location _____
Size _____ H2O Pressure: N/A
Packing: type/location: _____
See RN Note # ____ for comments

Dressing: Location: _____

☐ ABD	☐ Cervical Collar	☐ Kling	☐ Steri-strips	☐ Benzoin
☐ Ace	☐ Coban	☐ Immobilizer	☐ Tape	☐ Mastisol
☐ Bias	☐ Drip Pad	☐ Plains	☐ Webril	☐ Bacitracin
☐ Band-Aid(s)	☐ Fluffs	☐ Sling	☐ Xeroform	
☐ Cast	☐ Kerlix	☐ Splint	☐ Other:	

N/A

Miscellaneous

Counts: (initials)
Scrub: RN: Correct?
Sharps ☐ Yes ☐ No ☐ N/A
Sponges ☐ Yes ☐ No ☐ N/A
Instruments ☐ Yes ☐ No ☐ N/A
N/A
See RN note # ____ for additional comments

Xray:
☐ None ☐ Other:
☐ Portable
☐ C-Arm
N/A

Skin Integrity:
☐ Clear & Intact (other than incision)
Comments: Stm
☐ See RN note # ___ for additional comments.

Implants:
Item / Lot # / Exp Date: None

See RN note # ___ for additional comments.

Discharge from Operating Room

Complications:
None Comments: None.
See RN note # ____ for additional comments

Transport From OR:
☐ gurney w/ siderails up
☐ Litter w/ safety strap in place
☐ w/ Oxygen
☐ w/ Monitor
☐ Other:

Transferred To:
☑ PACU Report by:
☐ ICU ☐ Anesthesia provider ☐ RN
☐ Medivac
☐ Ward ____
☐ Other ____

Surgical Procedure Performed: Colonoscopy, E61) A) Bx of Hepatic Flexure
1) Stool Specimen for Pathogens

RN Note: (number each note to corresponding area above)

Initial/Name Box: (please print)

(b)(6)-2

Signature Date 4/15/03

Relief OR RN Signature Date/Time

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(3)-1 DIAGNOSTIC RADIOLOGY (b)(3)-1

Procedure: CHEST, PA/LAT (NIPPLE MARKERS)
Requested by: (b)(6)-2
Ward/Clinic: WARD 5 FWD STBD (b)(3)-1

Exam Date: 11 Apr 2003@0948
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
gsw R/O INFILTRATE

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

PA and lat cxr cf port ap from 4/10 @ 1325:

Repeat film shows diffuse patchy infiltrates obscuring the heart obrders bilaterally c/w pneumonia, despite the increased lung volumes due to better inspiration. Atelectatic component also likely. No significant effusions noted on the lateral. Bones and soft tissues are unremarkable. Pulmonary vessels normal in size ruling out failure as cause for infiltrates.

Transcription Date/Time: 11 Apr 2003@1020

Interpreted by: (b)(6)-2 CAPT,MC,USN
Supervised by:

Approved by: (b)(6)-2 CAPT,MC,USN 11 Apr 2003@1025
Supervised by:

(b)(6)-4 (b)(6)-4

10 Apr 200› MALE

Reg #: (b)(6)-4

Loc: CASREC MAIN

Spon: (b)(6)-4

SF519-B Unit:

FOREIGN N VAL - POW/INTERN
H: W:
Room-Bed:
Rank: D:
RR:

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 12 Apr 2003@1254
Page: 1

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(3)-1

Procedure: ABDOMEN SERIES, ACUTE
Requested by: (b)(6)-2
Ward/Clinic: WARD 5 FWD STBD (b)(3)-1

DIAGNOSTIC RADIOLOGY (b)(3)-1
Exam Date: 11 Apr 2003@1457
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
ABD MASS

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

CXR shows low lung volumes but no gross abnormalities.
Abdomen films show large amount stool but no dilated large or small bowel, or free gas.
No abnormal calcifications. Bones normal.

Transcription Date/Time: 11 Apr 2003@1814

Interpreted by: (b)(6)-2 CDR,MC,USN
Supervised by:

Approved by: (b)(6)-2 CDR,MC,USN 11 Apr 2003@1816
Supervised by:

04/16/2003 08:17:53 AM

Rx:
Dx:

BP:

Da...
Ro...
Op...

Rate	92	. Normal sinus rhythm, rate 92 ...... Normal P axis, PR, rate & rhythm
PR	150	. Marked posterior QRS axis .... Late V-lead transition
QRSD	92	. Probable inferior infarct .... 20's 2,3 F 3 I-4e ~0 to 240
QT	32?	
QTc	407	

(b)(6)-4

Requested by:

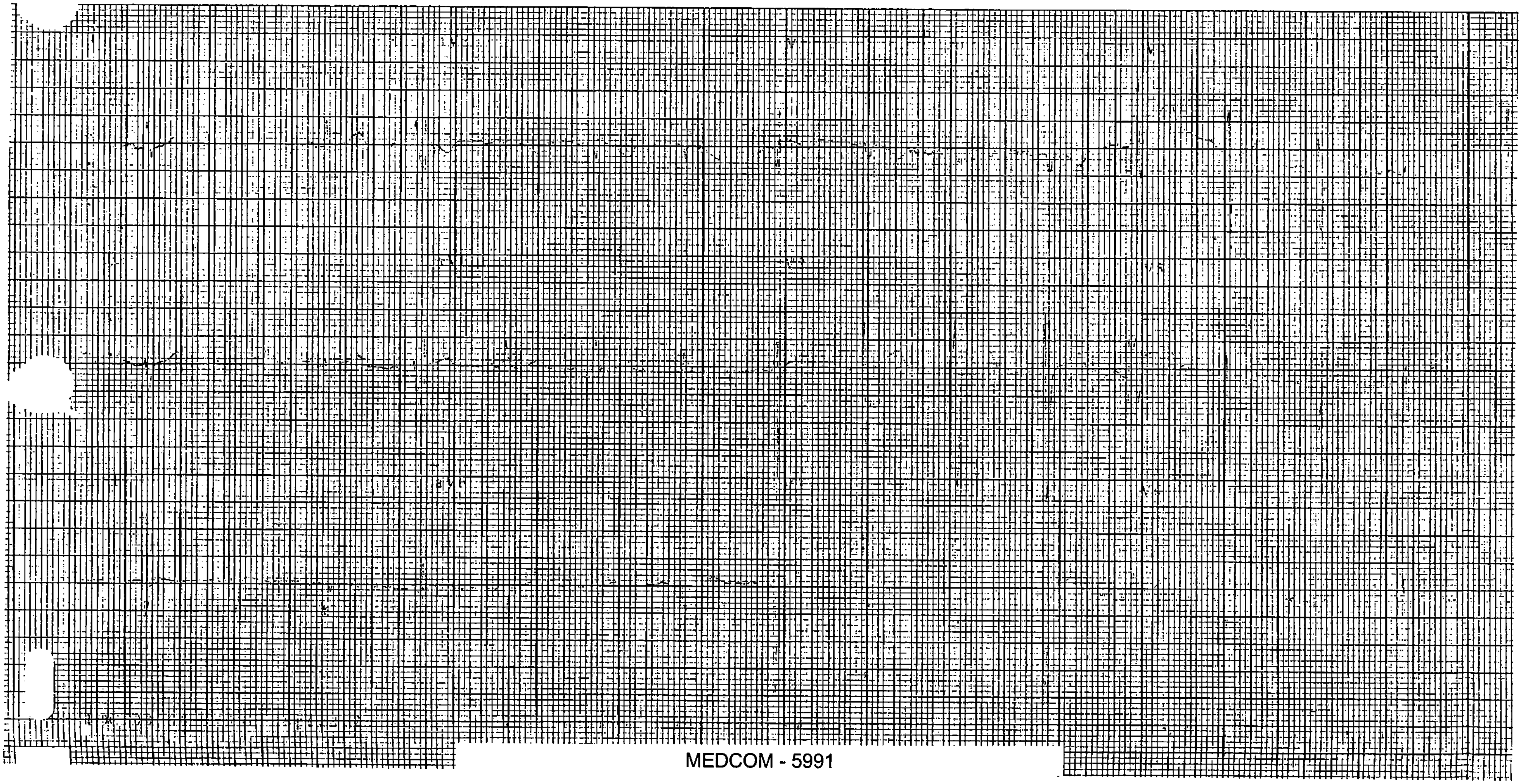
--AXIS--

P	6
QRS	-63
T	25

AQUIRED @ 2050
16 APRIL 03

- ABNORMAL ECG -

PRELIMINARY-MD MUST REVIEW



MEDCOM - 5991

Name: (b)(6)-4

NURSING FLOW SHEET

MEDT 6550/12/Ter rm

Date: [illegible]

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120													V											
100																								
80													•											
60													Λ											
40																								
RR													18											
TEMP													99.2											
SAO_2																								
MAP																								
O_2 Mode																								

Legend: ∨ CUFF ∧ — ⊥ AL ⊤ — • — DRIP / DOSE

Name: (b)(6)-4

NURSING [redacted] SHEET
[redacted]/Temp Form

Date: 02 May 13

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120													↓											
100		V																						
80		d											•											
60													↑											
40																								
RR		24											16											
TEMP		99.5											99.5											
SAO2																								
MAP																								
O2 Mode																								

DRIP / DOSE

RECOPY 4/25

NAVMED 6550/8 (REV. 4-74) S/N 0105-Lr-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH APR 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	25	26	27	28	29	30	1
4/18	FeSO4 1 tab PO TID	0700	(b)(6)-2				(b)(6)-2		
		1100							
		1700	(b)(6)-2		(b)(6)-2				
4/18	Folic Acid 1 mg PO qd	0700	(b)(6)-2						
4/18	MVI 1 tab PO qd	0700							
4/18	LOVENOX 30 MG SQ q12h	0900							
		2100							
4/22	ZANTAC 150 mg PO BID	0900	(b)(6)-2						
		1700							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2 HMS	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2 CCOR
			(b)(6)-2		

ADDRESSOGRAPH PLATE

(b)(6)-4

WARD NO.

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

RACK # 33

RACK # 33

1 OF 1

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
Tylenol 650mg PO	5/4	0300	(b)(6)-2				

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN															
4/10	Percocet	DATE	4/29	4/25	5/2	5/2												
	1-2 tabs PO	TIME	1800	1150	0735	2204												
	Q3° PRN	DOSE	2	2	2	2												
		INIT.	(b)(6)-2															
4/16	Benedryl 25mg	DATE	4/26	4/28														
	PO Q4° PRN	TIME	2045	2430														
		DOSE	25	25														
		INIT.	(b)(6)-2															
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH MAY 19 30 2003 — DATES GIVEN

ORDER DATE	MEDICATION-DOSAGE-FREQUENCY ROUTE OF ADMINISTRATION	HOURS	2	3	4				
4/18	FeSO4 1 tab PO TID	0700	(b)(6)-2		Refused				
		1100							
		1700							
4/18	FOLIC ACID 1 mg PO qd	0700			Refused				
4/18	MVI 1 tab PO qd	0700			Refused				
4/18	LOVENOX ~~30~~ 40 mg SQ q 12h	0900			(b)(6)-2				
		2100							
4/22	ZANTAC 150 mg PO BID	0900			(b)(6)-2				
		1700							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE

ADDRESSOGRAPH PLATE

(b)(6)-4

WARD NO.

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

SINGLE DOSE, PRE-OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

2 OF 2

Recopied 4/18 AM

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH April 19 03 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	18	19	20	21	22	23	24
4/18	Azithromycin 250mg po qday x4 days	0900	(b)(6)-2	✓	✓	(b)(6)-2			
			—	—	—	—	—	—	—
4/18	Heparin 5000 u SQ BID	0900	X	(b)(6)-2					
		2100	(b)(6)-2						give Lovenox
4/18	FeSO4 1 tab po T.I.D.	0700	X	(b)(6)-2					
		1100	X						
		1700	X						
4/18	Folic Acid 1mg po qd	0700	X						
4/18	MVI 1 tab po qd	0700	X						
4/17	METRONIDAZOLE 500mg IV Q8hr x 6 DOSES	0800	X	(b)(6)-2					
		1600	X	(b)(6)-2	X	D/C after 6 doses			
		2400	(b)(6)-2						
4/17	ZANTAC 50MG IV Q8°	0800	X	(b)(6)-2					
		1600	X	(b)(6)-2				(b)(6)-2	DCD
		2400	(b)(6)-2						
4/18	Lovenox 30 mg SQ q12h	0900	X	X	X	(b)(6)-2			
		2100	X	X	(b)(6)-2				
4/22	Tobramycin 350mg IVPB q8	1600	—	—	—	—	DCD	—	—
			—	—	—	—	—	—	—
4/22	Zantac 150 mg po BID	0900	X	X	X	X	X	(b)(6)-2	
		1700	X	X	X	X	X		

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2			(b)(6)-2	(b)(6)-2 LCDR
					(b)(6)-2

ADDRESSOGRAPH PLATE: (b)(6)-4

WARD NO.

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

rack # ~~26~~

Rack 23

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN			MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN		
	DATE	TIME	INITIAL		DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																		
4/10	MSO4 3-5mg	DATE	4/10																	
	IVP q 3° prn	TIME	0500																	
	pain	DOSE	5mg																	
		INIT.	(b)(6)-2																	
4/10	Percocet 5-325	DATE	4/22	4/23																
	po q 3° prn	TIME	0145	2215																
		DOSE	1	2																
		INIT.	(b)(6)-2																	
4/10	Tylenol 650mg	DATE																		
	po q 4° PR	TIME																		
		DOSE																		
		INIT.																		
4/10	Benadryl 25mg	DATE	4/22																	
	po q 4° prn	TIME	0145																	
		DOSE	50mg																	
		INIT.	(b)(6)-2																	
4/10	Phenergan 25 IV	DATE																		
	prn	TIME																		
		DOSE																		
		INIT.																		
		DATE																		
		TIME																		
		DOSE																		
		INIT.																		
		DATE																		
		TIME																		
		DOSE																		
		INIT.																		

(b)(3)-1

CHCS Name: (b)(6)-4

(b)(6)-4

EPW

Date of Admission: 4/10/2003

Date of Transfer:

Age: Gender: M

History:

GSW to abdomen. X-lap and oversew of small and large bowel injuries. Peritoneal implants suggestive of cancer or granulomatous disease noted. Transferred here, tolerating diet. Hx of COPD;

Hospital Course:

Poor appetite led to CT scan and above procedures. Once drained, eating and feeling well.

Diagnoses:

s/p GSWto abdomen;, Bilious ascites,

Surgeries/Treatment:

EGD neg. Colonoscopy showed inflammation at GSW site, hepatic flexure. X-lap(17Apr) for washout and drainage of loculated bilous ascites. Dense adhesions precluding complete exam. No leak noted., Percutaneous drain placement right
subphrenic space for drainage of collection of bile.(21Ap).,

Recommendations:

Local wound care to midline abdominal incision; Drains out ~~any day~~

Special Needs:

Prognosis: Good

Physician: (b)(6)-2 LCDR Dept of General Surgery 4/24/2003

Copy 1 original admin

Level II

(b)(3)-1 [redacted]

(b)(3)-1 [redacted]

Lift of Opportunity Application

[illegible] Name: (b)(6)-4 [redacted]

Social Security / Pseudo SSN:

Name of escort accompanying applicant:

[illegible] | [illegible] | [illegible] | Birth date | Gender | Religion

[illegible] Name & Address of Command/Unit | Homeport Location

[illegible] Name & complete Address | Relationship of NOK | Next of Kin's Phone Number

[illegible] attending physician authorizing [illegible] specified location: (b)(6)-2 [redacted]

Signature of attending physician listed above (b)(6)-2 [redacted]

[illegible] REQUIRED [illegible]

[illegible] HOBD Coordinator (if applicable):

Signature of [illegible] HOBD Coordinator listed above:

[illegible]

MEDCOM - 6000

AUTHORIZED FOR LOCAL REPRODUCT

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
(b)(6)-2 30 Mar 03 1242	Patient transferred to ICU1 from ER. Dressing to midline gastric region CDI. ⊕ gastric sounds ē inflator through NG tube. Ventic in use per protocol. Dressing to Ⓡ UQ CDI, dressing to Ⓡ Ulnar region CDI, Vitals HR 119, 141/86, RR 23, SPO2 97% on 2150 O2. (b)(6)-2
(b)(6)-2 1245	Foley draining medium dark colored urine. Vitals Stable (b)(6)-2
30 Mar 03 1300	Resp Care Note: pt. on mech vent as ordered, all settings checked + set properly. All alarms set + working. Ambu bag @ bedside. BBS fairly decreased. Vent settings V_T 750 mL, SIMV, RR 12, peep 5 cm H_2O, FIO_2 [illegible] Bleed-in. Ex. V_T 758 mL, PIP 35, Mean 12; SpO_2 94% (b)(6)-2 91V3H
30 March 2003	Physician Note 40-50 [illegible] S/P laparotomy & [illegible] colon resection, not extensive. Pt reportedly had resp arrest.
	O - on vent ē O2 sats > 95
	Abdm - soft, tender on palp; s̄ BS.
	Heart RR s̄ @
	Lungs - coarse [illegible] heard throughout
	Ext - move well
	A - ① S/P lap for GSW
	② COPD (b)(6)-2 [illegible] per orders (b)(6)-2 MD LTC
	③

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT
	(b)(3)-1	

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)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

DATE	NOTES
30 Mar 03	2100 PT sedated, (R) nare bleeding, (L) nare NG Tube To LIMS, placed @ 3rd tick mark, minimal drainage. PT intubated c̄ vent setting FIO2 21%, TV 750, peep 5 rate 16, on AC. Partially compensated resp acidosis, c̄ history of copd. Tube @ 22 @ the hub. Lung sounds course bilat A to B; PT HR Tachycardic @ 110-120, Hypotensive Distal Pulses +3 upper & Lower Ext. Cap ref < 3 sec. Midline incision from sternum to groin, Dressing C D I. Gunshot wound To (R) side abdomin, Dressing C D I. Foley to Gravity draining QS. IV in (L) hand inf. LR 125/hr
	(b)(6)-2 Spc LPN
30 mar 2130	350 cc via foley (b)(6)-2 Spc LPN
30 mar 2240	ABG drawn, compensated Resp acidosis
	(b)(6)-2 Spc LPN
0100 30 mar	- Suction PT minimal secretions (b)(6)-2 Spc LPN
30 mar 0240	- 500 cc via foley (b)(6)-2 Spc LPN
31 Mar 0605	- Urine via Foley 200 cc (b)(6)-2 Spc LPN
31 Mar 0750	Resp Care Note: pt. on mech vent as ordered, all settings checked + set properly. All alarms set + working. Ambu @ bedside. BBS slightly course t/o. Admin 10 puffs Albuterol MDI. HR 111, RR 15. SpO2 95-96%. Vent settings A/C RR 15, Vt 750, Peep 5, FIO 1 l/min bleed-in. Exhaled Vt 748, PIP 36, Mean 13. (b)(6)-2 RRT
0900	STABLE, VS WNL, SATS 95 c̄ VENTS CHANGES DONE OVERNIGHT STILL ON FULL COMP. RESP. ACIDOSIS c̄ PCO2 AROUND 50 AND PO2 -84%. LUNGS MILDLY COARSE THROUGHOUT, ↓BS, ABD DRESSING CHANGE DONE BY MD, HEALING WELL, NG TO (L) NARE TO INT. SUCT. PAST HX OF COPD, DRESSING ON (R) FA C/D/I, GOOD PULSES, CAP REFILL < 4

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
30 March	2003
1445	S- pt ~~40~~-60 yo Iraqi male c̄ ~~gss~~ GSW, c̄ frag to abdm, S/P (b)(6)-2
	O- xray of (R) forearm shows multiple metallic fragments throughout forearm. No fracture noted.
	abdm - soft, pain on deep palp; s̄ BS
	wound dressing not disturbed
	Heart - RR
	Lungs - diffuse coarse rhonchi on inspiration throughout
	Neck - supple
	A- (1) GSW abdm s/p lap c̄ reanastomosis of colon
	(2) Shrapnel injury to (R) forearm
	(3) Probable COPD
	P- Unasyn, IV fluids, treat COPD as best as possible
	Watch
	(b)(6)-2 MS LTC

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)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTI

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

31 March 2003 Physician note
1235 50ish

Pt operated on 29 March 2003 for GSW to abdomen, S/P resection & reanastomis of colon at that date. Pt had episode of resp. arrest ? 2° to COPD.
Now pt is on vent, c F_iO_2 21% c SpO@ 97%
RR 13, pulse 114, BP 139/78.
Lungs - coarse rhonchi throughout in all lung fields
Abdmn - soft, very tender to minimal palp.
BS absent.
Ext. (R) forearm has fragment wound, c fractures.
~~ABGs on 30 March~~ (b)(6)-2
A - (1) GSW to Abdmn - S/P resection & reanastomis ? early peritonitis
(2) fragment wound to (R) forearm
P - Cont as is:
Recheck Abdmn c xrays

(b)(6)-2

MA LTC

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.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

DATE	NOTES
1300	CPAP TRIAL DONE, PT RR ↑ 55 BUT HELD SATS ABOVE 9%, 3 mg OF MSO4, 2mg VALIUM AND 5 mg VECURONIUM GIVEN IV PER ↑ AGITATION
3/31/02 1326	Respiratory Care Note: pt. vent settings A/C RR 15, VT 750 mL, Peep 5 cmH2O, FIO2 2 l/min Bleed in. PIP 39 cmH2O, Mean 14 cmH2O. HR 111, SpO2 95%. (b)(6)-2
1430	STABLE, VS - SEE FLOW SHEET, MOSTLY RONCHI ON UPPER LOBES BILATERALLY UNASYN 3G GIVEN IV, ZANTAC 300 SEE MED SHEET. (b)(6)-2
1600	PT EXTUBATED VS STABLE, VENTURI MASK @ AT 40% SATS AT 96% P - 115 BP 155/82, RR 32, RONCHI BREATH SOUNDS CLEAR UPON DEEP SUCTION BY RT, MOSTLY CONGESTED (b)(6)-2
1800	UNASYN 3GM GIVEN IV, HEPARIN 5000 U SQ GIVEN AS CALL SATS 95 P 110, VS STABLE SEE FLOW SHEET STILL ON VM 40%. LUNGS COARSE ON UPPER LOBES BILATERALLY ALL OTHER FIELDS CLEAR, ↓ B: GOOD PULSES x 4. DRESSING CHANGE DONE ON Ⓡ FA, STILL OOZING (b)(6)-2

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
31 Mar 03	Respiratory Care Note: Vent settings, AC RR 15, V_T 750, Peep 5, FIO_2 1[illegible]
10:15	Bleed-In. Exh. V_T 760, PIP 36, SpO_2 96%. Admin 10 puff Albuterol
	MDI, HR 111, Small ~~[illegible]~~ white secretions. (b)(6)-2 91V3H
1020	5 mg of Vecuronium given IV c̄ 2 mg of Valium 20
	minutes before, stable. Albut. Tx given by RT, lungs
	still coarse, sats at 96% no changes in Vent settings.
1155	5 mg of Vecuronium given IV, plus 5 mg of Valium IV, see
	VS flow sheet, (b)(6)-2
	SpO_2 97
	RR 13
	HR 114
	139/7[illegible]
31 Mar 2130	- PT AEO x3, Lung sounds course throughout, satting 93-96
	on 30% O2 via venturi mask. PT has very productive cough c̄
	Traces of blood in sputum. Normal Sinus tachy, cap ref < 3sec
	all pulses +3, superficial shrapnel wound on ~~left~~ (R) forearm
	Dressing CDI, Gunshot wound to (L) upper quad abdomin
	Dressing CDI, midline incision, Dressing CDI, No bowel
	Sounds, abdomin distended, muscle strength weak, Foley to
	Gravity QS Dark concentrated.
31 Mar 03 2300	- LR 50/cc/hr TKO (b)(6)-2 SPC LPN

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

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

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

DATE	NOTES
1 APR 03 1340 Z	Patient ō ↓ Sats to 88% Dr Smith notified. ↑FiO2 to 40% VM. 24 RRs CXR ordered New Abx orders noted. O2 Sats ō immediate ↑ 91-92%
1429 Z.	Unasyn D/C, changed to Rocephin 1GM b new order, followed By 50 mg of Zantac, and 400 mg of Cipro piggy bag, CXR done pending results, neb tx done by R/T, still coarse throughout, ↓ At the bases, ST c̄ good distal pulses, still utilizing secondary muscles to breath, will continue to monitor [redacted]
01 APR 03 10:49	BP 159/84 P 93 SpO2 91%
01 Apr 03 1909	PT A&Ox3. PT lung sound coarse. PT IV fluids ↓ to 20cc/hr. PT has foley draining clear yellow urine. PT HR in low 100's. Plan for PT to be transported to ICW 2. [redacted]
1 Apr	Pt transferred from ICW #2 pt came in c̄ Δ in LOC did not follow commands c/o abd pain received MSO4 4mg IV x2 Pt on O2 concentrator range from 4-8 LPM to maintain SpO2 of 92-97%. Will continue to monitor [redacted]
02 APR 03 0800	VS T 98.7 AX B P 121/79 P 80 R 24 POX 96% O2 SP [redacted]
02 APR 03	s/p ex-lap c̄ colon resection 2° to GSW (surgery 29 MAR 03) afebrile VSS 47% (4L face mask) abx: Rocephin / Cipro / Clindamycin ? COPD H/H (01 APR) = 12/35 [redacted]
	Cont current mgt, AllIN, pulm. Toilet [redacted]
1000 hrs	Dsg chg Abd given Morphine 2mg pr. SPC Winkler Andrea
1451	Resp Care Note: pt admin 2.5mg c̄ 0.5mg Atrovent via HHN. BBS w/ slight I&E wheezes. p̄ tx. Aeration improved HR 98, 99 98. SpO2 on 6 lpm 97%. Tol tx well. [redacted]

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 6007

AUTHORIZED FOR LOCAL REPRODUCTIC

MEDICAL RECORD	PROGRESS NOTES
DATE	**NOTES**
1 APR 03 0820	Patient alert c̄ arousal to stimuli. Venturi mask @ 6 LPM SaO_2 @ 92%
	Bilateral lungs present to auscultation c̄ ↑ rhonchi. ⊖ cough. Mild
	hypertension c̄ prior hx. Dressing to midline abdomen secure & clean
	Respirations moderately labored. Secondary dressing to Ⓡ abdomen CDI c̄
	⊕ distension, ⊖ fecal output. Unable to determine flatus status.
	Ⓡ FA present c̄ 2cm wound to dressing which is CDI. Patient (b)(6)-2
	c/o thirst gave sips. Started Alaris pump & vanf 1/0's
0930	Patient midline incision/wound pink/beefy red c̄ small amount
	of bleeding. Wet to dry dressing performed, ⊖ purulent drainage or
	odor (b)(6)-2
0939	Ⓛ lateral wound packed c̄ wet/dry dsg, ⊖ drainage (b)(6)-2
1315 1 APR 03	Patient c/o incisional pain → MSO4 2 mg IVP for pain ——— (b)(6)-2
1 April 2003	Pt's O_2 sat down to 89%; lungs - have
	diffuse insp & exp coarse rhonchi. Pt lethargic
	but arousable.
	Abdomen is soft, tender, ↓ BS (almost absent)
	Δ antibiotics to Rocephin & Cipro, & Clindamycin -
	Will notify surgeons
	(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
4 Apr 03 1100	Pt recieved ~~2mg~~ 6 lasix via IV to (L) hand. (b)(6)-2
1105z	Pt placed on 2L O2 NC to keep O2 sat 90% or better, Pt was 81%. Levaquin 500mg PO Given
1110z	Late Note for 1030z, Pt Dressing Δ done W-D, no signs of infection
4 Apr 03 1235	Nutrition – Patient has been NPO for 6 days will provide clear liquids and monitor progess will advance as tolerated to Full liquid. (b)(6)-2 MAJ SP RD Nutrition Care
1246	93% SpO2 / 108 pulse
1511	Vitals – 92% SpO2 102 pulse, 98.3 temp, 138/76 BP, 24 RR, (b)(6)-2
1620	B/P 14?/76 P 101 R 24 SAO2 95% T-[illegible] Pt Heplok flushed; Pt has wheezes in upper quadrents of (L/R) Lungs. Pt abdominal dressing needs changed. New dressing applied. Pt given Neb treatment. Pt refused to corropeerate c̄ treatment
2200(Z)	Pt c/o pain, motions to (L) side abd, 2 vicodin P.O. given (b)(6)-2
5 Apr 03 0445	B/P 148/80, P-92, R-18, Temp 97.6, Pulse Ox - 93% on 2L O2, HRR at 92 BPM. Wheezing noted upon expiration in L and R lungs anterior and posterior. NO IV access, Abdominal dressing soiled. Cap refill +3 - Pt has weakness in right arm - impaired use for ADL's - (b)(6)-2
06 Apr 03 0800z	Chem 7 + H/H drawn and sent to lab (b)(6)-2

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME — LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

DATE	NOTES
4/5/03	GSW ABD S/P EX-LAP c̄ colectomy & 1° Reanastomosis
	(3/29/03)
	COPD / S/P Ventilatory Failure
	VS: 148/80 92 18 97.6 93% 2L
	C/o ABD PAIN ø flatus
	LUNGS: Diffuse inspiratory rales / exp coarse wheezy
	ABD: Midline incision (wound - granulating well)
	Distended ↓ BS but present
	Diffuse TTP mild
	Rectal: small amount stool in vault
	P) ① Clears (cautiously) ③ Hold narcotics (b)(6)-2
	② Supplemental O2 (b)(6)-2
1615	B/P 158/82 P 104 R 24 SAO2 2L 95% T 98.9 Pt took neb treatment
	Pt abdominal dressing needs changed ——— SPC (b)(6)-2
	Pt has decreased strength in Ⓡ hand. Pt can feel
	and has good cap refill. ———→ SPC (b)(6)-2
2340	Pt c/o Abdominal PN, Pt has decreased bowl sounds in
	all 4 quadrents. Pt stomach is distended. Consult c̄
	Dr (b)(6)-2 a.m. for advise ——— SPC (b)(6)-2
2220	Pt recieved Neb Treatment c̄ saline and Atrivent — SPC (b)(6)-2
0600	LE Pt recieved Neb Treatment c̄ Saline + Atrivent 2200 SPC (b)(6)-
6 APR 03	Vitals — Temp 98.2, B/P 160/96, Pulse 96, SpO2 95%
0445	Resp 26 ——— SPC (b)(6)-2
1654	RR 32 oral 100.9 Tmp sup O2 92% SpO2 HR 106 108/94
	Pt recd 650mg Tyl PO for Pain & Fever ——— LPN, SGT
	Pt c̄ Bowel Sounds Hypo x4 c̄ distended abd. Decreased strength in Ⓡ hand
	=V to (L) Arm Good. (b)(6)-2 LPN, SGT

LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 6010

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
(b)(6)-2 Apr03 /2254	no vicodin, Tylenol #3 ī tab given for pain (b)(6)-2 1LT/AN
2200	Pad 5485 p? 15 evac in AM. (b)(6)-2 LPN, SGT
2230	Pt given Albuterol/Atrovent NRB/Nebulizer @10L SPC (b)(6)-2
7Apr03/0300	B/P 138/68 P99 R24 T98.2 SAO_2 94%. Pt dressing
	looks okay Pt prepared for transport —— SPC (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
07 Apr 03	(b)(3)-1 [redacted]
1017	S/p GSW to abdomen S/p Ex lap colectomy
	c̄ 1° anastomosis 27 Mar 03
	also c̄ ~~colectomy~~ COPD.
	Denies SOB. Denies N/V.
	+ flatus.
	O: T = 99° SO_2 = 82-85%
	General alert
	Lungs - diffuse coarse breath sounds
	good air movement
	Heart RRR ∅ m/r/g
	abdomen soft; slightly distended
	+ BS; slightly tender
	∅ peritoneal signs incision-healthy
	Ext ∅ c/c/e [illegible]
	A/P ① s/p Ex lap colectomy 1° anastomosis
	- AAS
	- NPO for now
	② COPD
	- albuterol/atrovent
	- O_2 prn keep sat > 90%

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | (b)(6)-2 [redacted] | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY ✓ | (b)(6)-2 [redacted] | MD

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)-4 [redacted]

REGISTER (b)(6)-2 [redacted] | WARD NO.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | (b)(3)-1 [redacted] **S NOTES**

DATE	
	NKDA [redacted]
1030	Arrived via litter from aerovac. S/P
RT TX:	GSW c̄ exploratory lap. pulse ox 86% RA
0.5 Albuterol	chart states possible hx of COPD, neb
	treatment given by RT, pt on 4L @ 28% O_2
	via mask → pulse ox ↑ to 91%, P100, T99.4
	118/80, RR 28, lungs sounds wheezes bilateral
	abdomen dressing changed by Dr. (b)(6)-2 [redacted]; pt
	denies pain @ this time (b)(6)-2 [redacted]
1100	given 5Mg MSO4 for c/o pain; IV site changed
	to (L) AC; LR wide open, pt c/o of thirst but
	told thru interpreter that he's NPO; pulses equal
	all extremities; abdomen distended - minimal
	bowel sounds heard, heparin 5000 u given SQ;
	Zantac 50mg given IVPB
1230	5mg MSO4 given IVP for c/o pain; pt state
	NKDA thru interpreter; Abd X-ray completed;
	pt sat 90% on 4L @28% O_2; pt states thru
	interpreter that he smokes 2 packs/day
1310	0.5 Albuterol c̄ unit dose atrovent given to
	pt via neb tx by RT (b)(6)-2 [redacted] CPT/AO
1310	X-Ray report shown to Dr. (b)(6)-2 [redacted]; keep pt NPO (b)(6)-2 [redacted]

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

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

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

(b)(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

DATE	NOTES
1420	P 104, O2 Sat 90% on 4L 28% O2 Vanden
	200cc dark urine, LR wide open (b)(6)-2
1642	Pt given albuterol/atrovent neb by RT. O2 sat 94%
	P 103; pt remains on 4L Mask @ 28%
1835	BP 143/64, P 105, T 106.0, 90% on 4L Mask @ 28% On
	RR 20; RT tx albuterol/atrovent @ 1800
1900	pt voided 300cc/hr dark urine (b)(6)-2
	PO liquid 300cc orang drink & water (b)(6)-2 CPT/BD

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02 APR 03 1600	VS T 98.1 BP 156/84 P 96 R 22
2 Apr 03	Resp Care Note pt. admin 2.5mg Albuterol / 0.5mg Atrovent
	via HHN. BBS prior to tx. both coarse, post tx
	no Δ. HR 99-100-100, RR 20, 22, 22. Tol tx well
	∅ adverse reaction to therapy. SpO2 96% on 4L NC
02 Apr 03	Assessment Completed - IV (R) FA, HL (R) wrist (?) Rhonchi all
1800	lung fields - NC @ 10L - ... 95% Dry (R) wrist c/d/i,
	... - ... ABD ... - distended. DP x 4 ...
	Pt requesting water - ... NPO - will ... (doing). -
	(b)(6)-2
1835	IV infiltrated (R) wrist HL d/c'd - New IV (L) Hand
1900	New IV (R) ... (b)(6)-2
3 Apr 03	Resp Care Note; pt. admin 2.5mg Albuterol / 0.5mg
0830	Atrovent via Aerosol mask pt. BBS ... slight
	I+E wheezes
03 APR 03 0830	V S T 99.7 BP 163/89 P 101 R 22 POX 96 SPC ... (b)(6)-2
3 Apr 03 0850	Nutrition - Patient NPO ~~...~~ since 29 mar (5 days) dr. (b)(6)-2
	ordered 10% Dextrose LR @ 125ml/hr will provide 1020 kcal per day. Would
	recommend starting TF of Ensure at a drip rate to stimulate BS
	5-7cc/hr. (b)(6)-2
	MAJ SP RD

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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
03APR03	RT Notes: Pt received HHN via FM ē 0.5cc Albuterol
1120	UD Atrovent HR 97→ 102 RR:24 BS exp wheezes +
	rhonchi throughout ā + p̄ tx. NPC. NAR - (b)(6)-2 [redacted] 91L
03APR03 1230	VS T 99.0 BP 149/90 P 100 R 22 POX 98 IV would not flush
	after receiving Rocephin; D'c'd IV Ⓡ Arm and tried Ⓛ Arm. Unsucc.
	Did not receive Cipro. PT took (2) dumps, stool was brown
	semi soft/runny. SPC (b)(6)-2 [redacted] 91W MC
1500	was unable to give Clindamycin due to Ø IV Access
	Head Nurse notified. VS T 99.1 BP 140/84 P 100 R 22 POX 100
1530	Dsg chg of abdomen SPC (b)(6)-2 [redacted] 91W MC
1600	Restraints on both wrists. Pt refuses to keep O2 mask on face or
	Pox on finger. SPC (b)(6)-2 [redacted] 91W MC
1730	Foley - Drn 1200 cc DAU SPC (b)(6)-2 [redacted] 91W MC
	Nutrition - Patient continues on D10% @ 125cc hr, minimal
	bowel sounds - again recommend Drip TF of 5-7 cc Ensure per hour
	Ensure would stimulate gut motility. (b)(6)-2 [redacted]
4-4-03 0700	pt assessment complete he offers no c/o pain, his lungs have
	exp. wheezing throughout he has no c/o dyspnea or SOB, dressing on
	midline abd CDI dressing to Ⓑ flank CDI, IV fluids infusing @
	125/hr into Ⓛ hand IV started today, Foley D/C @ 0430, pulses present
	all ext Ø periph edema, pt has simple mask ē O2 @ 4L sats 94% pt has
	hypoactive b/s abd large round + soft (b)(6)-2 [redacted] 91W

STANDARD FORM 600 (REV. 6-97) **BACK**
*U.S. GPO: 2002 - 491-600/50618

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

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/4/03	MCW #1 Admit
	POD #6 GSW ABD S/P ExLap c̄ colectomy & 1° REANASt
	H/O COPD ? O2 Requiring S/P Ventilatory Failure
	T - 98° BP: 144/82 P - 106 81% SaO2 (RA)
	Lungs: Rales c̄ course wheezing (B)
	CV: RRR s̄ (R) ø S3
	ABD: Protuberant ↓ BS
	Midline incision - granulating well
	EXT: +2/= DP mild edema
	P) ① Supplemental O2
	② Atrovent / Albuterol nebs } Need RT (notified already)
	③ D/C IV Abx
	④ Levaquin 500g po Q day x 5 days
	⑤ Heplock IV
	⑥ Lasix 20g IV push now
	⑦ Regular Diet
	⑧ Bowel Control
	⑨ Q Day WTD dressing Δ's (b)(6)-2

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

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

REGISTER NO. | WARD NO.

(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5apr03	Changes pts dressings, wet to dry @ 0645
	(b)(6)-2 [redacted]
5apr03 1112	put in heplock (b)(6)-2 [redacted]
4/6/03 0655	(b)(6)-4 [redacted] GSW ABD s/p Ex-LAP c̄ colectomy & 1° Recurrs
	h/o COPD O_2 Dependent s/p ventilatory failure
	c/o ABD pain
	VS: T - 98.2 160/96 96 SaO_2 95% (2L) Resp 26
	CV: RRR s m
	Lungs: Coarse Inspiratory rhonchi
	Coarse exp. wheezy (B)
	ABD: Distended; BS present but hypoactive
	TTP RLQ > LLQ
	Ø flatus today
	G/U ⊕ pink UOP yesterday
	P) ① Cont Clears
	② D_{10} LR @ 70cc/°
	③ Chem 7 / H/H today
	④ AMBULATE TID
	⑤ OOB IN Chair BID
	⑥ WOUND Care
	(b)(6)-2 [redacted]

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODU

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4/4/03 1105Z	① ADMIT MCW #1
	② DX: GSW ABD S/P EXLAP & colectomy ? 1° REANASTOMOSIS (3/29/03)
	COPD? H/O ~~pneumonia~~ VENTILATORY Failure
	③ CONDITION: STABLE
	④ VSMS Q SHIFT
	⑤ DIET: Regular
	⑥ Heplock IV
	⑦ > LASIX 20mg IV NOW
(b)(6)-2	> Albuterol / ATROVENT NEBS Q 6°
	> 2L NC O2
	> Levaquin 500mg PO Q DAY
	> Tylenol 650mg Q 4° PRN
	> VICODIN 1-2 TABS Q 8° PRN
	⑧ W → D Dressing c/s Q DAY
4/4/03 1230	P/C Regular Clear liquid DIET

HOSPITAL OR MEDICAL FACILITY | SERVICE | RECORDS MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

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

(b)(6)-4 (b)(3)-1

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

DATE	SYMPTOMS, ~~DIAGNOSIS~~, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/5/03	[ORDERS]
0725z	① HOLD NARCOTICS for NOW
	② KUB (Flat/upright) (b)(6)-2 [redacted]
4/6/03	① D10 LR @ 70cc/°
0500	② Chem 7 now (b)(6)-2 [redacted]
	③ H/H now
	④ ~~NPO for now~~
	Cont Clears
	⑤ AMBULATE TID

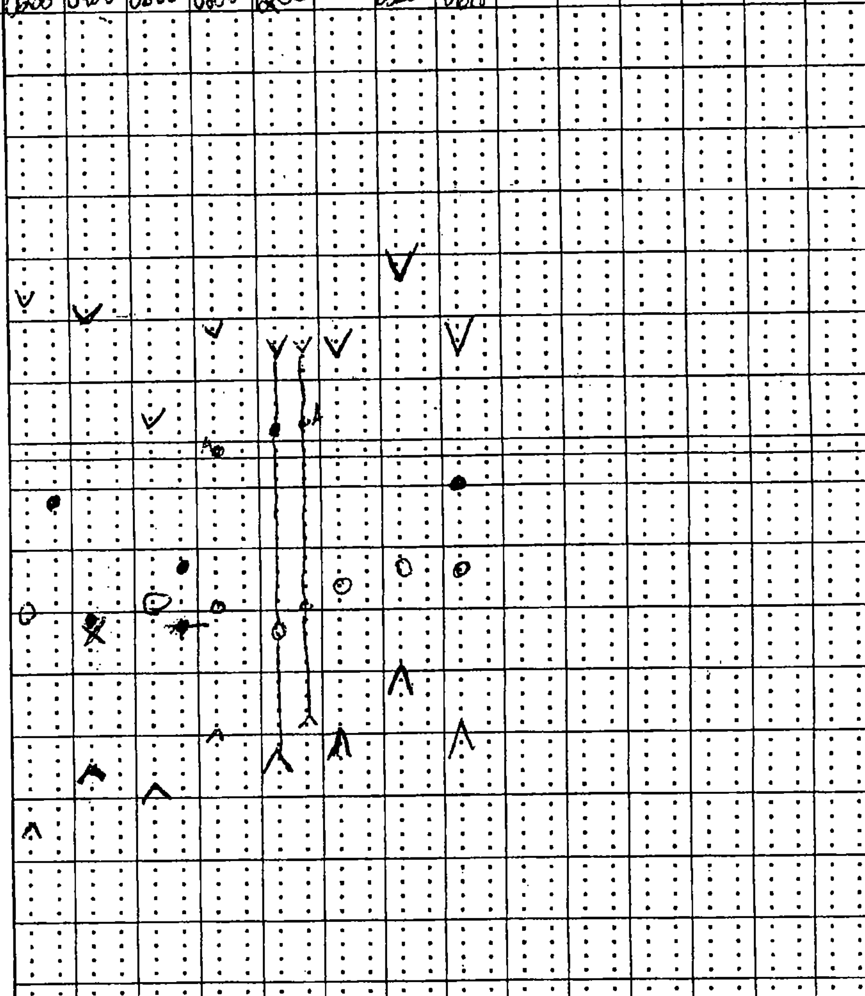
511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY									
POST- DAY									
MONTH-YEAR 10AX / DAY	1APR03				16 / 02Apr		03Apr	04Apr	
19 / HOUR	2200	0400	0608	0800	1200		0325	0615	

PULSE (O) — TEMP. F (•) — TEMP. C

PULSE	TEMP. F	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° / 98.6°	37.2° / 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		



(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered	2200	0400	0608	0800	1200		0325	0615
				147/81	141/77 145/93			
BLOOD PRESSURE PO	1680		95		540		932	872
Urine			550	200	350		1800	
SpO2		97		91	96 90 94			
HEIGHT: WEIGHT →				urine 350				
HR		97	100 101		98 101			
RR		22	24 20		22 24 22			24

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

REGISTER NO.

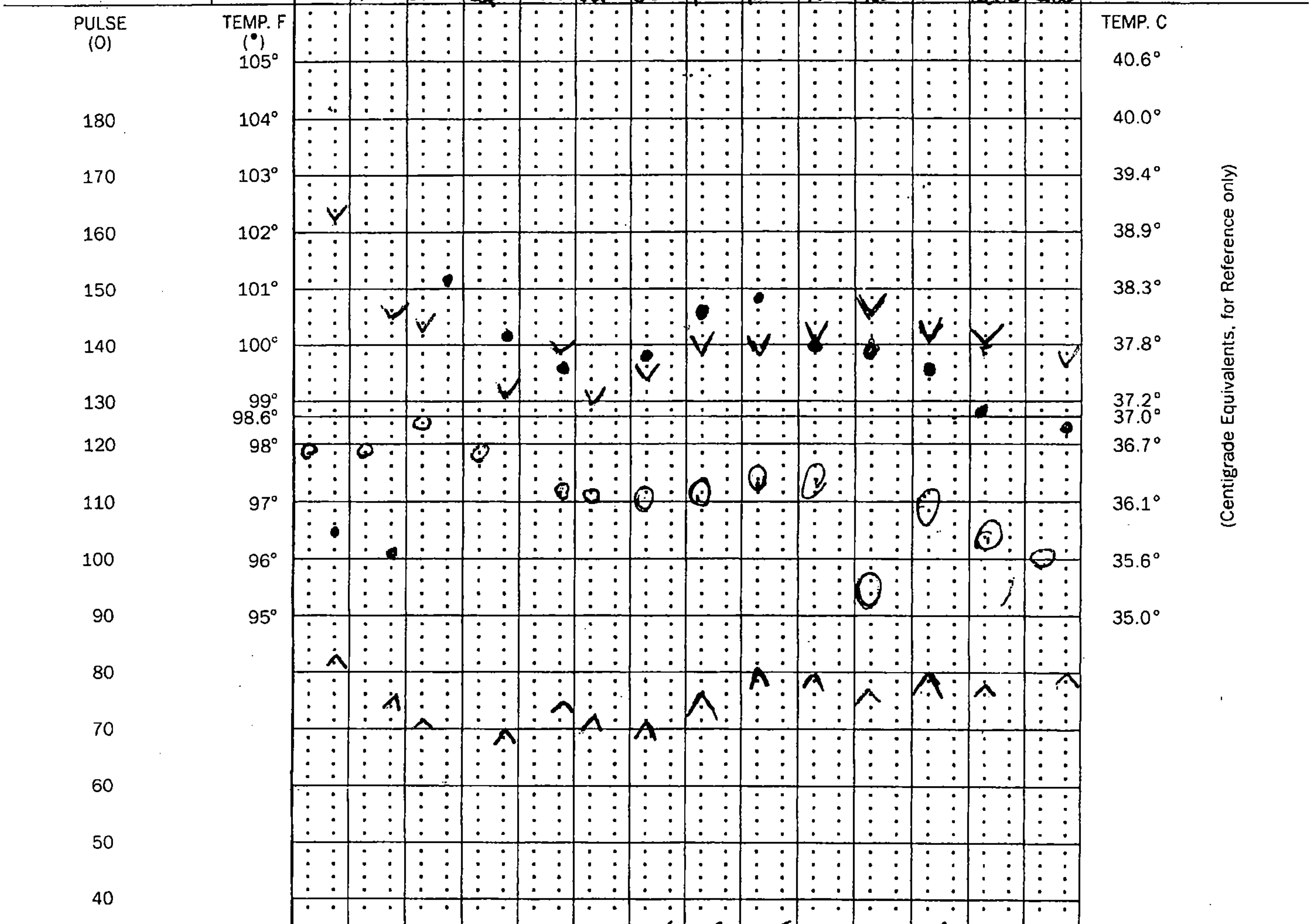
WARD NO.

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

MEDICAL RECORD		VITAL SIGNS RECORD													
HOSPITAL DAY															
POST- DAY															
MONTH-YEAR 29 mar	DAY					31 mar 03		31 MAR 03		31 mar		31 mar		31 MAR 03	
19	HOUR	2000	2200	2400	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200



RESPIRATION RECORD	Rsp	10	15	12	14	16	16	15	15	15	15	20	18	20	24
BLOOD PRESSURE	pulsox	95%	96%	95	96%	96%	96%	96%	96	96	95	96	95		97%
								AC	AC	AC	AC	VENT	VENT		
	RR							RR-15	15	RR 15	RR 15	EXT			
HEIGHT: WEIGHT →	TV							TV-750	750	TV 750	760	/			
	PEEP							PEEP 5	5	PEEP 5	5	/			
	FIO2							FIO2 21	21	FIO2 21	21	/			
Urine														350	

Record special data only when so ordered

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

STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 6022

CHEM I

RESULTS	REQUESTED	(X)
138	GLUCOSE	
11	UREA N.	
	CREATININE	
	URIC ACID	
142	SODIUM	
5.3	POTASSIUM	
106	CHLORIDE	
38	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

SPECIMEN TIME 1535 A.M. P.M.
DATE

REMARKS

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

(b)(6)-4

MD (b)(6)-2 TECH

DATE 1 Apr 03

LAB. ID. NO.

URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE ☐ BLOOD ☐ OTHER (Specify)

SPECIMEN/LAB. RPT. NO

PATIENT'S MED. RECORD

546-107

MISCELLANEOUS

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

557-107

SPECIMEN TAKEN DATE 30 Mar 03 TIME 2040 A.M. P.M.

TEST(S) REQUESTED

RESULTS

TCO2 (34)
PCO2 63.3
PO2 88
HCO3 32
ph 7.309
FiO2 .30

REMARKS 63+

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE Dr (b)(6)-2

REPORTED BY

(b)(6)-4

MD (b)(6)-2 TECH

DATE 30 Mar 03

LAB ID NO.

MISC URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT NO.

PATIENT'S MED. RECORD

MISCELLANEOUS

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

557-107

SPECIMEN TAKEN DATE 30 Mar TIME 1010 A.M. P.M.

REQUESTED

RESULTS

ph 7.381
PCO2 52.6
PO2 84
HCO3 31
BEecf 6
FiO2 .30

REMARKS 63+

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE Dr (b)(6)-2

REPORTED BY

(b)(6)-4

MD (b)(6)-2 TECH

DATE 30 Mar 03

LAB ID NO.

MISC URGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT NO.

PATIENT'S MED. RECORD

MEDCOM - 6023

NSN 7540-01-165-7294

519-30

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

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

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

Distended abdomen; s/p GSW to abd c exploratory lap;

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)
7 Apr 03	7 Apr 03	

RADIOLOGIC REPORT

- markedly suboptimal exam 2° pt body habitus and portable technique
- Abdomen markedly distended and opaque, may reflect ascites
- Air seen within non-distended descending colon

(b)(6)-2

(b)(3)-1

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

(b)(6)-4

FOREIGN NATIONAL

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4		07 April 03 — 1200 HOURS	
	1	admit ICU-5	
	2	D(x) s/p Ex Lap; bleeding	
	3	vitals q 1hr	
	4	O_2 to keep SO_2 > ~~92%~~ 90%	
	5	notify MD abnormal vitals	
NURSING UNIT / ROOM NO. / BED NO.	6	IVF = D5NS @ 100cc/hr	
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ____ HOURS	
(b)(6)-4	7	NPO	
	8	Morphine 1-5 mg IV q 1hr	
	9	I+O	
	10	albuterol/atrovent nebs	(b)(6)-2
		q 1hr prn	
NURSING UNIT / ROOM NO. / BED NO.	11	Zantac 50mg IVPB q 8hrs	
	12	Heparin	1330 [illegible]
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ____ HOURS	
(b)(6)-4	13	Acute abdominal series	
		rule out SBO	
		(b)(6)-2	
		(b)(6)-2 MD	
		(b)(3)-1	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER 7 April '03 / TIME OF ORDER 1852 HOURS	7
	1)	Clarify Heparin order	1850
		Heparin 5000 u BID	(b)(6)-2
	2)	Tylenol 650 mg po [illegible]	
	3)	Clear liquid diet	[illegible]
	4)	Δ IVF to KVO 100 cc/hr	
NURSING UNIT / ROOM NO. / BED NO.		(b)(6)-2	

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER 1440 HOURS | LIST TIME ORDER NOTED AND SIGN

① Δ Albuterol 2.5mg / 3cc NSS to Albuterol 2.5mg / 0.5mg Atrovent Q4

V.O. Dr. (b)(6)-2 [redacted]

03APR03 / 0535 (b)(6)-2 [redacted] 3Apr/1V36

① wean O2 to sat ≥ 80% (b)(6)-2 [redacted] (b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER 03APR03 / 0840 HOURS

Δ IVF to D10LR @ 125/h (b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 4APR03 | TIME OF ORDER 0410 Z HOURS

① D/C Foley ē dom

② Transfer to minimal care p̄ voiding

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

(b)(3)-1 [redacted]

NURSING UNIT ICU-2 | ROOM NO. | BED NO. 1

DATE OF ORDER 4-4-03 | TIME OF ORDER HOURS

① V/O V/s q 8 per Dr (b)(6)-2 [redacted] 2 mls (b)(6)-2 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30 March 2003 TIME OF ORDER: 1445 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Δ Versed to Valium 2-5mg IV q4h prn agitation

(2) Valium 10mg IV q6 prn agitation

(3)

[redacted]

Noted [redacted] 3 Mar

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: 2030 HOURS

Δ Valium to 10mg IV q4h prn

[redacted]

Noted 30 Mar 03 [redacted] CPT, AN

Chart ✓ 31 Mar 03 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

Chart ✓ 31 Mar 03 2200 [redacted] CPT, AN

1 April 2003

Δ Dressing change wet to dry qd

[redacted]

Noted [redacted] 1 APR

PATIENT IDENTIFICATION [redacted]

[redacted]

NURSING UNIT: ICU-1 | ROOM NO. | BED NO. 1

DATE OF ORDER: 1 April 2003 TIME OF ORDER: 1330 Z 1630 local HOURS

Give Albuterol nebs q4h

D/C Imipenem

(1) Rocephin 1gm IV qd ✓ — 1 stat & tonite @ 1800

(2) Cipro 400mg IV BID ✓

(3) ~~Flagyl~~ (3) Clindamycin 600mg IV tid ✓

(4) P & PD (5) ↑ FiO2 to keep sat above 89%

(5) CXR

[redacted] [redacted]

DA FORM 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE [redacted]

MEDCOM - 6027

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)-4

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	30 MAR 03	1125 HOURS	
1	Admit ICW1 - Gen Surg / (b)(6)-2		
2	S/P Ex lap - Colon resection c 1° anastomosis		
3	Stable		
4	VS q 1° I & O's		✓
5	NKDA		✓
6	Bedrest		✓
7	NC to MWS		✓

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
8	Foley → gravity HOURS		✓
9	Vent setting : SIMV Rate 12 TV 700		
	Peep 5 FiO2 - wean to keep > 93%		✓
10	NPO		✓
11	LR @ 125 cc/hr		✓
12	MSO4 1-2 mg IV q 1-3° PRN pain		✓
13	Versed 1-2 mg IV q 1-2° PRN sedation		✓
14	Unasyn 3.0 gm IVPB q 6° - 1st now		✓

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
15	Albuterol neb q6 PRN HOURS		✓
16	Heparin 5000 u SQ q 12°		✓
17	Zantac 50 mg IVPB q 8°		✓
18	Notify MD for T > 102 P > 130 < 60		✓
	SBP > 170 < 110 UOP < 30 cc/hr for		✓
	2 consecutive hrs		(b)(6)-2
	(b)(6)-2 MD		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	30 MAR 03 1430	(b)(6)-2 HOURS	MAJ, MC
0	Bolus T Later LR IVF now.	(b)(6)-2	1630 30 MAR 03
	Verbal Order Dr (b)(6)-2	(b)(6)-2 (b)(6)-2	

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

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. Mar Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR.	DATE DISPENSED 30 31 / 2 3 4
30	(b)(6)-2	LR @ 125 cc/hr	07 15 19 23	(b)(6)-2 (b)(6)-2 DC 4-3-03
30	(b)(6)-2	Unasyn 3.0 gm IVPB q6° (first now)	06 12 18 24	(b)(6)-2 (b)(6)-2 Del 1 APR 03 1340 Z
30	(b)(6)-2	Heparin 5000 u SQ q12° Z03 Z15	06 18	(b)(6)-2 (b)(6)-2
30	(b)(6)-2	Zantac 50 mg IVPB q8° Z03 Z11 Z19	06 14 22	(b)(6)-2 (b)(6)-2 (b)(6)-2
1 APR 03	(b)(6)-2	Rocephen 1 Gm IV qd Z11	14	(b)(6)-2
1 APR 03	(b)(6)-2	Ciprofloxacin 400 mg IV BID Z03 Z15	03 15	(b)(6)-2 (b)(6)-2
1 APR 03	(b)(6)-2	Clindamycin 600 mg IV Z23 TID Z07 Z15	02 10 18	(b)(6)-2 (b)(6)-2 (b)(6)-2
01 APR 03	(b)(6)-2	T, Stat O2 to Keep Sats > 89%	07/15 19/23	(b)(6)-2 M
1 APR	(b)(6)-2	Alternate Wds q4°	03 07 11 15 19 23	(b)(6)-2 (b)(6)-2

ALLERGIES: ☐ YES ☑ NO
NKA

PRIMARY DIAGNOSIS:
? GSW @ PA
SIP Ex Lap - Colon resection & 1° anastomosis

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

PATIENT IDENTIFICATION:
(b)(6)-4
(b)(3)-1

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 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

Mo. MAR / APR Yr. 03

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
30	(b)(6)-2	MSO4 1-2MG IV q 1-2° PRN Pain	2MG 1220, 2mg 1430, 2MG [illegible], 30mar 1910, 4mg [illegible], 2mg [illegible] … 0210 (b)(6)-2
30		Versed 1-2mg IV q1-2° PRN Sedation	1mg [illegible], 1.5mg 1335, 1.0mg 1430, 2.0mg [illegible] (b)(6)-2 DC
30		Albuterol Nebs PRN	1 APR (b)(6)-2 1220
30		Valium 2-5mg IV q4° PRN agitation	1700 2mg (b)(6)-2 30mar, 1830 3mg (b)(6)-2 30 Am, 0300 5mg (b)(6)-2, 0900 2.5mg 31 mar, (b)(6)-2 5.0mg 31 mar, 2140 5mg (b)(6)-2, 1 APR, 5 … (b)(6)-2
30		Vecuronium 10mg IV q6° PRN agitation	10mg IVP 30 Mar (b)(6)-2 1515, [illegible] DC
30		Vecuronium 10 mg IV qh prn	0330 10mg 30 mar, 0400 30 mar 10mg, 1300 30 mar 10mg, 0530 30 mar 10mg, 0705 31 mar 10mg, 5 mg 31 mar 11 [illegible] DC S/P extubation [illegible]
31		MSO4 1-2mg IV q 1-2° PRN Pain	1 APR (b)(6)-2, [illegible] (b)(6)-2, [illegible] (b)(6)-2, [illegible] (b)(6)-2 2230

*U.S. GPO: 1998-454-110/95216

MEDCOM - 6030

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. 3 Yr. 03

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	31	1	2	3	4								
30 mar	(b)(6)-2	Vital Signs q2° ē I/O's	07 19	(b)(6)-2													
		Notify MD T>102, P>120 <60	19 07	(b)(6)-2		(b)(6)-2											
		SBP >170 <110, UOP < 30cc/hr x2°															
30 mar		Bedrest	07 19	(b)(6)-2													
			19 07														
mar 30		NG to LIWS	07 19	(b)(6)-2			D/C 31 mar 03										
			19 07	(b)(6)-2													
30 mar		Foley to Gravity	07 19	(b)(6)-2			D/Ced 4/1/03										
			19 07	(b)(6)-2	/	(b)(6)-2											
mar 30		Vent: SIMV Rate 12	07 19	(b)(6)-2		D/C 31 MAR 03											
		TV - 700	19 07	(b)(6)-2													
		PEEP - 5															
mar 30		FiO2 - wean to keep >92%	07 19	[illegible]	[illegible]	D/C 31 MAR 03											
			19 07	JF													
mar 30		NPO for Diet	07 19	(b)(6)-2													
			19 07														
31 mar		Dressing Δ Oday Wet to dry	08	/	/	(b)(6)-2											
01 APR		Percussion & Postural Drainage	07/19	/	/	(b)(6)-2											
		(PPD)	19/07	/	/												

ALLERGIES: ☐ YES ☑ NO
NKA

PRIMARY DIAGNOSIS: S/P Ex Lap - Colon Resection ē 1° anastomosis 2° ē GSW Ⓡ FA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:
(b)(6)-4
(b)(3)-1

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.

(b)(6) MEDCOM - 6031

...cRAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. MAR Yr. 03

Verify by Initialing

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
30 MAR 03	(b)(6)-2	Admit to ICU/ Gen Surgery (b)(6)-2	30	1150	1150	
		Condition Stable				
01 APR		CXR AP Portable	01 APR	now	1345 Z	(b)(6)-2
01 APR		ISTAT @ 1800 hr	01 APR	1800 (L)		

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

*U.S. GPO: 1998-454-110/95216

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. 03

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 7 8
7Apr03	(b)(6)-2	Zantac 50mg IVPB q8	11	(b)(6)-2
			19	
			03	
7Apr03		IVF @ 100cc/hr LR	07	(b)(6)-2
			19	
7Apr03		NPO	07	NPO
			19	
7Apr03		Heparin 5000U bid	11	07 (b)(6)-2
			23	
7Apr03		Diet: Clear liquid	07	(b)(6)-2
			19	(b)(6)-2

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: GSW to abd: E ex lap

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: (b)(6)-4

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
7 Apr	(b)(6)-2	Albuterol/Atrovent inhaler/Neb tx q 1hr prn	7 Apr 1030; 7 Apr 1310; 7 Apr 1640
.....	.....		
7 Apr	(b)(6)-2	MS04 1-5mg q 1hr prn	7 Apr 1100 5mg; 7 Apr 1230 5mg; 7 Apr 1645 2mg; 7 Apr 1945 3mg; 8 Apr 0750 5mg
.....	.....		
.....	.....	Tylenol 650mg PO prn	(b)(6)-2 7 Apr 650mg
.....	.....		(b)(6)-2
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		

M RECORD - SUPLEMENTAL MEDI(A [redacted]

r use of this form, see AR 40-66; the propo. ...ncy is the Office of the Surgeon General

EPORT TITLE

TRAUMA FLOWSHEET

OTSG APROVED *(Date)*

INITIAL ASSESSMENT ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL

ate: 30 mar 08 Arrival Time: 1120 Sex: (M) F Age: _____ Wt: _____

llergies: _____ Tetanus Status: UTD Unknown

MP: Last Meal:

hief Complaint:

MH: Medications:

reatments PTA:

ITAL SIGNS: 1125 BP: 144/86 P: 113 RR: BVM TEMP: SAO_2: 92

HEST
RAUMA ☐YES ☐NO
AIN ☐YES ☐NO
OB ☐YES ☐NO
UNG SOUNDS
R L
☐ ☐ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECREASED
☐ ☐ ABSENT

SKIN
☐ WARM ☐ DRY ☐ PALE ☐ DUSKY ☐ MOIST

ABDOMEN
☐ SOFT ☐ DISTENDED ☐ TENDER
BOWEL SOUNDS
☐ YES ☐ NO
GUIAC TEST
☐ POS ☐ NEG

NEURO
PERRL ☐ YES ☐ NO R_____mm L_____mm
GLASCOW SCORE:_____

PUPIL SIZES: 2 3 4 5 6 7 8 9

GLASCOW COMA SCALE

1. EYE OPENING	2. VERBAL RESPONSE	3. MOTOR RESPONSE
Spontaneous - 4	Oriented - 5	Obedient - 6
To Voice - 3	Confused - 4	Purposeful - 5
To Pain - 2	Inappropriate - 3	Withdrawal - 4
None - 1	Incomprehensible - 2	Flexion - 3
	None - 1	Extension - 2
		None - 1

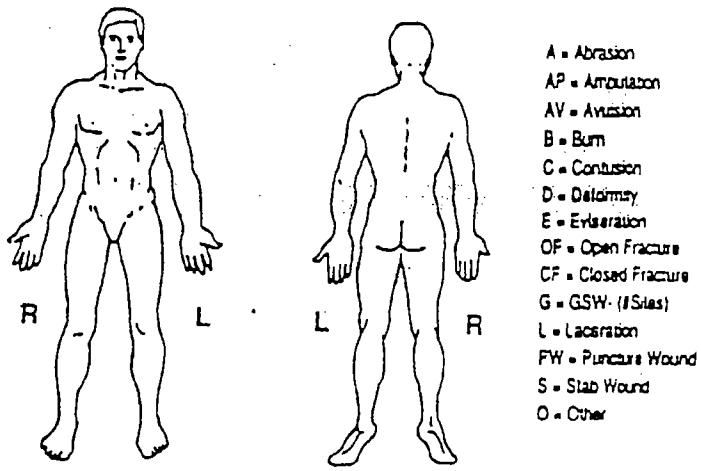
XTREMETIES
] DISTAL PULSES
] RT X 2 ☐LT X 2
MOVES EXTREMETIES X 4
NO EDEMA
NO DEFORMITIES

XCEPTIONS TO BOVE ARAMETERS:

REATMENTS:

SPLINTS:

2: LPM NC MASK ORAL AIRWAY
TT # MM NASAL AIRWAY
IONITOR ☐Y ☐N EKG ☐Y ☐N
IG TUBE #
OLEY: # DPL ☐ POS ☐ NEG
HEST TUBE ☐R ☐L CM H20



A = Abrasion
AP = Amputation
AV = Avulsion
B = Burn
C = Contusion
D = Deformity
E = Evisceration
OF = Open Fracture
CF = Closed Fracture
G = GSW - (# Sites)
L = Lacsration
PW = Puncture Wound
S = Slab Wound
O = Other

(Continue on reverse)

REPARED BY *(Signature & Title)* DEPARTMENT/SERVICE/CLINIC (b)(3)-1 DATE

ATIENT'S IDENTIFICATION *(For typed or written ntries give: Name - last; first; middle; grade; date; ospital or medical facility)*

(b)(6)-4

(b)(3)-1

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

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.*____ *Yr.*____

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6
4-4-03	(b)(6)-2 [redacted]	~~Δ IV fluids to Dlock~~	07	(b)(6)-2 [redacted]		
	-----	Heplock	14	/		D/C
4-4-03	(b)(6)-2 [redacted]	VS q 8	06	/	(b)(6)-2 [redacted]	
	-----		14		(b)(6)-2 [redacted]	
	-----		22			
4-4-03	(b)(6)-2 [redacted]	Albuterol 2.5mg / 0.5mg atrovent	10	(b)(6)-2 [redacted]		
	-----	q6	16			
	-----		22			
	-----		04	(b)(6)-2 [redacted]		
4-4-03	-----	Levaquin 500mg QD po	1100	(b)(6)-2 [redacted]		
4-4-03	-----	2L NC O2 keep O2 sat 90%	0400			
	-----		1600		(b)(6)-2 [redacted]	
~~4/4/03~~	-----	~~Regular Diet~~				D/C

4/6/03	-----	D10 LR @ 70cc/hr	D	/		(b)(6)-2 [redacted]
	-----		N	/		
4/6/03	-----	Clear Liquid Diet	D	/		(b)(6)-2 [redacted]
	-----		N	/		

ALLERGIES: ☐ YES ☐ NO | PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

(b)(3)-1 [redacted]

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

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4

DIAGNOSIS:

DATE: 4-7-03

PATIENT ACUITY: HOSPITAL DAY: POST OP DAY:

	TIME:	1900	2000	21	22	23	24	01	02	03	04	05	06
VITAL SIGNS	BP ARTERIAL LINE												
	BP CUFF	140/70				142/76				142/72			
	MAP												
	TEMPERATURE	100.4				98.1				99.3			
	PULSE	96				78				100			
	RESPIRATIONS	26				26				28			
	PULSE OXIMETER	87	97	90	92	92				92			
	CVP	Before TX	after TX			TX done							
	PAIN (0 – 10)	7 pain											
			3 mg Morphine							Abd discomfort			
RESPIRATORY	OXYGEN (L/%)	4L	"	"	"	4L				4L			
	O2 METHOD	Mask	"	"	"	Mask				Mask			
	VENT SETTINGS:												
	FIO2												
	MODE												
	TV												
	RATE												
	PEEP												
	PS												
	Respiratory Treatments												

Oxygen Method Key: NC = Nasal cannula NR = Non-rebreather FM = Face mask VM = Venturi mask V = Ventilator TC = Trach collar

Respiratory Treatment Key: HHN = Hand-held nebulizer MDI = Metered-dose inhaler CPT = Chest physiotherapy IS = Incentive spirometer

	TIME:	1900	2000	2100	22	23	24	01	02	03	04	05	06
INTAKE	IV	100	100/200	100/300	100/400	100/500	100/600	100/700	100/800	100/900	100/1000	100/1100	100/1200
	PO												
	TOTALS												
OUTPUT	URINE												
										175			150/325
	STOOL												
	TOTALS												

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4

DATE: 4-7-03 / 4/8/03

	TIME:	07	08	09	10	11	12	13	14	15	16	17	18
VITAL SIGNS	BP ARTERIAL LINE	140/88											
	BP CUFF												
	MAP												
	TEMPERATURE	98.0											
	PULSE	104											
	RESPIRATIONS	~~18~~ 20											
	PULSE OXIMETER	92%											
	CVP												
	PAIN (0 – 10)												
RESPIRATORY	OXYGEN (L/%)	4L											
	O2 METHOD	MASK											
	VENT SETTINGS:												
	FIO2												
	MODE												
	TV												
	RATE												
	PEEP												
	PS												
	Respiratory Treatments												

24 HOUR I & O: TOTAL IN _____ TOTAL OUT _____

	TIME:	07	08	09	10	11	12	13	14				
INTAKE													
	PO												
	TOTALS												
OUTPUT	URINE	400											
	STOOL												
	TOTALS												

MEDICAL RECORD - ICU FLOWSHEET

SECTION I - PATIENT ASSESSMENT DATA

PATIENT NAME: (b)(6)-4 DATE: 4-7-08

IV SITE ASSESSMENT:

LEGEND: WNL = NO REDNESS/SWELLING/OTHER S/S INFILTRATION/INFECTION
R = REDDENED P = PUFFY I = INFILTRATED CL = CENTRAL LINE

	LOCATION	CONDITION
IV SITE # 1	(L) Art Q.	wnl (positional)
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED	1900	THD
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS:

	LOCATION	CONDITION
IV SITE # 1	(D) AC	patent
IV SITE # 2		
IV SITE # 3		

	TIME	INITIALS
IV PATENCY CHECKED	0700	(b)(6)-2
IV SITE CARE PROVIDED		
IV TUBING CHANGED		

COMMENTS:

AM STRIP

PM STRIP no Propag

SECTION III - SHIFT NOTES

1930 Pt c/o pain to Abd (b)(6)-2
Pt was given 3mg Morphine IVP
2000 Pt states no Abd pain but pressure or tightness (b)(6)-2
2100 Pt resting i eyes closed (b)(6)-2
2300 Heparin 5th Q to Abd LLQ 5000u (b)(6)-2
0300 Pt c/o ↑ discomfort to Abd but not pain. Pt waves hands out from Abd as if saying Abd is tight. Pt now responds to palpation of Abd as tender, but it is noted Abd. is not firmer. (b)(6)-2
0340 Benadryl 25mg for rest (b)(6)-2
0315 M.D. on call ordered Benadryl for rest. MD was updated on status. (b)(6)-2
0430 Ambien 5mg P.O. one time now given for difficulty in sleeping (b)(6)-2

ICAL RECORD - ICU FLOWSHE

SECTIO.. - PATIENT ASSESSMENT DATA - REVIEW OF S..EMS

PATIENT NAME: (b)(6)-4

DATE: 4-7-03 / 8APR03 0700

	TIME: 1930 INITIALS: 7AO	TIME: 0700 INITIA (b)(6)-2
NEUROLOGICAL Alert and Oriented to time, place and name; Responds appropriately; Communication is adequate to express needs; Pupils equal and reactive to light.	A+O x 3 PERRLA needs translator	A+Ox3 PERRLA needs translator
CARDIOVASCULAR Age appropriate Rate, Rhythm, and Pulses; Capillary refill < 3 sec; No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. Pressure monitoring	Heart - RRR Ⓒ murmur Cap R. 3sec no edema,	RRR . S1 S2 cap refill brisk 2-3sec. no edema
PULMONARY Respirations within normal limits for age; Breath sounds quiet and regular; Depth is regular; No dyspnea; No cough; Suction; Secretions; Oxygen; ETT; Trach	Mild labor breathing Rhonchi & wheezing. B/L to lungs - SaO2 87 to 90	inspiratory wheezes this AM. RT doing tx. mild labored breathing. O2 mask 4L O2 Sats 92%. this am
G.I. Abdomen soft and non-distended; Bowel sounds active in all quadrants; No difficulty chewing or swallowing; No abdominal pain; Frequency and type of stool; No diarrhea; No constipation; No N/V; NG Tube placement; Type of secretions	Minimal Bowel sounds, Nontender, soft, Abd. mild Abd pain. No drainage to dressings	Ø BS asculated. NO aware. ABD distended + firm. ML ABD dsg - CDI - RLQ dsg CDI.
G.U. Voiding; Catheters; Urine clear yellow/amber No odor, discharge, frequency, urgency, nocturia	Dark amber urine Minimal output.	DTV this am
MUSCULOSKELETAL: Normal muscle mass and development for age; No deformities; No assistive devices needed; Normal movement and tone; Normal active ROM without pain; No joint swelling, tenderness, weakness, or paresthesia	Full ROM to all extremities. = strength to Arms & legs no paresthesia	MAE 5 diff.
SKIN Color; warm; dry; intact; Turgor; No Wounds; lesions; rashes, inflammation, ulcers, breaks in skin; No redness, blanching, irritation, over bony prominences; Mucous membranes moist; Wounds – location, condition, drainage, dressing	Dry & Intact	warm dry + intact
PAIN No complaints of pain/discomfort; Note Location; Duration; Intensity	Mild pain to Abd.	mild pain to abd.
PSYCHOSOCIAL: Behavior is appropriate to the situation; Anxiety is controlled or mild and appropriate to the situation; Interacts appropriately with others		

MEDCOM - 6040

3500
500
400

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2MAR03	OP Note
1700	Preop Dx: Abdominal GSW, umbilical hernia, (R) Forearm GSW
	Postop Dx: • Abdominal GSW ± Colotomy x2
	• umbilical hernia, Nodular deposits on Anterior parietal peritoneum & Mesentery c/w Metastatic CA with No obvious Intra-abdominal 1°
	• Superficial (R) Forearm GSW
	Procedure: Exploratory Laparotomy ± oversew (R) colon Seromuscular Injury
	Resection of Mid Transverse Colon
	Surgeons: (b)(6)-2 / (b)(6)-2
	Anesthesia: (b)(6)-2 / (b)(6)-2 / (b)(6)-2
	Findings: • Seromuscular Injury (R) Colon - oversewn
	• Large Transverse Colon Injury (thru & thru) ± adjacent Mesocolic Hematoma & minimal contamination - resected & 2 layer anast performed
	• Nodular deposits on anterior parietal peritoneum & at root of SI Mesentery (both isolated) c/w Metastatic CA VRS Granulomatous Dz (NO evidence of Intra-abd 1° CA seen)
	• umbilical hernia - closed ± Midline Fascial closure
	• Superficial GSW to (R) posterio-lateral, proximal Forearm with No evidence of Fx or Vascular compromise - irrigated & dressed
	Complications: ∅
	EBL: 500cc (400cc cell, 100cc intraop) UOP: 400cc
	Fluids: 3500 cc NS

(b)(6)-2 MD

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

ATIENT'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.

DLAQI CIV. DOB ~50YO

(b)(6)-4 (b)(3)-1

29 MAR03 @ 1419-

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3/29/3	Surg
1830	S- Pt extubated + resting quietly currently. HR trending up along c̄ RR over last 20 minutes. UOP good at 300 cc since OR.
	O- Lungs - (B) rhonchi, O_2 sat 95% on 6L face mask
	Cardiac - tachy c̄ RR
	Abd - dressing C, D, I
	Ext: (R) Forearm soft c̄ 2/2 Radial pulse + clean dressing
	A/P- Tachycardia prob 2° to post-op pain. Will medicate + follow Resp + HD status closely.
	(b)(6)-2 [redacted] MD
3/29/03	NSG Pt A/O x O O_2 7L/P NRBM. O_2 Sat 95%. NG intact to INT Low suc.
1845	Foley intact. 300cc Clear yellow urine p̄ op. BP 139/75, Drsg to midline abd
	D/I, Drsg to (R) FA D/I. MSO_4 5mg IV done —— (b)(6)-2 [redacted]
3/29/3	Surg
1900	Over the last ½ hr pt ~~has~~ has become ↑ingly tachypneic c̄ RR in high 30s currently. VBG obtained which revealed significant Resp Acidosis c̄ pH 7.1 pCO_2 80.
	We will ∴ move to reintubate pt expediently.
	~~Hgb~~ Hct 46 141/5 Ca I 4.7
	Pt is reportedly a heavy smoker + his post-op Resp Failure may at least in part be 2° to this.
	(b)(6)-2 [redacted] MD
3/29/03	RSI Meds: Vecuronium 5mg IVP, Succinylcholine 200mg IVP, Ketamine 75mg IVP.
1915	

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

DD FORM FEB 6; 602

REPLACES DD FORM 602
PREVIOUS EDITIONS ARE
REMPLACE DD FORM 602, 1 or OC;
LES ÉDITIONS PRÉCÉDENTS SONT

U.S.GPO: 1992-348-678

PATIENT EVACUATION TAG – FICHE D'ÉVACUATION DE PATIENT
(Tie this tag to patient – Attacher cette fiche au patient)

FROM *(Medical treatment facility)*
ORIGINE *(Installation de trai*(b)(3)-1

NAME *(Last–first–middle initial)*
NOM *(Nom de famille–premier prénom–initiale deuxième prénom)*
#(b)(6)-4

SERVICE NUMBER / NUMÉRO MATRICULE	RANK/RATING/GRADE / GRADE	CATEGORY OF PERSONNEL *(Service or employer and nationality)* / CATÉGORIE DE PERSONNEL *(Service ou employeur et nationalité)*
—	—	OD

DIAGNOSIS
DIAGNOSTIC

CLASS–CLASSE		DISEASE / MALADIE	BATTLE CASUALTY / BLESSÉ AU COMBAT	INJURY / BLESSURE
1A	2A X			
1B	2B			
1C		CABIN OR COMPARTMENT NO. / NO. CABINE OU COMPARTIMENT		BUNK NUMBER / NUMÉRO COUCHETTE
3	4			

VSI
TRES GRAV. MAL.
☐ Yes / Oui ☐ No / Non

BAGGAGE TAG NUMBER(S) / NUMÉROS ÉTIQUETTES BAGAGE

DESTINATIO(b)(3)-1
DESTINATIO

SHIP/AC *(Number/type)*
NAVIRE/AVION *(Matricule/type)*

TREATMENT RECOMMENDED EN ROUTE *(If no treatment is required a notation to this effect is made)*
TRAITEMENT RECOMMANDÉ EN ROUTE *(Indiquer si aucun traitement n'est nécessaire)*

SIGNATURE OF MEDICAL OFFICER / SIGNATURE DU MÉDECIN	DATE / DATE

REGULAR DIET / RÉGIME NORMAL	SPECIAL DIET *(Describe)* / RÉGIME SPÉCIAL *(Description)*

SHIP'S RECORD OFFICE TAB – FICHE POUR ARCHIVES TRANSPORTS

FROM *(Medical treatment facility)*
ORIGINE *(Installation de traitement médical)*

NAME *(Last–first–middle initial)*
NOM *(Nom de famille–premier prénom–initiale deuxième prénom)*

SERVICE NUMBER / NUMÉRO MATRICULE	RANK/RATING/GRADE / GRADE	CATEGORY OF PERSONNEL / CATÉGORIE DE PERSONNEL

BAGGAGE TAG NUMBER(S) / NUMÉROS ÉTIQUETTES BAGAGES	DATE OF SHIPMENT / DATE DÉPART
DESTINATION / DESTINATION	ARRIVAL DATE / DATE ARRIVÉE

EMBARKATION TAB – FICHE D'EMBARQUEMENT

DD FORM 1 FEB 61 602

REPLACES DD FORM 602, PREVIOUS EDITIONS ARE REMPLACE DD FORM 602, 1 er OCT LES ÉDITIONS PRÉCÉDENTS SONT L...

U.S.GPO: 1992-318-878

PATIENT EVACUATION TAG – FICHE D'ÉVACUATION DE PATIENT

(Tie this tag to patient – Attacher cette fiche au patient)

FROM *(Medical treatment facility)*
ORIGINE *(Installation de t(b)(3)-1*

NAME *(Last—first—middle initial)*
NOM *(Nom de famille—premier prénom—initiale deuxième prénom)* (b)(6)-4

SERVICE NUMBER NUMÉRO MATRICULE	RANK/RATING/GRADE GRADE	CATEGORY OF PERSONNEL *(Service or employer and nationality)* CATÉGORIE DE PERSONNEL *(Service ou employeur et nationalité)*
—	—	OD

DIAGNOSIS
DIAGNOSTIC

CLASS—CLASSE		DISEASE MALADIE	BATTLE CASUALTY BLESSÉ AU COMBAT	INJURY BLESSURE
1A	2A X			
1B	2B			
1C		CABIN OR COMPARTMENT NO. NO. CABINE OU COMPARTIMENT		BUNK NUMBER NUMÉRO COUCHETTE
3	4			

VSI
TRÈS GRAV. MAL.
☐ Yes Oui ☐ No Non

BAGGAGE TAG NUMBER(S)
NUMÉROS ÉTIQUETTES BAGAGE

DESTINATIO(b)(3)-1
DESTINATIO

SHIP/AC *(Number/type)*
NAVIRE/AVION *(Matricule/type)*

TREATMENT RECOMMENDED EN ROUTE *(If no treatment is required a notation to this effect is made)*
TRAITEMENT RECOMMANDÉ EN ROUTE *(Indiquer si aucun traitement n'est nécessaire)*

SIGNATURE OF MEDICAL OFFICER
SIGNATURE DU MÉDECIN

DATE
DATE

REGULAR DIET RÉGIME NORMAL	SPECIAL DIET *(Describe)* RÉGIME SPÉCIAL *(Description)*

SHIP'S RECORD OFFICE TAB – FICHE POUR ARCHIVES TRANSPORTS

FROM *(Medical treatment facility)*
ORIGINE *(Installation de traitement médical)*

NAME *(Last—first—middle initial)*
NOM *(Nom de famille—premier prénom—initiale deuxième prénom)*

SERVICE NUMBER NUMÉRO MATRICULE	RANK/RATING/GRADE GRADE	CATEGORY OF PERSONNEL CATÉGORIE DE PERSONNEL

BAGGAGE TAG NUMBER(S) NUMÉROS ÉTIQUETTES BAGAGES	DATE OF SHIPMENT DATE DÉPART
DESTINATION DESTINATION	ARRIVAL DATE DATE ARRIVÉE

EMBARKATION TAB – FICHE D'EMBARQUEMENT

Standard Form 508

CLINICAL RECORD — **DOCTOR'S ORDERS** *(Sign all orders)*

DATE AND TIME START	STOP	Rx	DRUG ORDERS (Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s), may be administered UNLESS checked here)	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
29MAR03					
3/29/3 - 1700		(1)	Admit to Postop		
		(2)	Dx: GSW to abd s/p Transverse Colectomy		
		(3)	Condition: Stable		
		(4)	VS: Q 15 minutes x4 then Q 30 minutes x 4 then Q 1°		
		(5)	Activity: Bed Rest		
		(6)	Allergies: NKDA		
		(7)	Nursing: • NG to (I) LWS		
			• Foley to drain to gravity - Notify Dr. (b)(6)-2 a (b)(6)-2		
			a (b)(6)-2 if UOP < 30cc/hr		
			• Leave dry dressing in place		
			• NOK: PT does not speak English		
			• Wean vent to extubation		
			• Continuous pulse ox monitoring - Notify surgeon if O_2 sat		
			<92% on 2L NC		
			• Q 1° x4 pulse ✓ (R) arm - pt should have palpable radial pulse		
		(8)	Diet: NPO		
		(9)	IVF: NS @ 150 cc/hr		
		(10)	Meds: Cefoxitin 1gm IV Q6° x 4 doses then D/C		
			MSO4 5-10mg IV Q 2° prn pain (1-4mg IV q 5min prn pain [illegible]) (b)(6)-2		
			Phenergan 12.5-25mg IV Q 4° prn N/V		
		(11)	Medevac Priority: Priority		
				(b)(6)-2	MD

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give Name—last, first, middle, grade, date, hospital or medical facility) | REGISTER NO | WARD NO

IRAQI CIV. 0> 250410

(b)(3)-1

29 MAR 03

(b)(6)-4

DOCTOR'S ORDERS
Standard Form 508
508-109

General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8
October 1975

CLINICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	DATE AND TIME STOP	Rx	DRUG ORDERS (Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s), may be administered -UNLESS checked here)	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
3/24/13		(1)	~~Abg~~ Initial Vent Settings:		
	1915		AC at 20, TV 650, F_{IO_2} 100%, PEEP 5		
		(2)	Re✓ VBG in 1/2hr		
		(3)	Wean O_2 to 50% gradually; keeping O_2 sat > 92%		
				(b)(6)-2	

☆ GPO : 1984 O - 461-275 (290)

DOCTOR'S ORDERS
Standard Form 508
(Reverse)

Standard Form 508

Progress Notes

CLINICAL RECORD

~~DOCTOR'S ORDERS~~
(Sign all orders)

DATE AND TIME START	STOP	℞	DRUG ORDERS (Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s), may be administered UNLESS checked here)	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
	29 Mar 03		- Pt intubated xlap → RSI		
	1915		DL x2 Noted to Rapidly Desat to 50's		Day Intubated
			In Post Op w/ Nasal Trumpet	Sats 92-95 (RR 30's)	w/ 7 liters
			on Face Mask - Venous (Blood) Gas	Demonstrated	Resp
			Distress PCO2 = 86 -	Reintubation	w/ Sux / Ketamine
			Difficult AW - DL x2	After Two (2)	Mask Mask
			+ ORAL AW Sat's ≈ 50 →	2nd Attempt	w/ Miller 3
			Successful. + ETCO2 + BBS →	Tracheal	Suction
			Sats 100 - ETT at 24 cm at edge of Tube teeth.		
			ME Conyers		
29 MAR 03 2035			Mefoxin 1 gm IVPB given as ordered.	Vecuronium	10 mg IVP
			given as ordered.		(b)(6)-2 [redacted]
3/29/3			SURG		
	2020		Pt is tachycardic + hypercapnia gradually resolving c̄		
			Ventilatory support (AC at 20, TV 800, PEEP 5, FiO2		45%
			pH 7.29/42.8 pCO2 on VBG.		
			The pt appears to have significant	COPD + will	probably
			require significant pulm toilet, etc...	post-op.	
			? Lung CA as explanation of	peritoneal seeding	
			Rec'd CXR on arrival to next level of care.		
				(b)(6)-2 [redacted]	MD

(Continue on reverse side)

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

REGISTER NO	WARD NO

DOCTOR'S ORDE
Standard Form 5
508-109

General Services Administration and Interagency Committee on Medic
FPMR 101-11.806-8
October 1975

508-111

NSN 7540-00-6

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
29 MAR 03			Admit → ICU		
2050 (b)(6)-2			S/P Ex lap GSW abd c̄ colon resection		
			② Resp failure / CO_2 retention		
			fair cond NPO		
			ICU routine vitals. Monitor		
			NGO (?)		
			Nursg: NG → LCWS, Drygauze → abd incision,		
			RCQ GSW, forearm GSW	Δ PRN	
			foley → gravity		
			IVF LR or NS at 100 cc/h		
			Meds Mefoxin 2g IV q 8° x 3 doses		0100 1700 0900
			MSO4 5-10 mg IV q 1° PRN		0100 1700 0900
			Valium 5 mg IV q 2-4° PRN		
			Zantac 50 mg IV q 12°		
			albuterol nebs prn		
			CXR		
			Ⓡ forearm xray r/o fx		
			vent SIMV 10/800/21% FiO_2	(b)(6)-2	
			Vecuronium 5 mg IV x 1	(b)(6)-2	[illegible] mc
0001 30MAR03			Pt in ICU, activated above orders, pt muscle relaxed c̄ Vec, sedated c̄ Valium 5 mg [illegible] pain relief c̄ MSO4 5 mg IVP, pupils constricted, BS [illegible] bilat on vent, minimal bile drainage from NGT; ST, S_1-S_2, palpable pulses x 4 extremities, ABD drsg C/D/I, Ⓡ arm drsg min drainage, foley intact –		

(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)-4

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)

Trauma Resuscitation Form

N (b)(6)-4	SSN:
Date and time of injury: 29 Mar 03	Date and time of arrival: 29 Mar 03

Chief complaint: S/P Evac OSW Hand (FRSS)

Pre-hospital information

Mechanism of injury:
- ☑ Gunshot wound
- ☐ Stabbing
- ☐ Burn
- ☐ Chemical casualty
- ☐ Other: _____

Procedures before arrival
- ☐ Airway: type _____ size # _____
- ☐ O_2 @ _____ L/min via _____
- ☐ IV's: location and # _____
- ☐ Chest tube: location _____ size # _____
- ☐ Splints: Type _____
- ☐ Medications: _____
- ☐ Chemical casualty:
  - ☐ Decontamination date/time: _____

	Dosage	Date/time
☐ Atropine:		
☐ 2-PAM:		
☐ Other:		

☐ Other procedures: _____

AMPLE history

Allergies:

Medications:

Past illnesses: Heavy smoker ? COPD

Last meal: Last Tetanus:

Events:

Initial assessment

Airway
- ☐ Patent
- ☐ Obstructed

Breathing
- ☐ Normal
- ☐ Labored
- ☐ Symmetrical
- ☐ Asymmetrical

Trachea midline? ☐ Yes ☐ No

Breath sounds:	Right	Left
Present	☐	☐
Clear	☐	☐
Decreased	☐	☐
Absent	☐	☐
Rales/Rhonchi	☐	☐

Crepitus: ☐ Yes ☐ No

Initial assessment

Circulation

Skin/mucous membrane color:
- ☒ Pink
- ☐ Flushed
- ☐ Pale
- ☐ Jaundiced
- ☐ Ashen
- ☐ Cyanotic

Skin temperature:
- ☒ Warm
- ☐ Hot
- ☐ Cool

Skin moisture:
- ☒ Normal
- ☐ Dry
- ☐ Moist

Pulses:

	Carotid R	Carotid L	Radial R	Radial L	Femoral R	Femoral L
Normal	☐	☐	☑	☒	☐	☐
Bounding	☐	☐	☐	☐	☐	☐
Weak	☐	☐	☐	☐	☐	☐
Absent	☐	☐	☐	☐	☐	☐

Disability

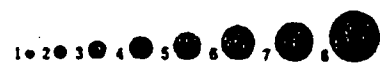
Glasgow Coma Scale (circle appropriate scores):

		Score:
1. Eye opening:	Spontaneous	4
	To voice	3
	To pain	2
	None	1
2. Verbal:	Oriented	5
	Confused	4
	Inappropriate words	3
	Incomprehensible words	2
	None	1
3. Motor:	Obeys commands	6
	Localizes to pain	5
	Withdrawls to pain	4
	Flexion	3
	Extension	2
	None	1

Total GCS _____

Pupillary response

Pupil reaction:	Right	Left
Brisk	☐	☐
Constricted	☐	☐
Sluggish	☐	☐
Dilated	☐	☐
Nonreactive	☐	☐
Size	___mm	___mm



Trauma Resuscitation Form

Physical examination:

Age (years):_____ Height (inches):_____ Weight (kg's):_____

Head, eyes, ears, nose, throat:

Neck: Intubated, sedated

Chest: Equal, rhonchorous breath sounds

Back: (—)

Cervical/Thoracic/Lumbar spine: (—)

Abdomen: Midline laparotomy, incision, RLQ GSW

Perineum and rectum:

Extremity: (R) forearm GSW

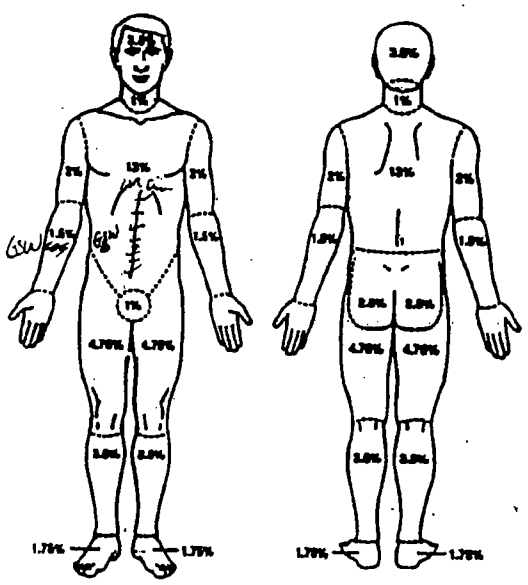
Skin: Warm

Neurologic: sedated, chemically paralyzed

Other:

Diagram for documenting injuries
(Identify injury site by number)

1. Laceration
2. Abrasion
3. Hematoma
4. Contusion
5. Deformity
6. Fracture
7. GSW(s)
8. Stab wound(s)
9. Pain
10. Cold injury
11. Edema
12. Amputation
13. Avulsion
14. Burn
15. Other (Describe)



(With permission from JB Lippincott Company. After Deming RH. Burns. In: Greenfield LJ, Mulholland MW, Oldham KT, and Zelenock GB, eds. Surgery: Scientific Principles and Practice. Philadelphia, JB Lippincott Company, 1993.)

Trauma Resuscitation Form

Procedures performed by trauma team		Medications			
Time:	Procedure:	Time:	Drug:	Dosage:	Route:
		2030	VERSED	2½ mg	IV
		2032	VECURONIUM	10 mg	IV

ZULU TIME

Vent set
TV 800
RR 18
I:E 1:2.5
FiO2 30%

Trauma fluid resuscitation data

Estimated initial postburn IV fluid requirement

1. IV fluid of choice: Lactated Ringer's solution.
   (Use the following equations)
2. Total fluid requirement (TFR):
   TFR = 4 ml x wt (kg's) x % burn (2° and 3°)

   TFR = (4 x _______ x _______) = __________cc
3. Estimated fluid requirement 1st 8 hours post burn:

   (TFR/2) = __________cc
4. Estimated fluid requirement next 16 hours post burn:

   (TFR/2) = __________cc

Resuscitation area fluid intake and output

Intake:		Output:	
LR	________ml	Blood	________ml
PRBC	________ml	Urine	________ml
FFP	________ml	NG tube	________ml
Platelets	________ml	Chest tube	________ml
Other	________ml	Other	________ml
Total	________ml	Total	________ml

Vital signs

Time:	2025							
BP:	130/90							
Pulse:	100							
Temp:	R							
Resp:								
GCS:								

93% 02

Notes:

Impression:

Plan:

Signature:

(With permission from the American College of Surgeons Committee on Trauma, *Advanced Trauma Life Support Student Manual*, 1993 edition)

ocedures performed by trauma team

Procedure	Time:	Medications Drug:	Dosage:	Route
1424 Foley Cath, NS Intubation Exp Laparotomy (POSTOPS)	See anesthesia record 1725	MSO4	10mg	IV

Trauma fluid resuscitation data

Estimated initial postburn IV fluid requirement

1. IV fluid of choice: Lactated Ringer's solution.
   (Use the following equations)
2. Total fluid requirement (TFR):
   TFR = 4 ml x wt (kg's) x % burn (2° and 3°)
   TFR = (4 x _____ x _____) = _____cc
3. Estimated fluid requirement 1st 8 hours post burn:
   (TFR/2) = _____cc
4. Estimated fluid requirement next 16 hours post burn:
   (TFR/2) = _____cc

Resuscitation area fluid intake and output

Intake:		Output:	
LR	1500 ml	Blood	_____ ml
PRBC	_____ ml	Urine	150 ml
FFP	_____ ml	NG tube	Then see anes/Nsg report ml
Platelets	_____ ml	Chest tube	_____ ml
Other	_____ ml	Other	_____ ml
Total	_____ ml	Total	_____ ml

29 MAR 03

Vital signs

POST OP Notes

Time:	1428					
BP:	154/98	See anes/Nsg record				
Pulse:	91					
Temp:	37					
Resp:	Intubated/Vented					
GCS:	3/Trauma					

Notes: Pt taken from STP E resuscitation and brought immediately back to OR c (b)(3)-1 for exp lap and treatment as indicated

Impression: 1) GSW to RUQ ABD x(1)
2) Superficial Graze Injury to (R) forearm

Plan: Immediate Surgical Exploration and treatment prn
(b)(3)-1 See progress notes dated 29 MAR 03 for additional remarks, post op plan and care as well as pt disposition. Wounds to (R) forearm to be cleaned and dressed post op. Before refer to progress note and dictation by Surg (b)(6)-2 (b)(3)-1

(With permission from the American College of Surgeons Committee on Trauma, ...nual, 1993 edition.)

(b)(6)-4

UNK

Date and time of injury: 29MAR03

Date and time of arrival: 1499Z 29MAR03

Chief complaint: GSW

Pre-hospital information

Mechanism of injury:
- [x] Gunshot wound
- [ ] Stabbing
- [ ] Burn
- [ ] Chemical casualty
- [ ] Other:

Procedures before arrival

- [ ] Airway: type ____ size # ____
- [ ] O_2 @ ____ L/min via ____
- [x] IVs: location and # LAC 18G
- [ ] Chest tube: location ____ size # ____
- [x] Splints: Type (R) forearm
- [ ] Medications: ____
- [ ] Chemical casualty:
  - [ ] Decontamination date/time: ____

	Dosage	Date/time
[ ] Atropine:		
[ ] 2-PAM:		
[ ] Other:		

- [ ] Other procedures: ____

AMPLE history

Allergies: ?

Medications: ?

Past illnesses: ?

Last meal: ? Last Tetanus: ?

Events: WAR INJURY

Initial assessment

Airway
- [x] Patent
- [ ] Obstructed

Breathing
- [x] Normal
- [ ] Labored
- [ ] Symmetrical
- [ ] Asymmetrical

Trachea midline? [x] Yes [ ] No

Breath sounds:	Right	Left
Present	[x]	[x]
Clear	[ ]	[ ]
Decreased	[ ]	[ ]
Absent	[ ]	[ ]
Rales/Rhonchi	[ ]	[ ]

Crepitus: [ ] Yes [x] No

Initial assessment

Circulation

Skin/mucous membrane color:
- [x] Pink
- [ ] Flushed
- [ ] Pale
- [ ] Jaundiced
- [ ] Ashen
- [ ] Cyanotic

Skin temperature:
- [x] Warm
- [ ] Hot
- [ ] Cool

Skin moisture:
- [x] Normal
- [ ] Dry
- [ ] Mois

Pulses:

	Carotid R	Carotid L	Radial R	Radial L	Femoral R	Femoral
Normal	[x]	[x]	[x]	[x]	[x]	[ ]
Bounding	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Weak	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Absent	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Disability

Glasgow Coma Scale (circle appropriate scores):

		Score:
1. Eye opening:	Spontaneous	(4)
	To voice	3
	To pain	2
	None	1
2. Verbal:	Oriented	(5)
	Confused	VS (4)
	Inappropriate words	3
	Incomplete words	2
	None	1
3. Motor:	Obeys commands	(6)
	Localizes to pain	5
	Withdrawls to pain	4
	Flexion	3
	Extension	2
	None	1

Total GCS 14-15

Pupillary response

Pupil reaction:	Right	Left
Brisk	[x]	[x]
Constricted	[ ]	[ ]
Sluggish	[ ]	[ ]
Dilated	[ ]	[ ]
Nonreactive	[ ]	[ ]
Size	___mm	___mm

1 2 3 4 5 6 7 8

(b)(6)-4 Surg CO

Physical exam

Age ~50 Height (inches) [illegible] Weight (kg's) [illegible]

Head, eyes, ears, nose, throat: Normal exam

Neck: Supple, ? mild JVD ⊕ Pharynx

Chest: clear ⊖ trauma

Back: ⊖ trauma ⊖ TTP

Cervical/Thoracic/Lumbar spine: ⊖ TTP ⊖ step off

Abdomen: ⊕ GSW RUQ ⊖ exit soft ⊕ distended

Perineum and rectum: Neg Gross Blood on DRE

Extremity: RUE - forearm - superficial lacs 1cm penetrating wounds ⊖ evidence of compartment syndrome

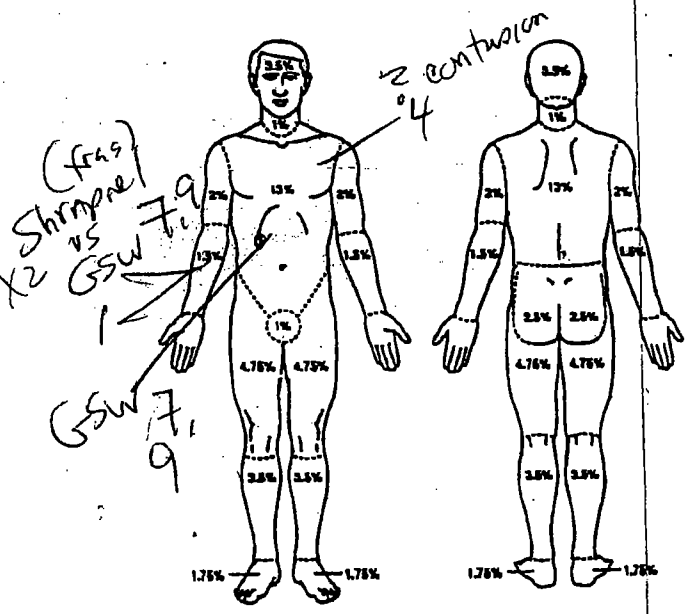
Skin: clear - ⊖ rash

Neurologic: GCS 15-14

Other:

Diagram for documenting injuries
(Identify injury site by number)

1. Laceration
2. Abrasion
3. Hematoma
4. Contusion
5. Deformity
6. Fracture
7. GSW(s)
8. Stab wound(s)
9. Pain
10. Cold injury
11. Edema
12. Amputation
13. Avulsion
14. Burn
15. Other (Describe)



(With permission from JB Lippincott Company. After Demling RH. Burns. In: Greenfield LJ, Mulholland MW, Oldham KT, and Zelenock GB, eds. Surgery: Scientific Principles and Practice. Philadelphia, JB Lippincott Company, 1993.)

NSN 7540-00-634-4176

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
29 Mar 03	Surg staff
2050 Zulu	Pt Medevac'd from forward (b)(3)-1 S/P Elap for GSW. Procedures included oversew colon injury, resection portion of transverse colon ⊂ 1° anastomosis. NO significant spillage. EBL 500 cc. Incidental finding of nodular deposits in abdomen x 2, ? CA vs granulomatous disease. Pt hemodynamically stable post op but unable to remain extubated 2° to resp acidosis. Pt is a heavy smoker and may have COPD.
	Exam – Intubated, Sedated, Chemically paralyzed
	Vitals P 105 BP 130/94 95% (21% FIO2) T 3
	HEENT NG, ET tube in place
	Lungs: equal / unlabored breath sounds
	abd soft, midline incision, intact ⊂ staples open RLQ GSW dressed
	ext (R) forearm GSW dressed ⊂ dry gauze. (+) palp radial pulse

continued on

(b)(6)-2

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

(b)(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME (Last, First, Middle Initial)		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRT

Dx (1) Dragi civilian middle aged male s/p GSW abd
c post op CO_2 retention / resp failure.

(2) (2') forearm GSW

Plan ○ Continue Vent support
(2) ✓ CXR
(3) Bronchodilators
(4) NG
(5) Wound care

(b)(6)-2

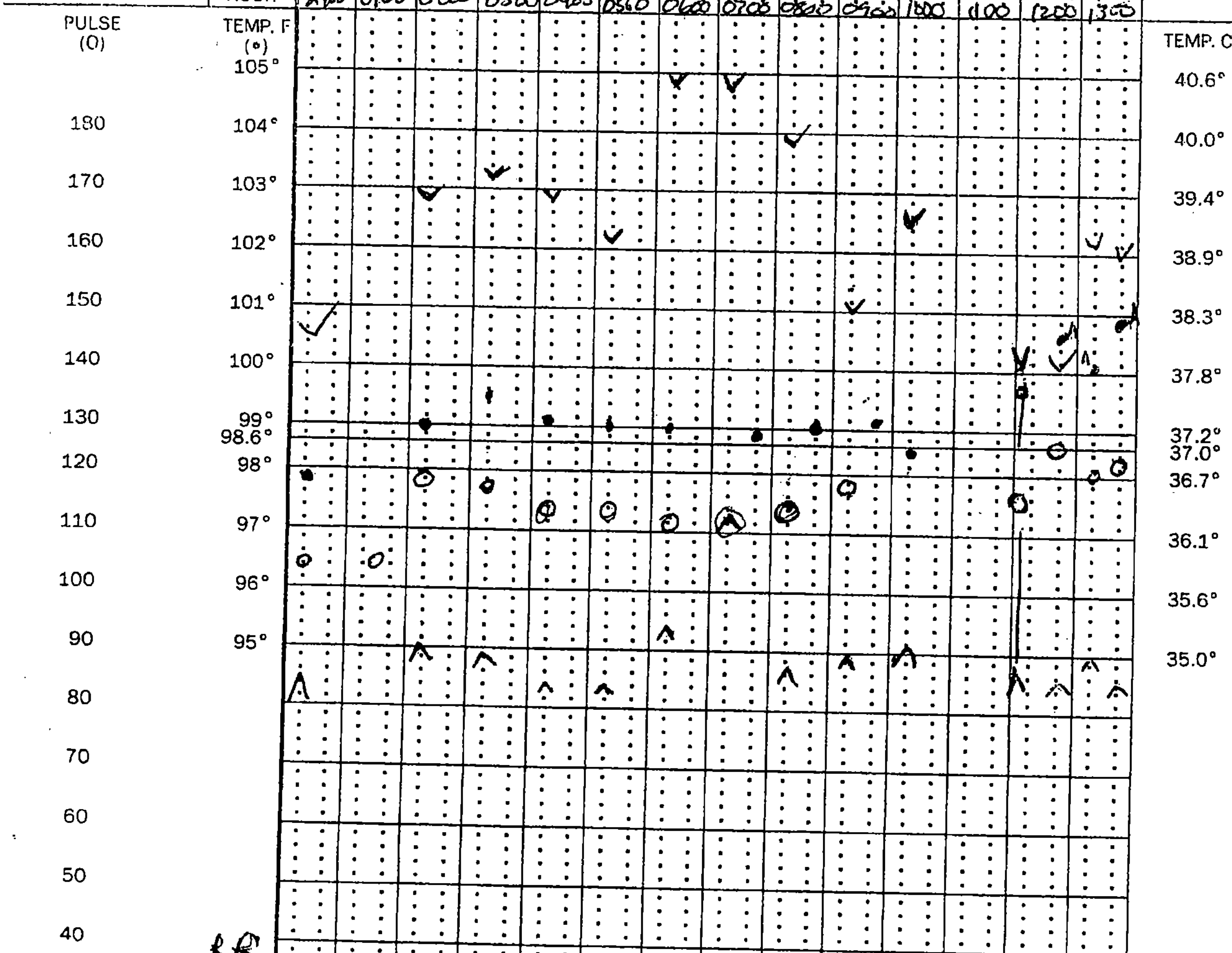
CCXR MC

-118

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
DAY	30MAR03														
HOUR	2400	0100	0200	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300	1400 1600 1800



PULSE (O) · TEMP. F (•) · TEMP. C (Centigrade Equivalents, for Reference only)

	2400	0100	0200	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300
RESPIRATION RECORD RR BPM	10	12	10	16	16	16	16	10	10	10	10	13	26	11 31
BLOOD PRESSURE SpO2	98	95	94	92	93	93	93	93	93	93	93	97	91	98% 95%
FiO2	30.	.21	30	30	30	30	30	20	30	30	.10		30	21% 21%
PIP	35	34	31	31	22	25	24	36	39		38		25	5 PEEP 5
HT: WEIGHT ~~96.6~~														
													161/84	160/85
Fortaz 2gm IV Q8	X								X					
NGT (LIWS)	Φ	0	0	Ø	Ø	Ø	Ø				10cc			
IVF's (LR)	100	100	100	30	100	60	50 ~~100~~							
UO	800	100	100	50	150	30	100 100	50	60				350cc	150cc 200cc

(CATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO. 997

WARD NO.

(b)(6)-4

BP 171/86
P = 111
R - 18

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 6057

999

AUTHORIZED FOR LOCAL REPRODUCTION

ICAL RECORD	PROGRESS NOTES
ATE	NOTES
1 Ma 03	0700 / 0600 Pt unchanged from previous assessment, pt agitated, med c̄ MSO4 + Valium,
	high peak pressures, lung fields tight, responded to meds, BP normalizing [redacted] LCDR
MAR03	MD Note
1350 hrs	Reviewed Xrays. (R) forearm multiple shrapnel areas
	∅ fx
	Chest - poor Resp, rotated, ∅ infiltrate, [illegible]
	ET tube well placed, NG tube does not appear to
	be in stomach. Some patchy atelectasis.
	NG replaced by nurses [redacted] MD
	[redacted]
30 May 03	———
0700	MSO4 4mg + Valium 5 mg given ——— [redacted]
0800	Cefoxitin 2gm IVP given to pt. ——— [redacted]
0925	MSO4 5mg + Valium 5mg given ——— [redacted]
1000	Pt ready for medevac, NG to gravity, new 1000cc of LR hung, foley
	drained, report given to CCR [redacted]

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

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

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

PROGRESS NOTES
Medical Record

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

[redacted]

MEDCOM - 6058

509-113 NSN 7540-00-634-4012

MEDICAL RECORD | PROGRESS NOTES

DATE	
3/30/08	MEDS
0001	Versed 5mg IV, MSO4 3mg IV, Valium 5mg IV (b)(6)-2
0030	MSO4 2mg IVP for tachypnea / pain (b)(6)-2
0100	Mefoxin 2g IV given as per MD order. (b)(6)-2
0100	Zantac 50mg IV given as per MD orders
0125	Valium 5mg IV given. (b)(6)-2
0200	MSO4 3mg IV given
0230	MSO4 2mg IV given. (b)(6)-2
0300	MSO4 2mg IV given (b)(6)-2
0330	Valium 5mg IV given. (b)(6)-2
0600	MSO4 2mg IV given (b)(6)-2

NAE

(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)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.20

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

FINAL AUTOPSY EXAMINATION REPORT

Name: (b)(6)-4
SSAN: (b)(6)-4
Date of Birth: BTB 1943
Date of Death: 8 FEB 2004
Date of Autopsy: 28 FEB 2004
Date of Report: 29 JUN 2004

Autopsy No.: ME 04-100
AFIP No.: 2917546
Rank: Iraqi Civilian
Place of Death: Tikrit, Iraq
Place of Autopsy: BIAP Mortuary
Baghdad Airport, Iraq

Circumstances of Death: This believed to be 61 year old male Iraqi civilian was a detainee of the U.S. Armed Forces at the Detention Central Collection Facility, Tikrit, Iraq when he was discovered deceased in his bed when he failed to report to the morning head count procedure. The decedent reported a medical history of diabetes and renal disease at the time of his capture.

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

Identification: Identification is established by visual examination by CID agents. DNA testing was performed and is on file for comparison should exemplars become available.

CAUSE OF DEATH: Atherosclerotic Cardiovascular Disease

MANNER OF DEATH: Natural

FINAL AUTOPSY DIAGNOSES:

I. Atherosclerotic Cardiovascular Disease
   1. Moderate calcified atherosclerosis of the right coronary artery (50% stenosis), the left circumflex (50% stenosis) and left anterior descending branches of the left coronary artery (50-75% stenosis).
   2. Moderate aortic atherosclerosis with bilateral renal artery take-off stenosis.
   3. Bilateral renal atrophy with intraparenchymal arteriole atherosclerosis and marked arterionephrosclerosis and cortical cysts.
   4. Cranial artery atherosclerosis of the vertebral, basilar, posterior communicating and middle cerebral arteries.

II. Mild to moderate decomposition.

III. Toxicology is positive for ethanol, acetone, 1-propanol and acetaldehyde (urine only) in the blood and urine. Drugs of abuse were not detected.

EXTERNAL EXAMINATION

The body is that of a cachetic male Iraqi national. The body weighs approximately 130 pounds, is 69 ½ inches in length and appears the reported age of 61 years. The body temperature is ambient. Rigor is present to an equal degree in all extremities. Lividity is difficult to assess because of dark skin pigmentation but is present and fixed on the posterior surface of the body, except in areas exposed to pressure. There is mild to moderate decomposition of the body with areas of skin slippage on the posterior scalp, the right wrist and anterior right lower leg and marbling of the skin of the back, buttocks, posterior surface of the arms and legs, palms of the hands and the abdomen.

The scalp hair is black and gray and the decedent has frontal baldness. Facial hair consists of a full gray and black beard and mustache. The irides are brown. The corneae are slightly cloudy. The conjunctivae are free of injuries and hemorrhages. The sclerae are free of hemorrhages. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The nasal septum and skeleton is palpably intact. The lips are without evident injury. The teeth are natural and poor condition with multiple unrepaired caries. Examination of the neck reveals no evidence of injury. The hyoid bone and thyroid cartilage are intact.

The chest is free of injuries and deformities. A 3.3 x 1.2 cm oval scar is on the anterior left costal margin and a 3.2 x 2.3 cm oval scar is in the left upper quadrant of the abdomen. No injury of the ribs or sternum is evident externally. The abdomen is flat and free of palpable masses. The external genitalia are those of a normal circumcised adult male with bilateral descended testes. The testes are free of palpable masses. The buttocks and anus are unremarkable.

The extremities show injuries that will be described below. The fingernails are intact. An 11.5 x 4.5 cm area and an area of 7.0 x 3.0 cm of non-descript black ink writing is on the medial surface and lateral surface of the left knee, respectively. There is a paper identification tag affixed to the right wrist and right second toe.

The back has a 2.5 x 2.0 cm scar immediately right of midline in the thoracic region and a 2.5 x 2.0 cm oval scar immediately below the scar just described.

CLOTHING AND PERSONAL EFFECTS

The following clothing items and personal effects are present on the body at the time of autopsy:
A blue shirt, a green sweater, a white linen undergarment, and two white socks.

MEDICAL INTERVENTION

There is no medical intervention.

RADIOGRAPHS

Full body postmortem radiographs are obtained and demonstrates the following:
1. No long bone fractures
2. No foreign bodies

EVIDENCE OF INJURY

The ordering of the following injuries is for descriptive purposes only, and is not intended to imply order of infliction or relative severity. All wound pathways are given relative to standard anatomic position.

A 2.4 x 1.4 cm crusted abrasion and a 1.5 x 1.4 cm crusted abrasion are on the forehead. A 1.0 x 0.5 cm abrasion is on the nose.

On the volar surface of the right forearm are multiple oval purple contusions that average 1.0 cm in diameter. A 1.5 x 0.4 cm crusted abrasion and a 1.2 x 1.2 cm crusted abrasion are on the medial and the lateral surface of the left forearm, respectively.
On the posterior surface of the left hand are a 2.5 x 1.5 cm purple contusion and a 1.5 x 1.0 cm purple contusion. There is a 1.8 x 1.7 cm crusted abrasion with surrounding contusion on the lateral surface of the left knee and a 1.5 x 1.0 cm crusted abrasion immediately below the left patella.

Over the spinous processes of the lumbar spine is a 1.8 x 1.1 cm contusion.

INTERNAL EXAMINATION

HEAD:
The galeal and subgaleal soft tissues of the scalp are free of injury. The calvarium is intact, as is the dura mater beneath it. There is congestion and pooling of blood over the posterior aspect of the brain from livor mortis. Clear cerebrospinal fluid surrounds the 1325 gm brain, which has unremarkable gyri and sulci. The brain parenchyma is soft and pink/red from refrigeration. Coronal sections demonstrate sharp demarcation between white and grey matter, without hemorrhage or contusive injury. The ventricles are of normal size. The basal ganglia, brainstem, cerebellum, and arterial systems are free of injury or other abnormalities. There are no skull fractures. The atlanto-occipital joint is stable. There is atherosclerosis of the vertebral, basilar and middle cerebral arteries.

NECK:
The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact gray/white mucosa. The thyroid gland is symmetric and red-brown, without cystic or nodular change. The tongue is free of bite marks, hemorrhage, or other injuries.

BODY CAVITIES:
The ribs, sternum, and vertebral bodies are visibly and palpably intact. 50 ml of serosanguineous fluid are in each hemithorax. No excess fluid is in the pericardial or peritoneal cavities. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 750 and 725 gm, respectively. The external surfaces are smooth and deep red-purple. The pulmonary parenchyma is diffusely congested and edematous. No mass lesions or areas of consolidation are present.

CARDIOVASCULAR SYSTEM:
The 390 gm heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show moderate calcified atherosclerosis of the right coronary artery (50% stenosis), the left circumflex (50% stenosis) and left anterior descending branch of the left coronary artery (50-75% stenosis). The myocardium is homogenous, red-brown, and firm. The valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.3 and 0.4 cm thick, respectively. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels. The renal arteries have moderate stenosis of their origins at the aorta from aortic atherosclerosis. The mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 1125 gm liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder contains about 4 ml of green-black bile and no stones. The gallbladder mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 80 gm spleen has a smooth, intact, red-purple capsule. The parenchyma is maroon and congested, with distinct Malpighian corpuscles.

PANCREAS:
The pancreas is soft and yellow-tan, with the usual lobular architecture. No mass lesions or other abnormalities are seen.

ADRENALS:
The right and left adrenal glands are symmetric, with bright yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 55 and 60 gm, respectively. The external surfaces are coarsely granular with multiple renal cortical cysts, ranging from 0.3 –1.0 cm in diameter. The cut surfaces are dark red-tan and congested, with uniformly thick cortices and sharp corticomedullary junctions. There is marked intra-renal atherosclerosis of the arterioles of the renal parenchyma. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The bladder contains approximately 100 ml of cloudy yellow urine. The prostate is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, grey-white mucosa. The stomach contains approximately 500 ml of brown fluid and rare food particles. The gastric wall is intact.

The greater curve of the stomach is densely adherent to the duodenum. The duodenum, loops of small bowel, and colon are otherwise unremarkable. The appendix is present.

ADDITIONAL PROCEDURES

- Documentary photographs are taken by OAFME photographer.
- Specimens retained for toxicologic testing and/or DNA identification are: blood, urine, spleen, liver, lung, kidney, brain, bile, gastric contents, and psoas muscle.
- The dissected organs are forwarded with body.
- Personal effects are released to the appropriate mortuary operations representatives.

MICROSCOPIC EXAMINATION

Selected portions of organs are retained in formalin, without preparation of histologic slides.

OPINION

This believed to be 61 year old Iraqi male died from atherosclerotic cardiovascular disease. The mechanism of death is often cardiac arrhythmia secondary to the diseased myocardium and conduction system. The presence of systemic atherosclerosis and the marked renal changes, including renal atrophy, is suggestive of the decedent having diabetes mellitus. The manner of death is natural.

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

FINAL AUTOPSY REPORT

Name: (b)(6)-4
Alternate spellings: (b)(6)-4
Date of Birth: unknown
Date of Death: 5 April 2004
Date of Autopsy: 26 April 2004
Date of Report: 22 November 2004

Autopsy No.: ME 04-309
AFIP No.: 2924040
Rank: Civilian, Iraqi National
Place of Death: Mosul, Iraq
Place of Autopsy: Mosul, Iraq

Circumstances of Death: This approximately 27 year-old male civilian, presumed Iraqi national, died in US custody approximately 72 hours after being apprehended. By report, physical force was required during his initial apprehension during a raid. During his confinement, he was hooded, sleep deprived, and subjected to hot and cold environmental conditions, including the use of cold water on his body and hood.

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

Identification: Visual, per detention facility records; postmortem fingerprints and DNA profile obtained

CAUSE OF DEATH: Undetermined

MANNER OF DEATH: Undetermined

FINAL AUTOPSY DIAGNOSES:

I. Evidence of restraint
   a. White plastic "Flexcuffs" around each wrist
   b. Abrasions and contusions around wrists

II. Evidence of injury
   a. Minor abrasions and contusions of extremities
   b. Laceration above right eyebrow, 1 cm
   c. Contusion of right side of neck
   d. Minor abrasions of left side of forehead
   e. Subgaleal hemorrhage of bilateral frontal regions of scalp
   f. Intramuscular hemorrhage of anterior aspect of right shoulder
   g. No internal evidence of trauma

III. No evidence of significant natural disease within the limitations of the examination
   a. Cardiovascular System: No specific pathologic changes (AFIP Cardiovascular Pathology consultation)
      i. Heart weight, 450 gm
      ii. Histologically, left ventricular myocyte hypertrophy with focal mild subendocardial interstitial fibrosis
      iii. Contraction band necrosis, anterior right ventricle
      iv. Mildly thickened intramural coronary arteries
      v. Mild medial thickening of the sinus nodal artery
      vi. Focal mild dysplasia of penetrating branches of the AV nodal artery without increased fibrosis in the crest of the ventricular septum
   b. Neuropathology System: (AFIP Neuropathology Consultation)
      i. Cerebral edema, brain 1400 gm
      ii. Early acute neuronal injury
   c. Liver (AFIP Hepatic Pathology Consultation)
      i. Microvesicular steatosis, etiology undetermined
      ii. Marked congestion, likely agonal
   d. Pulmonary edema; right lung 700 gm, left lung 900 gm

IV. Early to moderate decomposition
   a. Green discoloration of abdomen
   b. Focal skin slippage

V. Evidence of medical intervention
   a. Endotracheal tube in place
   b. Intravenous catheter in the left antecubital fossa
   c. Intravenous catheter in the right inguinal region
   d. Three adhesive EKG tabs on anterior torso
   e. Pulse oximeter on left index finger

f. Curvilinear abrasion on upper chest, consistent with defibrillation
g. Fractures of anterior aspect of left 3rd rib and right 2nd-4th and 6th ribs, consistent with CPR efforts

VI. Toxicology (AFIP)
a. Volatiles: Mixed volatiles consistent with postmortem production; mg/dL
    i. Blood: acetone 20, 2-propanol 7
    ii. Urine: acetone 67, 2-propanol 3
b. Drugs: Consistent with resuscitation efforts
    i. Lidocaine detected in the urine
    ii. Urine negative for other screened medications and drugs of abuse

EXTERNAL EXAMINATION

The body is that of an unclad well-developed, well-nourished male. The body weighs approximately 190 pounds, is 72" in height and appears compatible with the reported age of 27 years. The body temperature is cold, that of the refrigeration unit. Rigor has dissipated, and the body is flaccid. Lividity is present and fixed on the posterior surface of the body, except in areas exposed to pressure.

There is early to moderate decomposition consisting of focal skin slippage of the arms, green discoloration of the abdomen, and early corneal clouding.

The scalp is covered with dark brown hair averaging 7 cm in length. Facial hair consists of a dark mustache and dark facial stubble. The irides are brown, and the corneae are slightly cloudy. The sclerae and conjunctivae are pale and free of petechiae. The earlobes are not pierced. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The nasal skeleton is palpably intact. The lips are without evident injury. The teeth are natural and in good condition.

The neck is straight and the trachea is midline and mobile. The chest is symmetric and well developed. No injury of the ribs or sternum is evident externally. The abdomen is flat and soft. Healed surgical scars are not noted. The extremities are well developed with normal range of motion. The fingernails are intact. Tattoos are not noted, and needle tracks are not observed. The external genitalia are those of a normal adult circumcised male. The testes are descended and free of masses. The pubic hair is shaved but is present in a normal distribution. The buttocks and anus are unremarkable.

A tag with the name of the decedent is secured to the right first toe.

EVIDENCE OF THERAPY

There is an endotracheal tube in place, and there are three adhesive EKG tabs on the body, two on the upper chest and one on the lower left side of the abdomen. There is an intravenous catheter in the left antecubital fossa, and there is an intravenous catheter in the right inguinal region. There is a 12 x 6 cm oval curvilinear abrasion on the upper right side of the chest, consist with defibrillation attempts. There is a pulse oximeter taped over the end of the left index finger. There are fractures of the anterior aspect of the right 3rd rib and left 2nd-4th and 6th ribs, consistent with CPR efforts.

EVIDENCE OF INJURY

The ordering of the following injuries is for descriptive purposes only and is not intended to imply order of infliction or relative severity. All wound pathways are given relative to standard anatomic position.

There is bilateral periorbital ecchymosis, more pronounced over the lower lids and slightly more prominent on the left side. On the left side of the forehead, there are two

diagonally oriented parallel, linear abrasions. The medial one measures 4 x 0.2 cm and the lateral one is 3 x 0.1 cm. There are multiple small, ill-defined areas of excoriation and superficial abrasion over the central forehead and bridge of the nose. There is a 1 cm laceration just above the lateral aspect of the right eyebrow. There is a 6 x 6 cm red brown contusion on the right lateral aspect of the neck, just below the angle of the mandible.

Upon reflecting the scalp, there is bilateral frontal subgaleal scalp hemorrhage. The most prominent area is 3 x 2 cm, surrounding the laceration near the left eyebrow.

There is an 8 x 1 cm faint abrasion of the anterior aspect of the right shoulder, and there is a faint 3 x 3 cm red contusion of the anterior aspect of the left shoulder. There is a 9 x 0.2 cm curved linear abrasion just to the left of the umbilicus. There is a 1 x 0.3 cm abrasion of the lower left aspect of the abdomen.

Upon opening the chest, there is intramuscular hemorrhage of the anterior aspect of the right shoulder.

There is a 12 x 8 cm area of contusion and faint abrasion on the anterior lateral aspect of the right upper arm. There is a 6 x 2 cm red contusion on the anterior medial aspect of the right upper arm. There are three ill-defined bands of erythema and red contusion over the back of the left wrist, 7 x 3 cm in aggregate.

INTERNAL EXAMINATION

BODY CAVITIES:
The body is opened by the usual thoraco-abdominal incision and the chest plate is removed. No adhesions are present in any of the body cavities. There is 100 ml of serosanguinous fluid in each pleural space. There is no significant pericardial or peritoneal fluid. All body organs are present in the normal anatomical position. The vertebral bodies are visibly and palpably intact. The subcutaneous fat layer of the abdominal wall is 2 cm thick. There is no internal evidence of blunt force or penetrating injury to the abdominal region.

HEAD: (CENTRAL NERVOUS SYSTEM)
The scalp is reflected, and no skull fractures are found. The calvarium of the skull is removed. The dura mater and falx cerebri are intact. There is no epidural or subdural hemorrhage present. The leptomeninges are thin and delicate. The cerebrospinal fluid is clear. The cerebral hemispheres are symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels, are intact. Coronal sections through the cerebral hemispheres revealed no lesions, and there is no evidence of infection, tumor, or trauma. The ventricles are of normal size. Transverse sections through the brain stem and cerebellum are unremarkable. The dura is stripped from the basilar skull, and no fractures are found. The atlanto-occipital joint is stable. The brain weighs 1400 grams.

NECK:
Examination of the soft tissues of the neck, including strap muscles, thyroid gland and large vessels, reveals no abnormalities. The anterior strap muscles of the neck are homogeneous and red-brown, without hemorrhage. The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact white mucosa and is unobstructed. The thyroid gland is symmetric and red-brown, without cystic or nodular change. There is no evidence of infection, tumor, or trauma, and the airway is patent. Incision and dissection of the posterior neck demonstrates no deep paracervical muscular injury, hemorrhage, or fractures of the dorsal spinous processes.

CARDIOVASCULAR SYSTEM:
The pericardial surfaces are smooth, glistening and unremarkable; the pericardial sac is free of significant fluid and adhesions. A moderate amount of epicardial fat is present. The coronary arteries arise normally, follow the usual distribution and are widely patent, without evidence of significant atherosclerosis or thrombosis. The chambers and valves exhibit the usual size-position relationship and are unremarkable. The myocardium is dark red-brown, firm and unremarkable; the atrial and ventricular septa are intact. The left ventricle is 1.3 cm in thickness and the right ventricle is 0.4 cm in thickness. The aorta and its major branches arise normally, follow the usual course and are widely patent, free of significant atherosclerosis and other abnormality. The venae cavae and their major tributaries return to the heart in the usual distribution and are free of thrombi. The heart weighs 450 grams. See "Cardiovascular Pathology Report" below.

RESPIRATORY SYSTEM:
The upper airway is clear of debris and foreign material; the mucosal surfaces are smooth, yellow-tan and unremarkable. The pleural surfaces are smooth, glistening and unremarkable bilaterally. The pulmonary parenchyma is red-purple, exuding moderate amounts of bloody fluid; no focal lesions are noted. The pulmonary arteries are normally developed, patent and without thrombus or embolus. The right lung weighs 700 grams; the left 900 grams.

LIVER & BILIARY SYSTEM:
The hepatic capsule is smooth, glistening and intact, covering dark red-brown, moderately congested parenchyma with no focal lesions noted. The gallbladder contains 10 ml of green-brown, mucoid bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of calculi. The liver weighs 1450 grams.

ALIMENTARY TRACT:
The tongue is free of bite marks, hemorrhage, or other injuries. The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is arranged in the usual rugal folds and the lumen is essentially empty with only a film of mucous. The small and large bowel are unremarkable. The pancreas has a normal pink-tan lobulated appearance and the ducts are clear. The appendix is present and is unremarkable.

GENITOURINARY SYSTEM:
The renal capsules are smooth and thin, semi-transparent and strip with ease from the underlying smooth, red-brown cortical surfaces. The cortices are sharply delineated from the medullary pyramids, which are red-purple to tan and unremarkable. The calyces, pelves and ureters are unremarkable. White bladder mucosa overlies an intact bladder wall. The urinary bladder contains 200 ml of clear, yellow urine. The prostate gland is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities. The right kidney weighs 150 grams; the left 160 grams.

RETICULOENDOTHELIAL SYSTEM:
The spleen has a smooth, intact capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles are unremarkable. The regional lymph nodes appear normal. The spleen weighs 160 grams.

ENDOCRINE SYSTEM:
The pituitary, thyroid and adrenal glands are unremarkable.

MUSCULOSKELETAL SYSTEM:
Muscle development is normal. No bone or joint abnormalities are noted.

MICROSCOPIC EXAMINATION

HEART: See "Cardiovascular Pathology Report" below.

LUNGS: The alveolar spaces and small air passages are expanded and contain no significant inflammatory component or edema fluid. The alveolar walls are thin and slightly congested. The arterial and venous vascular systems are normal. The peribronchial lymphatics are unremarkable.

LIVER: The hepatic architecture is intact. The portal areas show no increased inflammatory component or fibrous tissue. The hepatic parenchymal cells are well-preserved with no evidence of cholestasis or sinusoidal abnormalities. See "Hepatic Pathology Report" below.

SPLEEN: The capsule and white pulp are unremarkable. There is minimal congestion of the red pulp.

TESTES: Unremarkable.

THYROID GLAND: Unremarkable.

ADRENALS: The cortical zones are distinctive, and the medullae are not remarkable.

KIDNEYS: There is moderate autolysis. The subcapsular zones are unremarkable, and the glomeruli are mildly congested without cellular proliferation, mesangial prominence, or sclerosis. There is no interstitial fibrosis or significant inflammation. There is no thickening of the walls of the arterioles or small arterial channels.

BRAIN: See "Neuropathology Report" below.

CARDIOVASCULAR PATHOLOGY REPORT

Department of Cardiovascular Pathology, AFIP:

"AFIP DIAGNOSIS: ME-04-309 No specific pathologic changes

History: Arab male detainee, death in custody

Heart: 450 grams; normal epicardial fat; closed foramen ovale; normal cardiac chamber dimensions: left ventricular cavity diameter 30 mm, left ventricular free wall thickness 13 mm, ventricular septum thickness 15 mm; right ventricular dilatation: right ventricle thickness 4 mm, without gross scars or abnormal fat infiltrates; grossly normal valves and endocardium; no gross myocardial fibrosis or necrosis; histologic sections show left ventricular myocyte hypertrophy with focal mild subendocardial interstitial fibrosis; contraction band necrosis, anterior right ventricle; mildly thickened intramural coronary arteries

Coronary arteries: Normal ostia; right dominance; no gross atherosclerosis

Conduction system: The sinoatrial node is histologically unremarkable, but there is mild medial thickening of the sinus nodal artery. The compact atrioventricular (AV) node shows mild fragmentation (Mahaim fibers) within the central fibrous body, but is otherwise unremarkable. The penetrating bundle is centrally located without inflammation, increased fat, vascularity or proteoglycan. The proximal bundle branches are intact and unremarkable. There is focal mild dysplasia of penetrating branches of the AV nodal artery, but no significantly increased fibrosis in the crest of the ventricular septum.

Comment: The heart weight of 450 grams may reflect some degree of left ventricular hypertrophy, depending on the subject's body weight."

NEUROPATHOLOGY REPORT

Department of Neuropathology and Ophthamic Pathology, AFIP:

"Neuropathology consult (2924040-01; ME04-309): We reviewed the five H&E stained microscopic sections submitted in reference to this case.
Microscopic sections demonstrate multiple sections of grey and white matter, cerebellum and spinal cord/medulla. Sections show widened pericellular and perivascular spaces and

scattered neurons with cytoplasmic eosinophilia and shrunken, pyknotic nuclei, most prominent in the dentate nucleus and cerebellum. These morphologic features represent cerebral edema and early acute neuronal injury.
This material was reviewed in conference by the staff of the Department of Neuropathology and Ophthalmic Pathology."

HEPATIC PATHOLOGY REPORT

Division of Hepatic Pathology, AFIP:

"Liver: (1) Microvesicular steatosis, etiology undetermined
(2) Marked congestion

Some toxins can cause microvesicular fat, usually associated with profound metabolic disturbances, but it can also be stress-related. There is no way to distinguish between these by histology alone. The congestion is presumably agonal. There is some lipofuscin pigment in centrilobular hepatocytes, but no bile stasis. The Masson stain shows no fibrosis to suggest underlying chronic liver disease. The PASD and iron stains show no lipofuscin or hemosiderin laden macrophages to suggest hepatocellular necrosis."

ADDITIONAL PROCEDURES

- Documentary photographs are taken by OAFME photographers
- Specimens retained for toxicologic testing and/or DNA identification are: vitreous fluid, heart blood, urine, bile, spleen, liver, lung, brain, kidney, and psoas muscle
- The dissected organs are forwarded with the body

OPINION

Based on available investigation and complete autopsy examination, no definitive cause of death for this approximately 27 year-old male Iraqi civilian in US custody in Iraq could be determined. There is evidence of multiple minor injuries; however, there is no definitive evidence of any trauma significant enough to explain the death. The injuries include bilateral periorbital ecchymoses ("blackeyes"); abrasions and contusions of the face, torso, and extremities; contusion of the side of the neck; and subgaleal hemorrhage of the scalp.

There is evidence of restraint, consisting of "flexicuffs" around the wrists with associated minor contusions, and asphyxia from various means cannot be completely excluded in a restrained individual.

There are non-specific cardiac findings, including mild medial thickening of the sinus nodal artery and focal mild dysplasia of the penetrating branches of the atrioventricular nodal artery. However, there is no associated increased septal fibrosis, which can be a potential substrate for cardiac arrhythmia. There is no gross evidence of atherosclerosis of the coronary arteries. A cardiac arrhythmia related to various ion channelopathies or coronary vasospasm cannot be excluded.

The decedent was also subjected to cold and wet conditions, and hypothermia may have contributed to his death.

Therefore, the cause of death is best classified as undetermined, and the manner of death is undetermined.

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

FINAL AUTOPSY REPORT

Name: (b)(6)-4
US Detainee #: (b)(6)-4
Date of Birth: 01 JAN 1960
Date of Death: 28 APR 2004
Date of Autopsy: 18 MAY 2004
Date of Report: 18 JUN 2004

Autopsy No.: ME 04- 357
AFIP No.: 2929205
Rank: Iraqi National
Place of Death: Baghdad, Iraq
Place of Autopsy: LSA Anaconda Mortuary, Balad Iraq

Circumstances of Death: This 44 year old male, an Iraqi National, was apprehended by US Forces in Kirkuk, Iraq after he and two accomplices fired on coalition forces with rocket propelled grenades and small arms fire on 10 April 2004. (b)(6)-4 sustained gunshot wounds during the firefight and was transported to the (b)(3)-1 (b)(3)-1 for medical treatment. He was later transported to the Central Baghdad Detainee Facility (Abu Ghraib) where he died on 28 April 2004.

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

Identification: Presumptive identification accomplished by comparison to photographs and reports supplied by the investigative agency (b)(3)-1 (b)(3)-1 Iraq)

CAUSE OF DEATH: **Multiple Gunshot Wounds with Complications**

MANNER OF DEATH: **Homicide**

FINAL AUTOPSY DIAGNOSES:

I. Multiple Gunshot Wounds (5)

A. Gunshot Wound of the Left Axilla
   a. Entrance: Left axilla with no evidence of close range discharge of a fire arm on the surrounding skin
   b. Wound Path: Skin, subcutis and muscle of the left axilla, inferior to left clavicle, soft tissue of the left lateral side of the lateral neck
   c. No Exit
   d. Recovered: a portion of copper colored, medium caliber jacket and a portion of metal projectile core
   e. Wound Direction: Front to back, left to right and upward
   f. Associated Injuries: hemorrhage of the soft tissues of the chest and neck

B. Gunshot Wound of the Left Hip
   a. Entrance: Left hip with no evidence of close range discharge of a firearm on the surrounding skin
   b. Wound Path: Skin, subcutis and muscle of the left lateral hip, left iliac bone, deep muscles of the pelvis
   c. No exit
   d. Recovered: a deformed irregular portion of copper colored projectile jacket
   e. Wound Direction: Left to right with minimal front to back or vertical direction
   f. Associated Injuries: Comminuted (shattered) fractures of the left iliac bone, hemorrhage of the pelvic muscles and contusions of the sigmoid colon

C. Graze Gunshot Wound of the Left Ankle and Foot
   a. No evidence of close range discharge of a firearm on the surrounding skin
   b. Direction undetermined
   c. Associated open fracture of the left 5th metatarsal bone

D. Graze Gunshot Wound of the Left Arm
   a. No evidence of close range discharge of a firearm on the surrounding skin
   b. Direction undetermined

E. Graze Gunshot Wound of the Left Forearm
   a. No evidence of close range discharge of a firearm on the surrounding skin
   b. Direction undetermined
   c. Associated fracture of the left radius

II. **Moderate decomposition**

III. **Status post Exploratory Laporatomy and Cricothyrotomy**

IV. **Severe pulmonary congestion; pneumonia by clinical history**

V. **Toxicology: positive for mixed volatiles consistent with postmortem decomposition; negative for drugs of abuse (see page 7)**

EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished 69-inch tall, 170 pounds (estimated) Caucasian male whose appearance is consistent with the reported age of 44 years. Lividity is obscured by changes of moderate decomposition, which include green discoloration of the skin of the anterior and posterior torso and prominent, diffuse skin slippage of the posterior torso. There is a moderate collection of purge fluid on the posterior aspects of the torso and lower extremities. On the left side of the lower abdomen and thigh are areas of prominent skin slippage and splitting of the soft tissues. Rigor has passed, and the temperature of the decedent is cold, that of the refrigeration unit.

The scalp is covered with dark brown hair in a normal distribution. Posterior scalp slippage secondary to decomposition is noted. There is prominent clouding of the cornea however the irides are brown and the pupils appear equal. The external auditory canals are free of abnormal secretions and blood. The external ears are unremarkable. The nares are patent and the lips are atraumatic. The nose and maxillae are palpably stable. Facial hair consists of a full, dark brown beard.

The neck is straight, and the trachea is midline and mobile. The chest is symmetric. The abdomen is flat. The genitalia are those of a normal adult circumcised male. The testes are descended and free of masses. Pubic hair is present in a normal distribution. The buttocks and anus are unremarkable.

The upper and lower extremities are symmetric and without clubbing or edema. Injuries to the torso and extremities will be described below in the evidence of injury section. There are no significant identifying body marks such as tattoos and significant scars are not present. A toe tag is affixed to the right great toe and is inscribed Abu Ghraib
(b)(6)-4

CLOTHING AND PERSONAL EFFECTS

The deceased is unclad. There are no clothing items or personal effects accompanying the body at the time of autopsy.

MEDICAL INTERVENTION

- A 1-inch, midline cricothyrotomy incision is located in the midline of the anterior neck situated over cricothyroid cartilage
- Electrocardiogram monitoring pads are on the anterior chest and abdomen
- A vertical 6-inch sutured incision is on the mid abdomen extending from the umbilicus to the pubic symphysis
- A blue plaster cast covers the left mid arm and forearm
- A 3 x 2-inch area of ecchymosis with small puncture marks is on the right antecubital fossa consistent with previous intravenous therapy

RADIOGRAPHS

Postmortem radiographs are obtained and reflect the injuries as described in the autopsy report. Projectile fragments are visualized in the soft tissues of the left side of the neck and the left hip.

EVIDENCE OF INJURY

The ordering of the following injuries is for descriptive purposes only, and is not intended to imply order of infliction or relative severity. All wound pathways are given relative to standard anatomic position.

I. Multiple Gunshot wounds

A. Gunshot Wound of the Left Axilla

There is a gunshot entrance wound on the left axilla situated 15-inches below the top of the head and 8-inches left of the anterior midline. The wound is a ¾ x ¼-inch lacerated defect. The external appearance of the gunshot wound is altered by moderate decomposition of the tissue surrounding the entrance wound. There is no evidence of close range discharge of a firearm on the surrounding skin. The bullet perforates the skin, subcutaneous tissue and muscle of the lateral aspect of the left side of the chest and passes under the left clavicle into the soft tissue of the left side of the neck. Injury to vital structures of the neck and chest are not demonstrated. Recovered from the deep strap muscles of the left side of the neck is a ½-inch portion of irregularly shaped, copper-colored projectile jacket and a ¼-inch irregularly shaped core fragment. The wound direction is front to back, left to right, and upward. Associated with the wound path is extensive soft tissue hemorrhage of the muscles of the left chest wall and soft tissues of the left side of the neck.

B. Gunshot Wound of the Left hip

There is a gunshot entrance wound on the left side of the hip situated 30-inches below the top of the head and 6 ½-inches left of the anterior midline. The wound is an oval ¾ x ½-inch defect. Moderate decomposition of the tissues surrounding the entrance wound precludes determination of additional characteristics of the entrance wound. There is no evidence of close range discharge of a firearm on the surrounding skin. The bullet perforates the sin, subcutaneous tissue, and muscle of the left hip and perforates the anterior aspect of the left iliac bone, resulting in shattered fractures. The projectile continues into the deep muscles of the pelvis and left psoas muscle where a ½-inch

portion of irregularly shaped, copper-colored projectile jacket is recovered. The wound direction is from left to right with minimal back to front or vertical deviation. Associated injuries include scattered contusions of the sigmoid colon.

C. Grazed Gunshot Wound of the Left Ankle

On the dorsal aspect of the left ankle extending to the dorsal-lateral aspect of the distal foot is a 5 x 1 ½-inch grazing defect. The projectile causes injury to the skin and subcutaneous tissue of the ankle and foot and causes fractures the left 5th metatarsal bone. No bullet or bullet fragments are recovered from within the wound. The wound direction is undetermined. There is no evidence of close range discharge of a firearm on the surrounding skin.

D. Graze Gunshot Wound of the Left Arm

There is a graze gunshot wound of the anterior-medial aspect of the mid left arm situated 7-inches below the top of the left shoulder. The wound is an oblique 4 x 1-inch grazing laceration. There is no evidence of close range discharge of a firearm on the surrounding skin and directionality is undetermined. Injuries to vital structures of the arm are not demonstrated. The location and characteristics of the graze gunshot wound to the left arm make it likely that a single projectile grazed the arm and re-entered the axilla (GSW A).

E. Graze Gunshot Wound of the Left Forearm

There is a graze gunshot wound on the anterior-lateral aspect of the left forearm situated 17- inches below the top of the shoulder. The wound is a 2 x 1-inch lacerated defect. There is no evidence of close range discharge of a firearm on the surrounding skin and directionality of the wound path is undetermined. Associated with wound is fracture of the radius. The location and characteristics of the graze wound to the left forearm make it likely that a single projectile grazed the forearm and reentered the left hip (GSW B).

INTERNAL EXAMINATION

HEAD:

The galeal and subgaleal soft tissues of the scalp are free of injury. The calvarium is intact, as is the dura mater beneath it. The brain weighs 1450 gm and has unremarkable gyri and sulci. The brain parenchyma is extremely soft secondary to decomposition however; coronal sections demonstrate no hemorrhage or contusive injury. The ventricles are of normal size. The basal ganglia, brainstem, cerebellum, and arterial systems are free of injury or other abnormalities. There are no skull fractures. The atlanto-occipital joint is stable.

NECK:

Injuries to the neck have been described. Otherwise, the anterior strap muscles of the neck are red-brown and unremarkable. The thyroid cartilage and hyoid bone are intact.

The larynx is lined by unremarkable mucosa. The thyroid gland is symmetric and red-brown. The tongue is free of bite marks, hemorrhage, or other injuries.

BODY CAVITIES:
The ribs, sternum, and vertebral bodies are visibly and palpably intact. There are 40 ml of the decomposition fluid in each pleural cavity. The pericardial and peritoneal cavities are unremarkable. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 800 and 700 gm, respectively. There are bilateral pleural adhesions. The external surfaces of the lungs are deep red-purple. The pulmonary parenchyma is markedly edematous. No mass lesions or areas of consolidation are present.

CARDIOVASCULAR SYSTEM:
The 300 gm heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show minimal atherosclerosis. The myocardium is homogenous, red-brown, and firm. The valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.3 and 0.4-cm thick, respectively. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 1400 gm liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder contains 5 ml of green-black bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 200 gm spleen has a smooth, intact, red-purple capsule. The parenchyma is markedly softened secondary to decomposition.

PANCREAS:
The pancreas has undergone marked autolytic change, however the lobular architecture is maintained. No mass lesions or other abnormalities are seen.

ADRENALS GLANDS:
The right and left adrenal glands are symmetric, with yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 160 and 170 gm, respectively. The external surfaces are intact and smooth. The cut surfaces are brown and congested, with uniformly thick

cortices and sharp corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The bladder is empty. The prostate is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

GASTROINTESTINAL TRACT:
Injury to the sigmoid colon has been described. The esophagus is intact and lined by grey mucosa. The stomach is empty. The gastric wall is intact. The duodenum, loops of small bowel, and colon are unremarkable. The appendix is present.

ADDITIONAL PROCEDURES

- Documentary photographs are taken by (b)(6)-2 OAFME
- Projectile fragments are turned directly over to SA (b)(6)-1
- Specimens retained for toxicologic testing and/or DNA identification are: cavity blood, lung, liver, spleen, kidney, brain, bile, heart blood, psoas muscle
- The dissected organs are forwarded with body
- Attending the autopsy are SA (b)(6)-1 (b)(3)-1 (b)(3)-1
- Personal effects are released to the appropriate mortuary operations representatives

MICROSCOPIC EXAMINATION

Selected portions of organs are retained in formalin, with preparation of the following histologic slides:
Lungs: marked hemorrhagic edema, advanced decomposition preclude further histologic assessment
Liver: advanced decomposition preclude histologic assessment

TOXICOLOGY

AFIP Accession Number: (b)(6)-4 Dated 10 June 2004
Volatiles: Blood and Bile-mixed volatiles: mg/dL
Blood- Acetaldehyde 10; Ethanol 53; 1-Propanol trace
Bile- Acetaldehyde 5; Ethanol 52; 1-Propanol trace
Drugs: Blood-drugs of abuse are not detected; Meperidine 0.11 mg/L; Normeperidine 0.37 mg/L; Acetaminophen 13 mg/L

OPINION

This 44-year-old male, (b)(6)-4 died of complications from multiple gunshot wounds. The gunshot wound to the left side of the hip caused bleeding into the soft tissues and fractured the hipbone resulting in internal bleeding. The gunshot wound to the left axilla caused extensive hemorrhage into the soft tissue of the chest and neck. Clinically, the history of Klebsiella pneumonia complicated the hospital course. The manner of death is Homicide.

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

FINAL AUTOPSY REPORT

Name: (b)(6)-4
US Detainee #: (b)(6)-4
Date of Birth: 01 JAN 1929
Date of Death: 11 MAY 2004
Date of Autopsy: 18 MAY 2004
Date of Report: 18 JUN 2004

Autopsy No.: ME 04- 358
AFIP No.: 2929206
Rank: Iraqi National
Place of Death: Baghdad, Iraq
Place of Autopsy: LSA Anaconda Mortuary, Balad Iraq

Circumstances of Death: This 75 year old male, an Iraqi National, was a detainee at the Central Baghdad Detainee Facility (Abu Ghraib). On 11 May 2004 he reportedly abruptly collapsed and became unconscious. Resuscitation was initiated and continued during transport to the facility hospital where he died. According to records provided by the investigative agency, (b)(6)-4 had a past medical history significant for diabetes mellitus, hypertension and previous myocardial infarction.

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

Identification: Presumptive identification accomplished by comparison to photographs and reports supplied by the investigative agency (b)(3)-1 (b)(3)-1

CAUSE OF DEATH: **Severe Atherosclerotic Cardiovascular Disease**

MANNER OF DEATH: **Natural**

FINAL AUTOPSY DIAGNOSES:

I. Severe Atherosclerotic Cardiovascular Disease
   a. Right Coronary Artery: 95% to pinpoint stenosis
   b. Left Coronary Artery: 80% stenosis with concentric calcification
   c. Proximal Left Descending Coronary Artery: 90% stenosis
   d. Status Post Remote Posterior Left Septal Infarction
   e. Severe Aortic Atherosclerosis

II. Aortic Aneurysm (8cm)

III. Cardiomegaly (810gm)

IV. Marked Nephrosclerosis

V. No external injuries noted

VI. Toxicology: negative for drugs of abuse and ethanol

EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished 70-inch tall, 200 pounds (estimated) Caucasian male whose appearance is consistent with the reported age of 75 years. Lividity is fixed on the posterior aspect of the body and rigor has passed. The temperature of the deceased is cold, that of the refrigeration unit.

The scalp is covered with white hair and there is frontal and occipital balding. The irides are hazel, and the pupils are round and equal in diameter. The external auditory canals are free of abnormal secretions or blood. The ears are unremarkable and they are not pierced. The nares are patent and the lips are atraumatic. The nose and maxillae are palpably stable. The deceased is edentulous.

The neck is straight, and the trachea is midline and mobile. The chest is symmetric. The abdomen is mildly protuberant. The genitalia are those of a normal adult circumcised male. The testes are descended and free of masses. Pubic hair is present in a normal distribution. The buttocks and anus are unremarkable.

The upper and lower extremities are symmetric and without evidence of clubbing, edema, and injuries. A well-circumscribed, ¼-inch verrucoid lesion is noted on the posterior-medial aspect of the mid right leg.

Tattoos are not present and scars are noted in the following locations:

- An oblique 1 ¾ x 1/16-inch well-healed scar is on the dorsal aspect of the left hand
- A vertical ¾ x ¼-inch well-healed scar is inferior to the left knee
- An ovoid ¼ x ½-inch well-healed scar is inferior to the right knee
- An oblique 1 x 1/8-inch well healed scar is on the anterior aspect of the left ankle

CLOTHING AND PERSONAL EFFECTS

The following clothing items and personal effects are present on the body at the time of autopsy:

- A long sleeved dark green shirt without a label
- Black briefs
- Additional items or personal effects are not present

MEDICAL INTERVENTION

Electrocardiogram monitor pads are affixed to the anterior aspect of the chest. Puncture marks consistent with intravenous devices are noted in the left antecubital fossa and right aspect of the groin.

EVIDENCE OF INJURY

None

INTERNAL EXAMINATION

HEAD:
The galeal and subgaleal soft tissues of the scalp are free of injury. The calvarium is intact, as is the dura mater beneath it. The brain weighs 1500 gm and has unremarkable gyri and sulci. Coronal sections demonstrate sharp demarcation between white and grey matter, without hemorrhage or contusive injury. The ventricles are of normal size. The basal ganglia, brainstem, and cerebellum are free of injury or other abnormalities. Mild atherosclerosis (20-30%) is noted in the basilar artery; otherwise the remainder of the arterial system is free of abnormalities. There are no skull fractures. The atlanto-occipital joint is stable.

NECK:
The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact mucosa. The thyroid gland is symmetric and red-brown, without cystic or nodular change. The tongue is free of bite marks, hemorrhage, or other injuries.

BODY CAVITIES:
The ribs, sternum, and vertebral bodies are visibly and palpably intact. No excess fluid is in the pleural, pericardial, or peritoneal cavities. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs are edematous and weigh 800 and 820 gm, respectively. There is prominent anthracotic pigment deposition on the pleura as well as throughout the lung parenchyma. The external surfaces are otherwise deep red-purple. The pulmonary parenchyma is diffusely congested and edematous and exudes edema fluid on cut sections. No mass lesions or areas of consolidation are present.

CARDIOVASCULAR SYSTEM:
There is marked enlargement of the heart. The heart weighs 820 gm. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show severe atherosclerosis. The proximal aspect of the left coronary artery show 80% calcific concentric stenosis; the proximal left anterior descending coronary artery shows 90% stenosis. The right coronary and circumflex arteries show 30-50% stenosis. The myocardium is red-brown and flaccid. The walls of the left and right ventricles measure 1.1 and 0.3-cm, respectively. Cut sections of the left ventricle show a 2 x 1 cm area of fibrosis on the posterior-septal left ventricular wall consistent with remote myocardial infarction. The valve leaflets are thin and mobile. The proximal aorta is involved by an

8 cm aneurysm. Prominent calcific atherosclerosis of the abdominal aorta obscures the origins of the renal and mesenteric vessels.

LIVER & BILIARY SYSTEM:
The 1900 gm liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder contains 23 ml of green-black bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 240 gm spleen has a smooth, intact, red-purple capsule. The parenchyma is maroon and congested, with distinct Malpighian corpuscles.

PANCREAS:
The pancreas is firm and yellow-tan, with the usual lobular architecture. No mass lesions or other abnormalities are seen.

ADRENALS GLANDS:
The right and left adrenal glands are symmetric, with yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 120 gm, each. The external capsules are removed with great difficulty from the underlying granular, dusky, cortical surfaces of the kidneys. Both kidneys demonstrate scattered cortical cysts ranging in size from ½ to ¾ cm. The cut surfaces are tan-brown and congested with poor demarcation of the cortico-medullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. The bladder is intact and empty. The prostate gland is normal in size with lobular yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, grey mucosa. The stomach contains 400 ml of partially digested food including corn and beans. The gastric wall is intact. The duodenum, loops of small bowel, and colon are unremarkable. The appendix is present.

ADDITIONAL PROCEDURES

- Documentary photographs are taken by (b)(6)-2 OAFME
- Attending the autopsy are SA (b)(6)-1 (b)(3)-1 (b)(3)-1
- Specimens retained for toxicologic testing and/or DNA identification are: brain, liver, spleen, psoas muscle, kidney, lung, vitreous fluid, blood, stomach contents, and bile
- The dissected organs are forwarded with body

- Personal effects are released to the appropriate mortuary operations representatives

MICROSCOPIC EXAMINATION

Selected portions of organs are retained in formalin, without preparation of histologic slides.

TOXICOLOGY

AFIP Accession Number: (b)(6)-4 Dated 7 June 2004
Volatiles: Blood and Bile- No ethanol detected
Cyanide: Blood- no cyanide detected
Drugs: Blood- no drugs of abuse detected, positive for atropine (a resuscitation medication)

OPINION

This 75-year-old man, (b)(6)-4 and Iraqi National detained at the Baghdad Central Detention Facility died of severe atherosclerotic cardiovascular disease. His condition was complicated by marked cardiomegaly.
The manner of death is Natural.

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: (b)(6)-4
Prisoner #(b)(6)-4
Date of Birth: BTB 1940
Date of Death: BTB 22 May 2004
Date of Autopsy: 1 June 2004
Date of Report: 29 Jun 2004

Autopsy No.: ME04-386
AFIP No.: 2929618
Rank: CIV
Place of Death: Abu Ghraib Prison
Place of Autopsy: BIAP Morgue

Circumstances of Death: This male died while in US custody in Abu Ghraib prison. By report he complained of chest pain to his son and then collapsed.

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

Identification: By CID, DNA sample obtained

CAUSE OF DEATH: Atherosclerotic cardiovascular disease (ASCVD)

MANNER OF DEATH: Natural

FINAL AUTOPSY DIAGNOSES:

I. Atherosclerotic cardiovascular disease
   A. Left anterior descending coronary artery with multifocal stenoses ranging from 50-80%
   B. Right coronary artery with multifocal stenoses ranging from 50-85%
   C. Left circumflex coronary artery with focal 50% stenosis
   D. Moderate to severe atherosclerosis of the distal aorta
   E. Thickening of the mitral valve leaflets
   F. Pulmonary congestion (right 800 grams, left 650 grams)
   G. Prominent facial suffusion
   H. Bilateral earlobe creases (Frank's sign)

II. Pleural adhesions
III. Status post appendectomy, remote
IV. Fractures of the anterior ribs (right #5, left #3-7) consistent with cardiopulmonary resuscitation
V. No significant trauma
VI. Toxicology negative

EXTERNAL EXAMINATION

The body is that of a thin male appearing greater than 50 years of age and measuring 69 inches in length and weighing approximately 160 pounds. Lividity is posterior, purple, and fixed. Rigor is passing.

The scalp is covered with gray hair in a normal distribution. There is a gray mustache and beard. Corneal clouding obscures the irides and pupils. The external auditory canals are unremarkable. The ears are significant for bilateral creases of the earlobes (Frank's sign). There is prominent facial suffusion. The nares are patent and the lips are atraumatic. The nose and maxillae are palpably stable. The teeth appear natural with partial upper plates.

The neck is straight, and the trachea is midline and mobile. The chest is symmetric. The abdomen is flat. The genitalia are those of a normal adult male. The testes are descended and free of masses. Pubic hair is present in a normal distribution. The buttocks and anus are unremarkable.

The upper and lower extremities are symmetric and without clubbing or edema.

Identifying marks and scars include a 3 ½ inch oblique scar on the right lower quadrant of the abdomen. On the posterior right arm and forearm is a 6 x 3 ½ inch area of depigmentation of the skin and scar. On the midline of the lower back is a ½ inch scar.

There is early decomposition consisting of skin slippage and vascular marbling.

CLOTHING AND PERSONAL EFFECTS

The following clothing items and personal effects are present on the body at the time of autopsy:

- Brown shirt
- Gray underpants
- Gray t-shirt
- White shirt

MEDICAL INTERVENTION

- Endotracheal tube in the oropharynx that enters the trachea
- Intravenous catheter (IV) in the back of the left hand
- Electrocardiograph (EKG) pads on the chest

RADIOGRAPHS

A complete set of postmortem radiographs is obtained and demonstrates the following:
No radiopaque projectiles or foreign matter

EVIDENCE OF INJURY

There are fractures of the right 5^{th} and left 3^{rd}-7^{th} ribs on the anterior aspects.

INTERNAL EXAMINATION

HEAD:
The galeal and subgaleal soft tissues of the scalp are free of injury. The calvarium is intact, as is the dura mater beneath it. Clear cerebrospinal fluid surrounds the 1250 gm brain, which has unremarkable gyri and sulci. Coronal sections demonstrate sharp demarcation between white and grey matter, without hemorrhage or contusive injury. The ventricles are of normal size. The basal ganglia, brainstem, cerebellum, and arterial systems are free of injury or other abnormalities. There are no skull fractures. The atlanto-occipital joint is stable.

NECK:
The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid are intact. The larynx is lined by intact white mucosa. The thyroid is symmetric and red-brown, without cystic or nodular change. The tongue is free of bite marks, hemorrhage, or other injuries.

The cervical spine is intact and there is no paraspinous muscular hemorrhage.

BODY CAVITIES:
The sternum and vertebral bodies are visibly and palpably intact. No excess fluid is in the pleural, pericardial, or peritoneal cavities. The organs occupy their usual anatomic positions.

There are fractures of the anterior left ribs 3-7 and the right 5^{th} rib on the anterior aspect.

RESPIRATORY SYSTEM:
There are dense fibrous adhesions of both pleural cavities. The right and left lungs weigh 800 and 650 gm, respectively. The external surfaces are deep red-purple. The pulmonary parenchyma is diffusely congested and edematous. No mass lesions or areas of consolidation are present.

CARDIOVASCULAR SYSTEM:
The 400 gm heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show 50-80% multifocal stenoses of the left anterior descending coronary artery, focal 50% calcific stenosis of the left circumflex coronary artery, and 50-75% multifocal stenoses of the right coronary artery with a focal 85% stenosis. The myocardium is homogenous, red-brown, and firm. The mitral valve is thickened and fibrotic but there are no vegetations. The remaining valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.4 and 0.4 cm thick, respectively. The endocardium is smooth and glistening. The aorta has moderate to severe atherosclerosis and gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 1800 gm liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder contains a minute amount of green-black bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 200 gm spleen has a smooth, intact, red-purple capsule. The parenchyma is maroon and congested, with distinct Malpighian corpuscles.

PANCREAS:
The pancreas is firm and yellow-tan, with the usual lobular architecture. No mass lesions or other abnormalities are seen.

ADRENALS:
The right and left adrenal glands are symmetric, with bright yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 175 and 200 gm, respectively. The external surfaces are intact and smooth. The cut surfaces are red-tan and congested, with uniformly thick cortices and sharp corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The bladder contains approximately 10 ml of cloudy urine. The prostate is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, grey-white mucosa. The stomach contains approximately 50 ml of dark green liquid. The gastric wall is intact. The duodenum, loops of small bowel, and colon are unremarkable. The appendix is surgically absent.

ADDITIONAL PROCEDURES

- Documentary photographs are taken by (b)(6)-2
- Specimens retained for toxicologic testing and/or DNA identification are: blood, urine, spleen, liver, lung, kidney, adipose, brain, bile, gastric, and psoas
- The dissected organs are forwarded with the body
- Personal effects are released to the appropriate mortuary operations representatives

MICROSCOPIC EXAMINATION

Selected portions of organs are retained in formalin, without preparation of histologic slides.

TOXICOLOGY

Toxicologic analysis of blood and bile was negative for ethanol and drugs of abuse. Cyanide was not detected.

OPINION

This elderly Iraqi male died of atherosclerotic cardiovascular disease (blockage of the arteries that supply blood and oxygen to the heart). The rib fractures noted at autopsy are consistent with cardiopulmonary resuscitation (CPR). There was no significant trauma.

The manner of death is natural.

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: (b)(6)-4
SSAN (b)(6)-4
Date of Birth: Unknown
Date of Death: BTB 19 May 2004
Date of Autopsy: 1 June 2004
Date of Report: 8 Jul 2004

Autopsy No.: ME04-387
AFIP No.: 292645
Rank: Civ
Place of Death: Abu Ghraib Prison
Place of Autopsy: BIAP Morgue

Circumstances of Death: This male died while in US custody at Abu Ghraib prison.

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

Identification: By family members only, DNA sample obtained

CAUSE OF DEATH: Peritonitis

MANNER OF DEATH: Natural

FINAL AUTOPSY DIAGNOSES:

I. Peritonitis
   A. 3 liters of cloudy brown liquid with feculent material and fibrinous adhesions in the peritoneal cavity
   B. Dense peri-splenic adhesions
   C. No perforations or injuries of the stomach, small bowel, or colon identified at autopsy
   D. Neutrophilic and histiocytic inflammation of the serosa (microscopic)

II. Pulmonary edema and congestion (right lung 1000 grams, left lung 750 grams)
   A. Moderate anthracosis (microscopic)

III. Chronic thyroiditis (microscopic)

IV. Healing 3/8 inch abrasion of the right shin

V. Tooth number 8 absent due to decay (used by family members as identification)

VI. No significant trauma

VII. Toxicology (blood clot)
   A. Meperidine 0.46 mg/L
   B. Promethazine 0.23 mg/L
   C. Diphenhydramine 0.37 mg/L
   D. No ethanol (bile) or illicit substances

EXTERNAL EXAMINATION

The body is that of a thin, 74 inches in length, 160 pounds (estimated), Caucasian male with an estimated age of 40 years.

Lividity is posterior, purple, and fixed. Rigor is absent.

The scalp is covered with black hair in a normal distribution. There is a beard and mustache. The irides are brown and the pupils are round and equal in diameter. The external auditory canals are unremarkable. The ears are unremarkable. The nares are patent and the lips are atraumatic. The nose and maxillae are palpably stable. The teeth appear natural and in poor repair. Tooth # 8 is missing.

The neck is straight, and the trachea is midline and mobile. The chest is symmetric. The abdomen is flat. The genitalia are those of a normal adult male. The testes are descended and free of masses. Pubic hair is present in a normal distribution. The buttocks and anus are unremarkable.

The upper and lower extremities are symmetric and without clubbing or edema.

There is early decomposition consisting of vascular marbling and skin slippage.

CLOTHING AND PERSONAL EFFECTS

The body is received nude at the time of autopsy.

MEDICAL INTERVENTION

There are no attached medical devices at the time of autopsy.

RADIOGRAPHS

No radiopaque foreign objects or displaced fractures are identified.

EVIDENCE OF INJURY

On the anterior right shin is a 3/8 inch red abrasion.

INTERNAL EXAMINATION

HEAD:
The galeal and subgaleal soft tissues of the scalp are free of injury. The calvarium is intact, as is the dura mater beneath it. Clear cerebrospinal fluid surrounds the 1350 gm brain, which has unremarkable gyri and sulci. Coronal sections demonstrate sharp demarcation between white and grey matter, without hemorrhage or contusive injury. The ventricles are of normal size. The basal ganglia, brainstem, cerebellum, and arterial systems are free of injury or other abnormalities. There are no skull fractures. The atlanto-occipital joint is stable.

NECK:
The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid are intact. The larynx is lined by intact white mucosa. The thyroid is symmetric and red-brown, without cystic or nodular change. The tongue is free of bite marks, hemorrhage, or other injuries.

The cervical spine is intact and there is no paraspinous muscular hemorrhage.

BODY CAVITIES:
The peritoneal cavity contains approximately 3 liters of cloudy brown liquid and feculent material. The left pleural cavity contains approximately 400 ml of cloudy brown liquid and has dense fibrous adhesions. The ribs, sternum, and vertebral bodies are visibly and palpably intact. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 1000 and 750 gm, respectively. The external surfaces are smooth and deep red-purple. The pulmonary parenchyma is diffusely congested and edematous. No mass lesions or areas of consolidation are present.

CARDIOVASCULAR SYSTEM:
The 300 gm heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show no significant atherosclerosis. The myocardium is homogenous, red-brown, and firm. The valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.3 and 0.4-cm thick, respectively. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 1450 gm liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder contains a minute amount of green-black bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 200 gm spleen has dense adhesions of the capsule.

PANCREAS:
The pancreas is autolyzed. No mass lesions or other abnormalities are seen.

ADRENALS:
The right and left adrenal glands are symmetric, with bright yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 150 and 175 gm, respectively. The external surfaces are intact and smooth. The cut surfaces are red-tan and congested, with uniformly thick cortices and sharp corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The bladder contains approximately 30 ml of red urine. The prostate is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, grey-white mucosa. The stomach is empty. The gastric wall is intact. The duodenum, loops of small bowel, and colon are unremarkable. The appendix is present and unremarkable.

ADDITIONAL PROCEDURES

- Documentary photographs are taken by (b)(6)-2
- Specimens retained for toxicologic testing and/or DNA identification are: vitreous, blood, urine, spleen, lung, kidney, liver, brain, bile, and psoas
- The dissected organs are forwarded with the body
- Personal effects are released to the appropriate mortuary operations representatives

MICROSCOPIC EXAMINATION

Heart: Sections show no significant pathologic abnormality.
Lungs: Sections show moderate anthracosis, atelectasis, and decomposition.
Thyroid: Sections show chronic inflammation.
Gastrointestinal tract: Sections show mucosal autolysis. Sections of appendix show a mixed, predominantly histiocytic, infiltrate of the attached soft tissue. The muscularis of the appendix has no significant inflammation.
Spleen: Sections show no significant pathologic abnormality.
Liver: Section shows no significant pathologic abnormality.
Pancreas: Section is unremarkable.
Kidney: Section is unremarkable.

TOXICOLOGY

Toxicologic analysis of bile was negative for ethanol and the blood clot was negative for illicit substances. The blood clot was positive for meperidine (0.46 mg/L), promethazine (0.23 mg/L), and diphenhydramine (0.37 mg/L).

OPINION

This Iraqi male died of peritonitis. Significant findings of the autopsy include a large amount of pus within the abdominal cavity. An anatomic source of the infection was not identified. Although trauma cannot be completely excluded as a potential source for peritonitis this is unlikely given the absence of visible injury to the organs of the abdominal cavity. Toxicology was positive for medications used for pain (meperidine), nausea (promethazine), and an antihistamine (diphenhydramine).

The manner of death is natural.

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

FINAL AUTOPSY EXAMINATION REPORT

Name: (b)(6)-4
SSAN: (b)(6)-4
Date of Birth: Unknown
Date of Death: 18 AUG 2004
Date of Autopsy: 30 AUG 2004
Date of Report: 12 OCT 2004

Autopsy No.: ME04-629
AFIP No.: 2940934
Rank: Detainee in U.S. Custody
Place of Death: Iraq
Place of Autopsy: BIAP Mortuary, Baghdad, Iraq

Circumstances of Death: This Iraqi male was a detainee in U.S. custody at Abu Ghraib prison in Baghdad, Iraq. A group of prisoners became unruly and the guards used lethal force to subdue the crowd. A shotgun was fired and this detainee was struck and killed.

Authorization for Autopsy: Armed Forces Medical Examiner, per 10 U.S. Code 1471

Identification: Circumstantial identity is established by paperwork accompanying the detainee and his designation as detainee number (b)(6)-4

CAUSE OF DEATH: Shotgun Wound of the Head

MANNER OF DEATH: Homicide

FINAL AUTOPSY DIAGNOSES:

I. **Shotgun Wound of the Head**

   A. **Penetrating Shotgun Wound of the Head**
      1. **Entrance: Right side of the back of the head; no evidence of close-range discharge of a firearm on the surrounding scalp**
      2. **Wound Path: Right parietal-occipital scalp, parietal-occipital skull, right cerebrum, left cerebrum**
      3. **Recovered: Deformed metallic foreign body located between the medial aspect of the left frontal lobe and the overlying dura**
      4. **Wound Direction: Right to left, back to front, and upward**
      5. **Associated Injuries: Subgaleal, subdural and subarachnoid hemorrhages, bilateral basilar skull fractures, cerebral contusions, and bone fragments along the hemorrhagic wound path**

II. **No evidence of significant natural disease processes, within the limitations of the examination**

III. **Changes of early to moderate decomposition**

IV. **The recovered projectile is placed in a labeled container and given to the investigating agent who was present at the autopsy**

V. **Toxicology is positive for morphine at a concentration of 0.23 mg/L in the blood. No ethanol or other drugs of abuse are detected.**

EXTERNAL EXAMINATION

The remains are received without clothing. No identification bands are present on the body. The unclad body is that of a well-developed, well-nourished appearing, 69-inches, 140-pounds (estimated), White male. The age of the individual is not known. Lividity is posterior and fixed, except in areas exposed to pressure. Rigor has passed. The body temperature is that of the refrigeration unit. Early to moderate decomposition changes are present, including mild skin slippage, prominent vascular marbling, and clouding of the corneae.

The scalp is covered with medium length, brown hair in a normal distribution. Facial hair consists of a beard and mustache. The irides are brown and the pupils are round and equal in diameter. The external ears are unremarkable. The nose and maxillae are palpably stable. Bloody fluid is present in the nares. The teeth are natural and in fair condition.

The neck is mobile and the trachea is midline. The chest is symmetric. The abdomen is flat. The external genitalia are those of a normal adult male. Pubic hair is shaved. There is no evidence of external trauma to the urogenital area. The buttocks and anus are unremarkable. There are areas of hypopigmentation present on the lower trunk and the extremities.

The upper and lower extremities are symmetric and without clubbing or edema. The fingernails are intact. No tattoos or significant identifying body marks are present. Black writing is present on both sides of the chest; "log #2" is on the right side and a series of illegible numbers is on the left side.

EVIDENCE OF MEDICAL INTERVENTION

- Vascular access devices in the left arm, both antecubital fossae, and the left subclavian area
- Oral-gastric intubation
- Endotracheal intubation
- Foley catheterization
- Electrocardiogram monitoring pads on the upper right chest and the left hip
- Contusion over the sternum, consistent with cardiopulmonary resuscitation

RADIOGRAPHS

Full body radiographs are obtained and show a metallic foreign body in the head.

EVIDENCE OF INJURY

I. Shotgun Wound of the Head

There is a penetrating ballistic entrance wound on the right side of the back of the head, situated 4 3/8-inches below the top of the head and 2 ¼-inches right of the posterior midline. The ovoid wound is ¼ x 3/16-inches, with a 1/16-inch marginal

abrasion from the 3 to 6 o'clock positions. No soot deposition or gunpowder stippling is present on the surrounding skin. The wound path goes through the occipital scalp and includes a 5/16 x 3/8-inch defect in the right side of the occipital bone, with appropriate beveling. The wound path through the brain perforates the right occipital, right parietal, and both frontal lobes. A slightly deformed, round, metallic projectile is recovered from the dura overlying the medial aspect of the left frontal lobe of the brain at the anterior midline. The projectile is placed in a labeled container and turned over to the investigating USACID agent present at the autopsy. The wound direction is right to left, back to front, and upward. Injuries associated with the wound path include fine linear fractures extending across the middle fossae of the basilar skull, a 1-inch linear fracture of the occipital bone extending from the 4 o'clock position of the entrance wound skull defect, and subgaleal, subdural, and subarachnoid hemorrhages. Scattered cerebral contusions and bone fragments along the hemorrhagic wound path are also present.

INTERNAL EXAMINATION

HEAD:
Injuries of the head have been described previously. The vessels at the base of the brain have a normal distribution and appearance. The brain weighs 1150-grams.

NECK:
The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact white mucosa. The thyroid gland is symmetric and red-brown, without cystic or nodular change. The tongue is free of bite marks, hemorrhage, or other injuries.

BODY CAVITIES:
The ribs, sternum, and vertebral bodies are visibly and palpably intact. Both pleural cavities contain 100-milliliters of decomposition fluid and the pericardial sac contains 20-milliliters of decomposition fluid. There is no abnormal accumulation of fluid in the peritoneal cavity. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 580 and 550-grams, respectively. The external surfaces are smooth and deep red-purple, with moderate anthracotic mottling. The pulmonary parenchyma is diffusely congested and edematous. No mass lesions or areas of consolidation are present. The pulmonary arteries are unremarkable.

CARDIOVASCULAR SYSTEM:
The 220-gram heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show no significant atherosclerosis. The myocardium is homogenous, red-brown, and soft, with early decompositional changes. The valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.1 and 0.3-centimeters thick, respectively. The endocardium is smooth. The aorta gives rise to three intact and patent arch vessels. Fatty streaking of the aorta is noted. The renal and mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 1050-gram liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture and changes of early decomposition. No mass lesions or other abnormalities are seen. The gallbladder contains 15-milliliters of green-black bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 240-gram spleen has a smooth, intact, red-purple capsule. The parenchyma is soft, maroon, and congested, with changes of early decomposition.

PANCREAS:
The pancreas has the usual lobular architecture and early decompositional changes. No mass lesions or other abnormalities are seen.

ADRENAL GLANDS:
The right and left adrenal glands are symmetric, with yellow cortices, gray medullae, and decompositional changes. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 150 and 120-grams, respectively. The external surfaces are intact and smooth. The cut surfaces are red-tan and congested, with uniformly thick cortices and distinct corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The urinary bladder is empty. The prostate gland is unremarkable. The testes have no masses and exhibit no evidence of trauma.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, hemorrhagic appearing mucosa. The stomach contains approximately 70-milliliters of dark brown fluid. The gastric wall is intact. The duodenum, loops of small bowel, and colon are unremarkable. The appendix is present.

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

MICROSCOPIC EXAMINATION

Selected portions of organs are retained in formalin, without preparation of histologic slides

ADDITIONAL PROCEDURES/REMARKS

- Documentary photographs are taken by OAFME staff photographer, (b)(6)-2 (b)(6)-2
- Specimens retained for toxicologic testing and/or DNA identification are: heart blood, spleen, liver, brain, bile, lung, kidney, adipose, and psoas muscle
- Full body radiographs are obtained and demonstrate the metallic foreign body subsequently recovered from the brain
- The dissected organs are forwarded with body

OPINION

This White male detainee in U.S. custody died as a result of a shotgun wound of the head that caused injury to the skull and brain. Toxicology was positive for morphine, which was likely the result of medical therapy received prior to death. One metallic projectile was recovered from the head and turned over to the investigating USACID agent who was present at the autopsy. The manner of death is homicide.

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

FINAL AUTOPSY EXAMINATION REPORT

Name: (b)(6)-4
SSAN: (b)(6)-4
Date of Birth: Unknown
Date of Death: 18 AUG 2004
Date of Autopsy: 30 AUG 2004
Date of Report: 12 OCT 2004

Autopsy No.: ME04-630
AFIP No.: 2940933
Rank: Detainee in U.S. Custody
Place of Death: Iraq
Place of Autopsy: BIAP Mortuary, Baghdad, Iraq

Circumstances of Death: This Iraqi male was a detainee in U.S. custody at Abu Ghraib prison in Baghdad, Iraq. A group of prisoners became unruly and the guards used lethal force to subdue the crowd. A shotgun was fired and this detainee was struck and killed.

Authorization for Autopsy: Armed Forces Medical Examiner, per 10 U.S. Code 1471

Identification: Circumstantial identity is established by paperwork accompanying the detainee and his designation as detainee number (b)(6)-4

CAUSE OF DEATH: Shotgun Wound of the Chest

MANNER OF DEATH: Homicide

FINAL AUTOPSY DIAGNOSES:

I. Shotgun Wounds of the Torso and Both Arms

A. Penetrating Shotgun Wound of the Chest
1. Entrance: Left side of the back; no evidence of close-range discharge of a firearm on the surrounding skin
2. Wound Path: Skin, subcutaneous tissue, and muscle of the left back, posterior left 9th rib (with fracture), lower lobe of left lung, left atrium, right atrium, upper lobe of the right lung, intercostal space below the anterior aspect of the right 2nd rib, muscle and subcutaneous tissue of the right upper chest
3. Recovered: Deformed metallic foreign body located in the subcutaneous tissue of the right upper chest
4. Wound Direction: Left to right, back to front, and upward
5. Associated Injuries: Bilateral hemothoraces (right 1400-milliliters; left 2100-milliliters), hemopericardium (50-milliliters)

B. Perforating Shotgun Wound of the Right Upper Back
1. Entrance: Right upper back; no evidence of close-range discharge of a firearm on the surrounding skin
2. Wound Path: Skin and subcutaneous tissue of the right upper back (tangential wound path)
3. Exit: Right upper back; no projectile recovered
4. Wound Direction: Left to right and slightly upward

C. Perforating Shotgun Wound of the Right Arm
1. Entrance: Posterior right arm; no evidence of close-range discharge of a firearm on the surrounding skin
2. Wound Path: Skin, subcutaneous tissue, and muscle of the posterior right arm; muscle, subcutaneous tissue, and skin of the anterior right arm
3. Exit: Anterior right arm; no projectile recovered
4. Wound Direction: Left to right and back to front (with the body in anatomic position)

D. Perforating Shotgun Wound of the Left Arm
1. Entrance: Posterior left arm; no evidence of close-range discharge of a firearm on the surrounding skin
2. Wound Path: Skin, subcutaneous tissue, and muscle of the posterior left arm; muscle, subcutaneous tissue, and skin of the anterior left arm
3. Exit: Anterior left arm; no projectile recovered
4. Wound Direction: Left to right, back to front, and downward (with the body in anatomic position)

II. **No evidence of significant natural disease processes, within the limitations of the examination**

III. **Changes of early to moderate decomposition**

IV. **The recovered projectile is placed in a labeled container and turned over to the investigating agent who was present at the autopsy**

V. **Toxicology is negative for ethanol and drugs of abuse**

EXTERNAL EXAMINATION

The remains are received clad in a cut away green shirt and white, boxer type shorts. No identification band is noted on the body, but the sequence of numbers (b)(6)-4 is written on the lower chest left of the anterior midline. The body is in an early to moderate state of decomposition, with changes that include clouding of the corneae, loss of turgor of the globes of the eyes, marbling of the soft tissue, and generalized skin slippage. Bloody fluid is present in the oral cavity.

The body is that of a well-developed, well-nourished appearing, 70 ½-inches, 180-pounds (estimated), White male. The age of the individual is unknown. Lividity is posterior and fixed, except in areas exposed to pressure. Rigor has passed. The body temperature is that of the refrigeration unit.

The scalp is covered with medium length, black hair in a normal distribution. Facial hair consists of a black beard. The irides are brown and the pupils are round and equal in diameter. The external ears are unremarkable. The nose and maxillae are palpably stable. The teeth are natural and in fair condition.

The neck is mobile and the trachea is midline. The chest is symmetric. The abdomen is flat. The external genitalia are those of a normal adult, circumcised, male. Both testes are descended into the scrotum. Pubic hair is present in a normal distribution. There is no evidence of external trauma to the urogenital area. The buttocks and anus are unremarkable.

The upper and lower extremities are symmetric and without clubbing or edema. The fingernails are intact. No tattoos or other significant identifying body marks are noted.

EVIDENCE OF MEDICAL INTERVENTION

- Electrocardiogram monitoring pads on both sides of the upper chest and on the left lower quadrant of the abdomen
- Gauze dressing is tied around the wrists and feet

RADIOGRAPHS

Full body radiographs are obtained and show a metallic foreign body on the right side of the upper torso.

EVIDENCE OF INJURY

I. Shotgun Wounds of the Torso and Both Arms

A. Penetrating Shotgun Wound of the Chest

There is an entrance shotgun wound on the left side of the back, situated 18-inches below the top of the head and 3 ½-inches left of the posterior midline. No soot deposition or gunpowder stippling is present on the surrounding skin. The 3/16-inch wound has a 1/8-inch marginal abrasion between 5 and 8 o'clock. The wound path goes through the skin, subcutaneous tissue, and muscle of the left side

of the back and enters the pleural cavity through the posterior aspect of the left 9th rib, which is fractured. The path then continues through the lower lobe of the left lung, the pericardium, both atria of the heart, the pericardium, and the upper lobe of the right lung. The wound path then exits the right pleural cavity below the anterior aspect of the right 2nd rib and perforates the chest wall musculature. A deformed, metallic projectile is recovered from the subcutaneous tissue of the right upper chest. The projectile is placed in a labeled container and turned over to the investigating USACID agent. Injuries associated with the wound path include bilateral hemothoraces (right 1400 milliliters; left 2100-milliliters) and hemopericardium (50-milliliters). The direction of the wound path is left to right, back to front, and upward.

B. Perforating Shotgun Wound of the Right Upper Back

There is an entrance shotgun wound on the right upper back, situated 16-inches below the top of the head and 7 1/8-inches right of the posterior midline of the body. The 5/16-inch wound has a ½ x 5/8-inch eccentric marginal abrasion between 6 and 12 o'clock. No soot deposition or gunpowder stippling is present on the surrounding skin. The wound path goes through skin and subcutaneous tissue prior to exiting the body through a ¼-inch skin defect situated 15-inches below the top of the head and 8-inches right of the posterior midline. A ¼ x ¼-inch eccentric marginal abrasion is present between 12 and 6 o'clock. No bullet or bullet fragments are recovered. The direction of the wound path is left to right and slightly upward.

C. Perforating Shotgun Wound of the Right Arm

There is an entrance shotgun wound on the posterior aspect of the right arm, situated 6-inches below the top of the right shoulder and 2-inches medial of the posterior midline of the right arm. The 1/4-inch, irregular, defect is surrounded by a minimal ring of contusion. No soot deposition or gunpowder stippling is present on the surrounding skin. The wound path goes through the skin, subcutaneous tissue, and muscle of the posterior right arm and the muscle, subcutaneous tissue, and skin of the anterior right arm. A ¼-inch exit wound within a 1 ½ x 1-inch area of contusion is situated 6-inches below the top of the right shoulder and 1 ¾-inches lateral to the anterior midline of the right arm. No bullet or bullet fragments are recovered. The direction of the wound path is left to right and back to front.

D. Perforating Shotgun Wound of the Left Arm

There is an entrance shotgun wound on the posterior aspect of the left arm, situated 5-inches below the top of the left shoulder and 2-inches medial to the posterior midline of the left arm. The 1/4-inch, irregular, ovoid defect has no associated abrasion or contusion. No soot deposition or gunpowder stippling is present on the surrounding skin. The wound path goes through the skin, subcutaneous tissue, and muscle of the posterior left arm and the muscle, subcutaneous tissue, and skin of the anterior left arm. A ¼-inch exit wound within a 1-inch area of contusion is situated 7 1/4-inches below the top of the left

shoulder and ¼-inch medial to the anterior midline of the left arm. No bullet or bullet fragments are recovered. The direction of the wound path is left to right, back to front, and downward.

INTERNAL EXAMINATION

HEAD:
The scalp is uninjured. There are no skull fractures or other evidence of significant trauma present. The calvarium is removed to demonstrate an absence of epidural or subdural hemorrhage. Examination of the brain reveals a normal pattern of gyri and sulci. Serial sectioning reveals no evidence of traumatic or atraumatic abnormalities. The vessels at the base of the brain have a normal distribution and appearance. The brain weighs 1380-grams.

NECK:
The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact white mucosa. The thyroid gland is symmetric and red-brown, without cystic or nodular change. The tongue is free of bite marks, hemorrhage, or other injuries.

BODY CAVITIES:
The ribs, sternum, and vertebral bodies are visibly and palpably intact. Injuries to the chest and mediastinum have been described previously. There is no abnormal accumulation of fluid in the peritoneal cavity. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 320 and 180-grams, respectively, and have the previously described injuries. The external surfaces are deep red-purple. No mass lesions or areas of consolidation are present. The pulmonary arteries are free of emboli.

CARDIOVASCULAR SYSTEM:
The 310-gram heart has the previously described injuries. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show no significant atherosclerosis. The myocardium is homogenous, red-brown, and firm. The valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.4 and 0.5-centimeters thick, respectively. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 1450-gram liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder is empty. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 180-gram spleen has a smooth, intact, red-purple capsule. The parenchyma is soft, maroon, and congested, with early decompositional changes.

PANCREAS:
The pancreas exhibits early to moderate decompositional changes.

ADRENAL GLANDS:
The right and left adrenal glands are symmetric, with yellow cortices, gray medullae, and early decompositional changes. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 140 and 110-grams, respectively. The external surfaces are intact and smooth. The cut surfaces are red-tan and congested, with uniformly thick cortices and sharp corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The urinary bladder contains 150-milliliters of light yellow urine.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, hemorrhagic appearing mucosa. The stomach contains approximately 100-milliliters food particles, including beans and rice. The gastric wall is intact. The duodenum, loops of small bowel, and colon are unremarkable. The appendix is present.

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

MICROSCOPIC EXAMINATION

Selected portions of organs are retained in formalin, without preparation of histologic slides

ADDITIONAL PROCEDURES/REMARKS

- Documentary photographs are taken by OAFME staff photographer, (b)(6)-2 (b)(6)-2
- Specimens retained for toxicologic testing and/or DNA identification are: cavity blood, spleen, liver, brain, bile, urine, lung, gastric contents, kidney, and psoas muscle
- Full body radiographs are obtained and demonstrate the metallic foreign body subsequently recovered from the right chest wall
- The dissected organs and clothing are forwarded with body

OPINION

This White male detainee in U.S. custody died as a result of a shotgun wound to the chest that caused injury to the lungs and heart. There was also extensive bleeding into the chest cavity. A metallic projectile was recovered from the subcutaneous tissue of the right upper chest and turned over to the USACID Agent who was present at the autopsy. Additional shotgun wound paths involved the right upper back and both arms. The location and appearance of the wound paths involving the right upper back and right arm make it likely that a single projectile resulted in both wounds, with re-entry of the projectile into the right arm after exiting the right back. The manner of death is homicide.