


**ARMED FORCES INSTITUTE OF PATHOLOGY**
**Office of the Armed Forces Medical Examiner**

1413 Research Blvd., Bldg. 102

Rockville, MD 20850

1-800-944-7912

**PRELIMINARY AUTOPSY REPORT**

Name: (b)(6)-4

SSAN: NA

Date of Birth: Unknown

Date of Death: BTB 19 May 2004

Date of Autopsy: 1 June 2004

Date of Report: 1 June 2004

Autopsy No.: ME04-387

AFIP No.: Pending

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. There is a verbal report only of pain.

**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 of undetermined etiology

**MANNER OF DEATH:** Natural

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.

## AUTOPSY REPORT ME04-387

(b)(6)-4

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## PRELIMINARY AUTOPSY DIAGNOSES:

- I. Peritonitis
  - A. 3 liters of cloudy brown liquid with feculent material and fibrinous adhesions
  - B. Dense peri-splenic adhesions
  - C. No perforations or injuries of the stomach, small bowel, or colon identified at autopsy
- II. Pulmonary edema and congestion (right lung 1000 grams, left lung 750 grams)
- III. Healing 3/8 inch abrasion of the right shin
- IV. Tooth number 8 absent due to decay (used by family members as identification)
- V. No significant trauma
- VI. Toxicology and histology pending

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MD

MAJ, MC, USA  
Deputy Medical Examiner



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[redacted] (b)(6)-4

**AUTOPSY EXAMINATION REPORT**

Name: [redacted]

Autopsy No.: ME04-387

SSAN: NA

AFIP No.: 292645

Date of Birth: Unknown

Rank: Civ

Date of Death: BTB 19 May 2004

Place of Death: Abu Ghraib Prison

Date of Autopsy: 1 June 2004

Place of Autopsy: BIAP Morgue

Date of Report: 8 Jul 2004

**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

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**AUTOPSY REPORT ME04-387**

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**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

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**AUTOPSY REPORT ME04-387**

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**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.

AUTOPSY REPORT NO. 04-387

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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.

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**AUTOPSY REPORT ME04-387**

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**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 PH3 (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).

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**AUTOPSY REPORT ME04-387**

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**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.

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MD

MAJ, MC, USA  
Deputy Medical Examiner

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Ex. 6

REPLY TO  
ATTENTION OF

**DEPARTMENT OF DEFENSE  
ARMED FORCES INSTITUTE OF PATHOLOGY  
WASHINGTON, DC 20306-6000**

AFIP-CME-T

TO:

**OFFICE OF THE ARMED FORCES MEDICAL  
EXAMINER  
ARMED FORCES INSTITUTE OF PATHOLOGY  
WASHINGTON, DC 20306-6000**

**PATIENT IDENTIFICATION**

AFIP Accessions Number	Sequence
2929645	01

Name

(b)(6)-4

SSAN: Autopsy: ME04-387  
 Toxicology Accession #: 042888  
 Date Report Generated: June 28, 2004

**CONSULTATION REPORT ON CONTRIBUTOR MATERIAL****AFIP DIAGNOSIS****REPORT OF TOXICOLOGICAL EXAMINATION****Condition of Specimens: GOOD****Date of Incident: 5/19/2004****Date Received: 6/17/2004**

**VOLATILES:** The BILE was examined for the presence of ethanol at a cutoff of 20 mg/dL. No ethanol was detected.

**DRUGS:** The BLOOD CLOT was screened for amphetamine, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, cocaine, dextromethorphan, lidocaine, narcotic analgesics, opiates, phencyclidine, phenothiazines, sympathomimetic amines and verapamil by gas chromatography, color test or immunoassay. The following drugs were detected:

**Positive Narcotic Analgesic:** Meperidine was detected in the blood clot by gas chromatography and confirmed by gas chromatography/mass spectrometry. The blood clot contained 0.46 mg/L of meperidine as quantitated by gas chromatography.

**Positive Phenothiazine:** Promethazine was detected in the blood clot by gas chromatography and confirmed by gas chromatography/mass spectrometry. The blood clot contained 0.23 mg/L of promethazine as quantitated by gas chromatography.

**Positive Antihistamine:** Diphenhydramine was detected in the blood clot by gas chromatography and confirmed by gas chromatography/mass spectrometry. The blood clot contained 0.37 mg/L of diphenhydramine as quantitated by gas chromatography.

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 (b)(3)-1 PhD  
 Certifying Scientist,  
 Office of the Armed Forces Medical Examiner

(b)(6)-2  
 (b)(3)-1 DMR BARRET  
 Director,  
 Office of the Armed Forces Medical Examiner

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0124-04-CID259-80199

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EXHIBIT 6

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Rockville, MD 20850

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### PRELIMINARY AUTOPSY REPORT

Name: (b)(6)-4

SSAN: N/A

Date of Birth: BTB 1943

Date of Death: 8 FEB 2004

Date of Autopsy: 28 FEB 2004

Date of Report: 28 FEB 2004

Autopsy No.: ME 04-100

AFIP No.: Pending

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.

**CAUSE OF DEATH:** Atherosclerotic Cardiovascular Disease

**MANNER OF DEATH:** Natural

### PRELIMINARY 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.

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.

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**AUTOPSY REPORT ME04-100**

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II. Mild to moderate decomposition.

III. Toxicology pending.



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D.O.

MAJ MC USA

Deputy Medical Examiner



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FINAL AUTOPSY EXAMINATION REPORT

Name: (b)(6)-2

SSAN: N/A

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

Bağdad 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

AUTOPSY REPORT ME04-100  
(b)(6)-4

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## 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.

AUTOPSY REPORT ME04-100

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EXTERNAL EXAMINATION

The body is that of a cachetic male Iraqi national. The body weighs approximately 130 pounds, is 69 1/2 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

AUTOPSY REPORT ME04-100

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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.

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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 pelvis 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.

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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.

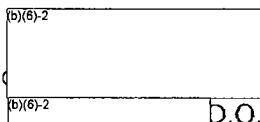
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AUTOPSY REPORT ME04-100

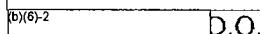
(b)(6)-4

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.



m.m.



D.O.

MAJ MC USA  
Deputy Medical Examiner



**REPLY TO  
ATTENTION OF**

**DEPARTMENT OF DEFENSE  
ARMED FORCES INSTITUTE OF PATHOLOGY  
WASHINGTON, DC 20306-6000**

AFIP-CME-T

## **PATIENT IDENTIFICATION**

**AFIP Accessions Number**      **Sequence**  
2917546                          00

Name \_\_\_\_\_

(b)(6)-4

**SSAN:** Autopsy: ME04-100  
**Toxicology Accession #:** 041072  
**Report Date:** MARCH 15, 2004

## **CONSULTATION REPORT ON CONTRIBUTOR MATERIAL**

## AFIP DIAGNOSIS

## REPORT OF TOXICOLOGICAL EXAMINATION

**Condition of Specimens: GOOD**

Date of Incident:                      Date Received: 3/3/2004

**CYANIDE:** There was no cyanide detected in the chest blood. The limit of quantitation for cyanide is 0.25 mg/L. Normal blood cyanide concentrations are less than 0.15 mg/L. Lethal concentrations of cyanide are greater than 3 mg/L.

**VOLATILES:** The BLOOD AND URINE were examined for the presence of ethanol (cutoff of 20 mg/dL), acetaldehyde, acetone, 2-propanol, 1-propanol, t-butanol, 2-butanol, iso-butanol and 1-butanol by headspace gas chromatography. The following volatiles were detected: (concentration(s) in mg/dL)

	Acetaldehyde	Ethanol	Acetone	1-Propanol
BLOOD		69	Trace	Trace
URINE	Trace	31	Trace	6

Trace = value greater than or equal to 1 mg/dL, but less than 5 mg/dL.

**DRUGS:** The BLOOD was screened for amphetamine, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, cocaine, dextromethorphan, lidocaine, narcotic analgesics, opiates, phencyclidine, phenothiazines, sympathomimetic amines and verapamil by gas chromatography, color test or immunoassay. The following drugs were detected:

None were found

(b)(8)-2 [redacted], PhD  
Certifying Scientist (b)(3)-1  
Office of the Armed Forces Medical Examiner

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(b)(8)-2 PhD, DABFT  
Director, Forensic (b)(3)-1  
Office of the Armed Forces Medical Examiner

MEDCOM - 605

## **EXHIBIT**

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0025 - 04 CID 469 - 79635

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

NAME OF DECEASED (Last, First, Middle) Nom du décédé (Nom et prénoms) (b)(6)-4		GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
ORGANIZATION Organisation Detainee in Iraq		NATION (e.g., United States) Pays Iraq	DATE OF BIRTH Date de naissance	SEX Sexe <input checked="" type="checkbox"/> MALE Masculin <input type="checkbox"/> FEMALE Féminin
RACE Race		MARITAL STATUS État Civil		RELIGION Culte
<input checked="" type="checkbox"/> CAUCASOID Caucasian  <input type="checkbox"/> NEGROID Negroid  <input type="checkbox"/> OTHER (Specify) Autre (Spécifier)	SINGLE Célibataire	<div style="display: flex; justify-content: space-around; align-items: center;"> <div>DIVORCED Divorcé</div> <div>PROTESTANT Protestant</div> </div> <div style="display: flex; justify-content: space-around; align-items: center;"> <div>MARRIED Marié</div> <div>CATHOLIC Catholique</div> </div> <div style="display: flex; justify-content: space-around; align-items: center;"> <div>WIDOWED Veuf</div> <div>SEPARATED Séparé</div> <div>JEWISH Juif</div> </div>	OTHER (Specify) Autre (Spécifier)	
NAME OF NEXT OF KIN Nom du plus proche parent		RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit		
STREET ADDRESS Domicile à (Rue)		CITY OR TOWN AND STATE (Include ZIP Code) Ville (Code postal compris)		
<b>MEDICAL STATEMENT Déclaration médicale</b>				
CAUSE OF DEATH (Enter only once cause per line) Cause du décès (N'indiquer qu'une cause par ligne)				INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et la mort
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <sup>1</sup> Maladie ou condition directement responsable de la mort <sup>1</sup>		Atherosclerotic Cardiovascular Disease		
ANTECEDENT CAUSES  Symptômes précurseurs de la mort.	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire			
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire			
OTHER SIGNIFICANT CONDITIONS <sup>2</sup> Autres conditions significatives <sup>2</sup>				
MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée <input checked="" type="checkbox"/> YES Oui <input type="checkbox"/> NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures		
<input checked="" type="checkbox"/> NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie			
ACCIDENT Mort accidentelle				
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste (b)(6)-2 MAJ MC USA			
HOMICIDE Homicide	(b)(6)-2	DATE Date 28 Feb 2004	AVIATION ACCIDENT Accident à Avion <input type="checkbox"/> YES Oui <input checked="" type="checkbox"/> NO Non	
DATE OF DEATH (Hour, Date de décès (l'heure, le jour, le mois, l'année) 08 Feb 2004		PLACE OF DEATH Lieu de décès Tikrit, Iraq		
I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE. J'ai examiné les restes mortels du défunt je conclus que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci-dessus.				
NAME OF MEDICAL OFFICER Nom du médecin militaire ou du médecin sanitaire (b)(6)-2	TITLE OR DEGREE Titre ou diplôme Deputy Medical Examiner			
GRADE Grade MAJ	INSTALLATION OR ADDRESS Installation ou adresse Dover AFB, DE 19902 (b)(6)-2			
DATE Date 13 MAY 04	<div style="display: flex; align-items: center;"> <span style="font-size: 2em; margin-right: 10px;">P</span> <span style="margin-right: 10px;">M.Y.T. Jr.</span> </div>			
<small>           1 State disease, injury or complication which contributed to death, but not related to the disease or condition causing death.            2 Precise the nature of the malady, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du cœur, etc.            1 Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du cœur, etc.            2 Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.         </small>				

DD FORM 2064

REPLACES DA FORM 3565, 1 JAN 72 AND DA FORM 3565-R(PAS), 26 SEP 75, WHICH ARE OBSOLETE.

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Law Enforcement Sensitive

MEDCOM - 606

**EXHIBIT**

35  
9

0181-04-C10259-60228  
0074-04-C10789

PRISONER IN-PROCESSING MEDICAL SCREEN

(b)(6)-4 [REDACTED]

NAME [REDACTED]

DATE 12 Jun 04

COMPOUND  
DOB

HISTORY BY TRANSLATOR  NO

NAME OF TRANSLATOR [REDACTED] B6-2

1956

48

DO YOU HAVE ANY NEW MEDICAL PROBLEMS OR INJURIES NOW?

Ø

DID YOU EVER HAVE TUBERCULOSIS? IF YES, WHEN AND HOW WERE YOU TREATED?

Ø

DO YOU HAVE A COUGH FOR MORE THAN 2 WEEKS? YES

DO YOU BEEN COUGHING UP BLOOD? YES

DO YOU BEEN LOSING A LOT OF WEIGHT? UNK

YES

YES

YES

NO

CHRONIC MEDICAL PROBLEMS (DIABETES, HYPERTENSION, HEART DISEASE)

HTN, IRREG HR.

ONE OR MORE

(b)(6)-2

CAPATIN

ARE YOU ABLE TO WALK UNASSISTED? YES  NO

ARE YOU ABLE TO FEED YOURSELF? YES  NO

NEEDS TO MEDICATIONS? NKA

HR 89

BLOOD PRESSURE 130/80

RESPIRATORY RATE 16

WEIGHT 245

HEIGHT 5'8

SIGNATURE 11/12

B6-2

ABUSE PT CLAIMS HE WAS  
PUNCHED  
IN STOMACH  
YESTERDAY  
By SOLDIER

ANSWER TO QUESTIONS 1-4 REQUIRES REFERRAL TO MD OR PA, UNLESS MINOR PROBLEM

TO QUESTION 5 AND TO QUESTION 5 OR 6 ALSO REQUIRES MD/PAT EVALUATION

MD/PAT FOLLOW UP NOTE DATE

ASSESSMENT

Refer to SF 600

Dated 16 Jun 04

TRANSLATOR SIGNATURE

B6-2

#  
= 000

TRANSLATOR SIGNATURE

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USE ONLY  
LAW ENFORCEMENT SENSITIVE

Exhibit 3

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

0074-04-C10784

DATE

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

16 June 04 9) 48 y/o ♂ Detainee referred by medic for evaluation.  
 P 92 Pt has multiple complaints.  
 BP 110 / 80 # 1 - Pt reports he was punched in the stomach after while  
 R 19 being transported in helicopter. He reports this was done by coalition forces.  
 # 2 IHN well control with propantheline and cimetidine. He was  
 started on metformin and pravastatin when seen by JIDC provider.  
 His BP was NC TOBT.  
 O IHN  
 PMH C) WND 3 NAD vs Stand GATM - NC  
 PSH - 10mm wound - IED 25-30mm Nerves: CN TB - T11, C4 - T1 motor + L1 - S2 motor  
 9 children  
 FH - married twice GROSSLY DISTORTED (7) DRS - 2+ (13)  
 - d 5004  
 SH - b tamoxifen HEENT - NC NECK - Supple  
 MCV Lungs - CTA (7) Heart - RR 12  
 Allergies - N/A ABG - O2Sat with large surgical scar otherwise benign  
 Genitals - NC ♂ ↓ T8S8S  
 LBT moves - LLL  
 ENTENTOMETER - NC for Echinococcus or scabies

A) 1. Pt Admits abuse by coalition forces  
 2. IHN

(b)(6)-2

B) 1. Refer to COT

2. Continue CTA and pravastatin as directed RET, SP, US  
 3. case and plan discussed @ length = pt through interpretation

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  
ISN: [redacted]

COMPOUND: B4

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)

Prescribed by GSA/ICMR

FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

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 LAW ENFORCEMENT SENSITIVE

Exhibit 3

08138-04-CID259-80202

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE			
DATE		SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)			
31 May 64	S - 42 y/o ♂	Definite referred by CIV for complaint			
CUFF 198/174	Mild physical + history. Otherwise his BP was elevated				
BR - 110/114	today in clinic. He denies any current chest pain				
C - 107	headache or visual changes				
T - 99.1					
R - 18	o) which 8° NAW vs ↑ BP ABNORMAL Gait - NC				
	Nerve CN II - CN XII, C4-T1 motor + C2-S2 motor gross intact				
28/11 -	OTRs 2+ (D)				
154 - 4	Height - 6'10 children	Heart - Systolic tachycardia or thyrotoxicosis			
FH - parental Leber's optic neuropathy	Lungs - (-)	Heart - RRR & murmurs			
SH - 6 CG 80 x 15 hours	ABD - Bowel	Colon - 1 cm mass on C: possible "lipoma" x 10 yrs			
MED - NO current		Stool - Brown H&G			
Allergies - NKA		Rectal - At sphincter tone no masses or hemorrhoids.			
		Prostate - smooth, symmetrical neg for nodules			
150/180 Q	CVT - moves all w/ pulse equal (B)				
135/180 Q	Pulses - Integumentary - neg for acute scabs, ecchymosis or lacerations				
A)	1. ↑ BP	2. Benign testicular mass x 10 yrs - probable GIC			
	3. Otherwise NL PE				
P)	1. Flu or sick call per provider BR checks				
	2. Use and plan discussed with pt through (b)(6)-2				
HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE			
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR			

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

NAME:

(b)(6)-4

RANK:

REGISTER NO.

WARD NO.

SSN:

DOB:

UNIT:

V C

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-67)

Prescribed by GSA/ICMR

FIRMA (41 CFR) 201-9.202-1

USAPA V2.00

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE		
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
<b>REPORT OF DETAINEE MEDICAL SCREENING:</b>			
History of Past Medical Conditions: (circle) High Blood Pressure, Diabetes, Heart Failure, Kidney Failure, Seizures, Stroke, Bleeding Ulcers, Chronic Bowel problems, Thyroid Dz. <i>N/A</i>			
Medication Allergies: (NO) (YES) List - <i>N/A</i>			
Current Medications: (Name/Dose/Frequency/Last Taken) (NONE) <i>N/A</i>			
Recent Injuries: (NO) (YES) Describe -			
Exam Findings: BP: <u>130</u> / <u>80</u> Pulse: <u>76</u> Resp: <u>17</u>			
Utilize Diagram and Space Below to Indicate Examination Findings. If additional space required, continue on reverse			
(Fit) (Unfit) For Confinement			
(Does) (Does Not) Require Further Eval			
Name/Rank/Unit of Screener			
HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
PONSOR'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.
Detainee Information: Name: (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 USAPA V2.00	
Control Number: (b)(6)-4		MEDCOM - 610	
Date/Time of Detention:		100-00000000	

## MEDICAL RECORD

## PROGRESS NOTE

DOD-01-CM139 - BOXES

DATE	NOTES
	"Brief note"
2 May 2002	35yo HVO C w/ myocardial infarction x 2, hypertension, hyperlipidemia, DM, tenuous past history of medical issues.
NKA	PWHX
	OMT: Initiated (date) 10 days EST. Condition MI (1999) + atypical LVEF ② Hyperlipidemia ? of last # on Zocor 20 mg po/d ③ Hypertension PSHX Hemorrhoids x 12yrs Meds ④ Atenolol 20 mg po/d FAIR 0L other than MI & 45yo Social Smokes 1/4 - 1/2 PPD Now ⑤ SL MTG 0.4 PRN Coca ⑥ Beer 20 mg po/d Hypertension (date) 1/1/92 ROS p/c/o/SOB/edema/pns/oedema 171 93 26 97% & visual loss (floaters) / maculopathy SKIN: urticaria, hives & rashes (date) ⑦ hemangioma ENT PERLN EOMT dry maculae. ABD obese (F) BS soft NTP Cervical/Clear TMs, barely palpable ext GEMAN ⑧ Horner Neck ⑨ JUN OP, PT 2/1 chest Throat NTP CTAB/C (b)(6)-2 Heart S/f + s., NL S2 5m/2/0 CAPT

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

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 RecordSTANDARD FORM 509 (REV. 5/1999)  
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)FOR OFFICIAL  
USE ONLY

EXHIBIT 3

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sum each entry)
26 Sept 03	C. vlt Blood Test Neg. Lab. 101-11
26 Sept 03	SST, Prod. - 1000 mg. Tchela. Currently asymptomatic. Last seen Appm. p. 010 10/03 24 12 18% sat. Wash and chest X-ray. Chest X-ray 201-111-12 Lab. 100-201-111-12 Tchela. Neg. Neg.
6th Oct 03	Oct 19 10/03 11/03 4,0 26 0.7 MT. 12 71 26 Chel 213 AMT 48 10/03 72 7.1 218 PSM 1.20
6th Oct 03	ASXND (Hemox) 10/03 72 7.1 Hypot. test negative. Chest X-ray normal. Lab. 100-201-111-12 Tchela. Neg. Neg.
6th Oct 03	10/03 72 7.1 218 Tchela. Neg. Neg. If taken for test ref. to lab. 100-201-111-12 Tchela. A full investigation is necessary with ref. to lab. 100-201-111-12 Tchela. Lab. 100-201-111-12 Tchela. Neg. Neg.
6th Oct 03	Please see. Neg. Neg. - 011-111-12 Tchela Lif. 100-201-111-12 Tchela Lab. 100-201-111-12 Tchela Rev PSM 100-201-111-12 Tchela Sometime sometime 10/03 72 7.1 218

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EXHIBIT 3

STANDARD FORM 600 (REV 6-97) BACK

## MEDICAL RECORD

## CHRONOLOGICAL RECORD / MEDICAL CARE

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

DATE	
7 August	<p>1130pm (230) Called to # 39 Rd For 96 MedStar Chest Pain (Burg)      Atct 1 hr PTA &amp; Assess Hx vehicle and found no      history to AHD/TAB once At Time NEED, S.O. and      SLand ECG Initiated. On Monitor Appear to be SR      ST Elevation in Lead II &amp; Q340 P4 became irregular      and Monitor 2nd to Pulseless VTach. T Preard Pleg Admin-      s Success, IV Infected # 16 (R)K i LR Kill 1 Lbk.      10mg Lidocaine Administered As QD Dose Initially Available. O21.      Airway placed, and Breathing Mask Unhook / CPR Started.      @ 1145 1mg Ep. Administerd IV. and CPR Continued. P Pulse S      CPR. 1mg Atropine Administerd via IV @ 1148. CPR Continued      Monitor showed V-fib &amp; Pulse (P) Pulsess &amp; CPR. @ 1152      Defib Armed P4 shocked @ 200, 300, 360. S Return of      Ry Pm as Pulsess. 2nd Ep 1mg given Pm IV. CPR Continued.      Attempt At Digital Initiation i 7.5FT Tube S Success.      Mouth to Mouth Continued. 2nd 1mg Atropine Administerd via IV      CPR Continued. @ 1205 E-Med Medic Arrived. Alleged      BVM Ventilation S Success. Hand repositioned and BVM Continued      &amp; CPR. Care of Patient Transferred To E-Med Medic i Full      Report and Code Summary Documentation P4 left AHD Fully      Full (Ends August 11) Care of E-Med Medic.</p>

(b)(6)-2

RECORDS MAINTAINED AT

HOSPITAL OR MEDICAL FACILITY

STATUS

(b)(6)-2

SPONSOR'S NAME

SSN/ID NO.

WARD NO.

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

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)  
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FMR (41 CFR) 201-9.202-1

USP LVN

## EXHIBIT

3

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USE ONLY

UUSI 11

(b)(6)-4

M/55

Req. Loc.: 78CCH  
Received: 02 Dec 2001  
ICF: MTF, OTHER

CSH28, IVD39  
Collected: 23 Sep 2001 1000  
Accession: 031002 LSP 57355

CHOLESTEROL  
TRIGLYCERIDES  
URIC ACID  
BILIRUBIN  
CHOLESTEROLOL  
PROSTATE SPECIFIC ANTIGEN

Creatinine  
Urea Nitrogen  
Creatinine  
Cholesterol  
Triglycerides  
Uric Acid  
Bilirubin  
Cholesterolemia  
Prostate Specific Antigen

1.20 <certified>

\*\*\* End of Report \*\*\*

(b)(6)-4

M/55

pt#

CSH28, IVD39

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USE ONLY

EXHIBIT 3

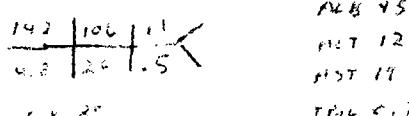
0000 15

## MEDICATION ADMINISTRATION RECORD

(b)(6)4

Name: HUD Month: Mar. 04

Medication Name	Dose	Time	Date																															
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
ASA	325 mg	Qday	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	A 1000 mg	Qday	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	25 mg	Qday	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	20 mg	Qday	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	20 mg	Qday	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	20 mg	Qday	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

<b>DETAINEE #:</b> (b)(6)-4	<b>ALLERGIES: NKDA</b>
<b>AGE:</b> 55	
<b>MEDICATIONS:</b>	<b>PROBLEM LIST:</b>
<p>Atenolol 25 qd          Aspirin qd  <del>Zocor</del> 20 mg qd          Colace 100 mg BID prn          Benadryl 25 mg qhs prn          SL NTG 0.4 mg prn x3 (chest pain)</p>	
<b>DIAGNOSTIC TESTS:</b>	<b>PMHX:</b>
<p>GUIAC STOOL- Sept. 2003, negative  <b>PEAK FLOW-</b>  <b>EKG-</b> June 2003  <b>PSA-</b>  <b>OTHER-</b></p>	<p>MI x2          hypercholesterolemia          hypertension          Hemmoriid surgery (1995)          smoker          hemmorioids</p>
<b>LABS:</b>  	
<b>HOSPITALIZATION SUMMARIES:</b>	

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EXHIBIT 3

0060-04-C10259-80165

PREVIOUS EDITION IS USABLE

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPOTMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3/8/04	Code Note Pt presents in cardiac arrest since 5 minutes
8845	midnight. Initial evaluation in the field reported by EMS to show that pt presented to jail medic in CP and quickly deteriorated
PMTx	to N/A + ind. 1 1/2 hours

Upon presentation to EMEDS full ACLS protocol was followed. CRNA placed a 7.5 CTT at 2cm, placement was confirmed ECGs. Telemetry confirmed asystole. Epinephrine in the usual dosage was given x 2 rounds while performing concurrent CPR. Despite all these efforts, pt remained in asystole & any signs of life. Code was stopped at 0832. Pt's pupils were fixed/dilated, he had no response to any stimuli. He had no respiratory effort and no pulse. Time of death is 0832.

(b)(6)-2

MD

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			Staff Emergency Physician ER
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

FMR (41 CFR) 201-9.202-1

Security Detainee # (b)(6)-4  
 117 ± MP Battalion FOR OFFICIAL USE ONLY EXHIBIT 3

UUL. 18

DD FORM 1 APR 77 2064 USE ONLY

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

NAME OF DECEASED (Last, First, Middle) Nom du décédé (Nom et prénom)		GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
(b)(6)-4				
ORGANIZATION Organisation		NATION (e.g., United States) Pays <b>IRAG 1</b>	DATE OF BIRTH Date de naissance	SEX Sexe <input checked="" type="checkbox"/> MALE Masculin <input type="checkbox"/> FEMALE Féminin
RACE Race		MARITAL STATUS Etat Civil		RELIGION Culte
CAUCASOID Caucaïque		SINGLE Célibataire	DIVORCED Divorcé SEPARATED Séparé	PROTESTANT Protestant
NEGROID Négrôïde		MARRIED Marié		CATHOLIC Catholique
OTHER (Specify) Autre (Spécifier)		WIDOWED Veuf		JEWISH Juif
NAME OF NEXT OF KIN Nom du plus proche parent		RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit		
STREET ADDRESS Domicile à (Rue)		CITY OR TOWN AND STATE (Include ZIP Code) Ville (Code postal compris)		
MEDICAL STATEMENT Déclaration médicale				
CAUSE OF DEATH (Enter only one cause per line) Cause du décès (N'indiquer qu'une cause par ligne)				INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et la mort
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <sup>1</sup> Maladie ou condition directement responsable de la mort. <sup>1</sup>		<b>Acute Myocardial Infarction</b>		
ANTECEDENT CAUSES  Symptômes précurseurs de la mort.	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	<b>Coronary artery Disease</b>		
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire			
OTHER SIGNIFICANT CONDITIONS <sup>2</sup> Autres conditions significatives <sup>2</sup>				
MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée <input type="checkbox"/> YES Oui <input type="checkbox"/> NO Non		CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures	
X NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie		<b>Cardio pulmonary arrest</b>	
ACCIDENT Mort accidentelle				
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste		AVIATION ACCIDENT Accident à Avion <input type="checkbox"/> YES Oui <input type="checkbox"/> NO Non	
HOMICIDE Homicide	SIGNATURE Signature		DATE Date	
DATE OF DEATH (Hour, day, month, year) Date de décès (l'heure, le jour, le mois, l'année)		PLACE OF DEATH Lieu de décès		
<small>I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE. J'ai examiné les restes morts du défunt et je conclus que la mort est survenue à l'heure indiquée et à la suite des causes énumérées ci-dessus.</small>				
(b)(6)-2	or du médecin sanitaire	TITLE OR DEGREE Titre ou diplôme <b>LtCol D.O</b>		
GRADE Grade <b>TACOL</b>	INST. <b>(b)(3)-1</b>	BIA P	(b)(6)-2	
DATE Date <b>08 Mar 2004</b>	(b)(6)-2		LtCol, USAF, MC, SFS (b)(6)-2	
<small>1 State disease, injury or complication 2 State conditions contributing to the death 3 Preciser la nature de la maladie, de la blessure ou de la complication qui a provoqué la mort, mais non la manière de mourir, telle qu'un arrêt du cœur, etc. 4 Preciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort</small>				

EXHIBIT 4

DD FORM 1 APR 77 2064 USE ONLY



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

**PRELIMINARY AUTOPSY EXAMINATION REPORT**

Name: (b)(6)-4

SSAN:

Date of Birth: 6 DEC 1948

Date of Incident: 8 MAR 2004

Date of Autopsy: 10 MAR 2004

Date of Report: 11 MAR 2004

Autopsy No.: ME04-110

AFIP No.: Pending

Rank: EPOW

Place of Death: Baghdad, Iraq

Place of Autopsy: Baghdad

International Airport

**Circumstances of Death:** Circumstances of Death: This 55-year-old male Enemy Prisoner of War had a history of ischemic heart disease. His past medical history includes hypertension, hypercholesterolemia, and possibly two previous myocardial infarctions. His medications included atenolol, Zocor, and aspirin, as well as sublingual nitroglycerin as needed. On the evening of 7 MAR 2004 he complained of chest pain and shortness of breath. He was brought to the medical clinic for evaluation where he became unresponsive. Resuscitation efforts, including Advanced Cardiac Life Support at a medical treatment facility, were unsuccessful.

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

**Identification:** Identification is obtained by paperwork accompanying the body, including a photograph with a matching prisoner number.

**CAUSE OF DEATH:** Atherosclerotic Cardiovascular Disease

**MANNER OF DEATH:** Natural

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USE ONLY

EXHIBIT 15

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.

(b)(6)-4

2

ME04-110

**PRELIMINARY AUTOPSY DIAGNOSES:**

- I. Atherosclerotic Cardiovascular Disease
  - A. History of ischemic heart disease
  - B. Cardiomegaly, marked (heart weight 620 grams)
  - C. Coronary atherosclerosis, focally severe
  - D. Diffuse myocardial scarring
  - E. Arterionephrosclerosis, mild
- II. Marked Pulmonary Edema
- III. Remote penetrating ballistic injury of the left buttock
  - A. Entrance: Inferior-medial aspect of left buttock (scar)
  - B. Wound Path: Skin, subcutaneous tissue, and muscle of left buttock, muscle of proximal left thigh
  - C. Recovered: Metallic foreign body encapsulated in fibrous tissue within muscle of proximal left thigh
  - D. Wound Direction: Left to right, back to front, and downward
- IV. Fractures of the 5<sup>th</sup> and 6<sup>th</sup> ribs on the right, associated with hemorrhage into chest wall musculature and abrasions/thermal injury of the chest (resuscitation efforts)
- V. Laceration of the nose and abrasion of the right index finger
- VI. Toxicology Pending

(b)(6)-2

MD, FS, DMO

CDR, MC, USN

Chief Deputy Medical Examiner

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EXHIBIT 15

58

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9 JUN 04	8) 19 y/o ♂ Detainee presents w/ multiple complaints
BP 136/78	# 1 - (6) Frank pain & dysuria. He denies any nausea or vomiting.
P 90	He denies any gross hematuria. He gives h/o kidney stones in 2000
TOMI 98 8	He reports that frank pain & dysuria have been x 4 days. He denies any abdominal pain.
R 18	# 2 - Continued back pain since being beaten by apparent
PMH	Civilian forces. He reports he was beaten at a house near Al-Adenes police. He states he was beaten for eight days
FH - Single Vendor during the eight days he reports that he was forced to	
SMOKING	sit on a water bottle, he was sodomized with a dildo, and
MED - d current	his head was submerged under water. In addition he states
Allergies - NKAU	he was electrified with electricity. He denies having any
WU 06 1000	blowings, scabs or scars currently. Otherwise this history was taken through interpreter.
BIO 14	0) WNW 8° NAWD VS STABIL/REFLEXES CSTR - SLOW
All other chm	Neuro: CN II - XII, C4-T1 motor NAWL-S2 mixed grossly intact (1)
WNL	Reflexes 2+ (1) SCL - NEG
	HONT - NL NECK - Supple w/ edema/edema of thyromegaly
	SPINE - TIP C,T,+L-Spine NO Bowel step offs
	LUNGS - CTA (1) HEART - PERR ADD - RENAL NUG CAT TENDerness
	EXT - MOVES SWOON + WITH APPARENT PAINS
	INTRUMENTARY - NEG FOR epihymosis or scars (OVER)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	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.

ISN: (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

USAPA V2.00

COMPOUND: GANCI #2

FOR OFFICIAL USE ONLY

A) 1 (C) FRANK PIAW Pyuric Prosthetic Decontamination  
 2. Alleged abuse of cultural Beta PIAW

0071-04-C10789

- A) 1. Torsol injection in clinic today than return PIAW  
 2. will refer to General surgeon for endoscope evaluation  
 due to Alleged sodomy  
 3. Refer to CEO for investigation.  
 4. Case and Plan discussed w length of patient through  
 interpreter

(b)(6)-2

PA-C

KLT, SP USA

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LAW ENFORCEMENT SENSITIVE  
 MEDCOM - 622

EXHIBIT 2

0086-04-C1D519-

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE		
DATE		SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
5/16/04		<p>Was at Abu Ghraib          Injured this past May -          Now (10 pain in area of kidney.          Has blood in the urine          Also pain referred to upper back &amp; bladder          He was beaten for 5 days          States he recalls the names - (b)(6)-2</p> <p>Interpreter for Egypt -          Two black soldiers -          (b)(6)-4</p> <p>Started beating him c sticks - on the          back -</p> <p>Placed in a small room underground -          Placed in handcuffs - very tight - injuries          to both wrists</p> <p>Head kept under water - did          it several hours to point of          passing out . . .</p> <p>Then he was placed in water &amp; wires          placed on him as if to shock          him - said he was shocked 23 times</p> <p>Vomited up blood c last under water</p>		

OSPITAL OR MEDICAL FACILITY  
CAMP BUCCA

SPONSOR'S NAME

STATUS  
Civilian Internee

SSN/ID NO.

DEPARTMENT/SERVICE  
INTERMENT FACILITY

RELATIONSHIP TO SPONSOR

RECORDS MAINTAINED AT

(b)(6)-2

PATIENT'S IDENTIFICATION:

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

REGISTER NO.

(b)(6)-4

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)

Prescribed by GSA/CMR  
FMRM-14 CFR 101-9.202-1OFFICIAL USE ONLY  
Law Enforcement Sensitive

USAPA V2.00

(b) (6) - Uncomfortable looking leaning side to left.  
 (b) (6) + Pains and body cont. from earlier  
 Neck + Pains pains on Lungs - Cough  
 Con - Difficult to breath.  
 Old -  
 Skin + All scars on  
 Wrist / back

Now he was punched by a big black soldier - on the chest. A second black man in a t-shirt. He looked like a scorpion on his (b) (6) arm - who was also beating him. He passed out in the beating. He was placed in an isolated room.

He says he was raped by a girl with the assistance of DR. Faraj, & (b) (6) -  
 an "industrial penis" placed in his rectum. He started yelling and they stopped injuring him but he had been bleeding by then. Then they kicked him. The Iraqi interpreter (b) (6)-4

can't tell right & was  
 wine drunk wine - ? hr after his  
 eyes were bloodshot.

Next day he was moved to a prison  
 NDCR of Baghdad - Al Taji  
 He has not been injured since.

Now (b) (6) pain (b) (6) cut.

Blood - wine (Stolen pac)  
 Placed on (b) (6) today -

for kidney stone -

- A) Injuries to skin  
 B) Ref to S-3 for (b) (6) -  
 C) Ref to S-3 for (b) (6) -

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 MEDCOM - 624

EVIDENCE  
 (b) (6)-2

15

MS

0093-04-CN519

EPW/CI Medical Report				
Last Name (b)(6)-4	First Name, MI (b)(6)-4	Internment Serial Num. (b)(6)-4		
EPW/CI Location C-IN CAMP		BirthDate 1986/01/01	Sex M	Height 66
Physical Condition G-GOOD	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Weight 163
Marital Status S-SINGLE				
Distinguishing Marks:				
Remarks				
Hair Color	Eye Color	Race X-OTHER	Blood Type	Diet
Examination Information				
Examination Number 160551-01	Date 2004/06/11	Time 1:02:23 AM	Exam Category A1-TO BE DEFINED	Type of Case BC-TO BE DEFINED
Diagnosis Please see attached page		Comments Please see attached page		
Disposition Type	Disposition Date 2004/06/12		Disposition Time 12:00:00 AM	
Immunizations				
Medical Officer Performing Exam				

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EXHIBIT

0093 - 04 - C1D519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4
-------------------------	------------------------------------

S

BACK PAIN, HX OF KIDNEY STONES, UNABLE TO URINATE X 1D

O

T- 98.0, BP- 157/84, P- 109

A

POSS KIDNEY STONE

P

REHYDRATE, TEST URINE

I

0102- INITIATED IV (L) ARM 1000CC NS

0111 BP- 164/95, P- 111

0130 1000CC 9% NS IV

0141: T- 97.7

0151

1000CC NS 9% IV

0153

BP 145/60, P-111

0154: 30MG IVP KETROLAC

0207: INITIATED FOLEY CATHETER, URINE OS LIGHT YELLOW

0220

SPG- 1.005, MOD BLOOD (NON-HEMOLYZED)

0222

CIPRO IV 40MG OVER 1 HR

0242

EMPTIED 1400CC CLEAR YELLOW URINE FROM FOLEY BAG

0320

250CC NS IV

0321

FOLEY REMOVED

IV DCD, RT COMP

F

UTI, CIPRO 500MG BID X 5D, IB 800MG TID X 5D

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EXHIBIT 9

0100 04-1104-07 80231

0043-04-010519

Internment Serial Num.

Comments (From Page 1)

(b)(6)-4

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MEDCOM - 627

EXHIBIT

0093-04-CID514

## EPW/CI Medical Report

Last Name (b)(6)-4	First Name, MI (b)(6)-4	Internment Serial Num. (b)(6)-4		
EPW/CI Location C-IN CAMP		BirthDate 1986/01/01	Sex M	Height 66
Physical Condition G-GOOD	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Weight 163
Marital Status S-SINGLE				
Distinguishing Marks:				
Remarks				
Hair Color	Eye Color	Race X-OTHER	Blood Type	Diet
Examination Information				
Examination Number 160551-02	Date 2004/06/12	Time 1:18:32 PM	Exam Category A1-TO BE DEFINED	Type of Case BC-TO BE DEFINED
Diagnosis Please see attached page		Comments Please see attached page		
Disposition Type	Disposition Date 2004/06/12	Disposition Time 12:00:00 AM		
Immunizations				
Medical Officer Performing Exam				

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Law Enforcement Sensitive

**EXHIBIT**

0093-04-CIV 519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4
-------------------------	------------------------------------

S

KIDNEY PAIN UNRESPONSIVE TO CIPRO

O

PT ARRIVED 10 JUNE, TREATED W/ CIPRO, HAS NOT COMPLETED TREATMENT DIAGNOSED W/ UTI

A

UTI

P

CIPRO IV 400MG IN 200ML 5% DEXTROSE (R) ARM 18G.

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MEDCOM - 629

EXHIBIT 9

0093-04-C1D519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4
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**EXHIBIT**

0093-04-1D519

## EPW/CI Medical Report

Last Name (b)(6)-4	First Name, MI (b)(6)-4	Internment Serial Num. (b)(6)-4		
EPW/CI Location C-IN CAMP		BirthDate 1986/01/01	Sex M	Height 66
Physical Condition F-FAIR	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Marital Status S-SINGLE
Distinguishing Marks:				
Remarks				
Hair Color	Eye Color	Race X-OTHER	Blood Type	Diet
Examination Information				
Examination Number 16055104	Date 2004/06/16	Time 2:58:08 PM	Exam Category A1-TO BE DEFINED	Type of Case BC-TO BE DEFINED
Diagnosis Please see attached page		Comments Please see attached page		
Disposition Type	Disposition Date 2004/06/17		Disposition Time 12:00:00 AM	
Immunizations				
Medical Officer Performing Exam				

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Law Enforcement Sensitive

**EXHIBIT 9**

0043-04-CID 519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4
-------------------------	------------------------------------

S: injuries at abu gharib in May 04, injuries to neck, back, chest c clubs, injuries to wrists c

hand cuffs, injuries to rectum c gigalo

O: lungs NAD, ms - walking bent over, positive tenderness over back and L neck, COR-RRR, Lungs

CDA,

A: injuries c hematuria

P: report case

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EXHIBIT 9

0093-04-CID 519

Comments (From Page 1)	Internment Serial Num.  (b)(6)-4
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**EXHIBIT** 9

0093-04-612519

## EPW/CI Medical Report

Last Name (b)(6)-4	First Name, MI (b)(6)-4	Internment Serial Num. (b)(6)-4		
EPW/CI Location C-IN CAMP		BirthDate 1986/01/01	Sex M	Height 66
Physical Condition F-FAIR	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Marital Status S-SINGLE
Distinguishing Marks:				
Remarks				
Hair Color	Eye Color	Race X-OTHER	Blood Type	Diet
Examination Information				
Examination Number 16055103	Date 2004/06/16	Time 6:56:39 AM	Exam Category A1-TO BE DEFINED	Type of Case BC-TO BE DEFINED
Diagnosis Please see attached page		Comments Please see attached page		
Disposition Type	Disposition Date 2004/06/17	Disposition Time 12:00:00 AM		
Immunizations				
Medical Officer Performing Exam				

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**EXHIBIT 1**

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4
-------------------------	------------------------------------

S: "kidney pain" x 1 d, able to urinate, says cipro no effect

O: t 97.7, bp 140/68

A: Possible UTI

P: Transport and test

I: 0636: u/a SpG 1.030, blood non-hemolyzed, pH 5.0

E: UTI, Bactrium 960 bid x 7d

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EXHIBIT 9

0093 04-C1D519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4
------------------------	------------------------------------

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**EXHIBIT 9**

0043-04-010519

## EPW/CI Medical Report

Last Name (b)(6)-4	First Name, MI (b)(6)-4	Internment Serial Num. (b)(6)-4			
EPW/CI Location C-IN CAMP		BirthDate 1986/01/01	Sex M	Height 66	Weight 163
Physical Condition F-FAIR	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Marital Status S-SINGLE	
Distinguishing Marks:					
Remarks					
Hair Color	Eye Color	Race X-OTHER	Blood Type	Diet	
Examination Information					
Examination Number 16055117	Date 2004/07/08	Time 10:44:15 PM	Exam Category A1-TO BE DEFINED	Type of Case BC-TO BE DEFINED	
Diagnosis Please see attached page			Comments Please see attached page		
Disposition Type	Disposition Date 2004/07/08		Disposition Time 12:00:00 AM		
Immunizations					
<p>Medical Officer Performing Exam</p>					

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Law Enforcement Sensitive

EXHIBIT 9

0093-04-CID 519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4
-------------------------	------------------------------------

S: with back pain, f/u for uti med allergy to pcn. Pt has taken cipro bactrin with no relief  
back pain still strong vomited upon arrival to aid station.

O: bp 148/69 p107 spo2 98 t 98.3

A: Kidney pain

P: IV 1000cc n.s. phenergan i.v. 25 mg.1cc n.s. im lu quad of buttocks 1000cc lr iv d/c 1415

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MEDCOM - 638

**EXHIBIT** 9

0093-04-61D519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4
------------------------	------------------------------------

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3f

**EXHIBIT**

9

0093-04-C112514

EPW/CI Medical Report

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# EXHIBIT

0043-04-CID519

Internment Serial Num.

## Diagnosis (From Page 1)

(b)(6)-4

S: UTI f/u, pt c/o LUQ pn radiating to shoulder

O: t-98.78, 169/79, p-96 no RQ pn, urine test- moderate blood

A: possible bladder infection

P: NKDA

currently taking Cirpo 500mg

Levaquin 500mg QIDx7d

38

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Law Enforcement Sensitive

0186-04-010254-80231

0093-04-010519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4
------------------------	------------------------------------

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MEDCOM - 642

**EXHIBIT**

0093-04-610519

## EPW/CI Medical Report

Last Name (b)(6)-4	First Name, MI (b)(6)-4	Internment Serial Num. (b)(6)-4		
EPW/CI Location C-IN CAMP		BirthDate 1986/01/01	Sex M	Height 66
Physical Condition F-FAIR	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Weight 163
Marital Status S-SINGLE				
Distinguishing Marks:				
Remarks				
Hair Color	Eye Color	Race X-OTHER	Blood Type	Diet
Examination Information				
Examination Number 16551-06	Date 2004/07/11	Time 11:30:01 AM	Exam Category A1-TO BE DEFINED	Type of Case BC-TO BE DEFINED
Diagnosis Please see attached page		Comments Please see attached page		
Disposition Type	Disposition Date 2004/07/12	Disposition Time 12:00:00 AM		
Immunizations				
Medical Officer Performing Exam				

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Law Enforcement Sensitive

0093-04-01D519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4
-------------------------	------------------------------------

S: pt states he had an artificial penis put into his anus up North while incarcerated, he had bleeding following this

O: Anus exterior hemorrhoid, oval fistula also present by (b)(6)-2 exam.

A: anal fistula

P: refer for further eval.

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MEDCOM - 644

EXHIBIT 9

0164-04-01D259-60271

0093 04-01D2519

Comments (From Page 1)	Internment Serial Num.  (b)(6)-4
------------------------	--

42  
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**EXHIBIT 9**

BS-089

QTB-04-10204-80237

## Sick Call

### EPW Medical Screen Form

### 39<sup>th</sup> Brigade Surgeons Office

Date: 15 May 04

Time: 1015

Name: (b)(6)-4

Interpreter Present  Yes  No

Understands English?  Yes  No  Fluent  Basic

Married  Yes  No

Estimated Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: 18

Any visible wounds/injuries/deformities: \_\_\_\_\_

Any visible scars/tattoos/identifying marks: \_\_\_\_\_

General Appearance:  Healthy  Malnourished  Ill  Other \_\_\_\_\_

Past Medical History: ② Kidney Stone - X 4yr

Allergies:

NKA

Medications:

Past.

Not taking any / nothing /

VS:

Pulse: 80

B/P: 130/74

Temp 97.8

HEENT:

NRN

Chest:

NRN

CV:

NRN

Abdomen:

SLR / % T ② Blank pain / P/NV

UE/LE/Spine:

NRN

Neurological:

NRN

General assessment:

RX: ② In toddler 3 years now

② Continue Motrin

③ no Fluid Intake

Follow up needed:  No

Yes:

Signed: SG (b)(6)-2

Date: 15 May 04

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

MEDCOM - 646

EXHIBIT

b2

(b)(6)-4

**C-MED PATIENT SURVEY**

Description:  
Small scar (1) / see

124  
100

(b)(6)-2

Medic

(b)(6)-2

MD/PA

DATE 15 April 04**FOR OFFICIAL USE ONLY**

Brigade Surgeon  
39<sup>th</sup> Brigade Combat Team  
1<sup>st</sup> Cavalry Division  
DETAINEE MEDICAL SCREENING FORM

DATE: 8 May 04

(b)(6)-4

NAME: (b)(6)-4AGE: 12 HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ALLERGIES:  NO  YES: \_\_\_\_\_MEDICATIONS: Col farn InvMEDICAL HISTORY:  ASTHMA,  DIABETES,  HEART DISEASE,  TUBERCULOSIS,  OTHER INFECTIOUS DISEASES: multiple Kidney Stones,  OPIUM USESMOKER:  YES  NO Kidney - Sust 2000EXAM: T-98P: 112 BP: 118/80 APPEARANCE:  HEALTHY,  MALNOURISHED, thinHEENT: Normal CHEST: CVA - Reports pain & Deep InhalationCV: Normal ABDOMEN: S/NTMS: Normal SKIN: W/D

DENTAL: \_\_\_\_\_

GENERAL ASSESSMENT: Painful breathing - Evidence of Fluids (b)(6)-2SIGNED: GJW/MC (CLS, 91W) MEDICAL OFFICER: COL MC (MC, DC, MS)SICK CALL: 8 May 04

DATE	COMPLAINT	DX/TX
<u>9 May 04</u>	<u>Kidney pain V Sahr. Currently under MD care in Baghdad</u>	<u>Kidney Stone.</u>
<u>10 May 04</u>	<u>Few Stones - Removal 3x Stones (1) Elong - 2nd 2nd small Stones</u>	<u>From (2) Kidney Since 2000 -</u>
<u>11 May 04</u>	<u>3rd Stone Treated in AM (2) P.O. Fluids (3) F/N on sick call in AM</u>	<u>(b)(6)-2</u>

<u>9 May 04</u>	<u>Renal Pain Much improved no precipitants</u>	<u>(b)(6)-2</u>
<u>10 May 04</u>	<u>leg cramps &amp; knee pain - Knee Stiff - R.R. D/F - R/Ibuprof 600g - ice</u>	<u>(b)(6)-2</u>
<u>11 May 04</u>	<u>NO obvious MS changes</u>	<u>(b)(6)-2</u>

DISCHARGE NOTE:  NO CHANGE IN HEALTH STATUS DATE: 11 May 04↓ Renal pain. Currently taking Motrin As directed.12 May 04 - No new medical / dental problemsSm ant (2) Kidney pain

SIGNED: <u>SG</u> (b)(6)-2	<u>GJW/MC</u> (CLS, 91W) MEDICAL OFFICER: <u>MAT MC</u> (MC, DC, MS)
----------------------------	--

14 May 04  
clu (2) Elbow P/W - Joint - P/W - (b)(6)-2  
P/W + Motion (b)(6)-2  
SG (b)(6)-2

FOR OFFICIAL USE ONLY

AW ENFORCEMENT SENSITIVE  
MEDCOM - 648

EXHIBIT 17

## BHA MEDICAL SCREENING FORM

1-82 FA, 1 BDE, 1 CAV  
CAMP CUERVO, BA GHADAD  
Last Revised: 11 JUL 04

Name: (b)(6)-4 D259-80271  
Age: 29  
Date/Time of Exam: 18 July 2004 1902  
Type: Initial / Transfer Release

HISTORY

B6-2

Current illness:  pt states no illnesses.PMHX/Hospitalizations/Surgeries/TB: Allergies: 

Medicines currently taken: Lorazepam 2mg q 12 hrs.

ETOH/Tobacco/Drug use: E-tob,  ETOH,  DrugsEXAM T: 98<sup>2</sup> P: 70 R: 16 B/P: 108/68

General: pt norm w/nr R/Fx 3 w/s

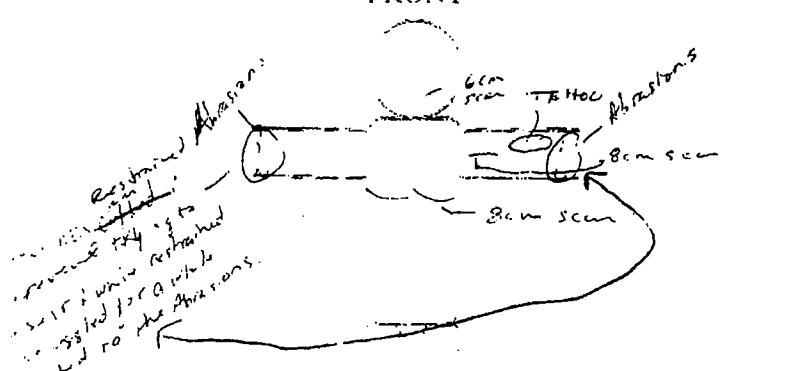
HEENT: N/A, blueness in (C, E, I, O, A) ns. b/r. Tm abd. 1; section wnr, throat c/u

CN: CTB R, lat x 6 ite and RRR

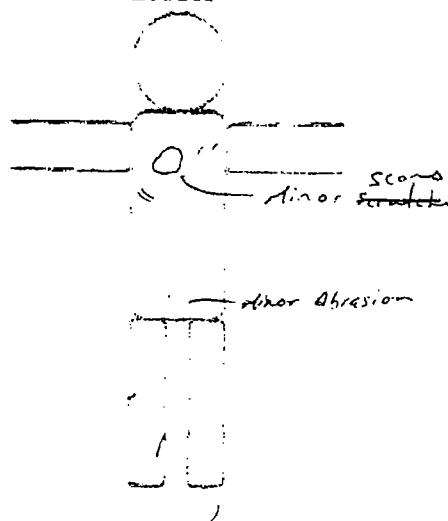
ABD: B11151

EXT: NNC

## FRONT



## BACK



Is this detainee fit for interrogation / transfer / release? YES NO

Notes: See page 18 JUN 04 2004.

(b)(6)-2

Signature: M.D.N.C.O

(b)(6)-2

HISTORY

Current illness: ✓

PMHX/Hospitalizations/Surgeries/TB: ✓

Allergies: ✓

Medicines currently taken: ✓

ETOH/Tobacco/Drug use: ✓ TOB, ✓ COTCA, ✓ DRUGS.

EXAM      T: 98.4°F P: 70      R: 16      B/P: 120/68

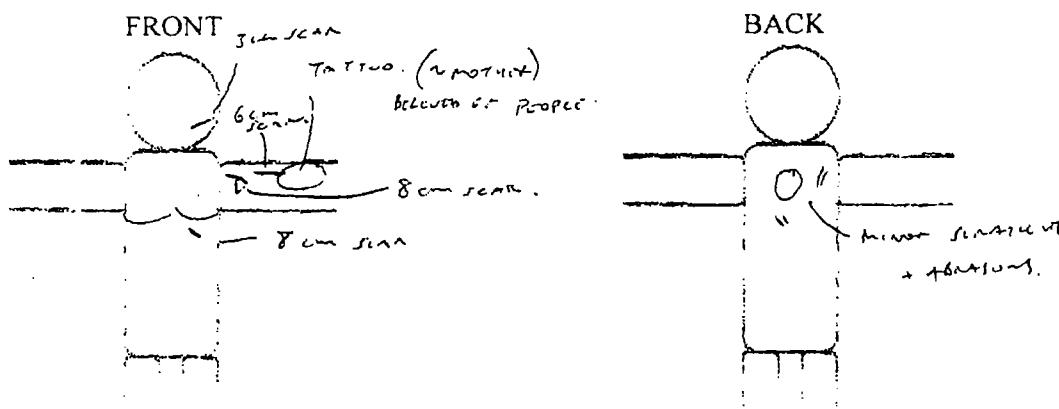
General: pt was unfrw. af/ox) vss.

HEENT: NCAT, sinus (no purulent discharge), OS-normal.

CX: bascals 2/n PR. Tm's clear, rectum -f, bowel clear.

ABD: benign. x waves.

EXT: WNL



Is this detainee fit for interrogation? YES / NO

Signature: (b)(6)-2

Date: 04/18/04

0234-04-CID259-80271

## AMP CUERVO MEDICATION ISSUE TRACKING SHEET

MEDICATION		NAME		DATE	
USAGE	P.O.	(b)(6)-4	(b)(6)-4	(b)(6)-2	(b)(6)-2
ROUTE	TIME	NAME	ISSUED BY	EXPIRATION	ISSUED BY
Oral	0930	(b)(6)-4	Lorraine Imms, RN, LPN	(b)(6)-2	Lorraine Imms, RN, LPN
Oral	2115		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	0930		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	2105		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	04 0600		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	0120		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	1445		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	2300		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	0700		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	1400		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	0100		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	1632		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	2200		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	0955		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	0910		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	0950		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	2150		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	0820		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	1445		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	0057		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	2120		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	0945		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	2000		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	0400		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	2115		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
Oral	0915		Lorraine Imms, RN, LPN		Lorraine Imms, RN, LPN
5 July 04 2130					

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

For Official Use Only / Law Enforcement Sensitive

0414-04-CID789

DATE

SYMP.

IS, DIAGNOSIS, TREATMENT, TREATING

ANIZATION (Sign each entry)

0234-04-CID259-80271

3 JUL 04 Sp 23 16 50 obtained a scuba-diving certificate X 20 min

1305 Ago Guard heard pt fall and heard his calls down

Guard went to his loc and saw pt on floor

rolling to left and right pt then stood up with a groan

PM 8 Other AB-117 the loc was in station 1841-H-0400  
in 40. He then laid on the ground and kicked his

PM 8 feet up in the air and grabbed on his shoulder.

MINS PM PI 111 last episode w/ 6 worth 100 lbs was treated  
at 150 a doctor and physician was (un) & take

him scott. Pt did not take meds. Pt poison like

confirmed spasm on both sides. Was not able to

sleep last night. Pt no foul fire now; pt not

had any more pain and was able to go home.

Sp 17 had no further episodes.

Gen pt laying on floor with hands behind his head.

Vomit of shirt it causing nausea & potential  
fatigue. Pt able to stand.

Horn wear, OS - NC - OD - visual/polyuria, TOL's clear;

JTT - w/c, TOL's intact.

CZ human remains on dark jacket, w/ blood. (b)(6)-2

MNO C 2 - 12 (1-00) intact.

Glass worn in intact, not broken/bent

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT <i>only</i>

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

USAPA V2.00

(b)(6)-4

100-1000

100-1000

For Official Use Only / Law Enforcement Sensitive

EXHIBIT 3

J Juvol. cont

1325

0234-04-CID259-80271

A. Seizure - other mind vs anxiety disorder

- G 1. One c in random drugs  
 2. Lorazepam 2g.  $\frac{1}{2}$  T bid - ~~ft~~ \* 10.  
 3. One Canna 10 mg Releve.

(b)(6)-2

130-1

J Juvol 5 29% d obtained in silvano-like episode to w. age.  
 16Nbs

T M. Pj this episode he takes bromazepam before it occurs. Pj no drug. Pj the first episode  
 8 days. Also c/o pain in neck.  
 Admission - 4/17 hyperventilation - seizure. Guards state  
 that w. had a yell. When w. laid inside the cell the pj was slapping on the floor. It was  
 then heard back against the wall, fall to the floor  
 and started thrash about as he did the last time.  
 His colleague hear his lots, the guards inform the w.  
 and went up on his side. It stopped after 2 min.  
 Pj his opinion started after his father died in '94. Pj  
 he blessed his family and he wants to go home.

G 1. Pj has no past obs

Pj layed on floor when I arrived. Pj able to communicate  
 E intubation. Pj able to walk to exam room. Pj  
 unresponsive & non toxic & present content.

Hxpt heat, oo - diuresis/ polyuria as - some const, the const.  
 Slight t/t, throat clear, chest not inflam.

LHx minor abrasions on back, unif. redness, minor abrasions  
 from matress or bed. Unconscious.

ABNO CN II-III grossly intact (-OD)

(b)(6) For Official Use Only / Law Enforcement Sensitive

EXHIBIT - 3

0234-04-CID259-80271

4/10/04 (con't)

1720 hrs P.D. informed Big to T-4 IT BID

600

2 con's on. Acreo - AGNO 2nd is not

Signature - like quality. Appearance consistent.

Want for further communication.

(b)(6)-2

PA-

103-104 (3) Detainee had another episode which consisted of him rolling throughout the floor

1440 hrs. Specifically movements. Detainee received a cut to his left eye that is approx. 3cm long. B.A.C. 181/8ie was applied to the cut. Detainee vision is not compromised by the cut.

- 18 VSS. It's further injuries to self. Refer to the RHM PA

(b)(6)-2

P 38

R 20

11 July 04 (3) Detainee had another episode in his cell that appeared to be controlled  
1040 hrs by himself. He willingly fought off his cellmate. While he was on the

floor he appeared to be trying to hit his head on the ground. Immediately

P 92 person as we opened the cell door. Detainee's episode seems to subside. This

R 15 has happened three times that I have seen. Detainee did not further injure

(b)(6)-2

himself.

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

USAPA V2.00

(b)(6)-4

12-14-04

1 con's D.M.C.

0234-04-CID259-80271

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11-19-04 1745 hrs	B.H.A. Detainee called me to the B.H.A. due to the fact that this detainee had another episode (at 1725 hrs). The guards state the detainee was crying for 5 minutes before the episode occurred. This time the guards recorded the episode by way of camcorder. This time the inmate received about small circular bruises to his forehead & a few minor abrasions to his neck & arms. Detainee will not described that this detainee bit his own arm which did not break skin. - (b)(6)-2
11-19-04 1600	I saw two or one or two episodes. P <sup>1</sup> started out crying. After a time he stood up and hit his head on the grass. He pulled his response away and falls (continues) to the ground the patient then leg rolled to the left arm many until he is restrained by guards. 4 instances, 4 leg, 4 upper extremities 4 instances, 4 posterior period. P <sup>1</sup> said was restrained and tried to stand.
	If I anxiety disorder vs. psychotia.
	P <sup>1</sup> informed that his history is important and that we will continue to do this until he informs also, when now we can stop it.
	PS the only reason he does is to be around.
2	Contraction by TPO b.s.
3	CSC guard if 5/5 report

(b)(6)-2

0234-04-CID259-80271

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
----------------	--------------------------------------

DATE

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

1525 I was called to the BHP for the fact that this defendant had been beaten up by the guards. I was told by the guards: After my arrival, that the defendant started crying, putting his hands over his head. This is the typical place that happens, prior to him having an episode. The guards there at this time placed the defendant in wrist cuffs and cuffs in attempt to prevent the defendant from being himself. At 1540 the defendant had an episode. The defendant still put his hands with the restriction. He hit his head in the estimates. The defendant has cuffs in his hands to his front portion of body. After the guard(s) had physically restrained the defendant as to further prevent the defendant to cause further injury to self, they have the wrist restraints from the front portion of body to the rear portion of his body, or behind his back. The defendant also managed to hit his left side of head on the ground which left a ~~brownish~~<sup>to</sup> ~~knock~~<sup>(b)(6)-2</sup> record on his head. He also suffered from this incident some abrasions to his face, neck, elbows & knees. (b)(6)-2

DAMAGE'S ~~to~~<sup>(b)(6)-2</sup> LOC & Hyperextension of his contusion.

1526 I spoke to defendant and explained that this was not a punishment. I want him to have a positive effect. He is to now not harm anyone. It is not my intent to hurt him in any way. It is my responsibility to protect him. He is not under my control.

I am not a prison warden.

1. I am not a warden. 2. I am not if others are around.

(b)(6)-2

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

ENTRANT'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

USAPA V2.00

BHP

JAMES WILSON, BASHARD

0234-U4-CID259-80271

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1-3-04	Physical injury & physical complaints (b)(6)-2
1-3-04	103.10
1-3-04	Detainee started to typical crying. This was always hard to him taking physically violent action against himself. At 1810 Detainee was seen to be in cell B-16 his back straight up. Then (b)1650 the guard's stated that the detainee started bumping between the two blossoms inside his cell. After him hit his head against the wall properly, it was while at this time the guards went into the cell to prevent detainee from causing serious bodily harm to himself. With the assistance of the 316 SGT (b)(6)-2, the Guards of 316 Restrained Detainee with his hands behind his back & to Detainee's ankles. They also used leather restraints to the same areas listed above. The detainee was then placed in a litter to his back & a litter to his front that was secured together with tape. Blankets were placed around the detainees head to prevent any extension of the detainees neck as well as to protect the detainee from trying to injure himself or anything when I arrived (b)1735 hrs. I checked the detainees physical appearance which he appeared to be yellow. I checked the detainees pulse which was rapid. From his feeling & his breathing was rapid for the same reason. This did not at all seem to be encouraging the detainee. The detainee was running adequate on. The detainee was released from his restraints @ 0920 hrs. The PR saw the Detainee & stated he was in painful position, he's at the incisor hairs. The PR said he would show up in the a.m. to see if anything showed up over night. The Detainee has checks over both his arms due to him struggling while he was restrained — (b)(6)-2
1-3-04	no new detainee has markings of pain throughout his body. He stated it was from yesterday when he had an episode. He has some bruising to his lower back & he has marks around both wrists from when he was going around + op. will have to monitor it & will continue giving him morphine
	(b)(6)-2
	STANDARD FORM

USAPA V2.00

0234-04-CID259-80271

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION. (Sign each entry)	
15 July 04	<i>No medical complaints - no episodes</i>	(b)(6)-2
16 July	<i>No medical complaints - no episodes</i>	(b)(6)-2
17 July 04	<i>No medical complaints - no episodes</i>	(b)(6)-2
18 July 04	<i>No medical complaints - no episodes</i>	(b)(6)-2
19 July 04	<i>No medical complaints - no episodes</i>	(b)(6)-2
20 July 04	<i>No medical complaints - no episodes</i>	(b)(6)-2
21 July 04	<i>No medical complaints - no episodes</i>	(b)(6)-2
22 July 04	<p><i>This patient is being seen by (R) CIC and has</i></p> <p><i>been released. He was admitted from ward 400 on</i></p> <p><i>a litter to bed room now having minor head injury.</i></p> <p><i>He is not clear on timeline since he is intubated and</i></p> <p><i>conscious - there is no serious complaint. He has</i></p> <p><i>no memory of combat, has mild head injury to</i></p> <p><i>the right side now.</i></p>	(b)(6)-2
	<b>BATTALION SURGEON</b>	

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

USAPA V2.00

*RHD*  
*CAMP SPC. RASHID*

0040-04-C10789-83990

HOSPITAL REPORT OF DEATH		NAME AND LOCATION OF HOSPITAL			
IN USE OF THIS FORM, SEE AR 40-2: THE PROPOSER AGENCY IS OFFICE OF THE SURGEON GENERAL.					
<p><i>Instructions - Medical Officer in attendance will:</i>  <i>are, in one copy only, Items 1 through 10 and sign Item 11.</i>  <i>Send form, without delay to the Registrar or Administrative Officer</i>  <i>of the Day, for necessary action and for preparation of required</i>  <i>number of copies.</i></p>					
SECTION A - ATTENDING MEDICAL OFFICER'S REPORT					
PERSONAL DATA					
PATIENT DATA (Patient's ward plate will be used to imprint identifying data if available)  (b)(6)-4	2. TIME OF DEATH (Hour-day-month-year)  107 22 May 2004	3. MEDICAL EXAMINER/CORONER'S CASE  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
	4. RELIGION	5. CHAPLAIN NOTIFIED  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
	6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH				
Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
CAUSE OF DEATH					
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury, or complication which caused death)	DUE TO (or as a consequence of)  Cardiac Arrest		10 min		
7b. ANTECEDENT CAUSES (Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)	DUE TO (or as a consequence of) (1)				
	(2)				
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE CONDITION CAUSING IT	a.				
	b.				
9. DATE  22 May 2004	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE  (b)(6)-2	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE  (b)(6)-2			
SECTION B - ADMINISTRATIVE ACTION					
TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER (Specify)					
19.	SECTION C - RECORD OF AUTOPSY				
20. AUTOPSY PERFORMED (If yes, give date and place)  <input type="checkbox"/> YES <input type="checkbox"/> NO	21. AUTOPSY ORDERED BY (Signature)				
22. PROVISIONAL PATHOLOGICAL FINDINGS					
23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY		25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY		
DATE	27. TYPED NAME AND GRADE OF REGISTRAR		28. SIGNATURE OF REGISTRAR		

DA FORM 3894, OCT 72

REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED.

USAPPC V2.00

HEALTH RECORD		DETAINEE PREINTERROGATION EVALUATION		
DATE: 18 March	PATIENT COMPLAINT/INTERROGATOR CONCERNS:		ALLERGIES: NADA	
BP: 120/84	(64 yrs ♂ c/o coughing on & off x 2 yrs (Hypertension). Pt 40% glucose level following dinner (R) leg.		MEDICATIONS: HTN (b)(6)-2 Diabetes med B1 Diabetes med B1 Name of meds unknown	
P: 115				
R: 17				
TEMP: 100.6				
Pox: 98%	O: GENERAL NAD/w			
WEIGHT: 75kg	HEENT benign			
	NECK scad		PSHX: Appendicitis	
PMHX (CIRCLE)	LUNGS cTB			
HTN	CARD RRR 3M			
DM	ABD benign			
TB	EXT O/LICE		SOCHX: TOB ETOH	
<p>A/P: Type II DM → Gmz Glyburide Q.S.        HTN: not elevated off meds - hold on Rx        Hep A<sup>#1</sup> Hep B<sup>#1</sup>, MMR, TD        Accuchek B10 x 2 days &amp; per routine        → Ibuprofen 800 mg po        Dip Urine for glucose &amp; ketones once        DX: Gout</p>				
(b)(6)-4 ISN				
CAMP: 68				SEX: M
DOB: 1940				
DATE ARRIVED CAMP				

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.)

### Compound

15 Nt(b)(6)-4

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

## Medical Record

ISN't(b)(6)-4

**STANDARD FORM 600 (R)**  
Prescribed by GSA/ICMR  
**FIRMR (41 CFR) 201-9.202-1**

USAPA V2.00

372nd MP CO

(b)(6)-1

## MEDICAL RECORD

## CONSULTATION SHEET

(b)(6)-4

## REQUEST

EMT

FROM: (Requesting physician or activity)

DATE OF REQUEST

EASON FOR REQUEST (Complaints and findings)

Elderly gentleman went down @ defecation area

## PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> TODAY
		<input type="checkbox"/> BEDSIDE <input type="checkbox"/> ON CALL	<input type="checkbox"/> 72 HOURS	<input type="checkbox"/> EMERGENCY

## CONSULTATION REPORT

RECORD REVIEWED  YES  NOPATIENT EXAMINED  YES  NO

Elderly moderately obese male & unknown medical history collapses in yard, he had no sx's of life @ yard. Pt was intubated @ EMT by corpsman.

P/E Asystole  
Pupils fixed and dilated  
Cyan - good air entry & bypass  
no pulse

(A) Most likely massive cardiac arrest

(P) ① Code

② Called Code

(Continue on reverse side)

(b)(6)-2

(b)(6)-2

(b)(6)-2

REGISTER NO.

DATE

22 May 09

WARD NO.

TION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

\*U.S. GPO: 1994-377-624

(b)(6)-4

## CONSULTATION SHEET

Medical Record

STANDARD FORM 513 (REV. 8-92)  
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

## EMERGENCY RESUSCITATION RECORD - PART 1

For use of this form see MEDCOM Cir 40-5

Complete this report within 2 hours following the arrest/event. Place the original in the patient's record and provide a copy to the Nursing Supervisor.

1. DATE: 22 MAY 04 1055

3. WITNESSED ARREST?

- YES  NO  UNKNOWN  
 MONITORED AT ONSET?  
 YES  NO

2. LOCATION OF RESUSCITATION EVENT *Brought to EMT @ 1055*

- MICU  SICU  CCU  NICU  ED  PACU  OR  WARD: \_\_\_\_\_  
 DIAGNOSTIC / PROCEDURE AREA: \_\_\_\_\_  
 OUTPATIENT CLINIC: \_\_\_\_\_  
 OTHER (Specify): *Pt collapsed at GANZI 5-brought here C PR*

4. INTERVENTIONS (✓ - IN PLACE AT START OF ARREST)

- IV Access *RL 500cc*  
 Endotracheal Tube  
 Mechanical Ventilation  
 Arterial Line  
 Central Venous Line  
 Pulmonary Artery Catheter  
 Nasogastric Tube  
 Pacing Device (Specify type): \_\_\_\_\_  
 Implantable Defibrillator / Cardioverter  
 Other (Specify): \_\_\_\_\_

(✓ - INSERTED DURING ARREST)

- Time: \_\_\_\_\_ : \_\_\_\_\_  
 Time: *1100* : \_\_\_\_\_ *7.0 ET tube*  
 Time: *1055* : \_\_\_\_\_ *Bag Valve Mask*  
 Time: \_\_\_\_\_ : \_\_\_\_\_  
 Time: \_\_\_\_\_ : \_\_\_\_\_

COMMENTS *in place*5. IMMEDIATE CAUSE OF ARREST / EVENT  
(Check one)

- Lethal Arrhythmias  
 Hypotension  
 Respiratory Depression  
 Metabolic  
 Myocardial Infarction or Ischemia  
 Unknown  
 Other: \_\_\_\_\_

6. RESUSCITATION ATTEMPTED

 YES (Check all that were used)

- Chest Compressions  
 Defibrillation  
 Airway Management

 NO (Check one)

- False alarm/arrest (BLS / ALS not needed)  
 Do not attempt resuscitation (DNAR)  
 Considered futile  Found dead

7. INITIAL CONDITION

CONSCIOUS

- Yes  No

BREATHING

- Yes  No

PULSE

- Yes  No

Site: *Pulse only C PR*

8. INITIAL RHYTHM

- Ventricular Fibrillation  Perfusion Rhythm  
 Ventricular Tachycardia  Bradycardia  
 Pulseless Electrical Activity  Asystole

RETURN OF SPONTANEOUS CIRCULATION (ROSC)

- Returned at: \_\_\_\_\_ : \_\_\_\_\_  Never achieved  
 Unsustained ROSC:  < 20 min  > 20 min

CPR STOPPED AT: *1107*WHY:  ROSC  DNAR  
 Considered futile  Death

PATIENT DISPOSITION:

9. EVENT TIMES

(Times are required to calculate the American Heart Ass'n and European Resuscitation Council In-hospital chain of survival.)

HOUR MIN

Collapse / Arrest Onset: \_\_\_\_\_

CPR Started: *before arrival* : \_\_\_\_\_1st Defibrillation: *Pt arrived 1055* : \_\_\_\_\_Airway Achieved: *1100* : \_\_\_\_\_1st Dose Epinephrine: *1102* : \_\_\_\_\_

Code Team Called: \_\_\_\_\_

 Yes  No Time: \_\_\_\_\_

Code Team Arrived: \_\_\_\_\_

 Yes  No Time: \_\_\_\_\_

10. GLASGOW COMA SCALE

(Post-resuscitation)

Circle appropriate scores, then total.

EYE OPENING

- 4 - Spontaneously

- 3 - To voice

- 2 - To pain

- 1 - No response

VERBAL RESPONSE

- 5 - Oriented, converses

- 4 - Disoriented, converses

- 3 - Inappropriate responses

- 2 - Incomprehensible sounds

- 1 - No response

MOTOR RESPONSE

- 6 - Obeys verbal commands

- 5 - Localizes painful stimulus

- 4 - Withdraws from pain stimulus

- 3 - Flexion, decorticate posturing

- 2 - Extension, decerebrate

- 1 - Posturing

- 1 - No movement

SCORE: \_\_\_\_\_

PATIENT IDENTIFICATION

(b)(6)-4

AGE: *DOB 1940*GENDER: *MALE*

HEIGHT (in): \_\_\_\_\_

WEIGHT (lbs): \_\_\_\_\_

Ex 3

## EMERGENCY RESUSCITATION RECORD - PAGE 2 0040-04-C07A-83990

TIME (Hr/Min):	1055	10100	1102	1103	1104	1105	1107						
<b>VITALS</b>	BLOOD PRESSURE	none	none					none					
	HEART RATE (* = CPR)	*CPR	*CPR					Asystole					
	RHYTHM	Asystole	Asystole					CPR					
	PULSE PALPABLE (Y/N)	N	N					N					
	DEFIBRILLATION (Joules: 200, 300, 360)	none	none					-					
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	-	-					-					
	PACING PERFORMED (/)	-	-					-					
	RESPIRATIONS	O	-					O					
<b>AIRWAY</b>	BAGGED w / 100% O <sub>2</sub> (/)	/											
	INTUBATED (/)	/	Z										
	MASK (Specify type)												
	% OXYGEN	100%	100%	100%	100%	100%	100%						
	O <sub>2</sub> SATS	70%	70%	70%	70%	70%	70%						
<i>PT PREPARED READY - 1107</i>													
<b>MEDICATIONS</b>	EPINEPHRINE (1 mg - IV / ET tube)		/		/								
	ATROPOINE (0.6 - 1 mg - IV / ET tube)			/		/							
	LIDOCAINE (1-1.5 mg / kg - IV / ET tube)												
<b>IV Drips</b>	LIDOCAINE (1 GM / 250cc - IV at 1 - 4 mg / min)												
	DOPAMINE (400 mg / 250cc - IV at 1 - 20 mcg / kg / min)												
<b>LABS</b>	POTASSIUM (K)												
	GLUCOSE												
	CALCIUM (Ca)												
	MAGNESIUM (Mg)												
<b>ABGs</b>	PH												
	pCO <sub>2</sub>												
	pO <sub>2</sub>												
	HCO <sub>3</sub>												
PHYSICIAN (Signature & Title)				NURSE (Signature & Title)				(b)(6)-2					
DR (b)(6)-2													

MEDCOM FORM 679-R (TEST) (MCHO) AUG 99, Back

(b)(6)-4

(b)(6)-4

22 MAY 04.

LTC AA

EX 3



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

**PRELIMINARY AUTOPSY REPORT**

Name: (b)(6)-4

Autopsy No.: ME04-386

Prisoner (b)(6)-4

AFIP No.: Pending

Date of Birth: BTB 1940

Rank: CIV

Date of Death: BTB 23 May 2004

Place of Death: Abu Ghraib Prison

Date of Autopsy: 1 June 2004

Place of Autopsy: BIAP Morgue

Date of Report: 1 June 2004

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

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

**Identification:** BTB, DNA sample obtained

**CAUSE OF DEATH:** Atherosclerotic cardiovascular disease

**MANNER OF DEATH:** Natural

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.

14

EX 5

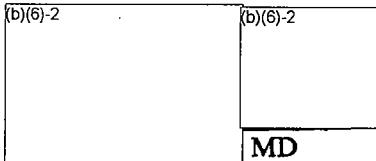
**AUTOPSY REPORT ME04-386**

(b)(6)-4

2

**PRELIMINARY 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 pending



MAJ, MC, USA  
Deputy Medical Examiner

10

Ex 5

EPW  
0040.04.789.83990



## 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

Autopsy No.: ME04-386

Prisoner #: (b)(6)-4

AFIP No.: 2929618

Date of Birth: BTB 1940

Rank: CIV

Date of Death: BTB 22 May 2004

Place of Death: Abu Ghraib Prison

Date of Autopsy: 1 June 2004

Place of Autopsy: BIAP Morgue

Date of Report: 29 Jun 2004

**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

**AUTOPSY REPORT ME04-386**

(b)(6)-4

2

**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

**AUTOPSY REPORT ME04-386**

3

(b)(6)-4

**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<sup>th</sup> and left 3<sup>rd</sup>-7<sup>th</sup> ribs on the anterior aspects.

**AUTOPSY REPORT ME04-386**

(b)(6)-4

**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<sup>th</sup> 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.

By 8

## AUTOPSY REPORT ME04-386

5

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 PH3(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.

**AUTOPSY REPORT ME04-386**

(b)(6)-4

**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.

(b)(6)-2

(b)(6)-2

MD (b)(6)-2

MAJ, MC, USA  
Deputy Medical Examiner

Ex 8

0040.04.783.8380.



DEPARTMENT OF DEFENSE  
ARMED FORCES INSTITUTE OF PATHOLOGY  
WASHINGTON, DC 20306-6000

REPLY TO  
ATTENTION OF

AFIP-CME-T

TO:

OFFICE OF THE ARMED FORCES MEDICAL  
EXAMINER  
ARMED FORCES INSTITUTE OF PATHOLOGY  
WASHINGTON, DC 20306-6000

PATIENT IDENTIFICATION  
AFIP Accessions Number      Sequence  
2929618                    01

Name

(b)(6)-4

SSAN:                        Autopsy: ME04-386  
Toxicology Accession #: 042887  
Date Report Generated: June 28, 2004

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS

REPORT OF TOXICOLOGICAL EXAMINATION

Condition of Specimens: GOOD

Date of Incident: 5/23/2004      Date Received: 6/17/2004

**VOLATILES:** The BLOOD AND BILE were examined for the presence of ethanol at a cutoff of 20 mg/dL. No ethanol was detected.

**CYANIDE:** There was no cyanide detected in the blood. The limit of quantitation for cyanide is 0.25 mg/L. Normal blood cyanide concentrations are less than 0.15 mg/L. Lethal concentrations of cyanide are greater than 3 mg/L.

**DRUGS:** The BLOOD was screened for amphetamines, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, cocaine, dextromethorphan, lidocaine, narcotic analgesics, opiates, phencyclidine, phenothiazines, sympathomimetic amines and verapamil by gas chromatography, color test or immunoassay. The following drugs were detected:

None were found.

(b)(6)-2

PhD

Certifying Scientist, Forensic Toxicology Laboratory  
Office of the Armed Forces Medical Examiner

(b)(6)-2

PhD, DABFT

Director, Forensic Toxicology Laboratory  
Office of the Armed Forces Medical Examiner

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B 8-

## MEDICATION ADMINISTRATION RECORD

Name: (b)(6)-4      Unit: \_\_\_\_\_      Month: \_\_\_\_\_

Medication /Dose /Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
PZA 500 mg 4 pills each day																															
Rifampin 300 mg 2 p.o. daily																															
TINH 300 mg one each day																															
Ethambutol 400 mg 3 pills each day																															

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0014-03-CID 919-63732

AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

TREATING ORGANIZATION (Sign each entry)

DATE

Tuesday 25 June

AS tuberculosis

Recommended Compassionate D/C to Medical City

he has 4 days of medication

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY

DEPART./SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: (For type of identification, name, address, telephone number, place of birth, Social Security number or SSN; Sex; Date of Birth; Rank &amp; 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

FOR OFFICIAL USE ONLY

OFFICE OF THE ARMED FORCES MEDICAL EXAMINER  
BAGHDAD DETACHMENT

PRELIMINARY AUTOPSY REPORT

Name: (b)(6)-2

Date of Birth: 01 January 1977

PW Number: 11672

Date of Death: 12 July 2003

Place of Death: EPW Camp, Baghdad International Airport, Baghdad, Iraq

Date of Autopsy: 13 July 2003

Place of Autopsy: Baghdad International Airport Compound, Baghdad, Iraq

**CLINICAL DIAGNOSES:**

1. Hemoptysis
2. Death in Custody

**PATHOLOGIC DIAGNOSES:**

A. RESPIRATORY SYSTEM:

1. Cavitary Lesion- Right Lung
2. Multiple Caseating Granulomata- Right Lung
3. Blood Within Tracheobronchial Tree
4. Focal Consolidation- Bilateral Lungs
5. Bilateral Pleural Adhesions

B. CARDIOVASCULAR SYSTEM

1. Pericardial Effusion- 30 cc.

C. GENITOURINARY SYSTEM

1. Absent Right Testicle

D. NO EVIDENCE OF SIGNIFICANT TRAUMA

**CAUSE OF DEATH:** MASSIVE HEMOPTYSIS DUE TO CAVITARY  
PULMONARY TUBERCULOSIS

**MANNER OF DEATH:** NATURAL



(b)(6)-2  
MD  
CAPT MC USN  
Regional Armed Forces Medical

TO:

ARMED FORCES INSTITUTE OF PATHOLOGY  
ATTN: DIVISION OF FORENSIC TOXICOLOGY  
BUILDING 54  
6825 16TH STREET, N.W.  
WASHINGTON, DC 20306-6000

FORWARD FINAL REPORT TO:

0014-03-C-919-G3132

**COMMANDER**  
(b)(3)-1 MP DET (CID)  
MP BN (CID)  
APO AE 09335

NAME OF PATIENT (Last, First, MI)	SOCIAL SECURITY #	AGE	SEX	RACE
(b)(6)-4	DETAINEE # (b)(6)-4	26	MALE	IRAQI
DATE OF INCIDENT/ ACCIDENT	TIME AND DATE OF DEATH		AUTOPSY #	
12 JUL 03	12 JUL 03 / 05,5		EPLW 071303	

MEDICATION HISTORY (Prescribed or administered, in patient's possession, containers found near body, etc.)

N/A Note: TUBERCULOSIS VICTIM

SPECIMEN/ AMOUNT	SPECIMEN/ AMOUNT	SPECIMEN/ AMOUNT
1. LIVER	5. RIGHT LUNG	9. EPW CAPTURE TAG # (b)(6)-4
2. SPLEEN	6. BRAIN	10. INDEX CARD WITH NAME (b)(6)-4
3. KIDNEY	7. RIGHT HAND FINGERPRINT CARD	11.
4. LEFT LUNG	8. LEFT HAND FINGERPRINT CARD	12.

INCIDENT/ACCIDENT DETAILS (Include pertinent information regarding crash site, autopsy or investigation: (e.g., What happened?)

VICTIM (b)(6)-4 WAS APPREHENDED ON 10 JUL 03 IN POSSESSION OF A PIPE BOMB. HE WAS SUBSEQUENTLY TRANSPORTED TO CAMP CROPPER DETENTION FACILITY AT BIAP. AT APPROXIMATELY 0445, 12 JUL 03, VICTIM (b)(6)-4 WAS OBSERVED COUGHING UP BLOOD. MEDICAL PERSONNEL ATTEMPTED TO ASSIST BUT WAS NEGATIVE. HE DIED 0510.

PRINTED NAME OF REQUESTER/ TITLE (b)(6)-1	SIGNATURE (b)(6)-1	DATE 13 JUL 03	TELEPHONE #: COMM: DSN: 302-550-2525 FAX:
/SAC			

## CHAIN OF CUSTODY (CO)

Each individual charged with custody of specimens must complete information below (consecutive CC, if reverse is required).

RELEASED BY	RECEIVED BY	DATE & TIME	PURPOSE OF TRANSFER
(b)(6)-1	SIGNATURE PRINTED NAME		
SIGNATURE PRINTED NAME	SIGNATURE PRINTED NAME		
PRINTED NAME	PRINTED NAME		
PRINTED NAME	PRINTED NAME		
SIGNATURE	SIGNATURE PRINTED NAME		
PRINTED NAME	PRINTED NAME		
SIGNATURE PRINTED NAME	SIGNATURE PRINTED NAME		
PRINTED NAME	PRINTED NAME		

AFIP FORM 1323, FEB 99 PREVIOUS EDITIONS OBSOLETE. FOR OFFICIAL USE ONLY

13

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004-03-CID919-63732

CERTIFICATE OF DEATH (OVERSEAS) Acte de décès (D'Outre-Mer)				
NAME OF DECEASED (Last, First, Middle) (b)(6)-4	GRADE Grade N/A	BRANCH OF SERVICE Arme N/A	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale X10	
ORGANIZATION Organisation	NATION (e.g., United States) Pays	DATE OF BIRTH Date de naissance	SEX Sexe	<input type="checkbox"/> MALE Masculin <input type="checkbox"/> FEMALE Féminin
RACE Race	MARITAL STATUS État Civil	RELIGION Culte		
CAUCASOID Caucasiq	SINGLE Célibataire	DIVORCED Divorcé SEPARATED Séparé	PROTESTANT Protestant	OTHER (Specify) Autre (Spécifier)
NEGROID Nigroïde	MARRIED Marié		CATHOLIC Catholique	
OTHER (Specify) Autre (Spécifier)	WIDOWED Veuf		JEWISH Juif	
NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit			
STREET ADDRESS Domicile à (Rue)	CITY OR TOWN AND STATE (Include ZIP Code) Ville (Code postal comoros)			
MEDICAL STATEMENT Déclaration médicale				
CAUSE OF DEATH (Enter only one cause per line) Cause du décès (N'indiquer qu'une cause par ligne)				INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <sup>1</sup> Maladie ou condition directement responsable de la mort <sup>1</sup>		<i>Tuberculosis Cardiac Arrest</i>		
ANTECEDENT CAUSES Symptômes précurseurs de la mort.	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	<i>Tuberculosis</i>		
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire			
OTHER SIGNIFICANT CONDITIONS <sup>2</sup> Autres conditions significatives <sup>2</sup>		<i>Unknown</i>		
MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée <input type="checkbox"/> YES Oui <input checked="" type="checkbox"/> NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures		
NATURAL Mort naturelle	<i>Unknown</i>			
ACCIDENT Mort accidentelle				
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste			
HOMICIDE Homicide	SIGNATURE Signature	DATE Date	AVIATION ACCIDENT Accident à Avion <input type="checkbox"/> YES Oui <input type="checkbox"/> NO Non	
DATE OF DEATH (Hour, day, month, year) Date de décès (l'heure, le jour, le mois, l'année)	PLACE OF DEATH Lieu de décès BIAF			
I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE. J'ai examiné les restes mortals du défunt et je conclus que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci-dessus.				
NAME OF MEDICAL OFFICER Nom du médecin ou du médicin sanitaire (b)(6)-2	TITLE OR DEGREE Titre ou diplôme MD			
GRADE Grade Lt Col	INSTALLATION OR ADDRESS Installation ou adresse EMED (b)(3)-	(b)(6)-2		
DATE Date 12 Jul 03	Lt Col, USAF, MC Chief, Ortho Sports Med. (b)(6)-2 WHMCPAC (b)(3)-1			
1 State disease, injury or complication w/ 2 State conditions contributing to the death 3 Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du cœur, etc. 4 Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.				

DD FORM 2064 APR 77 REPLACES AF FORM 716, MAR 68, WHICH IS OBSOLETE.

FOR OFFICIAL USE ONLY

13-03-03-61830-62147

10-1-03-C-0519-62147

ALTACE

Ramírez, Luis

(b)(6)-4



63yo ♂ presenta con  
Corto de respiración y  
Tocando mucho con Sospe  
por favor de cojer  
placa del pecho  
(CXR) PA y lateral

R/O Bronquitis o Tubercolosis

Croquis

(b)(6)-2

CPT MC

FL

Por favor venga a las 20,00h. de hoy 10-1-03  
hoy (13-V-03) para realizar la RX EXTRAS 34  
MEDCOM-679 de donde el >

1201-03-C10510-62147

CHRONOLOGICAL Record

13 May 03	④ shoulder HA constipation x4 66 yrs old male. 1350 hrs c/o dyspnea x today PO <sub>2</sub> 88% O - rates, putting edema ⑤ leg only. (a) 1350 hrs 100% = O <sub>2</sub> Therapy ② 4 L/min
	A. f - refer to Spanish for CXR 1500 → Spanish X Ray is down. Return (a) 1700 hrs. SSG (b)(6)-1 (b)(3)-1 MP BN
13 May 03 2055	Rec'd CXR. Will hold pt. in Medical Holding Tent to intent of further eval. & possible expediting his release. SSG (b)(6)-1 (b)(3)-1 MP BN!

NAME

OS / (b)(6)-4

(b)(6)-4

1700 38

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MEDCOM - 680

UVL 105

EXHIBIT 34

1031-03-C10518-62147

## CHRONOLOGICAL Record

14 Mayo 03

Paciente con fxs y expectoración hemoptórica

AP: nucus e sputo de predominio blv

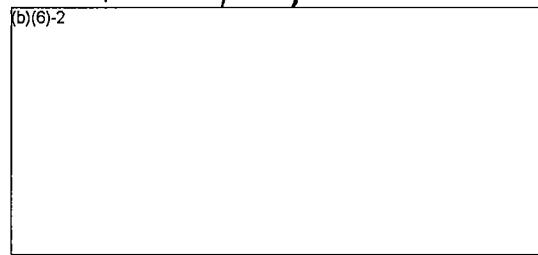
Rx: Tratamiento randomizado no clonulado.

> c. tubo medio supuesto de gran  
fibrinolisis en los pulmones aéreos

El paciente es accesible que sea liberado  
aislado para recibir Tto específico

J. clínico: Tubercolosis pulmonar.

Tt: Tratamiento Tto con Ciprofloxacina



NAME:

(b)(6)-4

#

(b)(6)-4

DOB:  
17 Jan 29

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FOR OFF.  
MEDCOM - 681

000 105

EXHIBIT 34

1203-CID519-62147

4 May 03

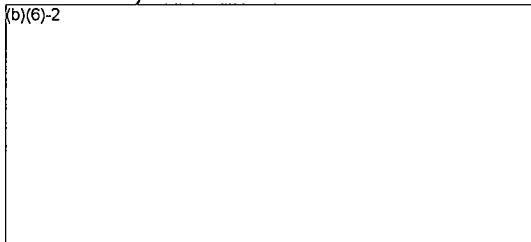
~~XXXXXXXXXX~~, Chest pain

Fractura por arma de fuego de tibia ilic  
1 mes de evolucion, tratado con fijacion  
externa → despues con escayola

Rx: Fractura en evolucion

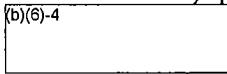
- Tx:
- Mantener escayola
  - " descaja 3 semanas mas

(b)(6)-2

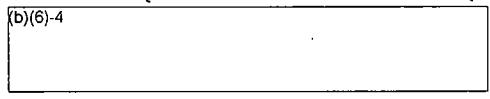


US

(b)(6)-4



(b)(6)-4



UU 107

FOR OFFICIAL USE ONLY

EXHIBIT 34

11  
CHRONOLOGICAL RECORD

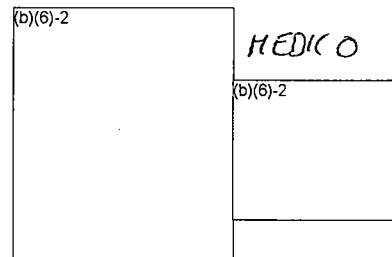
1031-03-C10519-62147

17 MAY 03

Paciente que refiere fue golpeado hace 4 días. Desde entonces presenta dolor a la movilización articulación hombro  $\oplus$  y muñeca izqd. No hematomas, ni signos de contusión en hombro; inflamación Rx de hombro  $\oplus$  ~~golpeo~~ muñeca

Presenta además una erosión en región coxigena como consecuencia (según refiere) de haber sido arrastrado.

- Tto: - Cura local de la ~~erosión~~  
- Inmovilización <sup>y vendaje</sup> de la muñeca  
- Butafen 600 1C/12h



US



(b)(6)-4

0081-03-C1D519-621V7

PACIENT: (b)(6)-4  
VS (b)(6)-4 EPW

CLINIC HISTORY:

Traumatic osteoarthritis of right elbow (4 days ago) in old injury (Gulf war).  
When he was 6 years old probably epiphysiolyis or fracture-dislocation.  
Nothing to do, only pills analgesics-AINE,s.

DIAGNOSTIC: Traumatic osteoarthritis of right elbow.

26, may, 2003

(b)(6)-2  
Tcol. Commander EMATCEN.  
(b)(6)-2



0081-03-109

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EXHIBIT 34

031-03-CID 519-62147

PACIENT: (b)(6)-4  
ISN #: (b)(6)-4 EPW

CLINIC HISTORY:

Hematoma in posterior region of left elbow with pain in epitroclea and epicondyle. X-rays suggest small fragment (acute or old) of epicondile, because he was operated in the past of humeral fracture, consolidated actually (with osteosynthesis).

I recommended brachial splint that was refused by the patient waiting for evolution.

He wanted pills AINE,s and so it was done.

DIAGNOSTIC: Traumatic hematoma of left elbow.

26, may, 2003

Tcol. Commander EMATCEN.

(b)(6)-2



For Official Use Only  
Law Enforcement Sensitive 0180-04-CID259-80227 0065-04-CID789

MEDICAL RECORD

PROGRESS NOTES

DATE

21 March 20xx S/ EPH States interrogated last evening.  
Reported this is swelling + blisters.  
Reports thermal burn left ear  
Noted 5's in wounds ant. ~~to~~ knee.

C/ AVES

EXT: (1) LE: Ant knees noted ↑ erythema  
+ multiple blisters. Noted: singed  
tissue appears 2nd degree burns w/  
necrotic margins.

A/P: 2nd degree burn w/ blister R/L.

(1) Continue Bacitracin topically  
to affected areas.

(2) Start Penicillin 4-6" PRN for  
Severe pain.

(3) Continue daily dressing & will  
use Silverdene (dark)

2-6 - Morphine 1/2 [REDACTED]

B6-2

(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)

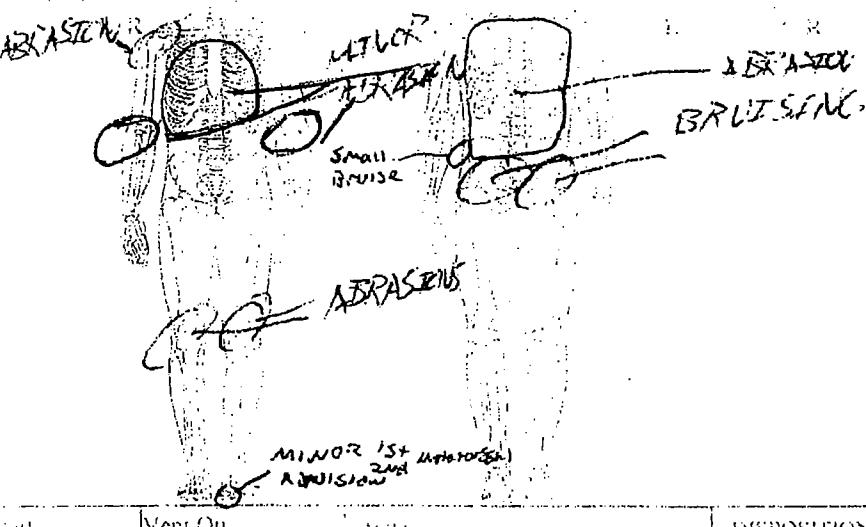
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9-202-1

(b)(6)-4

20

### Theater Trauma Registry Record

For use of this form, see DA PAM XXX; the proponent agency is OTSG

AUTHORITY:	SOME REGULATION							
PURPOSE:	To provide a standard means of documenting combat trauma for care at echelons 1-3							
ROUTINE USES:	The "Blanket Routine Uses" set forth at the beginning of the Army compilation of systems of records notice apply.							
DISCLOSURE:	This is protected health information. HIPAA laws apply.							
MTF DESIGNATION:			CASUALTY NAME: <u>(b)(6)-4</u>			CASUALTY SSN: <u>(b)(6)-4</u>		
Arrive DTG:			Rank	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Unit		
ARRIVAL METHOD:	<input checked="" type="checkbox"/> Non-MED GND <input type="checkbox"/> WALKED <input type="checkbox"/> CARRIED <input type="checkbox"/> ROLLED <input type="checkbox"/> OTHER <u>ARRIVAL</u>		Nation <input type="checkbox"/> US Hostile Non-hostile Neutral Condition	Service <input type="checkbox"/> Civilian <input type="checkbox"/> Combatant <input type="checkbox"/> Contractor	USA <input type="checkbox"/> USA <input type="checkbox"/> USN <input type="checkbox"/> USMC <input type="checkbox"/> USAF	SOF <input type="checkbox"/> ANG <input type="checkbox"/> ARNG <input type="checkbox"/> CJTF <input type="checkbox"/> MCRC		
Depart DTG:			PROTECTION:	Not Worn <input type="checkbox"/> TELNET <input type="checkbox"/> TEAK VEST <input type="checkbox"/> TAN VEST <input type="checkbox"/> TAN VEST <input type="checkbox"/> TAN VEST	Worn <input type="checkbox"/>	Struck <input type="checkbox"/>	Penetrated <input type="checkbox"/>	TRAUMA CATEGORY: <input type="checkbox"/> INTRACRANIAL <input type="checkbox"/> PELVIC <input type="checkbox"/> AXILLAR <input type="checkbox"/> HEPATIC
TYPE OF INJURY:	<input type="checkbox"/> GUN <input type="checkbox"/> BULLET <input type="checkbox"/> BLADE <input type="checkbox"/> BLUNT TRAUMA <input type="checkbox"/> SHELL FRAGMENT <input type="checkbox"/> SHOT FRAGMENT		TYPE <input type="checkbox"/> GUN <input type="checkbox"/> BLADE <input type="checkbox"/> BLUNT <input type="checkbox"/> SHELL <input type="checkbox"/> SHOT	LOCATION <input type="checkbox"/> HEAD <input type="checkbox"/> CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> EXTREMITIES <input type="checkbox"/> BACK <input type="checkbox"/> BUTT <input type="checkbox"/> EYES <input type="checkbox"/> GENITALS <input type="checkbox"/> SPINE <input type="checkbox"/> OTHER	%IBSA <input type="checkbox"/> 1% <input type="checkbox"/> 2% <input type="checkbox"/> 3% <input type="checkbox"/> 4% <input type="checkbox"/> 5% <input type="checkbox"/> 6% <input type="checkbox"/> 7% <input type="checkbox"/> 8% <input type="checkbox"/> 9% <input type="checkbox"/> 10% <input type="checkbox"/> 11% <input type="checkbox"/> 12% <input type="checkbox"/> 13% <input type="checkbox"/> 14% <input type="checkbox"/> 15% <input type="checkbox"/> 16% <input type="checkbox"/> 17% <input type="checkbox"/> 18% <input type="checkbox"/> 19% <input type="checkbox"/> 20% <input type="checkbox"/> 21% <input type="checkbox"/> 22% <input type="checkbox"/> 23% <input type="checkbox"/> 24% <input type="checkbox"/> 25% <input type="checkbox"/> 26% <input type="checkbox"/> 27% <input type="checkbox"/> 28% <input type="checkbox"/> 29% <input type="checkbox"/> 30% <input type="checkbox"/> 31% <input type="checkbox"/> 32% <input type="checkbox"/> 33% <input type="checkbox"/> 34% <input type="checkbox"/> 35% <input type="checkbox"/> 36% <input type="checkbox"/> 37% <input type="checkbox"/> 38% <input type="checkbox"/> 39% <input type="checkbox"/> 40% <input type="checkbox"/> 41% <input type="checkbox"/> 42% <input type="checkbox"/> 43% <input type="checkbox"/> 44% <input type="checkbox"/> 45% <input type="checkbox"/> 46% <input type="checkbox"/> 47% <input type="checkbox"/> 48% <input type="checkbox"/> 49% <input type="checkbox"/> 50% <input type="checkbox"/> 51% <input type="checkbox"/> 52% <input type="checkbox"/> 53% <input type="checkbox"/> 54% <input type="checkbox"/> 55% <input type="checkbox"/> 56% <input type="checkbox"/> 57% <input type="checkbox"/> 58% <input type="checkbox"/> 59% <input type="checkbox"/> 60% <input type="checkbox"/> 61% <input type="checkbox"/> 62% <input type="checkbox"/> 63% <input type="checkbox"/> 64% <input type="checkbox"/> 65% <input type="checkbox"/> 66% <input type="checkbox"/> 67% <input type="checkbox"/> 68% <input type="checkbox"/> 69% <input type="checkbox"/> 70% <input type="checkbox"/> 71% <input type="checkbox"/> 72% <input type="checkbox"/> 73% <input type="checkbox"/> 74% <input type="checkbox"/> 75% <input type="checkbox"/> 76% <input type="checkbox"/> 77% <input type="checkbox"/> 78% <input type="checkbox"/> 79% <input type="checkbox"/> 80% <input type="checkbox"/> 81% <input type="checkbox"/> 82% <input type="checkbox"/> 83% <input type="checkbox"/> 84% <input type="checkbox"/> 85% <input type="checkbox"/> 86% <input type="checkbox"/> 87% <input type="checkbox"/> 88% <input type="checkbox"/> 89% <input type="checkbox"/> 90% <input type="checkbox"/> 91% <input type="checkbox"/> 92% <input type="checkbox"/> 93% <input type="checkbox"/> 94% <input type="checkbox"/> 95% <input type="checkbox"/> 96% <input type="checkbox"/> 97% <input type="checkbox"/> 98% <input type="checkbox"/> 99% <input type="checkbox"/> 100%	TYPE <input type="checkbox"/> INTRACRANIAL <input type="checkbox"/> PELVIC <input type="checkbox"/> AXILLAR <input type="checkbox"/> HEPATIC		
INJURY:			TYPE <input type="checkbox"/> GUN <input type="checkbox"/> BLADE <input type="checkbox"/> BLUNT TRAUMA <input type="checkbox"/> SHELL FRAGMENT <input type="checkbox"/> SHOT FRAGMENT	LOCATION <input type="checkbox"/> HEAD <input type="checkbox"/> CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> EXTREMITIES <input type="checkbox"/> BACK <input type="checkbox"/> BUTT <input type="checkbox"/> EYES <input type="checkbox"/> GENITALS <input type="checkbox"/> SPINE <input type="checkbox"/> OTHER	%IBSA <input type="checkbox"/> 1% <input type="checkbox"/> 2% <input type="checkbox"/> 3% <input type="checkbox"/> 4% <input type="checkbox"/> 5% <input type="checkbox"/> 6% <input type="checkbox"/> 7% <input type="checkbox"/> 8% <input type="checkbox"/> 9% <input type="checkbox"/> 10% <input type="checkbox"/> 11% <input type="checkbox"/> 12% <input type="checkbox"/> 13% <input type="checkbox"/> 14% <input type="checkbox"/> 15% <input type="checkbox"/> 16% <input type="checkbox"/> 17% <input type="checkbox"/> 18% <input type="checkbox"/> 19% <input type="checkbox"/> 20% <input type="checkbox"/> 21% <input type="checkbox"/> 22% <input type="checkbox"/> 23% <input type="checkbox"/> 24% <input type="checkbox"/> 25% <input type="checkbox"/> 26% <input type="checkbox"/> 27% <input type="checkbox"/> 28% <input type="checkbox"/> 29% <input type="checkbox"/> 30% <input type="checkbox"/> 31% <input type="checkbox"/> 32% <input type="checkbox"/> 33% <input type="checkbox"/> 34% <input type="checkbox"/> 35% <input type="checkbox"/> 36% <input type="checkbox"/> 37% <input type="checkbox"/> 38% <input type="checkbox"/> 39% <input type="checkbox"/> 40% <input type="checkbox"/> 41% <input type="checkbox"/> 42% <input type="checkbox"/> 43% <input type="checkbox"/> 44% <input type="checkbox"/> 45% <input type="checkbox"/> 46% <input type="checkbox"/> 47% <input type="checkbox"/> 48% <input type="checkbox"/> 49% <input type="checkbox"/> 50% <input type="checkbox"/> 51% <input type="checkbox"/> 52% <input type="checkbox"/> 53% <input type="checkbox"/> 54% <input type="checkbox"/> 55% <input type="checkbox"/> 56% <input type="checkbox"/> 57% <input type="checkbox"/> 58% <input type="checkbox"/> 59% <input type="checkbox"/> 60% <input type="checkbox"/> 61% <input type="checkbox"/> 62% <input type="checkbox"/> 63% <input type="checkbox"/> 64% <input type="checkbox"/> 65% <input type="checkbox"/> 66% <input type="checkbox"/> 67% <input type="checkbox"/> 68% <input type="checkbox"/> 69% <input type="checkbox"/> 70% <input type="checkbox"/> 71% <input type="checkbox"/> 72% <input type="checkbox"/> 73% <input type="checkbox"/> 74% <input type="checkbox"/> 75% <input type="checkbox"/> 76% <input type="checkbox"/> 77% <input type="checkbox"/> 78% <input type="checkbox"/> 79% <input type="checkbox"/> 80% <input type="checkbox"/> 81% <input type="checkbox"/> 82% <input type="checkbox"/> 83% <input type="checkbox"/> 84% <input type="checkbox"/> 85% <input type="checkbox"/> 86% <input type="checkbox"/> 87% <input type="checkbox"/> 88% <input type="checkbox"/> 89% <input type="checkbox"/> 90% <input type="checkbox"/> 91% <input type="checkbox"/> 92% <input type="checkbox"/> 93% <input type="checkbox"/> 94% <input type="checkbox"/> 95% <input type="checkbox"/> 96% <input type="checkbox"/> 97% <input type="checkbox"/> 98% <input type="checkbox"/> 99% <input type="checkbox"/> 100%	TYPE <input type="checkbox"/> INTRACRANIAL <input type="checkbox"/> PELVIC <input type="checkbox"/> AXILLAR <input type="checkbox"/> HEPATIC		
<b>BROWN EYES — 10"</b>								
								
VENT ON:	Off	RTG IN:	Out	DISPOSITION:	EVACUATED to			
Stop				RTD	<input type="checkbox"/> URGENT			
Stop				DECEASED	<input type="checkbox"/> URGENT SURGEON			

## STATE OF CALIFORNIA

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NAME OF PERSON

(b)(6)-4

(b)(6)-4

Date of Birth

(b)(6)-4

Gender

Lmt

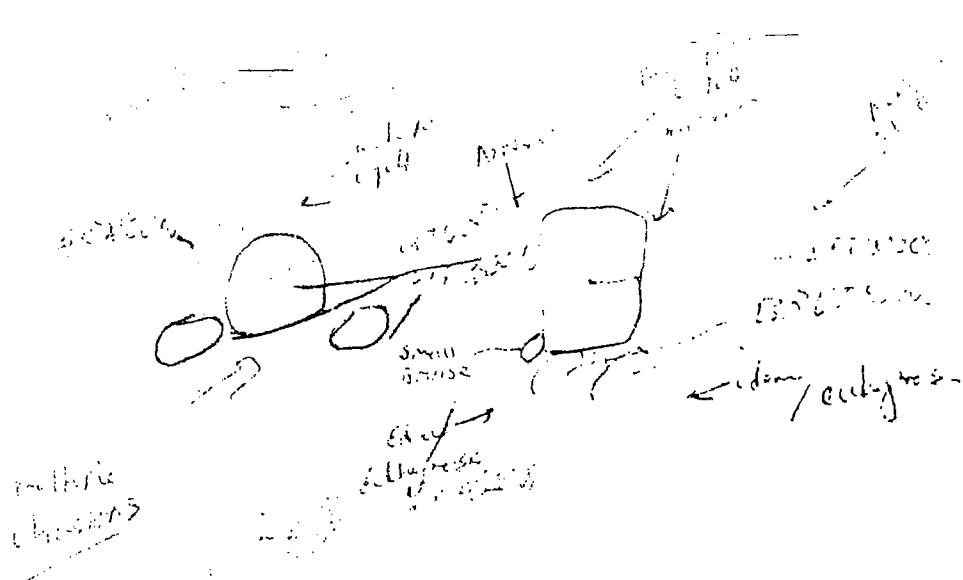
 Male  Female

Address:

OF 1200 S MARINA

X

APR 2001

345 1816 145  
125 44 125  
669 77 125  
125 1 125  
116 1 125German Report 11/11/01  
ACC 118th ASMB

SEARCHED	INDEXED
SERIALIZED	FILED
APR 2001	

- URGENT
- URGENT
- ROUTINE
- MINIMAL

NSWCON-7

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LAW ENFORCEMENT USE ONLY

31

FD-302 (Rev. 1-25-60)

EXHIBIT

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

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

8/21/04 31 year old ♂ debilitated for physical

PMH- "broken back" 4 mo ago

PSH- ♂ meds- ♂ Allergies ♂

SH- ♂

Vitals HT 6'0" wt 69 kg 132/62 P61 R16

Healthy fit African Young ♂

HEENT- Mouth moist + pink multiple fillings.

No evidence of active disease.

PEACE, DON / myalgias

Neck- spine straight, no tenderness

Chest CXR (B) good AE

CV- Systolic (B) A

Mid- Systolic NT BS (B)

Ext- abdomen - multiple areas of ecchymosis over (B) knees.

Skin- several old scars on back no bruising

Musculoskeletal system all 9 limbs good strength

No muscle wasting no bone/bleeding problems.

Imp: ① healthy young ♂ &amp; no acute injury or illness

② old trauma evident by Scarring.

(b)(6)-2

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART./SERVICE

SPONSOR'S NAME

SSN/ID NO.

RELATIONSHIP TO SPONSOR

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

REGISTER NO.

WARD NO.

ISBN:

(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

USAPAV2.00

COMPOUND: 1973 31 yr.

FOR OFFICIAL USE ONLY

MEDCOM - 689

# Theater Trauma Registry Record

0180-04-CID259-80227

For use of this form, see DA FORM X-3; the proponent agency is OTSG

AUTHORITY:

SOME REGULATION

PURPOSE:

To provide a standard means of documenting combat trauma for care at echelons 1-3

ROUTINE USES:

The "Blanket Routine Uses" set forth at the beginning of the Army compilation of systems of records notice apply.

DISCLOSURE:

This is protected health information. HIPAA laws apply.

MTF DESIGNATION:

100-0000

100-0000

CASUALTY NAME  
(b)(6)-4

CASUALTY SSN:

Arrive DTG:

R

Birth

Gender

Male  Female

Unit

ARRIVAL METHOD:  
 WALKED  
 CARRIED  
 Non-MED AIR  
 OTHER \_\_\_\_\_

Nation  
 US  
 Host Nation  
 Enemy( )  
 Coalition( )

Service  
 Civilian  
 Combatant  
 Contractor  
 Coalition( )

USA  SOF  
 USN  NGO( )  
 USMC  Other  
 USAF

Wound DTG:

WOUNDED BY:

- ENEMY  UNK
- FRIENDLY
- CIVILIAN (Host Country)
- TRAINING
- SELF ACCIDENT
- SELF NON-ACCIDENT
- SPORTS-RECREATION
- OTHER: \_\_\_\_\_

PROTECTION:  
 HELMET  
 FLAK VEST  
 CERAMIC PLATE  
 EYE PROTECTION  
 OTHER:

Not Worn  
 Worn  
 Struck  
 Penetrated

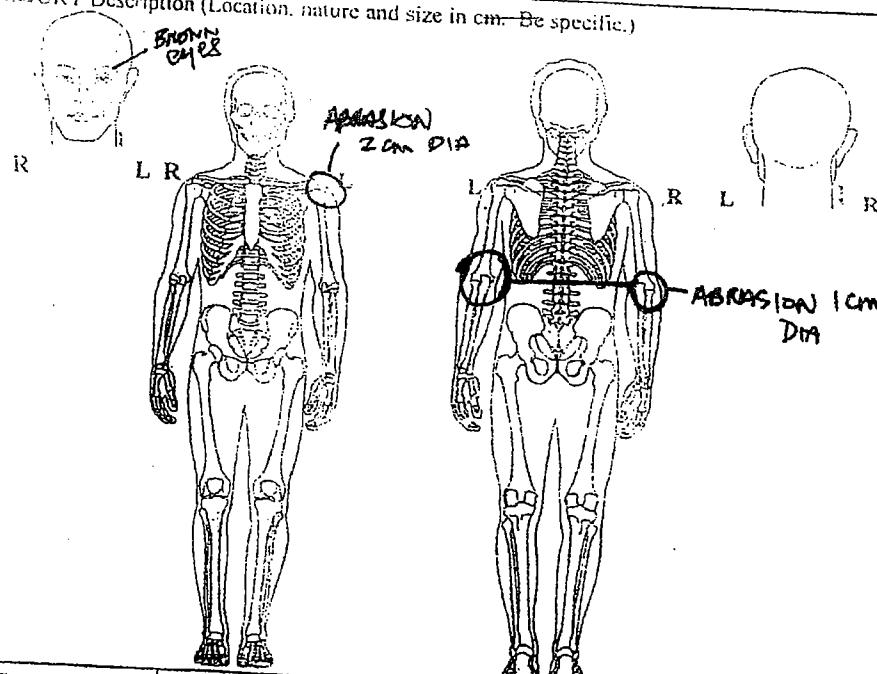
TRIAGE CATEGORY:  
 IMMEDIATE  
 DELAYED  
 MINIMAL  
 EXPECTANT

GLASCOW COMA SCALE (check one)  
 3      8      12      15  
 UNC      STEP POR      LETARGY      STUPOR

MECHANISM OF INJURY:  
 GSW/BULLET  MVC  BURN 1° 2° 3° \_\_\_\_\_ %TBSA  
 BLUNT TRAUMA  AIRCRAFT CRASH  CRUSH  
 SINGLE FRAGMENT  KNIFE/EDGE  FALL  
 MULTI FRAGMENT  CBRNE  IED  
 BLAST  BLAST  OTHER \_\_\_\_\_

TIME	2020	2132	2250
Pulse	140	100	120
Temp	98.6	—	98.4
B/P	—	—	—
Resp	16	12	18
SpO <sub>2</sub>	—	—	—

INJURY Description (Location, nature and size in cm. Be specific.)



R Start	Vent On	ICU in	DISPOSITION:	EVACUATED to
Stop	Off	Out	<input type="checkbox"/> RTD	<input type="checkbox"/> URGENT
PROVIDER:			<input type="checkbox"/> DECEASED	<input type="checkbox"/> URGENT SURGICAL
SPECIALTY: FOR OFFICIAL USE ONLY			<input type="checkbox"/> ROUTINE	<input type="checkbox"/> MINIMAL
DATE: DTG: YDTG: 0000			<b>EXTRAIT</b>	

EDCOM Test Form 1381, OCT 2005  
 SAW ENFORCEMENT USE ONLY

# Theater Trauma Registry Record

For use of this form, see DA PAM XXX; the proponent agency is OTSG

## Observations/Notes (Holding, En route, etc.)

TIME	BP	PULSE	RESP	SpO <sub>2</sub>	MENTAL Status	DRUG	DOSE	ROUTE	DTG
0005		110	18		A V P U				
0106		112	16		A V P U				
0215		110	16	T97.6	A V P U				
0310		110	16		A V P U				
0500		100	19		A V P U				
					A V P U				

NOTES: PT RECEIVED H2O / MRE / 4 HOURS SLEPT DURING THIS SHIFT

(b)(6)-2

Hm,

MEDICATIONS:	LABS:	XRAYS:	PMH:
			Allergies:

## Discharge Summary Information (Diagnosis, Procedures and Complications)

Head and Neck:

Chest:

Abdomen:

Upper:

Pelvis:

Lower:

Skin:

Cause of Death at \_\_\_\_\_

ANATOMIC:

Airway  Head  Neck  Chest  Abdomen  Pelvis  Extremity (Upper/Lower)  Other

PHYSIOLOGIC:

Breathing  CNS  Hemorrhage  Total Body Disruption  Sepsis  Multi-organ failure  Other

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT USE ONLY

EXHIBIT

AUTHORIZED FOR LOCAL REPRODUCTION

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

**SPONSOR'S NAME** \_\_\_\_\_ **SSN/RD NO.** \_\_\_\_\_ **RELATIONSHIP TO SPONSOR**

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

NAME (LAST FIRST) John A. Smith (by 1)  
of Birth; Rank/Grade.)

**NAME (LAST, FIRST) (b)(6)-4**      **CHRONOLOGICAL RECORD OF MEDICAL CARE**

STANDARD FORM 500 (REV. 6-87)  
Medical Record

UNIT: **S-1** STANDARDS FORM 1 (REV. 3-67)  
Prescribed by GSA/RCMR  
HEARNS 22

FIRMR (41 CFR) 201-9.202-1 USAPKA v2.00

**SEX:**                   **STATUS: (AD, NG, B)**

**FOR OFFICIAL USE ONLY**

LAW ENFORCEMENT USE ONLY

ENFORCEMENT USE ONLY EXHIBIT

MEDCOM - 692

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

## THE RECORDS OF Medical Record

STANDARD FORM 600 (REV. 6-97)

Prescribed by GSACMR

USAPA V2.00

**STATUS: (AD, NG, R)  
FOR OFFICIAL USE ONLY  
LAW ENFORCEMENT USE ONLY**

## **EXHIBIT**

## MEDICAL RECORD

B6-2

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12/11/04	H&H [REDACTED] HIGHLIGHTS MEDICAL DUTIES (e 1245)
1245	Pt arrives A+D X 3 and in NO imminent distress. Evaluation reveals multiple contusions and ecchymosis. No effusion throughout abdomen and perihepatic areas. No tenderness and skin findings are all benign. If small nodule present in epigastrium, without tenderness it is likely fibrosis, no evaluation is required + I will discuss it with Dr. [REDACTED] if patient is found to have abdominal pain during a future visit or if medical treatment is required.

NAME OF PATIENT	SSN	RELATIONSHIP TO PATIENT	RELATIONSHIP TO BUREAU	REGISTER NO.	WARE NO.
PATIENT IDENTIFICATION (First, Middle, Last Name, Social Security No. or SIN, Service No., Date of Birth, Rank/Race)					
NAME:(LAST, FIRST)					
SSN:	(b)(6)-4				
DOB:					
UNIT:					
RANK:					
SEX:					
STATUS: (AD, NG, R)					

190

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LAW ENFORCEMENT USE ONLY

EXHIBIT

CHRONOLOGICAL RECORD OF MEDICAL CARE  
Medical Record  
STANDARD FORM 600 (REV. 6-87)  
Prescribed by GSA/CMR  
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

0180-04-STD-2-9-27

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (See back entry)

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (See back entry)		
3/8/04	1700 - P 100 Rest 16 Pt Doug leg w/ exercises for 30 min 1800 - P 110 R 16 Pt Devil water Pt Doug Stand up Sit Down Exercise for 30 min 1845 Pt placed next to fire to get warm 1900 P 112 R 18 Core Temp taken Pt will 98.2° 2010 R 114 R 18 Pt placed w/ stress postures w/ chest on wall & pt received abrasions on <del>left</del> <sup>R</sup> knee 2043 P 114 R 16 core temp 99.0° 20cc H2O		
	(b)(6)-2 Huz 2		
	<del>REFILED</del>		
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.
NAME: (LAST, FIRST)			
SSN:			
DOB:			
UNIT:			
RANK:			
SEX:	STATUS: (AD, NG, R)		

## CHRONOLOGICAL RECORD OF MEDICAL CARE

## Medical Record

STANDARD FORM 600 (REV. 6-87)

Prescribed by GSA/CMR

FIRMR (41 CFR) 201-8.202-1

USAPA V2.00

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EXHIBIT

MEDICAL RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
DATE		
08 MARCH 04	Pt presents A+OX3 T 76.0°F P 70 R 18.	APR 45 min
2100	2100 PT placed in Trendelenburg Position on Gluteal Medication or Granules	
2200	PT sleeping I applied PT to R 12	
2300	PT a/c r/r T 96.0°F P 70 R 12	
2400	Pt AOX3 T 96.0°F P 70 R 12	
	Steth/turnees connected C	
	HU 2	(b)(6)-2
	HU 1	(b)(6)-2
	N/E	
	E	

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.
<p><b>CHRONOLOGICAL RECORD OF MEDICAL CARE</b>  <b>Medical Record</b>  <b>STANDARD FORM 600 (REV. 6-67)</b>  <b>Prescribed by GSA/ICMR</b>  <b>FIRMER (41 CFR) 201-8.202-1</b> </p> <p>USAPA V2.00</p>			
NAME:(LAST, FIRST)	SSN:	STATUS: (AD, NG, R)	(b)(6)-4
DOB:	UNIT:		
RANK:	SEX:		

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## **EXHIBIT**

## **MEDICAL RECORD**

## CHRONOLOGICAL RECORD OF MR. AL GARE

0180-04-GLD250-00027

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (See back side)	
29MAR04	(b)(6)-2	Hm2 Assumed Hm WATCH
0045	VS: P 70 R 12 T 97.0 PT REVIEWED & A\$0 X3.	
0045	(b)(6)-4	By FIRE, SLEPT 30 MIN.
0100	T 97 P 70 R 12	
0215	Pulse 90 R 16	
0245	PT DRANK 12 oz H2O S ASISTANCE	
0315	P 80 R 12	
0405	P 80 R 12 Pt cooperative A\$0 X3 SITTING By FIRE & WARM blanket x45 min. Pt unstable / falls limp while transporting.	(b)(6)-2
		11m
	AIR E TP	
	(b)(6)-2	
	Hm2	

**HOSPITAL OR MEDICAL FACILITY**

**STATUS**

#### **DEPARTMENT**

**RECORDS MAINTAINED AT**

**SPONSOR'S NAME**

ESANNO NO

REF ID: E1100000000000000000000000000000

—

**PATIENT'S IDENTIFICATION:** (For typed or written entries)  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**REGISTRATION**

NAME:(LAST, FIRST)

SSN

500.

**DUB.  
DUBL-**

UNIT:  
DANCE

KANT

**STATUE (AD. NO. B)**

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

## **Medical Record**

STANDARD FORM 606 (REV. 6-97)

Prescribed by GSAC/CI

FIRMR (41 CFR) 201-9.202-1

USAPA V2 GM

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**EXHIBIT**

AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19 MAR 74	
24 MAR 74	ATC PHC FMP CICKIE, AGENT CRIMINAL X 3 SIGHT - BY FACE. V/S, P \$2 R 12
24 MAR 74	ATC PHC FMP CICKIE, AGENT CRIMINAL.
25 MAR 74	PT GITHAN - BY CLOUDY, HEADACHE, COUGH E. B. MARKET
27 MAR 74	COUGHING.
28 MAR 74	AGITATED BY THERAPY.
29 MAR 74	COMPLAINING AGITATED, AHD, CRIMINAL X 3
30 MAR 74	COMPLAINING, AHD.
	(b)(6)-2

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

SSN: (b)(6)-4

DOB:

UNIT:

RANK:

SEX:

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-67)

Prescribed by GSA/ICMR

FIRMR (41 CFR) 201-8.202-1

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STATUS(OFFICIAL USE ONLY)  
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EXHIBIT

MEDICAL RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	AUTHORIZED FOR LOCAL REPRODUCTION
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
09 MAR '04	Hm <sup>(b)(6)-2</sup>	Assumes medical duties @ 0800	
0800	PT A <del>XXXX</del> C 80 R10, TEMP 98° F		
0900	P 76 R10		
1000	P 80 R10, SHOWERED		
1100	P 80 R10		
1115	DRANK 500CC WATER		
1200	P 80 R12 TURN-OVER TO Hm <sup>(b)(6)-2</sup>		
	NFE T10		
	Hm		
	D		
	J		
	L		
	C		
	S		
	F		
	A		
	R		
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	X		
	Y		
	Z		

HOSPITAL OR MEDICAL FACILITY

STATUS

**DEPART SERVICE**

**RECORDS MAINTAINED AT**

SPONSOR'S NAME

SSWIND 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.

**NAME:(LAST, FIRST)**

SSN:

DOR.

**BOB.  
LINT.**

UNIT:  
B42

RANT

$$(h)(6)=4$$

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

## THE RECORDS OF Montreal Record

**STANDARD FORM 600 (REV. 6-97)**

Prescribed by GSA/ICMF

FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

**STATUS: (AD, NG, R)**  
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**EXHIBIT**

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

0180-04-GTDS-19-20  
(SAC/ICMR)

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SAC/ICMR)

DATE

3/9/04

1200 Sleeping 1 hr 3:59 Total Sleep time R 90 R 12

1300 Awoke To Eat MRE Wheat Snack Bread SORC H20 P88R12

1400 Sleeping 1 hr 4:59 Total sleep time P 88 R 12

1523 ST 20cc H20 P 86 R 12

(b)(6)-2  
H20

N F E T P

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

SSN:

DOB:

UNIT:

RANK:

SEX:

STATUS: (AD, NG, R)

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-87)

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EXHIBIT

**HOSPITAL OR MEDICAL FACILITY**

STATICS

**Journal of Health Politics, Policy and Law**, Vol. 32, No. 4, December 2007  
ISSN 0361-6878 • 10.1215/03616878-32-4 © 2007 by The University of Chicago

ANSWER

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10.000-15.000 €

[View Details](#)

*If for typed or written entries, give: Name - last, first, middle - Date - Relation*

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(b)(6)-4

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**CAL RECORD 6**  
**Medical Record**

Musical Record

STANDARD FORM OF  
Prescribed by GSA FCMR

Prescribed by GSAC/CMR  
FIRMB (41 CFR) 201-8.302-1

USAPer v1.00

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**EXHIBIT**

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
09 MAR 84	Assumed WATCH, HM 2 (b)(6)-2
2000	P 110 R 20 T 97
2010	Pt by fire, sitting on blanket. Ad O X3 verbally responds to questions/commands. Pt falls limp while transporting.
2050	15 MIN Sleep.
2100	P 110 R 20 T 96.5R
2145	Pt drank 12 oz Sunkist (orange) 5 oz H2O
2200	P 106 P 18 T 97.0
2215	Slept 15 MIN by fire, Ad O X3
2300	P 110 Resp 18 temp - 97.4°F
2330	Pt cleaned in SOAP & H2O. ADDRESSED KNEES & hands bedoline SOLUTION. Pt AMBULATED UNDER OWN CONTROL TO HEAD in SHOES. Pt Detached & URINATED. (R) 4TH MEDIUM in SMALL APPRIALION (1cm) from Rocks. PLACED SHOES ON for all further ambulations
2340-2350	SITTING in chair by fire. DRANK 10 oz H2O. (b)(6)-2
	NF E T P (b)(6)-2
	HmB

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

SSN:

DOB:

UNIT:

RANK:

SEX:

STATUS: (AD, NG, R)

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 8-67)

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EXHIBIT

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE		
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
10 MAR 04	PT IS AWARE ORIENTED X3, SITTING DOWN - FED RICE / DRUNK 20 cc H <sub>2</sub> O v/s P 98 R 116 NAD		
0030	NOTED CANTATION TO GUTTENES MAXIMUS REGION, AGITATIONS NOTED TO KNOTS, -PLAQUES IN DENTURES. D/C SITTING ON GRAVEL.		
0045	PT IS IN PRONE POSITION, SLEEPING		
0145	PT STILL SLEEPING		
0200	20 cc H <sub>2</sub> O GIVEN P.O.		
0300	SLEEPING, NAD. (b)(6)-2		
0400	SLEEPING, NAD.		
	(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.
NAME:(LAST, FIRST)	(b)(6)-4	CHRONOLOGICAL RECORD OF MEDICAL CARE	
SSN:		Medical Record	
DOB:		STANDARD FORM 800 (REV. 6-87)	
UNIT:		Prescribed by GSA/ICMR	
RANK:		FIRMR (41 CFR) 201-9.202-1	
SEX:		USAFA V2.00	

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EXHIBIT

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AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
03-11-04	0000 Pt in Recumbent pos feet elevated on cot w/ blanket Pt kept awake. P 128 R 18 T 98.6. NO new abrasions noted All abrasions seen appear to be healing very well as expected. All abrasions treated w/ bacitracin. Pt AOK Talkative Pt denies water at this time.
	0000 Pt stood up and walked to Parr-e-John and defecated. URINATED Pt walked under own power no stumbling or falling. Pt very compliant. P 118 R 16 T 94.6°
0127	Pt drank 50cc (approx) H2O
0214	Pt Denies water P 115 R 16 T 97.°
0252	Pt trying by fire on cot keepin him awake P 110 R 17 T 97.°
0255	Pt FINELY RELIEVED by fire (b)(6)-2

NAME OF MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
PATIENT'S NAME	SS/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)

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EXHIBIT

HOSPITAL OR MEDICAL FACILITY

1674

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#### THE SERVICE

(For typed or written entries, give: Name - last, first, middle; I.D. No. or CRM #)

REGISTER NO.

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**CASE RECORDS**  
**Medical Record**

**STANDARD FORM 600 (REV. 6-63)**

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USAPPC v1.00

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## **EXHIBIT**

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
23/11/04	MEDICAL WATCH ASSUMED BY HMO <sup>(b)(6)-2</sup> @ 0611 1/2 P84
	R12 T. 98.3 PT ASLEEP UNDER BLANKET AWAKENED
	FOR VITALS A TOOK THEN ASLEEP AGAIN ON SIDE ON COT.
26/11/04	P86 R12 PT AWAKENED FOR 250cc WATER AND EGGS SANDWICH ROTATED FRIED. TOURNAMENT WELL - BACK SLEEP.
27/11/04	PT AMBULATES TO TOILET & ASSISTANCE. DRANK 250cc WATER.
28/11/04	P82 R16 ASLEEP.
29/11/04	P94 R16 AWAKE. SIT ON CHAIR A 40 x 5
30/11/04	WATCH PROBABLY RELIEVED BY HMO <sup>(b)(6)-2</sup>

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPT./SERVICE	RECORDS MAINTAINED AT
SURGEON'S NAME	SSN./IC NO.	RELATIONSHIP TO SPONSOR	

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

REGISTER NO.	WARD NO.
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(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE  
Medical Record  
STANDARD FORM 600 (REV. 6-97)  
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FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

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AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

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

DATE	
3-1404	Pt laying down on cot when on floor noted change in color
1800	were pink (b)(6)-2 purple. Appears to be heading very rapidly. P 100 R 12 T 98.6°
1100	Pt laying on back on cot P 86 R 12 T 98.5° Lungs sound clear x 3 fields heart is RRR. Pt Aox3 Pt is compliant
1200	Pt defecated walked w/no help to Port-a-John and there was no stumbling or falling. Pt is stumbling w/stab in left hand raised above head P 88 R 12 T 98.5°
1230	Pt drank 30cc water
1320	Pt laying on cot P 86 R 12 T 99.7°
1349	Pt drank 30cc water

## DATA OF MEDICAL FACILITY

## STATUS

## DEPART./SERVICE

## RECORDS MAINTAINED AT

CONTRACTOR'S NAME

SSN/AD 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

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FIRMR (41 CFR) 201-9.202-1

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EXHIBIT

Date of screening: 3/16/04 Second name: EPW Tag# U180-04-CH 259-80227  
 MOI: Blood type

HPI:

PMHX:

PSHX:

Meds:

Allergies:

### Primary Survey

Airway: Patent	Mechanically maintained by	N/A
Breathing: Spontaneous	Assisted by	N/A
Circulation:		
Pulse: Present	Absent	CPR
Color: Normal	Abnormal	
Cap refill: Normal	Delayed 4 SEC (PEDAL)	

@ 19:49

Initial Vital Signs: b/p pulse 110 Resp 12 Pulse Ox N/A Temp 98.4(R)

GEN: SEE P.Z NOTES

HEAD: NORMAL, ATTRAUMATIC, (B) FERIA (NEG) ECHOGRAFFIC.

NECK: SUPPLE, (NEG) JVD, TRACHEA MIDLINE

HEART: WNL

LUNGS: EQUAL TIEG + FALL, (NEG) DEFORMITIES, DISCOLORATIONS OR STEP-OFFS  
 NORMAL S.S.

THORAX: CLEAR TO 6 HEARTS

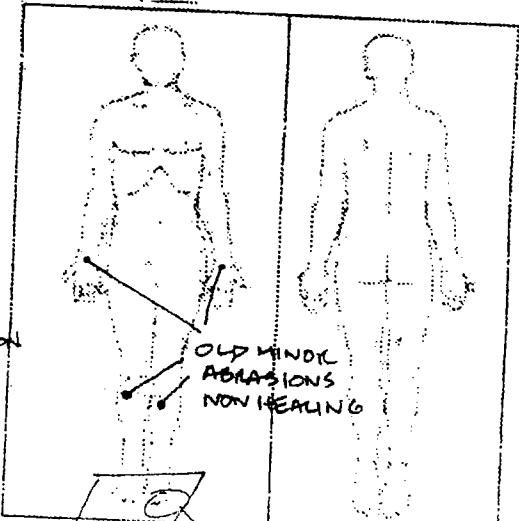
ABD (B) BOWEL SOUNDS & QUADRANTS (NEG) GRISSACE, DISTENTION, DISCOLORATION

PELVIS: ATTRAUMATIC (NEG) GRISSACE, CREPITUS

EXT: SEE P.Z NOTES

RECTAL: NA

SUP PO ORGANIZED X 3



→ DIFF. AMBULATING.

GLASCOW COMA	
EYES OPEN	Spontaneously 5
	To Speech 3
	To Pain 2
	None 1
BEST VERBAL RESPONSE	Oriented 5
	Confused 4
	Inappropriate sounds 3
	Incomprehensible sounds 2
	None 1
BEST MOTOR RESPONSE	Obey Commands 6
	Localizes Pain 5
	Withdraws w/Pain 4
	Flexes to Pain 3
	Extends to Pain 2
	None 1
	TOTAL 15

Revised Trauma Score	
GLASCOW COMA	13-15 4
TOTAL	4-12 3
	6-8 2
	4-5 1
	3 0
SYSTOLIC BLOOD PRESSURE	>85mmHg 4
	76-89 mmHg 3
	50-75 mmHg 2
	0-49 mmHg 1
	No pulse 0
RESPIRATORY RATE	16-29 / min 4
	>29 / min 3
	6-9 / min 2
	1-5 / min 1
	None 0
	TOTAL

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EXHIBIT

0180-04-CME159-801EVS

4Y:

Breathing:

Time	Drug	Dose	Route	Initials

Circulation:

Other:

**Blood Components**

Unit #	Type	Time	Response

**Vital Signs**

Time	B.P.	Pulse	Resp	Pulse Ox	Temp	GCS
19:49		110	12		98.4	15
20:30		100	12			15

**Transfer Instructions:**

NOTES: PT ATOX3 @ 19:50 SITTING IN CHAIR BY FIRE, ANSWERING QUESTIONS. HE IS COMINGLABLE AND IN NO DISTRESS. PHO R12 WE HAVE RECEIVED HIM FROM FROM DETENTION FACILITY WHERE HE HAS RECEIVED MEDICAL ATTENTION. HM (b)(6)-2 ON DUTY @ 19:50 3/16/04. 2005 PT HAS DIFFICULTY WALKING. HE GUARDS L FOOT. (1) FOOT PEd + SWOLLEN & BROKEN "BUSTERS ON THE TIPS OF 1ST + SECOND TOES (NEG) CARRIUS + ERY + ELLY. (+) PEDAL PULSE, SLOW CAP. REFIL + GUNMALE UPON PALP. (R) FOOT PEd + SWOLLEN & 1.5" UNBROKEN BLISTER ON 1ST TOE (NEG) CARRIUS + ERY AND ELLY. (+) PEDAL PULSE & SLOW CAP. REFIL APPROX 4SEL. BOTH FEET. (R) Foot (+) GUNMALE BUT LESS THAN (1) FOOT UPON PALP. PT UNCOOPERATIVE FOR STRENGTH TESTS. - RELIEVED OF DUTY COMPENSATION WATCH IS BY HM. (b)(6)-2

(2) 21:45 PT SITTING, HX AS ABOVE. NO A's UNREMARKABLE CONDITION OTHER THAN EDema TO (L) PEdS, ANTERIOR ASPECT CAP. REFIL + OZ, DISCH PULSES PRESENT.

Prepared By:

[Redacted]

(CONT.)

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EXHIBIT

0180-04-GID259-80227  
MEDICATIONS

Time	Drug	Dose	Route	Initials

Breathing:

Circulation:

Other:

## Blood Components

Unit #	Type	Time	Response

## Vital Signs

Time	B-P	Pulse	Resp	Pulse Ox	Temp	GCS
/						
/						
/						
/						
/						
/						

NOTES: V/S AS ABOVE. H2O + MRE PROVIDED.  
IC & C - TAKEN BY HUMV TO  
INTERROGATORIUM (H.I.D.)

(b)(6)-2

HUMV / USN / 181

## Transfer Instructions:

Prepared By:

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EXHIBIT

AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2100 19 MAR 04	PULSE 110, R 14 B/P 132/78 AWAKE, O/X 3, TALKING & INTERROGATOR THIS PI (DETAINEE) WAS TRANSFERRED HERE FROM MOSUL INTELLIGENCE CAMP HE HAS A HISTORY OF SEVERAL VISITS IN THE LAST WEEK, P.E. FINDINGS ARE ON RECORD. P.E.
	<ul style="list-style-type: none"> <li>- GEN: A/O X 3 ATROPHIC AREA S, 31 Y.O. ABILATES BY HIMSELF, SLOWLY. NKA TO MADS</li> <li>+ HEAD: ATROPHIC, E: PERRLA, E: TM'S WNL, VAS<sup>(+)</sup> SALVA</li> <li>+ NECK: ATROPHIC, TRA. MIDLINE &amp; JVD</li> <li>+ HEART: NORMAL IT'S E MURMUR PMI NOTED</li> <li>+ CHEST: ATROPHIC, LUNG-SOUNDS, CLEVER BILAT</li> <li>- ABD: ATROPHIC, TENDER &amp; masses, E PREDOMINANT. E GASTROINTESTINAL: BILAT. sounds &amp;c</li> <li>- PELVIS: ATROPHIC, STIFFNESS</li> <li>- RECTAL: WNL, ATROPHIC</li> <li>- NEURO: A/C X 3, 12 CRANIAL N. WNL, REFLEXES UN-</li> <li>- ABRATION NOTES TO <u>L KNEE</u>: TX ED PRIOR TO DELIVERY HOME. SAME TYPE NOTES TO <u>R KNEE</u>. ANATOMICAL ASPECT 3-4 CM IN DIAMETER.</li> <li>- ABRASIONS, CLEAVAGE / PROXIMAL, BEING DRIED, EXCISED &amp; DRY STERILE DSG.</li> </ul>

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.
NAME:(LAST, FIRST) SSN: DOB: UNIT: RANK: SEX:		

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

STANDARD  
LAW ENFORCEMENT USE ONLY

EXHIBIT

# 2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2200	CONDUCTING INTERVIEW, PT IS SITTING, CALM, ANSWERING QUESTIONS. VERY COMPLIANT.
2324	STILL UNDERRING INTERVIEW. NAD.
0100	SITTING BY FIRE NAD.
0300	SA Review BY HMZ (b)(6)-2
0300	PT SITTING BY FIRE NAD
0610	PT SITTING IN STALL IN CHAIN NAD
0840	PT SITTING IN CHAIR IN STALL
0900	A+O X3 P120 R12 SITTING COMFORTABLY AND NO APPARENT DISTRESS DRANK 250CC water
1200	P110 R10 AMBULATES TO TOILET & ASSISTANCE DRANK 350CC
1215	ASLEEP IN CHAIR
1335	AWAKENED P100 R10 DRANK 250CC
1450	P107 R12 SITS EASILY NO DISTRESS
1500	ARMED GUARD PRESENT SITTING ON STOOL IS AWAKE, A/C X-2 SITTING NAD.
1700	DSG △ TO ABRASIONS ON KNEE'S BOTH CLEARED = BETADINE, BACITRACIN APPLIED = DRY STERILE DSG ALSO (L) 1 <sup>ST</sup> + 2 <sup>ND</sup> DIGITS OF (L) FEET CLEARED + DRESSED IN THE SAME MANNER SLIGHT SWELLING NOTED TO (L) FOOT, PT IS SITTING = (L) FOOT ELEVATED.
1800	STILL SITTING = FOOT ELEVATED. NO △ T 98.6 P 100, R12 B/P 130/78
2000	RETURN TO DETENTION CAMP, AMULATION. 138 WELL, SLIGHT EDema TO (L) FOOT (b)(6)-2 AT&T 3 MIN OFFICIAL CALLS 14 HOURS EACH NIGHT

(b)(6)-4

LAW ENFORCEMENT USE ONLY

STANDARD EXHIBIT (REV. 6-97) BACK

USAPA V2.00

## MEDICAL RECORD

## PROGRESS NOTES

DATE  
 March 2004 S/ EPW states interrogated last evening.  
 R pain this is swelling + blisters.  
 Reports thermal burn left ear  
 Noted 8's in wounds Ant - ~~R~~ knee

## (1) AVSS

Ext: (1) LC: Ant knees noted ↑ erythema  
 + multiple blisters. noted: singed  
 tissue appears 2nd degree burn's &  
 necrotic margins.

A/P: 2nd degree burn in blister R > L.

(1) Continue Bacitracin typically  
 to affected areas.

(2) Start Percocet 4-6" PRN for  
 Severe pain

(3) Continue daily dressing as will  
 use Silverdene (dual)

(b)(6)-2

1-1/2 oz

(Continue on reverse side)

PATIENT IDENTIFICATION (For typed or written entries only. Name - last, first, middle; grade/rank/rate:  
hospital or medical facility)

REGISTER NO.

MARC NO.

(b)(6)-4

## PROGRESS NOTES

Medical Record

150

STANDARD FORM 509 (REV 7-91)

Prescribed by GSA-ICMR, FIRM, 41 CFR, 101-9.202-1

(b)(6)-4

OFFICIAL USE ONLY

LAW ENFORCEMENT USE ONLY

EXHIBIT

## 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			13 Mar 04	11:16	HOURS (b)(6)-2
			(1) LFTs, CK x 1 Now		
			(2) ↓ IV Fluid rate to 75cc/hr		
			(b)(6)-2		
			(b)(6)-2	CPT, MC, USA	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			14 Mar 04	0802	HOURS
			(1) LFTs, CK this AM		
			(2) Pt may shower, c onard in attendance		
			(b)(6)-2		
			(b)(6)-2	CPT, MC, USA	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			14 Mar 04	0805	HOURS
			(1) Flexeril 10 mg po bid prn muscle spasm (neck pain)		
			(b)(6)-2		
			(b)(6)-2	CPT, MC, USA	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
					HOURS
NURSING UNIT	ROOM NO.	BED NO.			

DA FORM 1 APR 79 4256 FOR OFFICERS EDITION OF 1 JUL 77 WHICH MAY BE USED.  
LAW ENFOR ONLY

EXHIBIT

## CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AF 40-68, 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

## DATE OF ORDER

## TIME OF ORDER

LIST TIME  
ORDER  
NOTED AND  
SIGN

11 Mar 04

1805

HOURS

(b)(6)-4

Admit to TCW.

DX: multiple abrasions/contusions.

Condition: stable.

Allergies: NKDA.

Vital signs per ward protocol.

Activity: bedrest & bedpan/urinal  
Record E/O

## NURSING UNIT

## ROOM NO.

## BED NO.

## PATIENT IDENTIFICATION

## DATE OF ORDER

## TIME OF ORDER

HOURS

Encourage hydration.

Diet: regular, may supplement &  
ensure if patient desires.IVF: NS @ 125 cc/hr until first  
bag done, then LR @ 125 cc/hr

Meds: Toradol 15mg IV Q6HR

Morphine sulfate 2-4 mg Q3-4<sup>o</sup>

## NURSING UNIT

## ROOM NO.

## BED NO.

## PATIENT IDENTIFICATION

## DATE OF ORDER

## TIME OF ORDER

PRN pain not  
HOURS

Controlled &amp; toradol.

Regall 10mg JV Q6<sup>o</sup> prn nausea  
CBC, Metlyte B, Liver panel, coags

X it in AM please.

Call Dr. (b)(6)-2 for questions.  
Elevate feet on pillows (b)(6)-2

## NURSING UNIT

## ROOM NO.

## BED NO.

## PATIENT IDENTIFICATION

## DATE OF ORDER

## TIME OF ORDER

(b)(6)-2 CPT, MC  
HOURS

12 Mar 04

1004

① D/C IV toradol

② Begin Motrin 800mg po tid

③ Colace 100mg po bid

④ Keflex 250 mg po QID

⑤ Dexamol 25-50mg po q4hr

oral, through

⑥ IV morphine sulfate

(b)(6)-2

(b)(6)-2

U.S. GOVERNMENT PRINTING OFFICE: 2002-018-041

CPT MC 0497

EMERGENCY CARE AND TREATMENT (Medical Record)			TREATMENT FACILITY (Stamp)	LOG NUMBER
ARRIVAL		TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE DAY MONTH YR.	TIME 1025	<input type="checkbox"/> PRIVATE VEHICLE <input checked="" type="checkbox"/> AMBULANCE <input type="checkbox"/> OTHER (Specify)	Cryptoeptidine	<input type="checkbox"/> PATIENT <input checked="" type="checkbox"/> OTHER (Specify) ALLERGIES NKDA
PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code) EPW			HOME TELE. NO. (Inc. area code)	
CHIEF COMPLAINT(S) (Include symptom(s), duration) Cubrasics over body, neck pain			SEX M	AGE 31
VITAL SIGNS			POSSIBLE THIRD PARTY PAYER? <input type="checkbox"/> YES <input type="checkbox"/> NO	
TIME 11438	BP 129/84	PULSE 116	TIME SEEN BY PROVIDER	
RESP. 17	TEMP. 99.5	WT. (KG) 98	(b)(6)-2	
CATEGORY (See reverse)			ProTx - Major FDtx - /	
EMERGENT				
URGENT				
NON-URGENT				
ORDERS	INITS.	(b)(6)-2		
C.R.C. Chem		(b)(6)-2		
Coag				
Vitamin(B) 1000 Ketosterol 1000	1700			
Morphine sulfate 4 mg	(b)(6)-2	1800		
ASSESSMENT/DIAGNOSIS Multiple abrasions - ecchymosis				
DISPOSITION (Check all that apply)				
HOME	FULL DUTY			
QUARTERS				
24 Hrs.	48 Hrs.	72 Hrs.		
MODIFIED DUTY UNTIL: DAY MONTH YEAR				
REFERRED TO (Indicate clinic)				
EMERGENCY	TODAY			
72 HOURS	ROUTINE			
ADMIT. TO HOSP. UNIT/SERVICE ICU				
CONDITION UPON RELEASE				
IMPROVED	UNCHANGED			
DETERIORATED				
TIME OF RELEASE: 1805				
PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name, last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREAT- MENT RECORD).				
(b)(6)-4			SIQ(b)(6)-2 INS plans)	
(b)(6)-4			(b)(6)-2 DO (PT, INC.) Instructions ordered, any limitations and follow-up	
31 years FOR OFF LAW ENFOI			<p>(CONTINUE ON SF 507, IF NEEDED)</p> <p>(A): Multiple abrasions/ecchymosis (P): ① Admit to ICU ② cleanse wounds ③ pain control</p> <p style="text-align: right;">1 F, 3</p>	
EMERGENCY CARE AND TREATMENT				
EXHIBIT				
STANDARD FORM 558 (Rev. 6-82)				

## MEDICAL RECORD - PATIENT RELEASE / DISCHARGE

For use of this form see MEDCOM Circular 40-5

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care treatment or discharge from an inpatient hospital stay.

SECTION I TO BE COMPLETED BY PRIVILEGED PROVIDER		SECTION II TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE
1. DATE OF PROCEDURE/ADMISSION: <b>11 MAR 04</b>	1. DISPOSITIONED TO: <input type="checkbox"/> HOME <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> OTHER	
2. ADMITTING/DIAGNOSIS: <b>multiple contusions/ abrasions</b>	<input type="checkbox"/> AMBULATORY <input type="checkbox"/> TRUCKS <input checked="" type="checkbox"/> CONSULTANT <input type="checkbox"/> OTHER	
3. PERTINENT LAB/X-RAY FINDINGS:  <b>No fracture on X-rays. ↑ CK, ↑ LFTs 3/14 - CK &gt;5,000; ALT 158; AST 338 tbili 2.0</b>	2. ACCOMPANIED BY: <input type="checkbox"/> FAMI <input checked="" type="checkbox"/> FRIEND <input type="checkbox"/> OTHER	
4. PROCEDURES/TREATMENT/HOSPITAL COURSE:  <b>Pain control w/ Motrin, occasional Demandol. Muscle spasm treated w/ Flexeril Keflex x 4 days.</b>	3. PATIENT EDUCATION  Completed and patient prepared for home care. <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain _____	
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:  <b>Condition improved; pt ambulatory. DX: multiple contusions/ abrasions.</b>	Patient <input type="checkbox"/> states <input type="checkbox"/> demonstrates understanding of home care needs Printed educational materials provided _____ NA	
6. ACTIVITY: <b>as tolerated</b>	4. CLINICAL OUTCOMES (intra- and post-discharge) - referrals made <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If no, explain _____	
7. DIET: <b>Regular</b>	5. If transferred to another health care facility, report called in by <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If no, explain _____	
8. MEDICATIONS:  <b>Motrin 800 mg po tid Flexeril 10 mg po bid Keflex 250 mg po QID x 3 more days</b>	6. NUTRITION CARE - Comments _____ NA	
9. INSTRUCTIONS (To Home Health Providers, Patient, etc):  <b>To P.A. → may need to periodically check CK, LFTs to continue to document decreasing levels; bloodwork can be brought to CSH and processed</b>	7. MEDICATIONS  Explained by: <input type="checkbox"/> Nurse <input type="checkbox"/> Doctor <input type="checkbox"/> Other <input type="checkbox"/> Written <input type="checkbox"/> Oral Printed medication literature provided <input type="checkbox"/> Yes <input type="checkbox"/> No Patient states understanding of prescribed medications <input type="checkbox"/> Yes <input type="checkbox"/> No	
(b)(6)-2	8. EQUIPMENT/SUPPLIES PROVIDED _____ NA	
(b)(6)-2	9. FOLLOW-UP APPOINTMENTS/POINT OF CONTACT & PHONE _____ NA	
(b)(6)-4	10. FOR PROBLEMS OR EMERGENCY CONTACT & PHONE _____	
(b)(6)-4	11. COMPLETED BY (b)(6)-2 <b>3/15/04 R2L</b> Signature and Date Date and Time	
I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.  <b>FOR OFF LAW ENFO</b>		
(Patient Responsible Adult's Signature) <b>ONLY</b> <b>EXHIBIT</b>		

## MEDICAL RECORD

## PROGRESS NOTES

DATE	NOTES
11 MAR 04 1830	<p>Admit notes: Pt. brought over from E.R. @ 1750.</p> <p>Pt. slumped - feet, A=0x3, translator assisting</p> <p>Pt. Edward @ PSS. W running in (E)AC.</p> <p>Toradol 15mg given on admission for pain.</p> <p>Shrugs CTA, audi, non-tender. Bruises noted on back &amp; chest. (B) knees are swollen &amp; Clark red, (B) feet are swollen &amp; red, ecchymosis noted on 3 toes. Legs elevated on one pillow.</p> <p>Pt. states most pain is in his feet. Pt. on a reg. diet, hydrated, N/V. Pt. does not report any difficulty breathing or SOB @ this time. (b)(6)-2</p>
12 MAR 04 0130	<p>Pt awake. Scattered abrasions to chest and back, (B) knees swollen, dark red, small abrasions to legs, (B) feet swollen C+T pedal pulses, ecchymoses (B) feet and toes, cap refill &lt; 3 secs, pt able to slightly move toes, unable to flex and extend ankles. IVF infusing to (E)AC. Toradol 15mg IV given as scheduled. Pt. 1/0 slight pain to (E) ribs. Pt. stated he was hungry, ate 2 rolls and is currently sleeping. (b)(6)-2</p>
12 MAR 04 0200	<p>Second bag LR @ 1830 hung. 267 AM ALTAN ID NUMBER</p>

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME

LAST

FIRST

MI

LAST OR OTHER

ART/SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

ENTRANCE NUMBER / ROOM NUMBER / BED NUMBER

NAME - Last, first, middle  
(Last, first, middle)

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

LAW ENFORCE

NY

EXHIBIT

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
DATE	NOTES		
12 Mar 04 1100	<p>NS6 Note: PT lying flat in bed on (R) side. (B) feet P<sub>on</sub> blankets. A+Ox3 speaks some english. Guard @ bedside. PT has multiple abrasions and scratches to face, torso anterior+posteriorly, (B) L C-acute drainage noted (S/s of infection). +1 pitting edema in (B) hands ↓ ROM &amp; tenderness cap refill &lt;3sec to all nail beds +2 radial pulses. (S) 2 non-pitting edema to (B) ankles and feet. Able to ambulate a slow shuffle slightly unsteady. Ordered 600cc of amber color urine 3 diff. Tol Reg diet. (T) balance.</p> <p>IV of LR @ 125cc 1° 18G to (B) FM patient (S/s of infection will cont to monitor comfort level and med PRN.</p> <p>(b)(6)-2 SS6 91W30M6 APRN</p>		
12 Mar 04 1400	<p>PT ambulated to void. voided 800cc of dark yellow urine. (B) low extremities P<sub>on</sub> pillows. Tol 30% of Kosher diet 3 diff. 50cc (b)(6)-2 1400</p>		
12 Mar 04 1730	<p>PT tol 40% of Kosher meal. States pain level of 3 out declines pain meds. Ambulated X1 for void. voided 650cc straw color urine.</p> <p>(b)(6)-2 SS6 91W30M6 APRN</p>		
12 MAR 04 1900	<p>NS6 note: Pt awake. Scratches and abrasions unchanged, (S) oozing or bleeding. Pedal pulses +2 currently, feet still swollen, cap refill &lt;3secs to all extremities. Pt clc. Slight ache to (L) foot and belly button, pt refuses pain med. IVF infusing - difficulty. New bag of LR @ 125cc 1° hung. Pt talking to guard at bedside. Feet elevated.</p> <p>(b)(6)-2 SS6 91W30M6 APRN</p>		
FOR OFF LAWENFOR		ONLY	STANDARD FORM 609 (REV. 5/1999) BACK EXHIBIT USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES	
DATE	Physician Progress Note	NOTES
12 Mar 04	(S): HD#2 admitted last evening for pain control/ monitoring of multiple abrasions/ecchymoses & foot swelling sustained during capture. Tolerated regular diet overnight. Less pain in feet but able to ambulate & assist for using restroom. No fevers.	
(O): 108/64 P76 T98.6°F R16 I/O 1700/600	Ken: HxOx3, cooperative, conversant	
<del>14.3</del> <del>5.2</del> <del>135</del> <del>41.5</del>	MS: (B) feet/ankles & slight ↓ in swelling Erythema noted. Dorsalis pedis pulses now palpable. Edema on feet & pitting to ankle	
<del>133/98</del> <del>18</del> <del>4.0</del> <del>27</del> <del>11.2</del>	(A): Multiple abrasions/ecchymosis (B) pedal to ankle edema.	
atb 34 Atp 62 Alt 185 Amy 51 AST 572 Urea 3.1 CK > 10,000 GGT 7 tProt 5.7	(P): (1) Will begin Keflex to prophylax for infection (2) Will change to oral pain med's Motrin + Demerol (3) Begin colace (4) May ambulate & assist as tolerated.	
PT 14.9 PTT 31.6	(b)(6)-2	
	(b)(6)-2 CPR, Me Gust	

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

DEPART. / SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT
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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
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(b)(6)-4

Y  
ONLY

## PROGRESS NOTES

Medical Record

EXHIBIT

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

(b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL ID NUMBER
DATE	NOTES	
13 Mar 04 1115	<p>(Cont)</p> <p>MS - ↓ swelling / edema in feet + ankles, persistent blood blisters, ecchymoses to knees / ant tibia implored. (7) dorsalis pedis pulses equal bilaterally. ↑ tenderness to palpation of feet. Abrasions healing &amp; evidence of infection.</p> <ul style="list-style-type: none"> <li>(A) Multiple abrasions / contusions</li> <li>(B) foot swelling - resolving</li> </ul> <p>(P): (1) Will replete LFB, CR today</p> <p>(2) ↓ IV fluid rate to 75cc/hr + encourage po fluids</p> <p>(3) Continue pain control</p>	
	(b)(6)-2	R.D.
	(b)(6)-2	CPT, MC, USA
		4-8-8
FOR OFF LAW ENFORCEMENT	Y ONLY	STANDARD FORM 609 (REV. 5/1999) BACK EXHIBIT USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES	
DATE	NOTES	
13 MAR 04	NSG note: Pt pulled IV out while sleeping, 206 tc 0330 (R) FA inserted & another bag of LR infusion. Pt back to sleep.	
13 Mar 04 0930	(b)(6)-2 207 AM NSG note: Scattered abrasions to upper chest & (b) arms. Large abrasions to bilateral knees & shins. Bilat feet swollen & black scabs on toes. Pedal pulses 2+. Pt ambulates well & little assistance. Tl' to R forearm running LR @ 125 cc/o. No redness or swelling to site. Pt C/O pain @ neck states unable to turn head from side to side or look up. 25 mg Demerol IV given per prn pain orders. Pt setting up in bed eating breakfast @ this time.	
13 Mar 04	Progress Note	
1115	(b): HD#3 → receiving pain control/hydration for multiple abrasions/contusions. ↓ pain in feet → R better than L per pt. Able to ambulate better for short distances. Pain meds helping. Tolerating regular diet. No fevers.	
(b)	117/70 P75 R18 T97.3°F Tmax 99.2 Ilo ~2500/2190	
Hx: A+Ox3, in NAD, conversant, cooperative		
RELATIONSHIP TO SPONSOR	SPONSOR'S NAME	SPONSOR'S ID NUMBER (SSN or Other)
	LAST FIRST	(b)(6)-2 MI
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS (b)(6)-2
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO. (b)(6)-2
FOR OFFICE (b)(6)-4		Y ONLY
		PROGRESS NOTES Medical Record <b>EXHIBIT</b> STANDARD FORM 509 (REV. 5/1999) Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10) USAPA V1 00
(b)(6)-4		MEDCOM - 721

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
DATE	(cont)		
14 Mar 04 0808	<p>NOTES</p> <p>in feet. Ambulating better. Cl 0 ① shoulder + neck pain this AM. Tolerating regular diet. Pain control mainly w/ Motrin.</p> <p>(C): 103/66 P75 R16 T97.9°F I/O ~1800/1825</p> <p><u>Gen:</u> A+DX3, in NAD</p> <p><u>MS:</u> Full ROM to shoulders, some discomfort w/ ① shoulder abduction, mild tenderness to cervical musculature - no deformity; resolving ecchymoses on leg &amp; swelling to feet. ④ dorsalis pedis pulses.</p> <p>(A): Multiple abrasions/contusions Resolving swelling of feet. Cervical muscle strain</p> <p>(P): ① ✓ CK, LFTs this AM ② Flexeril 10mg po bid for muscle spasm ③ Pt may shower &amp; dress in attendance ④ Will consider d/c later today or tomorrow.</p> <p style="text-align: right;">(b)(6)-2</p> <p style="text-align: right;">DD.</p> <p style="text-align: right;">(b)(6)-2 CPT, MCU/ST</p> <p>14 MAR 04 0900 m/s - pt. resting in bed w/ running @ 75% hr. ④ feet are slightly less swollen, pedal pulse present. Pt. c/o pain in ① shoulder; refuses pain med. except for acet. Approx. 50% of meals tol. 3 NIV.</p> <p>Guard FOBSS. USS. LAW ONLY</p> <p style="text-align: right;">(b)(6)-2 2DPAW</p>		

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES	
DATE	NOTES	
13 MAR 04 2000	PT stable VSS. IVF's; LR running to 75 cfm in (R) FA. JV in benign cr. infection. PT currently only 4/0 on EMS of pain in (L) shoulder area. Gave scheduled morphine 50 mg and related saline 100 ml PO @ 2000 per MD order. PT instructed to inform me if pain gets worse. PT verbalized understanding. Scattered abrasions/ecchymosis in chest, back, (B) ANM, (B) knee/leg and (B) ker. (B) ret elevation: (+) to black and + white to (C) foot on first and second digits. PT ambulates well to bathroom w/ assistance from dorsal pectoral + bilaterally on feet. Unilateral N/V (-) (b)(6)-2. feet elevated on 2 blankets. PT was calm, cooperative, no tachypneic effort.	
13 MAR 04 2004	PT H/H: gout & prevent at Bedside. (b)(6)-2	
i - NAK 04 00 PL	Gave scheduled reflex 250 mg PO per MD order. (b)(6)-2	
14 MAR 04 0004	PT stable & A/P w/o pt untion. Gave ketor 30mg PO Q 8H00 and Motrin 800mg PO Q 8H00 per MD order. PT still (-) pain in (L) shoulder. PT notes pain has increase, but does not want any PT in M/L stronger than Motrin. More spastic, pt does a worse NAK WIC. PT currently sleeping. (b)(6)-2 PT desire to shower today and speak to DR. About (b)(6)-2. Will inform day shift nurse. (b)(6)-2	
14 MAR 04	Progress Note	
D808	(S): HD#4 - improving discomfort from multiple abrasions/contusions, improvement in swelling	
RELATIONSHIP TO SPONSOR	SPONSOR'S NAME	SPONSOR'S ID NUMBER (ISSN or Other)
	LAST	FIRST
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS (b)(6)-2
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. CPT, MC, (b)(6)-2 WARD NO. 2 F 3
(b)(6)-4	END	Y ONLY
(b)(6)-4	PROGRESS NOTES Medical Record	
STANDBY FORM 509 (REV. 5/1999) Prescribed by GSA/ICMR FPMR (41CFR) 101-11 203(b)(10) USAPA V1 00		

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14 MAR 04 NS Note: (R) shoulder abrasion turned a bit & some white pus.	
2330	(R) x 2 & bacitracin applied to shoulder. ↓ swelling to feet, pulses +2, capillary < 3 sec to all extremities. IVF infusing. Pt resting & eyes open. (b)(6)-2
14 MAR 04 2335	NSG note: Pt c/o body pain, after explaining side effects of Flexeril, pt accepted the pain med, Flexeril - 10mg PO given. (b)(6)-2
15 Mar 04 Progress Note	
1030	(③) HD#5 - improving contusions/abrasions; ↓ foot swelling. Ambulating better. Pain in neck better w/ Flexeril. Tolerating regular diet but no appetite. Showed yesterday & guard present.
3/14	(D): 115/67 P69 R14 T98.1°F. Urine output 1200cc
CK > 5, AST	Gen: ATX 3, w/ NAD.
LFRS improving	MS: bruising healing; ↓ swelling to feet; only +1 edema; (④) dorsalis pedis pulses.
(A)	Multiple abrasions/contusions Improved foot swelling
(P)	① Pt meets criteria for transfer to EPW Camp. ② Will continue Motrin + Flexeril.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME	SPONSOR'S ID NUMBER
	LAST	FIRST
		(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS M(b)(6)-2	CPT, MC, USA
PATIENT'S IDENTIFICATION: If 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

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ONLYPROGRESS NOTES  
Medical Record  
EXHIBIT  
STANDARD FORM 509 (REV. 5/1999)

100

Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)  
USAPA V1 00

(b)(6)-4

## MEDICAL RECORD

## ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION (Enter date of admission)

31yo Iraqi ♂ EPW captured in raid 4d ago sustained multiple abrasions, contusions and ecchymosis during episode & subsequent questioning. Brought to EPW camp today unable to walk 2° pain in feet / legs. ♀ chest pain / difficulty breathing ♀ bladder/bowel problems.

PMHx - migraine, HTA  
H/o hepatitis &  
PShx - none

Meds - ciprofloxacin

All - NKDA

## PHYSICAL EXAMINATION

129/84 P 116 R 17 T 97.5°F O<sub>2</sub> sat 98%

GEN alert, oriented, cooperative, conversant through interpreter  
CV tachycardic but regular & volume Reg: CTHB  
Chest/back multiple abrasions to back, (B) shoulders, chest  
extending to chest, (R) ASIS.

Abd flat, soft, non-tender to palpation.

MS: ♀ gross deformities, E active ROM to shoulders/ellbow  
Twisted fingers/knees (B) ankles/feet/hips & edema &  
femur (L) knee/ankle/foot/leg. Multiple ecchymosis  
to (B) knees, anterior tibia, fibula

PROGRESS (Enter date of discharge and initial diagnosis)

Inj: multiple abrasions/ 118 16.7 239 47.1 124 105 aluminum  
ecchymoses 11.0 alk phos  
(B) foot pain/swelling PT 27.4 ACT 25  
PTT 61.0 amylase AST 835  
CXR pelvis - df Chbi 3

Plan: (1) Admit to TCW for observation  
& IV hydration  
(2) Pain control

Xrays of (B) leg/feet  
CXR pelvis - df

(b)(6)-2

DATE  
DD/MM/YY

IDENTIFICATION NO.

ORGANIZATION

		REGISTER NO.	WARD NO.
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(b)(6)-4

(b)(6)-4

FOR OFFICER  
LAWLY  
ONLYABBREVIATED MEDICAL RECORD  
Form 524GENERAL ADMINISTRATION AND  
INTERROGATION COMMITTEE ON MEDICAL RECORDS  
FORM 524 (REV. 10-65)  
OCTOBER 1965  
USAFCOM

EXHIBIT

## INPATIENT TREATMENT RECORD COVER SHEET (For Plate Imprinting)

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 (Excluding Items 25 & 26)		LINE	LEGEND	ADMISSION REMARKS
(b)(6)-4		1	REGISTER NO. - NAME - GRADE	
(b)(6)-4		2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION	
		3	FMP - SSN - ORGANIZATION - WARD	
		4	FLY STAT - RATING/DESG - DERT/BEN - BRANCH/CORPS - UICZIP - TYPE CABE	
		5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC	
		6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
		7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION	
		8	NAME & LOCATION OF MEDICAL/TREATMENT FACILITY - DATE OF INITIAL ADMISSION	
25. TYPE DISPOSITION	26. DATE OF DISPOSITION			ADMITTING OFFICER
				32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

## 31. SELECTED ADMINISTRATIVE DATA

 CHECK IF CONTINUED ON REVERSE

## 33. CAUSE OF INJURY

## 34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Multiple abrasions / ecchymoses

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

FIRMA (41 CFR) 201-9.202-1

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## **EXHIBIT**

## **MEDICAL RECORD**

## **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE

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

(b)(6)-2

10/04/04 C822 Pt Lateral, Pt in standing position P88 R14 T 96.9

10/04 0902 Pt in standing position Drawt 15 cc water P82 R12 T 97.8

0919 Pt fed 1 piece of white wheat bread 20 skitties And Drawt 1 Liter of water

1000 Pt DOX3 Awake Alert Responsive To All Commands  
P 82 R 12 T 98.1<sup>o</sup>

1037 URG Color change on buttocks (6) Foot 1st and 2nd  
Posterior Anterior Metatarsal motor division from Standing Toes  
when moving to standing position from Recumbent  
Position

1100 P88 R14 T 97.8

1200 P80 R12 T 97.8 Turned over Pt to

AM- (b)(6)-2

N - F - I - P

**OSPITAL OR MEDICAL FACILITY**

**STATUS**

**DEPART./SERVICE**

**RECORDS MAINTAINED AT**

---

**Sponsor's Name**

SPN/03 NO

DATA MANAGEMENT FOR BUSINESS

**PATIENT'S IDENTIFICATION** (For typed or written entries,  
Date of Birth: Month/Grade)

**REGISTER NO.**

WARD NO.

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**CASE RECORD** or  
**Medical Record**

**STANDARD FORM 600 (REV. 6-97)**

**STANDARD FORM 80**  
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**EXHIBIT**

MEDICAL RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE		
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)			
3/10/04	Hm	(b)(6)-2	ASSUMES MEDICAL DUTIES @ 1200.	
1200	P110 R12 FEET SWOLLEN FROM STANDING. FEET FLACCID.			
1310	P100 R15			
1345	CLEANED AND WASHED ABRASIONS TO (P) 1ST + 2ND METATARSALS			
1350	DRANK 8OZ WATER			
1354	PROPERLY RELIEVED BY Hm (b)(6)-2			
1410	PT SLEEPING			
1411	Properly Relieved BY Hm (b)(6)-2			
1415	P88 R12			
1500	PT AMBULATES WITH ASSISTANCE TO TOILET			
1510	P86 R14			
1515	PT DRANK 330ML ORANGE SODA, BUT REFUSED FOOD.			
1520	PT SLEEPING			
1553	Duty Hm noted FEET SWOLLEN AND ELEVATED BLANKETS.			
1605	PT: P100 R10, C/o PAINFUL FEET. NO DISCOLORATIONS EXCEPT ABRASIONS. NOTED ABOVE GOOD CAP REFL (P) PEDAL PULSES (BLAT), (P) CERIPIUS (BLAT), (P) GUMMAE UPON PALPATION (BLAT). FEET CONTINUE TO BE ELEVATED.			
1644	Properly RELIEVED BY Hm (b)(6)-2			
	<del>NFETP</del> (b)(6)-2			

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

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

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE  
Medical Record  
STANDARD FORM 800 (REV. 6-97)  
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EXHIBIT

HOSPITAL OR MEDICAL FACILITY

**STATUS**

**DEPART / SERVICE**

RECORDS MAINTAINED AT

**RENTER'S NAME**

第 1 页

[View Details](#)

— 1 —

• 第四章

(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex;

第十一章 教育政策

— 1 —

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

## **CAL RECORD U**

### **Medical Record**

STANDARD FORM 600 (REV. 6-97)

**STANDARD FORM OF  
Prescribed by GSA/ICMR**

FIRM R (41 CFR) 201-9.202-1

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**EXHIBIT C**

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## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
0 MAR 04 2 P 00	ASSUMED WATCH From PO (b)(6)-2 THE TIME 2030. 2040-2100 (b)(6)-4 AMBULATED TO HEAD & SHOES UNDER his own control. Pt A&O X3. Pt APPEARS TO BE VERY TALKATIVE. Pt DRANK 10 <sup>oz</sup> Coke Cola. VS P120 R 14 RESP DEEP & REGULAR. (b)(6)-2
2215	Pt. A&O x3 T:99.2 R: 14 Pulse: 118 RRR Lungs clear all fields. PEARL x2. ALL ABRASIONS cleaned & bedadine & COVERED & BACON. ALL ABRASIONS healing & signs of infection. Pt tolerated procedure well / very cooperative. Pt sitting in chair by fire, FEET elevated. (b)(6)-2
2300	P:67 R:138 R:16 Pulse RRR b, Ausctn.
2317	Placed pt. on cot next to fire R/LAT. RECOMBENT pos.
2350	(b)(6)-4 SLEPT 1 hr. Pt. DRANK 20 <sup>oz</sup> H2O. P:125 R:19 T:98.6 Pt. ILL & SICK pos. (b)(6)-2 ILLNESS WHILE SICK IN BED RELIEVED BY H2O. (b)(6)-2
	NFETP
	(b)(6)-2
	i Hmz

NAME OF MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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SPONSER'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR
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ENTRANT'S IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)	REGISTER NO.	WARD NO.
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## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

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EXHIBIT

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

15 June 04

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

## REPORT OF DETAINEE MEDICAL SCREENING:

1023 hrs.

History of Past Medical Conditions: (circle) High Blood Pressure, Diabetes, Heart Failure, Kidney Failure, Seizures, Stroke, Bleeding

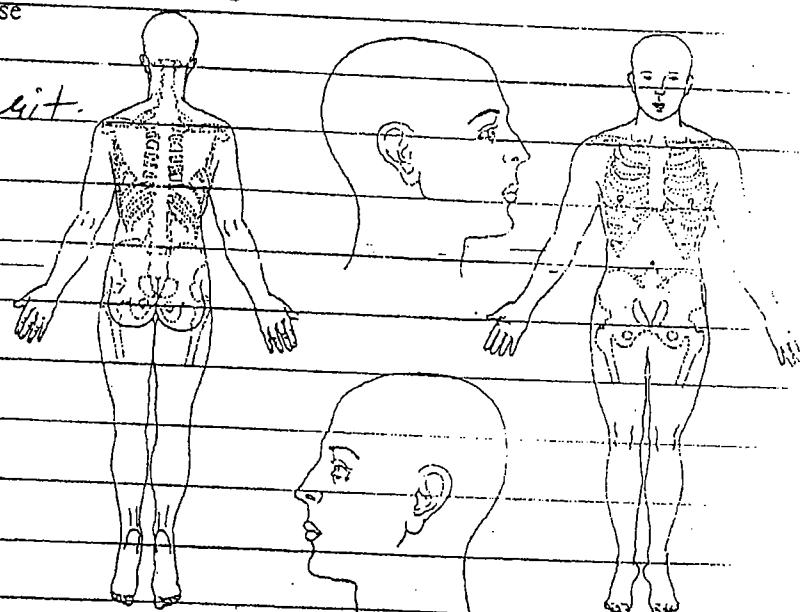
Neck PN x 6 yrs  
Medication Allergies: (NO) (YES) List - Ulcers, Chronic Bowel problems, Thyroid DzCurrent Medications: (Name/Dose/Frequency/Last Taken) (NONE) *Pv med's*Recent Injuries: (NO) (YES) Describe - *of unknown type*Exam Findings: BP: 131/80 Pulse: 103 Resp: 12T: 98.3 (T)Utilize Diagram and Space Below to Indicate Examination Findings.  
If additional space required, continue on reverse

Gen: WNL, NAD, NL gait.

Lungs: CTA/B

Ext: WNL

Hemat: WNL



(FIT) (UNFIT) For Confinement

(Does) (Does Not) Require Further Eval

(b)(6)-2

CPT, SP, PA-C

(b)(3)-1

OSPITAL 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.

Detainee Information:

Name: \_\_\_\_\_

Last,

First

Middle

Control Number: (b)(6)-4

Date/Time of Detention: \_\_\_\_\_

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

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EXHIBIT 7-1

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

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

12 June 04

DETAINEE IN-PROCESSING MEDICAL SCREEN

SUBJECTIVE: AGE 27 M F DOB: 1977

ANY NEW MEDICAL ILLNESS OR INJURY?

pain in back of neck

ANY HISTORY OF TB? YES / NO IF YES, WHEN AND HOW WERE YOU TREATED?

COUGH &gt; 2 WEEKS? YES / NO

COUGHING UP BLOOD: YES / NO

ANY WEIGHT LOSS? YES / NO IF YES, HOW MUCH AND IN WHAT TIME FRAME?

ANY HISTORY OF HTN? YES / NO

ANY HISTORY OF CAD? YES / NO IF YES, ANY HISTORY OF MI? YES / NO WHEN?

ANY HISTORY OF DM? YES / NO IF YES, HOW LONG?

ANY CHRONIC MEDICAL CONDITIONS NOT MENTIONED ABOVE? YES / NO

none

CURRENT MEDICATIONS:

(b)(6)-2

diox

MEDICATION ALLERGIES:

none

ABLE TO WALK UNASSISTED? YES / NO ABLE TO FEED YOURSELF? YES / NO

ANY MISTREATMENT SINCE BEING DETAINED? YES / NO

HISTORY OBTAINED THROUGH TRANSLATOR?

YES / NO

NAME:

(b)(6)-4

ORDS MAINTAINED AT

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME

PATIENT'S IDENTIFICATION:

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

STATUS

DEPART./SERVICE

(b)(6)-4

(b)(6)-4

REGISTER NO.

WARD NO.

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

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EXHIBIT 7-2

18

## OBJECTIVE:

HEIGHT: 5'4" WEIGHT: (b)(6)-2

BP: 131/179 PULSE: 97 RESP: 20

O2%:

TEMP:

MEDICS SIGNATURE: (b)(6)-2

REFER TO PA OR MD IMMEDIATELY IF:

CURRENTLY HAVING CHEST PAIN, ABNORMAL MENTAL STATUS OR ANY OTHER CONCERNS

## MD/PA REVIEW NOTE:

S) 27 y/o ♂ Retiree presents for inprocessing. Pt reports he was punched in the stomach 4 days ago by coalition forces. He denies any current bleeding or scars from incident.

O) WWSB ♂ NAO VS S GFRP-USC

Integumentary - No acute & Erythema or scars

a) Unfixed Musc

p) 1. Refer to CPT

T. 0282 2nd plan discussed @ length w/ pt  
through interpreter.

(b)(6)-2

PA-C

10, 8P 08/08

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STANDARD FORM 600 (REV. 1-64) EXHIBIT A BACK

USAPA V2.00

Exhibit 7-3

19

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

26 JUN 04

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

DETAINEE IN-PROCESSING MEDICAL SCREEN

SUBJECTIVE: AGE 22  M F DOB: 1982

ANY NEW MEDICAL ILLNESS OR INJURY?

Hyperpigmentation 3-7 days

ANY HISTORY OF TB? YES /  NO IF YES, WHEN AND HOW WERE YOU TREATED?COUGH > 2 WEEKS? YES / COUGHING UP BLOOD: YES / ANY WEIGHT LOSS? YES /  NO IF YES, HOW MUCH AND IN WHAT TIME FRAME?ANY HISTORY OF HTN? YES / ANY HISTORY OF CAD? YES /  NO IF YES, ANY HISTORY OF MI? YES / NO WHEN?ANY HISTORY OF DM? YES /  NO IF YES, HOW LONG?ANY CHRONIC MEDICAL CONDITIONS NOT MENTIONED ABOVE? YES / 

CURRENT MEDICATIONS: None

MEDICATION ALLERGIES: None

ABLE TO WALK UNASSISTED? YES /  NO ABLE TO FEED YOURSELF? YES /  NOANY MISTREATMENT SINCE BEING DETAINED? YES /  NOHISTORY OBTAINED THROUGH TRANSLATOR? YES /  NO NAME: (b)(6)-4

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.

NAME: (b)(6)-4

SN: (b)(6)-4

COMPOUND:

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## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)

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6

0224-04-CID259-80258

DATE

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

26 JUN 04

OBJECTIVE:

HEIGHT: 5'5" WEIGHT: 117

BP: 125/79 PULSE: 86 RESP: O2%: TEMP:

MEDICS SIGNATURE: N/A

REFER TO PA OR MD IMMEDIATELY IF:

CURRENTLY HAVING CHEST PAIN, ABNORMAL MENTAL STATUS OR ANY OTHER CONCERNS

MD/PA REVIEW NOTE:

26 JUN 04

S) 22 y/o ♂ Relates parents for medical unprogressive and reports while being interrogated he was punched in the chest, and choked, and punched in the back. He reports this happened 6 days ago at the al-muthne app't

PMH -

FH - Single unemployed denies any current bruising.

60 - 0 GPO 1<sup>t</sup>  
60 - 1 PK/yr smokes

Neuro: CN II - XII, C4-T1 motor, L1-S2 motor grossly intact

Allergies - NCDA

PDRS 2L (P)

HESNT - NL Neck - supple S<sup>t</sup> nontenderness/thyroidly

Lungs - CTA (P) HEART RRR ABD - BURRS

Genitals - NL ♂ U TESTES LAT - NOVUS NL WCE

Integumentary - no rect. ectymosis (G) Area of hyperpigmentation o.  
(R) FRAIL

4) 1. Alleged place

2. Distr. Hyperpigmentation? etiology

P) 1. Refer to GID

2. F/L PRN

(b)(6)-2

PAE

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USE ONLYSTANDARD FORM 600 (REV. 6-97) BACK  
U.S. GOVERNMENT PRINTING OFFICE 1997 7

USAPA V.2.00

EXHIBIT 2

PRISONER IN-PROCESSING MEDICAL SCREEN

(b)(6)-4

NAME

DATE: 5 May 04

HISTORY BY TRANSLATOR: YES

(b)(6)-4

NAME OF TRANSLATOR:

COMPOUND:

DOB: 1974

(b)(6)-4

ISN:

AGE: 30

- 1) DO YOU HAVE ANY NEW MEDICAL PROBLEMS OR INJURIES NOW?  
*Severe lacerations secondary to cuff  
 (on both wrists), was hit on the head [REDACTED] repeatedly  
 from pistol*
- 2) HAVE YOU HAD TUBERCULOSIS? IF YES, WHEN AND HOW WERE YOU TREATED? (See pt abuse form)  
*No*

- A) HAVE YOU HAD A COUGH FOR MORE THAN 2 WEEKS? YES
- B) HAVE YOU BEEN COUGHING UP BLOOD? YES
- C) HAVE YOU BEEN LOSING WEIGHT? YES

- 3) CHRONIC MEDICAL PROBLEMS (DIABETES, HYPERTENSION, HEART DISEASE):  
*None*

- 4) MEDICATIONS:  
*None*

- 5) ARE YOU ABLE TO WALK UNASSISTED? YES  NO
- 6) ARE YOU ABLE TO FEED YOURSELF? YES  NO
- 7) ALLERGIES: *None*

8) PULSE: 100 BLOOD PRESSURE: 100/88 RESPIRATORY RATE: 16  
 WEIGHT: 176 lbs HEIGHT: 5' 7"

SIGNATURE (b)(6)-2

A YES TO QUESTIONS 1-4 REQUIRES REFERRAL TO MD OR PA, UNLESS MINOR PROBLEM  
 FOR QUESTION 1. A NO TO QUESTION 6 OR 7 ALSO REQUIRES MD/PA EVALUATION.

MD/PA FOLLOW UP NOTE

DATE: 5 MAY 04

ASSESSMENT:

Refer to SP 600

Dated 5 MAY 04

RECOMMENDATIONS:

(b)(6)-2

SIGNATURE: (b)(6)-2

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EXHIBIT 4

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE		
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
5 MAY 04 118/16 P - 78 T - 98.3 R - 1L	<p>(3) 30 y/o ♂ referred by medic for evaluation pt reports he was hit on the head repeatedly and hit on (R) side 2nd (B) shatters pt reports this happened approx 3 wks ago. otherwise history was obtained through interpreter.</p> <p>(a) UNDO 3 MALE US STABLE/ABNORMAL GAIT - NL NECK: CN II-XII, C4-T1 "MOTOR" + L1-S2 MOTOR GROSSLY INTACT (b)(6)-2 HEART - (C) BM + ERYTHROCYT + SCAT WHAT APPEARS TO BE DILATED AORTA OTHERWISE NL</p> <p>PHT - NECK - SUPPLE &amp; EDENOPATHY LUNGS - COM (b)(6)-2</p> <p>PSTH - HEART - RRR &amp; MURMURS, CLICKS OR GURGLES</p> <p>FH - SINGLE EST STRIKING ABD - (D) AS 4 CHILD NO HIST NO GENEALOGY AND RESEARCH, SH - 12 pt/yr smokes GENTALS - NL MALE &amp; TESTICLES &amp; SCROTAL MASSES</p> <p>MED - ♀ Allergies - N/A</p> <p>1. Multiple well healing wound SCARS - CONSISTENT w/ H/O possible blunt trauma to extremes 2. Otherwise NL PE</p> <p>P) 1. F/U PAIN ON SICK CALL 2. CASE AND PAIN DISCUSSED w/ PT</p>		
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.)

ISBN # (b)(6)-4

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

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EXHIBIT 4

0140-04-C1D259-80204  
0041-04-C1D789

## HEALTH RECORD

## DETAINEE PREINTERROGATION EVALUATION

DATE: 23 MAY 04

PATIENT COMPLAINT / CONCERN: 30 y/o ♂ detainee who reports 23 days ago receiving maltreatment for 3 days at the Mosul airport location.

ALLERGIES: MEDS: SOC Hx: Tob:   
ETOH: 

PSHx:

J&amp;A

BP: 128/78  
P: 84  
R: 16

WEIGHT: 76Kg

O:

GENERAL:

Normal Abnormal

HEENT:

Normal Abnormal

NECK:

Normal Abnormal

PMHX:

HTN: Y N

CARDIAC:

Normal Abnormal

DM: Y N

ABDOMEN:

Normal Abnormal

TB: Y N

EXTREMITIES:

Normal Abnormal

CAD: Y N

scratches on shoulder & top, well healed compared to prior appearance per pt

ROS:

AP: cutaneous formation

Hep A, Hep B, MMR, Td: Given  Patient Refused

headache  
Symptom

Painful

CID report made - the Deputy Commander

Pictures in pt file already performed

Tylenol 325-680mg Q4-6H

(b)(6)-2

M.D.

M.C. USAF

(b)(6)-2

ISN: (b)(6)-4

SEX: M

CAMP:

V-C

DOB: 1974

0140-04-C10259-8020 4

0041-04-C10789

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## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
31 May 64	S - 30 y/o ♂ Detainee referred by CBN for complete H + P Pt reports approx 30-32 days ago he was beaten by coalition forces. He reports he was kicked and on his L shoulder he has a scar where they kicked him. Otherwise has BP less + nothing on chest
GP - 150 98	
P - 85	
J - 99.6	
R - 18	c) LUNH ♂ 190 lbs RPT HISTORY LEFT - RL Neck: C4-T1, C4-T1 motion loss L1-S2 motor CRUSSLE INVADIC PAST: Past history 91 PSH - tonsillectomy Lungs - CTG 3 children FA - M21 red shaper ABD - Biomechanics SH - ♀ Totals MED - no currrent Allergies - NFOHs OBT - moves well Integumentary → (b) (6) 2 1) (c) Shoulder scar consistent with C blood trauma > 7-14 days 2. T B?
	neck - diffuse & tenderly ex Thymus Thorax - RR 5 normal Gastro - O & E ↓ testes Rectal - no hemorrhoids or stool Prostate - smooth, symmetrical w/ no tenderness Urinary - normal Skin - 3 cm length scar (+) hyperpigmentation
	(b) (6) 2 PAC 16-T-SC-154

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.

NAME:

(b)(6)-4

RANK:

CHRONOLOGICAL RECORD OF MEDICAL CARE  
Medical Record

SSN:

DOB:

STANDARD FORM 600 (REV. 6-97)  
Prescribed by GSA/CMR  
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

UNIT:

C72

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L MEDCOM - 740

14

0140-04-C10259-60204

(b)(6)-4

First name (b)(6)-4

Second name (b)(6)-4

EPW T (b)(6)-4

Blood Type

Last name

Date of screening 13 Jun 04

Time of Screening 0415

MOI:

HPI: Pt states in past he has had ① knee pain - Dislocation from ② older mandible molar biting  
notion. Pt states he currently has no medical problems.

PMTX: ✓

PSHX:

Medis Q

Allergies: PCN

Airway: Patent Stabilized by

Breathing: Spontaneous Assisted by

Circulation:

Pulse: Present Absent

CPR

Color: Normal Abnormal

Cap refill: Normal Delayed

**Primary Survey**

Initial Vital Signs: bp 156 / 98 pulse 115 Resp 20 Pulse Ox 99% Temp 98.8

SEX: W DWN Age 21 Sex ♂

HEAD: Normal cephalic, PERRLA, ECMI I'm intact bilat. Cns of light noted. Normal caput midline. Severe tooth decay noted TONES: intact UPPR/lower molars

HEART: Regular Rate, Rhythm &amp; Murmurs/Gallops

LUNGS: CTABh x 6 Fields

CHEST: ① shoulder abrasion approx location acromion Chest equal rise & fall, otherwise unremarkable

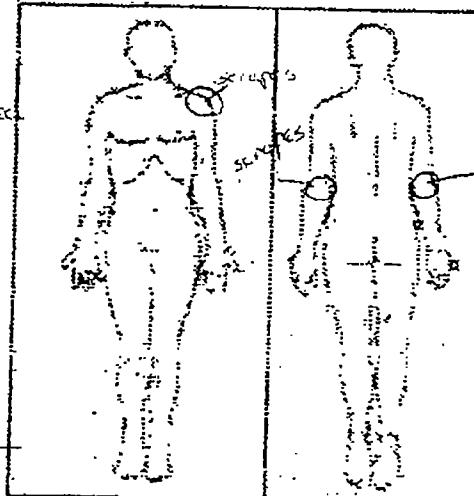
ABD: Bowel sounds noted x 4 quads. &amp; Masses, deformity or rigidity felt.

PUPILS: Stable

SKIN: Abrasion bilat at posterior of elbow

ERUPTION: Deferred

NERVO: Ac(+) x 3



GLASGOW COMA	
EYES OPEN	Spontaneously 14
	To Speech 3
	To Pain 2
	None 1
	Decided 3
BEST VERBAL RESPONSE	Confused 4
	Inappropriate words 3
	Incomprehensible words 2
	None 1
	Obey Commands 5
BEST MOTOR RESPONSE	Localizes Pain 2
	Withdraws Pain 4
	Flinches to Pain 3
	Extends to Pain 2
	None 1
TOTAL 15	

Revised Trauma Score	
GLASGOW COMA TOTAL	
13-15	4
14-12	3
6-4	2
4-2	1
2	0
SYSTOLIC BLOOD PRESSURE	
140-180 mmHg	4
110-139 mmHg	3
80-99 mmHg	2
60-79 mmHg	1
<60 mmHg	0
RESPIRATORY RATE	
16-29 / min	4
20-29 / min	3
16-19 / min	2
13-12 / min	1
None	0
TOTAL	16

(b)(6)-2

(b)(6)-2

FOR  
HM

MEDCOM - 741

33

(b)(6)

## EPW MEDICAL REC.

## PRECONFINEMENT SCREENING

DATE <b>4/MAY/04</b>	TIME <b>الوقت</b>	CAGE # <b>#4</b>			
DETAINEE # (b)(6)-4	NAME (b)(6)-4 <b>الاسم</b>	DOB: <b>22/Feb/1970</b> تاريخ ولادة			
PHYSICIAN: <b>Cell 4</b>	UNIT: <b>4</b>	PHONE #			
BP:	Pulse:	Resp: <b>15</b>	Temp:	Height: <b>175</b> الطول	Weight: <b>75</b> الوزن
Allergies to any medications? <i>(if yes explain)</i> <b>لديك حساسية من الأدوية؟</b>	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>			
Currently taking any medications? <i>(if yes explain)</i> <b>حالياً تستعمل أي علاج؟</b>	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>			
Past Medical History? <i>(if yes explain)</i> <b>لديك مرض مزمن سابق؟</b>	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>			
Past surgical History? <i>(if yes explain)</i> <b>فست باجراء عملية جراحية؟</b>	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>			
Communicable Diseases? <i>(if yes explain)</i> <b>لديك أمراض傳染ية (وبائية)؟</b>  <i>Alcohol - 2400 ml</i> <i>140</i>	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>			
Physical Exam:  HEENT:  LUNGS:  HEART:  ABDOMEN:  SKIN:	IDENTIFYING MARKS:				
	FIT FOR QUESTIONING?			YES	NO
	REMARKS: <i>-Seen Already</i> <i>Burn Lower back</i>				

6-7-2003

**SCREENING REPORT**

Screener, Team #:	DTG:
Capture Tag Number:	Capturing Unit:
<b>Biographical Information</b>	
First: (b)(6)-4	Middle: (b)(6)-4
Last: (b)(6)-4	Nickname: (b)(6)-4
Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F	DOB/POB: 22 FEB 70, MOSUL
Marital Status: S <input checked="" type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	Spouse Name: (b)(6)-4
Children/Name/Age: (b)(6)-4	(b)(6)-4
Religion: SUNNI MUSLIM	
Citizenship: IRAQI	Nationality: IE
Tribe: AL SABAWI	Ethnicity: ARAB
Height:	Weight:
Hair Color:	
Home address: AL KARIMA, MOSUL, TGT 121	
Phone #:	
Lives with: WIFE, KIDS, & MOTHER	
<b>Reason for Capture (Target #, Known Extremist/Terrorist.....)</b>	
TGT 121	
<b>Capture Data</b>	
Date/Time of Capture	Place of Capture TGT 121
Captured Documents/Currency:	
Captured Weapons/Equipment:	
Circumstances of Capture / Mission at time of capture:	
<b>Education</b>	

Level of Education:	9 <sup>TH</sup> GRADE		Degree:				
School:							
Specialized Training:	<b>ELECTRICIAN</b>						
<b>Language Proficiency</b> 1 = Native 2 = Good 3 = Poor							
Lang: ARABIC	<input checked="" type="checkbox"/>	2	3	Lang:	1	2	3
<b>Employment</b>							
Current	NINEVA POWER PLANT		Position				
Duties	<b>ELECTRICIAN</b>		Location	<b>NINEVA, MOSUL</b>			
Previous			Position				
Duties			Location				
Previous			Position				
Duties			Location				
Additional Skills							
<b>Military Service</b>							
Branch of Serv:	ARMY	Rank:	PVT	Service Number:			
Military Training: DRIVER							
Military Experience							
Full Unit Designation	KBIL BASIC TRAINING (INF)		Dates 05 MAR 88- 90				
Duty Pos:	DRIVER		Add Duties:				
Full Unit Des:			Dates				
Duty Pos:			Add Duties:				
Full Unit Des:			Dates				
Duty Pos:			Add Duties:				
<b>Category (1A = Highest / 3C = Lowest)</b>							
Cooperation	<input checked="" type="checkbox"/>	2	3	Knowledge	A	B C	
<b>Screener Observations</b>							
Physical Condition:	GOOD		Mental State:	ALERT			
Attitude:	Additional Observations:						
Recommended Approach:							
Screener Comments:							

## SCREENING REPORT

Screener, Team #:	(b)(6)-4	(b)(6)-4	DTG: 29 Apr 04	0523
-------------------	----------	----------	----------------	------

Capture Tag Number:	(b)(6)-4	Capturing Unit:
---------------------	----------	-----------------

## Biographical Information

First:	(b)(6)-4	Middle:	(b)(6)-4
--------	----------	---------	----------

Last:	(b)(6)-4	Nickname:
-------	----------	-----------

Sex:	<input checked="" type="checkbox"/> M / <input type="checkbox"/> F	DOB/POB:	22 Feb 70	Mosul	Karama
------	--	----------	-----------	-------	--------

Marital Status:	S	<input checked="" type="checkbox"/> M	D	W	Spouse Name: (b)(6)-4
-----------------	---	---------------------------------------	---	---	-----------------------

Children/Name/Age:	6 kids
--------------------	--------

	Religion:	Sunni
--	-----------	-------

Citizenship:	IZ	Nationality:	IZ
--------------	----	--------------	----

Tribe:	Al Sabawi	Ethnicity:	Arab
--------	-----------	------------	------

Height:	173	Weight:	75	Hair Color:	black
---------	-----	---------	----	-------------	-------

Home address:	Al Karama, Mosul
---------------	------------------

	Phone #:	NA
--	----------	----

Lives with:	Mother, wife and kids
-------------	-----------------------

## Reason for Capture (Target #, Known Extremist/Terrorist.....)

- DVK
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## Capture Data

Date/Time of Capture	Place of Capture
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Captured Documents/Currency:
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Captured Weapons/Equipment:
-----------------------------

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Circumstances of Capture / Mission at time of capture:
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EXHIBIT: 3

AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

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

(b)(6)-4

19 May 70

SN #

Camp: V-A

Valium 5 mg t po q HS pr insomnia - max 3 tab/week

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART./SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN/ID NO.

RELATIONSHIP TO SPONSOR

SPONSOR'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.

Impound V-A

(b)(6)-4

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)

Prescribed by GSA/ICMR

FIRMR (41 CFR) 201-8.202-1

USAPA V2.00

Ind MP CO

EXHIBIT 3

5 of 611

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## DETAINEE PRE-INTERROGATION EVALUATION

## HEALTH RECORD

ALLERGIES: NKA

## PATIENT COMPLAINT / CONCERN:

DATE: 19 May 04

PJ is 26 yrs old  
Acute complaints.

MEDS: Prn med &amp;

anxiety

Soc Hx: Tob: 2/4

ETOH: D

BP: 112/74

P: 84

R: 16

WEIGHT: 73kg

O:

GENERAL: Normal Abnormal

HEENT: Normal Abnormal

NECK: Normal Abnormal

LUNGS: Normal Abnormal

PMHX:

HTN: Y

N

CARDIAC:

Normal Abnormal

DM: Y

N

ABDOMEN:

Normal Abnormal

TB: Y

N

EXTREMITIES:

Normal Abnormal

CAD: Y

N

Pt C oce  
anxiety takes

A/P: (1) Lexam (2) Episodic anxiety  
Hep A, Hep B, MMR, Td: Given / Patient Refused

meds oxy to  
help sleep

Valium 5mg T po q 4S prn max 3 tabs/week  
Med - Note - 07. 07

(b)(6)-2

Timothy J Kozlmatka, M.D.  
Major, USAF, MC

ISN: (b)(6)-4

SEX: M

CAMP:

V-A

DOB:

1978

Brigade Surgeon

(b)(3)-1

DETAINEE MEDICAL SCREENING FORM

DATE: 1 May

(b)(6)-4

NAME: \_\_\_\_\_ AGE: 37 HEIGHT: 58 WEIGHT: 150

ALLERGIES:  NO  YES: Shellfish

MEDICATIONS: Most medicine does not know what

MEDICAL HISTORY:  ASTHMA,  DIABETES,  HEART DISEASE,  TUBERCULOSIS,  OTHER INFECTIOUS

DISEASES: \_\_\_\_\_  OPIUM USE

SMOKER:  YES  NO

EXAM:

P: 100 BP: 140/74 APPEARANCE:  HEALTHY,  MALNOURISHED,  ILL

HEENT: PERFECT CHEST: CTA

CV: HR 55pm, gallop, rub, ABDOMEN: S/NT slight bloating on (b)(6) no palpable

MS: WAG 5pm SKIN: W/D

DENTAL: No oral trauma noted

2. Is a healthy male & slight pain in kidney left.  
short tube from mouth.

GENERAL ASSESSMENT: \_\_\_\_\_

SIGNED: SSG

(b)(6)-2

MEDICAL OFFICER: LCpl SP

(b)(6)-2  
(MC, DC, MS)

SICK CALL:

DATE: 10 May 04 COMPLAINT

DX/TX

Chest pain when breath w/v/48 / crackly & 2-3wks

CTA Plan = R/V (b)(6) C/Mon today for X-ray chest Cervical P.R.

14 May 04 - No opm & deep breathing -

(b)(6)-2  
(b)(6)-2

pt:

DISCHARGE NOTE:  NO CHANGE IN HEALTH STATUS

DATE: 13 May 04

c/o sm short pain & Deep Breathing -

(b)(6)-2

14 May 04 - No pain mentioned / continue problem

SSG (b)(6)-2 91000011

SIGNED: SSG

(b)(6)-2

MEDICAL OFFICER: LCpl SP

(b)(6)-2  
(MC, DC, MS)

over  
16 months

.. v. 19

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)	
11 Mar. 1 (b)(3)-1	38 male c/o Ribs hurt when breath 1xday / chest hurts when breath w/ x/r. C/o liver problems & c/o ears hurt from bry	
TIME ht		
B/P	pt has <del>continuous</del> (b) lbs. pt TPR all 4 quadrants Ab. clear breath sounds	
P		
R	f. Reg. good pt has no signs or symptoms of lbs	
T	S an ab	
PULSE OX	O. Nal suppl on lab no TPR no res	
ALLERGIES KNTA	Shellfish anesthetic Ectomine Rx Ami	
MEDS rx	Clot Rx Pulm and RT by Clot + RT	
TOBACCO YRS	CVRD R 50 plant	
PMH	dt of B/S at single urine sample	
PSH	X-ray of clw and RT int A Contusion Ribs P. Card - Piller	
FMH	1bypuff 60g = 10 QID Rx for Cort - PDR x 4-6 hr	
	(b)(6)-2	(b)(6)-2
	1/2 ST	

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

EPU  
(b)(6)-4

10 Mar /

X RAY only maxilla

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 BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)  
Prescribed by GSA and ICMPR  
FIRMR (41 CFR) 201-45.505

RCAS V1.0





P-102

Brigade Surgeon

(b)(3)-1

## DETAINEE MEDICAL SCREENING FORM

DATE: 9 May 04

(b)(6)-4

(b)(8)-4

NAME: \_\_\_\_\_ AGE: 30 HEIGHT: 180cm WEIGHT: 90

ALLERGIES:  NO  YES: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

MEDICAL HISTORY:  ASTHMA,  DIABETES,  HEART DISEASE,  TUBERCULOSIS,  OTHER INFECTIOUS DISEASES: No  OPIUM USESMOKER:  YES  NO

EXAM:

P: 102 BP: 117/68 APPEARANCE:  HEALTHY,  MALNOURISHED,  ILL

HEENT: PERRLA CHEST: RRR (B) Lungs CTA

CV: RRR ABDOMEN: S/NT

MS: WNL SKIN: WNL

DENTAL: G WD. no oral TRAUMA -

GENERAL ASSESSMENT: G WD -

(b)(6)-2

SIGNED: SSG

(CLS, 91W)

MEDICAL OFFICE

(b)(6)-2  
LTC SP  
(C, DC, MS)

SICK CALL:

DATE COMPLAINT DX/TX

11 MAY 04 To RIC &amp; R6 per Report "Being Tortured."

 Chest Pain - Reports Being Shocked During Torture Insect Bites Both Feet.

11 MAY 04 Reports being beaten by U.S. forces about 2 weeks ago with resultant pain from being kicked in his chest and where he reports electricity was applied to his groin

Exam: PERRL, EOMI, OP clear of lesions, NC AT, no conjunctival hemorrhage, CN's intact Heart RRR RRR RRR Chest CTA (B) Good expansion (TTE over lateral chest wall No healing ecchymoses anywhere. Scattered insect bites. Gait &amp; speech WNL.

DISCHARGE NOTE:  NO CHANGE IN HEALTH STATUS

DATE: \_\_\_\_\_

Will give Motrin PRN

chest wall pain. 11

(b)(6)-2

CP, MC

SIGNED: \_\_\_\_\_

(CLS, 91W)

MEDICAL OFFICER: \_\_\_\_\_

(MC, DC, MS)

48

## EPW/CI Medical Report

Last Name (b)(6)-4	First Name, MI (b)(6)-4	Internment Serial Num. (b)(6)-4			
EPW/CI Location T-TRANSFER		BirthDate 1979/01/01	Sex M	Height 69	Weight 154
Physical Condition	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Marital Status M-MARRIED	
Distinguishing Marks:					
Remarks					
Hair Color	Eye Color	Race X-OTHER	Blood Type	Diet	
Examination Information					
Examination Number 15198901	Date 2004/03/02	Time 8:02:07 PM	Exam Category A1-TO BE DEFINED	Type of Case BC-TO BE DEFINED	
Diagnosis Please see attached page			Comments Please see attached page		
Disposition Type	Disposition Date 2004/03/03		Disposition Time 12:00:00 AM		
Immunizations					
Medical Officer Performing Exam					

88-74

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Law Enforcement Sensitive

Diagnosis (From Page 1)

Internment Serial Num.

134-04-C10519-8116<sup>Q</sup>

(b)(6)-4

S: Earache primary to injury in a fight x 2 days O: Erythema present A: Otitis externa P: Tylenol  
500 mg tid x 5 days, Gentec ointment bid x 3 days, Augmentin 500 mg bid x 5 days

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Ver. 7E

**EPW/CI Medical Report**

0084-04-CID 519-8116

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**EXHIBIT 18**

Internment Serial Num.

Diagnosis (From Page 1)

(b)(6)-4

0084-04-CID 519-8116

S: tried o hang himself in tent, spent one minute suspendedO: r 20, p 92, no abrasions on neck,  
lungs clearA: Major depressionP: Restraints x 2 h, 5 mg fast acign haldol IM, 40 mg qd Paxil x  
30 d

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66-77

EXHIBIT 18

## EPW/CI Medical Report

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EXHIBIT 18

Diagnosis (From Page 1)

Internment Serial Num.

(b)(6)-4

0084-04-CID 519-81169

S: c/o MP's beating him upO: no abrasions found anywhere(ankles, wrists, elbows, etc.) no lacerations, no contusionsA: depression (pt has hx of depression)P: continue to monitor

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Law Enforcement Sensitive

EXHIBIT 16

b6 b7c

Internment Serial Num.

(b)(6)-4

0114-04-CID 519-81169

Comments (From Page 1)

Medic witnessed incident and states that the MP's took the detainee to the ground in order to handcuff him because he was resisting them. Pt. has been refusing rx's.

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EXHIBIT 18  
100-80

## EPW/CI Medical Report

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Diagnosis (From Page 1)

Internment Serial Num.

(b)(6)-4

084-J4-CID 519-8116

S: corn on rt foot O: corn on foot A: removal of plantar corn needed P: removal under LA, keflex 500 mg qid x 5 d, tylenol 500 tid x5 d

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Law Enforcement Sensitive

EXHIBIT 18  
LJ. 82

## EPW/CI Medical Report

84-04-CI 0519-8110

Last Name (b)(6)-4	First Name, MI (b)(6)-4	Internment Serial Num. (b)(6)-4		
EPW/CI Location T-TRANSFER		BirthDate 1979/01/01	Sex M	Height 69
Physical Condition	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Marital Status M-MARRIED
Distinguishing Marks:				
Remarks				
Hair Color	Eye Color	Race X-OTHER	Blood Type	Diet
Examination Information				
Examination Number 15198905	Date 2004/03/29	Time 1:49:04 AM	Exam Category BC-TO BE DEFINED	Type of Case DIS-TO BE DEFINED
Diagnosis Please see attached page		Comments Please see attached page		
Disposition Type	Disposition Date 2004/04/06		Disposition Time 12:00:00 AM	
Immunizations				
<p>Medical Officer Performing Exam</p>				

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Law Enforcement Sensitive

EXHIBIT 18  
88

Diagnosis (From Page 1)

Internment Serial Num.

(b)(6)4

1084 - 04 - CID 519 - 81169

S: suture removal right foot

O: wound healing appropriate

A: sutures need removed

P: Sutures removed

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EXHIBIT 15  
cc: 84

EPW/CI Medical Report

4-04-CID 519-8116<sup>9</sup>  
Internment Serial Num.

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EXHIBIT 18

MEDCOM - 764

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4
-------------------------	------------------------------------

S: corn

O: corn on R foot

A: needs removal

P: surgical removal under LA, 5cc Marcaine, 4 sutures

Amoxil 500 tid x 7d, tylenol 500 tid x 5d, dsg chge 8 Apr, sut rem 11 Apr

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EXHIBIT 18

88

## EPW/CI Medical Report

0084-04-CID 519-81169

Last Name (b)(6)-4	First Name, MI (b)(6)-4	Internment Serial Num. (b)(6)-4		
EPW/CI Location T-TRANSFER		BirthDate 1979/01/01	Sex M	Height 69
Physical Condition	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Marital Status M-MARRIED
Distinguishing Marks:				
Remarks				
Hair Color	Eye Color	Race X-OTHER	Blood Type	Diet
Examination Information				
Examination Number 15198907	Date 2004/04/06	Time 9:15:57 AM	Exam Category A1-TO BE DEFINED	Type of Case BC-TO BE DEFINED
Diagnosis Please see attached page		Comments Please see attached page		
Disposition Type	Disposition Date 2004/04/11		Disposition Time 12:00:00 AM	
Immunizations				
Medical Officer Performing Exam				

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EXHIBIT 18  
87

Diagnosis (From Page 1)

Internment Serial Num.

(b)(6)-4

308 - 24 - CID 519 - 81169

S: dsg change

O: wound dirty

A: 0 s/s infection

P: dsg changed, returned to sick call 11APR04 for suture removal

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EXHIBIT 14  
88

## **EPW/CI Medical Report**

04-010014-81169

Last Name (b)(6)-4		First Name, MI (b)(6)-4		Internment Serial Num. 04-CID-314-31167		
EPW/CI Location T-TRANSFER		BirthDate 1979/01/01	Sex M	Height 69	Weight 154	
Physical Condition	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Marital Status M-MARRIED		
Distinguishing Marks:						
Remarks						
Hair Color	Eye Color	Race X-OTHER	Blood Type		Diet	
Examination Information						
Examination Number 15198908	Date 2004/04/07	Time 2:49:14 PM	Exam Category A1-TO BE DEFINED		Type of Case BC-TO BE DEFINED	
Diagnosis Please see attached page			Comments Please see attached page			
Disposition Type	Disposition Date 2004/04/12			Disposition Time 12:00:00 AM		
Immunizations						
<p>Medical Officer Performing Exam</p>						

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EXHIBIT 18

4

Diagnosis (From Page 1)

Internment Serial Num.

(b)(6)-4

00

04-C1D 519- 81169

S: Dsg chge to R foot

O: suture p surgery

A: healing wound s infection

P: cleaned and dressed as ordered

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BIT 18 90

## EPW/CI Medical Report

708-04-CID 519-81109

Last Name (b)(6)-4	First Name, MI (b)(6)-4	Internment Serial Num. (b)(6)-4		
EPW/CI Location T-TRANSFER		BirthDate 1979/01/01	Sex M	Height 69
Physical Condition	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Marital Status M-MARRIED
Distinguishing Marks:				
Remarks				
Hair Color	Eye Color	Race X-OTHER	Blood Type	Diet
Examination Information				
Examination Number 15198909	Date 2004/04/09	Time 9:57:15 AM	Exam Category A1-TO BE DEFINED	Type of Case BC-TO BE DEFINED
Diagnosis Please see attached page		Comments Please see attached page		
Disposition Type	Disposition Date 2004/04/13		Disposition Time 12:00:00 AM	
Immunizations				
<p>Medical Officer Performing Exam</p>				

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EXHIBIT 18  
91

Diagnosis (From Page 1)

Internment Serial Num.

(b)(6)4

COS - 04 - CID 519 - 81169

S: DSG CHNG, S/P CORN REMOVAL

O: GOOD MARGIN/GRANULATION, 0 S/S INF. NOTED

A: SUTURE REMOVAL & DRSG CHNG

P: BACITRACIN APPLIED DSG CHNG, LOCALIZED CLEANSING, RTC IF S/S INF NOTED

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Law Enforcement Sensitive

EXHIBIT 18  
92

## EPW/CI Medical Report

04 - 04 - CID 519 81169

First Name, MI

Internment Serial Num.

(b)(6)-4

(b)(6)-4

Last Name

(b)(6)-4

BirthDate

1979/01/01

Sex

M

Height

69

Weight

154

EPW/CI Location

T-TRANSFER

Physical Condition

Education

B-ELEMENTARY SCHOOL

Religion

33-SUNNI-ISLAM

Marital Status

M-MARRIED

Distinguishing Marks:

Remarks

Hair Color

Eye Color

Race

X-OTHER

Blood Type

Diet

## Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
11618910	2004/04/09	9:59:55 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

## Diagnosis

Please see attached page

## Comments

Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/04/13	12:00:00 AM

## Immunizations

Medical Officer Performing Exam

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93

Diagnosis (From Page 1)

Internment Serial Num.

(b)(6)4

D 8 - 14 - CID 519 - 81163

S: MULTIPLE SMALL SEBACIOUS CYSTS IN THE FACE AND BOTH EYELIDS

O:

A: REMOVAL OF SEBACIOUS CYSTS

P: KEFLEX CAP 250MG QID 5D

IBUPROFEN 800MG TID 5D

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EXHIBIT 18  
94

## EPW/CI Medical Report

04-C1D519-81+62

Last Name (b)(6)4	First Name, MI (b)(6)4	Internment Serial Num. (b)(6)4		
EPW/CI Location T-TRANSFER		BirthDate 1979/01/01	Sex M	Height 69
Physical Condition	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Marital Status M-MARRIED
Distinguishing Marks:				
Remarks				
Hair Color	Eye Color	Race X-OTHER	Blood Type	Diet
Examination Information				
Examination Number 15198912	Date 2004/04/10	Time 2:08:10 PM	Exam Category A1-TO BE DEFINED	Type of Case BC-TO BE DEFINED
Diagnosis Please see attached page		Comments Please see attached page		
Disposition Type	Disposition Date 2004/04/15		Disposition Time 12:00:00 AM	
Immunizations				
Medical Officer Performing Exam _____				

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EXHIBIT 16-95

Diagnosis (From Page 1)

Internment Serial Num.

(b)(6)-4

OUC - 04 - CID 519 - 81169

S: dsg change, some pain

O: wound open, stitches removed, 0 s/s infection

A: needs dsg change

P: IB 800mg TID x5d, dsg changed

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BIT 16  
96

EPW/CI Medical Report

0514-04-C TD 519 - 81159

Medical Officer Performing Exam

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Diagnosis (From Page 1)

Internment Serial Num.

(b)(6)4

- 04 - C I D S 19 - 8 116

refill meds: paxil 20mg bid--16 pills for 8 days

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EXHIBIT 98

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EXHIBIT 18-96

Diagnosis (From Page 1)

Internment Serial Num.

bX64

0084-04-C1D519-81165

S: c/o n/v dizziness, tooth pain

O: 0 emesis noted

bp 120/96, p 80, t 98.7, r 20, ps02 98%

A: dyspepsia

P: zantac 150mg bid x14d

acetaminophen 500mg bid x14d

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EXHIBIT 18  
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## HEALTH RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATING ORGANIZATION (Sign each entry)
7/28/04	<b>PRE-TRANSFER MEDICAL ASSESSMENT</b>

\*\*LIST ANY YES RESPONSES IN RAMARKS SECTION ON REVERSE SIDE OF FORM

AGE: 27

(Y) (N)

(Y) (N)

  Allergies  Recent illness/injury

left thigh G5C

  Dental Problems *pain*  History of psychological problems (Date)  HIV positive  Chronic health problems or infectious diseases  Previous Suicide Attempts (Date)  Females only; Are you pregnant?  History of alcohol abuse/treatment (Date)  Current medications  Current physical complaint(s)

1.

 1. Cough/Sputum Production

2.

 2. Rash

3.

 3. Diarrhea/Vomiting 4. Night sweats 5. Pain *feet* 6. Exposure to TB 7. Lice/Other infestation 8. Contagious disease in the past 12 months? 9. Other:\*\*\*\*\* FOR MEDICAL PERSONNEL USE ONLY DETAINEE'S INITIALS *[REDACTED]*

## HIV/TUBERCULOSIS QUESTIONNAIRE

Do you have a history or, or do you presently have any of the following symptoms or conditions:

(Y) (N)

(Y) (N)

  Persistent cough/shortness of breath  Cough with blood and/or dry cough  Unexplained weight loss/diarrhea X 2 weeks  Unexplained persistent fever  Night Sweats  Swollen glands/lymph nodes  Prolonged fatigue or run-down feeling  Loss of appetite and or white patches in mouth  Recent exposure to someone with TB  Past abnormal X-Ray (Date)  Hepatitis B series completed /  Previous TB infection or treatment  Stomach surgery, Kidney failure, Blood disorders

Stated he was forced to

  Scars, birthmarks, tattoos:

The guard by an MS

1.

4.

2.

5.

3.

6.

about 5 days ago which  
did not sit down for R.  
Canteen - at TCN - also seen

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

(b)(6)-4

RECORDS MAINTAINED AT:  
> CAMP BUCCA

(b)(6)-4

SEX

*m*

RELATIONSHIP TO SPONSOR

STATUS DETAINEE

RANK/GRADE  
*6*FOR OFFICIAL USE ONLY  
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MEDCOM - 780

ORGANIZATION

-----BELOW PORTION TO BE COMPLETED BY MEDICAL STAFF-----

0099-04-C10519

PHYSICAL APPEARANCE

0204-04-C1D289-80242

Clean, well groomed	(Y) (N)	Tremors, sweating	(Y) (N)
Rashes, needle marks	(Y) (N)	Exposure to tuberculosis	(Y) (N)
Body deformities	(Y) (N)	Infestations	(Y) (N)
Cuts, bruises, lesions	(Y) (N)	Confinement Phys. Date:	

VITAL SIGNS: Weight: Height: Temp: 97.5 B/P: 120/78 Pulse: 70 Resp:

PPD given: HIV drawn: RPR drawn:

Physical Exam: Within normal limits (Y) (N) See remarks for any (N) answers

Head (✓) ( )

Lungs/Chest (✓) ( ) LAB (If available)

Back (✓) ( ) CBC:

Heart (✓) ( ) U/A:

Extremities (✓) ( ) Chest X-Ray:

Skin: (✓) abrasion (R) elbow arm 4cm (R) shoulder 3x1cm

MENTAL STATUS

(Y) (N)

( ) ( ) Alert, well oriented

( ) ( ) Long and short term memory intact

( ) ( ) Experiencing hallucinations, delusions, or feelings of paranoia

( ) ( ) Calm, cooperative

DISPOSITION

(Y) (N) Prescriptions:

( ) ( ) Cleared for basic transfer procedures

( ) ( ) Cleared for litter transfer procedures

( ) ( ) NOT medically cleared for transfer \_\_\_\_\_ (days/weeks)

Recommended type of confinement ( ) Normal ( ) Solitary ( ) Other -explain:

I do not have any SUICIDAL and or HOMICIDAL feelings at this time. If I develop any such ideas or plans, I will notify a staff member before acting on such feelings or ideas. (SIG.)

(b)(6)-2

Date/Time information transmitted to component surgeon's office

Infection Control recommendations

( ) Standard Precautions

( ) Contact/Droplet Precautions

( ) Airborne Precautions

SCREENER

(b)(6)-2

MEDICAL STAFF SIGNATURE

SCREENER

(b)(6)-2

MEDICAL STAFF SIGNATURE

115

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