558-109 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21st CSH

LOG NUMBER

ARRIVAL — DATE: DAY 03, MONTH AUG, YR 07; TIME: 2235

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): ϕ

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: ϕ

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): [illegible]

SEX: M. AGE: 60.

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	2245		
BP	160/96		
PULSE	94		
RESP	20		
TEMP			
PAIN CODE	4		

CATEGORY (See reverse)

- EMERGENT
- URGENT
- NON-URGENT ☒

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 2302

ORDERS | INITS | TIME

- [illegible]
- [illegible]

ASSESSMENT/DIAGNOSIS

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

CONDITION UPON RELEASE

- IMPROVED | UNCHANGED
- DETERIORATED

TIME OF RELEASE: 2330

(CONTINUE ON SF 507 IF NEEDED)

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 TREATMENT RECORD).

(b)(6)-4

SIGNATURE (b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

EMERGENCY CARE AND TREATMENT — STANDARD FORM [illegible]

MEDCOM - 268

ACLU-RDI 1025 p.1

DOD 003395

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 11 | MONTH F | YR. 03 | TIME 1425

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data)

HISTORY OBTAINED FROM: ☐ PATIENT ☑ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration): Chest pain

SEX: M | AGE: 23

POSSIBLE THIRD PARTY PAYER? ☐ YES ☑ NO

TIME SEEN BY PROVIDER: on arrival

VITAL SIGNS

TIME	1430	1449
BP	122/74	117/64
PULSE	111	101
RESP.	30	23
TEMP.	99.8 (T)	
WT. (Lbs)		97

CATEGORY (See reverse)

☐ EMERGENT
☐ URGENT
☑ NON-URGENT BL-2

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

23 yo male, detainee brought by MP's for evaluation of chest pain and difficulty breathing. MP's report that detainee began refusing to drink water & apparent difficulty breathing. Through translator, detainee reports chest discomfort, dyspnea and sensation that he's choking. Also c/o hand spasms

Pain: 0 /10
Pulse: 0

Meds: None
Allergies: NKDA
Habits: Nonsmoker

ORDERS CONTINUE

General: Thin Iraqi male moaning and tachypneic
HEENT: WNL + dry O2 cracks
Neck: Unremarkable
Lungs: CTA B; tachypneic
CV: RRR; (no) m/r/g; 54/32; tachycardic
Abd: Benign
Extremities: 0 edema
(+) carpopedal spasm

PATIENT EVACUATED VIA MEDEVAC

ORDERS	INITS.	TIME
IV NS @ 125 cc/hr		1430
Repeat VS q hour		1520
CBC, Lytes, Mg		1420
Chest X-ray		1 hour
Ativan 2mg IM		1455
EKG, pain		1520

ASSESSMENT/DIAGNOSIS: Hyperventilation

Bowels 3rd L NSW LR

ED Course - symptoms completely resolved p 2mg lorazepam

Impression: Hyperventilation, dehydration, improved p atarax and 3L IV fluids

9.7	16.7	284	86	109	14
	57.0		3.2		106
					1.0

UA SG = 1.024
0 glucose, moderate ketones, 0 blood, 0 nit, 0 LE

(CONTINUE ON SF 507, IF NEEDED)

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): Sick Call
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT TO HOSP. UNIT (SERVICE)

CONDITION UPON RELEASE
☑ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE: 1600

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 TREATMENT RECORD.

B6-4

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

(b)(6)-2

LTC, MC

Diagnosis, instructions, orders, any limitations and follow-up plans)

1. DRINK PLENTY OF FLUIDS
2. IN EVENT OF RECURRENT SYMPTOMS → BREATHE INTO BAG

EMERGENCY CARE AND TREATMENT STANDARD FORM 558 (Rev. 6-82)

(See instructions on BACK of this Sheet) NSN 7540-01-075-3748

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 21st Hospital

LOG NUMBER

ARRIVAL — TIME: 1502 — MONTH/YR:

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Military

CURRENT MEDS. (tetanus immunization and other data): Blood Sugar ? BP ?

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Mosul, Iraq

HOME TELE. NO. (Inc. area code)

BRIEF COMPLAINT(S) (Include symptom(s), duration): Diabetes, HA, V

SEX: M AGE: 54

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: on arrival

VITAL SIGNS		
TIME	1502	1548
BP	138/84	154/75
PULSE	99	99
RESP	20	16
TEMP	97.2	98.6
OXIMETRY	98%	96%

CATEGORY (See reverse)
☐ EMERGENT
☒ URGENT
☐ NON-URGENT

B6-2

ORDERS	INITS.	TIME
IV NS at 125 cc/hr	[redacted]	1514
Notify MD if patient [illegible]		1515
CBC, Electrolytes, BUN, UA		1548
and VBG		1548

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

54 y/o Iraqi detainee presents c diabetes problem. Pt states has not had meds x 2 days. [illegible]

Pt states HA located in frontal head, PN is moderate, dull & constant, eyes sensitive to light. @V x 1 in 24 hours.

— K. Ann M. 9/W

54 y/o Iraqi detainee c hx SOB and HTN brought to ER for evaluation of polyuria, polydipsia, nausea and headache. Detainee claimed that he has not been able to take medications for past two days.

PMHx: HTN, SOB, PUD

Meds: Inderal, Benzyl

Allergies: NKDA

Habits: Nonsmoker

PSHx: Appendectomy, Vasectomy

General: Unkempt Iraqi ♂ in NAD/AT x 3, answers questions through interpreter

HEENT: Dry mucous membranes

Neck: Unremarkable

Lungs: CTA B/L

CV: RRR; (-) murmurs/gallops

Abd: Obese, (+) BS, soft, NT/ND

Extrem: (-) edema, cords or tenderness

Neuro: Nonfocal

17.6 / 155.4 | 10.3 | 32 | 141 | 112 | 94 | 22 | 39 | 28 | 1.8

UA - SG = 1.021

Glucose, Ketone, Large blood, Quit, PLE

ASSESSMENT/DIAGNOSIS: DIABETES, HYPERTENSION

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): REGULAR PHYSICIAN
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☒ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE:

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 1600

(CONTINUE ON SF 507, IF NEEDED)

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 TREATMENT RECORD).

Iraqi # [redacted] → B6-4

[redacted]

SIGNATURE OF PROVIDER AND ID STAMP (b)(6)-2 LTC, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

1. FOLLOW-UP WITH REGULAR PHYSICIAN WHEN RELEASED FROM DETENTION
2. HAVE FAMILY MEMBERS BRING REGULAR MEDICATIONS WHEN POSSIBLE
3. MEDICATIONS AT LEFT PROVIDED UNTIL REGULAR MEDS BROUGHT BY FAMILY

Meds: (1) Lisinopril 5mg, #2 tabs/day
(2) Atenolol 50mg, #2 tabs/day
(3) Trazodone 100mg - one tab per day

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 270

ACLU-RDI 1025 p.3

DOD 003397

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)
21st CSH

LOG NUMBER

ARRIVAL
DATE 03
TIME 2037

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE
☒ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data)
(-)

HISTORY OBTAINED FROM
☒ PATIENT ☐ OTHER (Specify)

ALLERGIES
(-)

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)
? skull fx

SEX M | AGE 19

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

TIME SEEN BY PROVIDER
2037

VITAL SIGNS

TIME	2037		
BP	112/56		
PULSE	88		
RESP.	18		
TEMP.	99.6		
WT. (Lbs.)	96		

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☒ NON-URGENT

ORDERS	INITS.	TIME
[redacted]		Bb-4

ASSESSMENT/DIAGNOSIS
Head Injury
Contusion

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):
TRAUMA

☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE

ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 0410 7120

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 TREATMENT RECORD)

(b)(6)-4
[redacted] Bb-4

Iraqi [redacted]

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

S. Transfer from BAS. Iraq. detained s/p fall from back of truck. ? LOC. Hit head + GSW to R arm. Seen by PA + sent here for ? skull fx. Scalp + post wounds s/p hx of GSW to head + craniectomy R arm on 9/1. old R sided defects

VR
Id cranial defects skull
R BUTTOCK. ADD
Pain. R buttock
R Buttock
TMs - nl B mono-dose tx
well-appearing. Pain c.
CL-Reg diet CR 7.12V R forearm
lungs - clear B
abd - soft, nt, nd bowel
sounds. AO x 3, GCS 15.
PERRL, EOMI, no CN deficit
no other

(CONTINUE ON SF 93 IF NEEDED)

(b)(6)-2
[redacted]

urinat, nic

plans)

d/c TO MPS
for further treatment.

MEDCOM - 271

STANDARD FORM 558 (Rev. 6-82)

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: [redacted] TIME: 1013

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): UNKNOWN

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX: M AGE: 22

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: on arrival

VITAL SIGNS

TIME	1000
BP	104/54
PULSE	110
RESP.	24
TEMP.	99.6
WT. (Lbs)	99 A

CATEGORY (See reverse): ☐ EMERGENT ☐ URGENT ☒ NON-URGENT

B6-2

ORDERS	UNITS	TIME
R femur PA + LAT		
CBC/Diff/Plt		
Lytes/Cr/BUN		1800
Bld T type & HIS		1980
(12) Rad X-ray		
Dig. #304	1 tab	1552

ASSESSMENT/DIAGNOSIS: MULTIPLE PENETRATING WOUNDS, EXTREMITIES

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): ORTHO PC Ward 6C

☐ EMERGENCY ☐ TODAY ☐ 72 HOURS ☐ ROUTINE

ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

22y [redacted] brought to CSH in custody of military police from local hospital. Individual sustained GSW and fragmentation wounds to (R) and (L) shoulder (R) hand and R/L lower extremities and feet; operated (?) debrided at local facility, details of same not available.

Pertx: 0 Meds: unknown Hosts: unknown

PSHx: 0 Allergies: NKDA

GENERAL: Thin [redacted] adult/pleasant 6.9 / 26.7 (2.7) (152) questions thoroughly cooperative

INTEG: Warm + dry 0 rashes - wounds as noted (377) (106) (3.0) (91) 1.0 1.0

HEENT: Fragments + abrasions (L) cheek, sutured scalp laceration (R) parietal area

LUNGS: CTAB 3 wheel adequate rise symmetric

CV: HRR, tachycardic wnl s1/s2

ABDO: Soft/NT/ND/0 mass abrasions (R) LQ

CHEST: Healing penetrating wounds (L) and (R) shoulder

BACK: Healing grazing wounds upper back no penetrating trauma

GU: 0 penetrating trauma

BUTTOCKS: 0 trauma

EXTREM: Penetrating wounds LE's feet BL hand & partial amputation (12) Rad Films

(12) CONTINUE ON SF 507 (IF NEEDED)

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 TREATMENT RECORD).

[redacted] B6-4

(b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

Transfer x-rays show (L) tibia/fib fracture

Case transitioned to orthopedic surgery at 1830.

(See Instructions on Back of this Sheet)

NSN 7540-01-025-6801

CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus toxoid immunization and other data)
Kidney problem w.e.f.

HISTORY OBTAINED FROM
☑ PATIENT ☐ OTHER (Specify)

ALLERGIES
Penicillin

TIME: 2034

HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

COMPLAINT(S): (Include symptom(s), duration)
Kidney stone

SEX: M AGE: 28

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

VITAL SIGNS

TIME	2056	
BP	146/85	
PULSE	76 (irr)	
RESP	14 (irr)	
TEMP	97.7	
PAIN	9/6	

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 2040

Pt. is 28 y/o pain right abdomen. Pt. States NAUSEA, HA, nausea,

2540 Iraqi detainee c/o R flank pain. Sent from Q ward for R/O kidney stone. (Dr Kennedy)
c/o mild N/. No D/. No f/c.
- Painful urination / burning
No V. Has hx calculus in R kidney, d/c'd by Iraqi doc - unknown meds. Similar hx/pain @ that time
c - unknown, d/c'd to ambulatory duty mm.
c. Neg d/u

2540 Iraqi detainee c/o R flank pain. Sent from Q ward for R/O kidney stone. (Dr Kennedy)
c/o mild N/. No D/. No f/c.
- Painful urination / burning
No V. Has hx calculus in R kidney, d/c'd by Iraqi doc - unknown meds. Similar hx/pain @ that time
c - unknown, d/c'd to ambulatory duty mm.
c. Neg d/u

ORDERS | INITS. | TIME

ORDERS	INITS.	TIME
Toradol 30mg IV	[redacted]	2045
EKG 12 lead		2045
CBC, chem 6, CK		2035
UA		2105
KUB (XR)		

ASSESSMENT/DIAGNOSIS
R flank pain (etiology unclear)

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): Dr. S. Kennedy
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED
TIME OF RELEASE: 2146

lungs - CTAB.
abd - soft, NT @ R side, no hsp, supra-umbilical NT @ CVA, no HSM
Guarding & heel tap
Minimal tenderness exam

1) Pain hx via translator, pt and benign exam c no or minimal abd pain. Pt hx of similar sxs in past d/t'd c kidney inflammation. Based on pt hx/exam, UA, labs, benign exam, functional etiology to pain. Highly unlikely appy based on exam, pt labs, benign exam

LPC - 13cc 1pm
PMH Inflammation of Kidneys
PSH ⊖

147	11.4	1.1
3.4		
165		191
	43	

UA ⊖ & blood 1.02c
KUB - NEG
Renal US NEG

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):

Iraqi [redacted] Bb-4

[redacted]

(b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

Return to medic @ detainee center for further problem.

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 273

(See instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL: DATE (DAY / MONTH / YR.) 7 Aug 09 — TIME 1900

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) 1C

CURRENT MEDS. (tetanus immunization and other data): None

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW (R) thigh

SEX: M — AGE: 25

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: on arrival

VITAL SIGNS

TIME	1913			
BP	136/62			
PULSE	76			
RESP.	18			
TEMP.	98.8°			
WT (Lbs)	198			

CATEGORY (See reverse)

- EMERGENT
- URGENT
- ☑ NON-URGENT

ORDERS	INITS.	TIME
CBC		
Tetanus booster if req		
Cipro 750mg PO		
Percocet 5/325 1-2 PO q4-6h PRN pain #20		

ASSESSMENT/DIAGNOSIS: GSW (R) THIGH

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): ORTHOPEDICS
  - EMERGENCY | TODAY
  - 72 HOURS | ☒ ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

- ☒ IMPROVED | UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1100

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

25y Iraqi ♂ detained brought in custody of MPs for evaluation of wound to (R) thigh sustained when shot by U.S. Soldier three days ago. Apparently cared for at Iraqi facility and brought to CSH for evaluation after arrival at detention facility. No fevers.

PMHx: Ø Meds: None

PSHx: Ø Allergies: NKDA

GENERAL: awake/Iraqi ♂/alert/interactive answers questions through interpreter

INTEG: warm + dry Ø rashes

HEENT: Unremarkable

LUNGS: CTAB's anterior

CV: RRR + (m) No s/s

ABDO: Soft/NTND/Ø mass

BACK: Ø penetrating trauma

PELVIS: Stable

EXTREM: GSW (R) thigh c proximal drainage/entry, posterior wound packed c fecal matter, sutures intact Ø drainage of pus or other signs infection Extensor function preserved distal NVX, ambulatory c antalgic gait.

A: NKDA
M: none
P: none
L: > Ø
E: smoke yes

Plain films femur — No fracture or FB

13.3 / 38.3 | 196

(CONTINUE ON SF 507, IF NEEDED)

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 TREATMENT RECORD).

[redacted] 4

SIGNATURE OF PROVIDER AND ID STAMP

(b)(6)-2

LTC, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

1. KEEP WOUNDS CLEAN, DRY, COVERED
2. DRESSING CHANGES DAILY
3. DISCHARGED ON Cipro 750mg PO BID x 7 days
4. Tylenol #3 1-2 tabs PO q4-6h PRN pain #20 tabs
5. SUTURE REMOVAL, WOUND REEVALUATION ORTHO CLINIC NEXT THURSDAY 7 AUG
6. SOONER REEVALUATION FOR SIGNS OF INFECTION

PREPARING AGENCY EMBLEM

STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 274

ACLU-RDI 1025 p.7

DOD 003401

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 21st CSH

LOG NUMBER

ARRIVAL DATE: DAY / MONTH / YR. TIME: 1245

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Unit

CURRENT MEDS. (Tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Mosul / Iraq

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Head wound

SEX: M AGE: 50

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: ON ARRIVAL

VITAL SIGNS

TIME	1247		
BP	156/91		
PULSE	95		
RESP.	16		
TEMP.	100.6		
WT. (Lbs)	176		

CATEGORY (See reverse)

- ☐ EMERGENT
- ☐ URGENT
- ☒ NON-URGENT

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

50% Iraqi civ. presents c head wound — ? blast inj vs assault. Also c/o R sided chest pain, both due to blast and assault.

50y male detained by U.S. personnel brought in custody of (b)(6)-2 (b)(3)-1 sustaining wounds in raid by US personnel. Patient reports he was kicked in face and assaulted by U.S. Soldiers. Also c/o HA, some dizziness and chest discomfort with deep breaths.

PMHx: Ø

PSxHx: Ø

Meds: None

Allergies: NKDA

Habits: Smokes cigarettes

Converse: Adult ♂ Local national w/ LMS answers questions appropriately through interpreter

Note: Warm + dry c rashes

HEENT: NC c 1cm laceration mid-forehead repaired/sutured c no evidence entrapment (L) > clear c SC hemorrhage and periorbital edema c ecchymosis c battle eyes c sclera anicteric PERRL's intact B/L c normal lid movements C-spine NT c FROM

Lungs: CTA B c exp wheeze R

CV: RRR c S1S2

Abd: Benign

Pelvis: Stable

Back: No penetrating trauma, abrasions

Extrem: Normal

Skin: Scattered abrasions c/w blast injury

Neuro: Alert c oriented x 3 c GCS 15 c PERRL c EOMI c no focal deficits

(Forehead laceration repaired c 4-0 nylon sutures)

(CONTINUE ON SF 507, IF NEEDED)

ASSESSMENT/DIAGNOSIS

(1) Forehead laceration

(2) Blunt facial trauma

ORDERS

ORDERS	INITS.	TIME
Full med records attention (L) wrist Bb-2 and Zygoma [redacted]		1425

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): Combat Support Hospital
- EMERGENCY / TODAY
- 72 HOURS / ☒ ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

- ☒ IMPROVED / UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1500

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 TREATMENT RECORD).

(b)(6)-2

Iraqi # [redacted] Bb-4

[redacted]

(Include medications ordered, any limitations and follow-up plans)

(1) Have sutures removed in 5 days

(2) Outpt. optical reevaluation if worsening pain, vomiting, or diplopia occurs

(3) Motrin 600 mg orally 3x/day as needed

(4) Keflex 250 mg 2 po 4x/day

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 275

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 21st CSH

LOG NUMBER

ARRIVAL — DATE: DAY 22 MONTH [illegible] YR [illegible] TIME 1600

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER (Specify) Private

CURRENT MEDS. (Tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☑ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Mosul, Iraq

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S): (Include symptom(s), duration): HA, Dizzy, poss. fever

SEX: M AGE: 25

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS			
TIME	1605	1855	1755
BP	135/85	87/54	87/58
PULSE	144	103	100
RESP.	20	16	16
TEMP.	96.2	97.1	101.0
WT. (KG/LB)	84/180	95%	95%

CATEGORY (See reverse)
- EMERGENT
- X URGENT
- NON-URGENT B6-2

ORDERS	INITS.	TIME
Motrin 800mg PO	[redacted]	1610
Cipro 500mg PO	[redacted]	1610
CBC, ISTAT+, CR, UA	[redacted]	1610
Motrin 800mg PO	[redacted]	1612
ADD FLUIDS AS INDICATED		
ORDERS CONTINUED →		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 1700

25 y/o Iraqi Detainee 70 HA, Dizziness, poss. fever. x1wk ago

Hx as above. 25y Iraqi DT detainee brought for evaluation of HA, fevers, myalgias and lightheadedness. Onset sx yesterday. Took unknown antipyretic. Hx of N/V/D cough or dyspnea.

1845
T=100.7
P=99
R=16
BP 134/76
96%

PMHx: Ø
Meds: Unknown antipyretic
PSHx: Ø

Allergies: NKDA
Habits: Recently quit smoking

Ibuprofen 25mg PO

GENERAL: conv w/s/(1)agi Ø/toxic/tired o/pacing
NOTE: Marked displeasure to ROS
HEENT: MMM/pink/supple/no meningismus
PERRL/anicteric/clear
Nares patent + DC
OM clear x2/Throat clear
TMs retract B/L c normal landmarks
LUNGS: CTAB x 4 w/E/R
CV: RRR x (4) nl S1/S2
ABD: Soft/NT/ND/Ø masses
Extremities: Ø edema

6.0	17.2	115	177	106
	152.9		3.7	

9
100
1.4

HA-36: 1-020
Ø glucose
Ø ketone
Ø blood
Ø nit
Ø LE

(CONTINUE ON SF 507, IF NEEDED)

DISPOSITION (Check all that apply)
- HOME — FULL DUTY
- QUARTERS — 24 Hrs. X 48 Hrs. 72 Hrs.
- MODIFIED DUTY UNTIL: DAY MONTH YEAR
- REFERRED TO (Indicate clinic): DETAINEE MEDICAL
- EMERGENCY — TODAY
- 72 HOURS — X ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE
- CONDITION UPON RELEASE: X IMPROVED — UNCHANGED — DETERIORATED
- TIME OF RELEASE: 1845

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 TREATMENT RECORD)

[redacted] B6-4

SIGNATURE OF PROVIDER AND ID STAMP (b)(6)-2 LT, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans):
1. DRINK PLENTY OF FLUIDS
2. MOTRIN 800mg 3x/day as needed
3. TYLENOL 325mg 2 tabs every 4-6 hours
4. SEEK RECURRENCE OF DISEASE, NOT IMPROVING WITHIN 72 HOURS

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 276

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): 21CSH- Mosul, Iraq

LOG NUMBER:

ARRIVAL — DATE: DAY 25 | MONTH 08 | YR. 03 — TIME: 1900

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): Vivaxine injections PCN TyTox

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: Ø

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): s/p blast multiple injuries/ (L) arm partial amputation

SEX: M AGE: 34

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1903

VITAL SIGNS

TIME	1905		
BP	125/86		
PULSE	130		
RESP.	22		
TEMP.	101.4 (D)		
WT. (Lbs)	95		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

34 yo Iraqi male EPW received from Mosul Hospital. Was wearing a backpack with an explosive in it yesterday. The explosive detonated. (L) arm partial amputee - mentally

PMHx: Disc prolapse in back

PSHx: Ø

LastMeal: Today 1200hrs

S: as above.

Blast injury 24 hrs ago.

Tx'd @ Iraqi facility

UA: Large blood 1.030

13 | 9 | 222 | 29

ID'd injuries: (L) femur fx

(L) arm/forearm amputation

(L) thigh ST injury

(4) MFWs: MFWs - (B) fact (L) tib fx

127 | 104 | 18 | 4.0 | 21 | 9.9

EKG 1305

CATEGORY (See reverse)

EMERGENT	
URGENT	
NON-URGENT	B6-2

ORDERS	INITS.	TIME
IVF 2L LR	[redacted]	1915
CBC, Chem 6, Ca		1935
T+S		1935
Pain + 6m		1940

ASSESSMENT/DIAGNOSIS

(L) (L) femur fx c massive soft tissue defect/avulsion

(L) forearm amputation

73) Traumatic injury NOS

C - Alert. GCS 15. Airway intact

CC - tachy

lungs - (B) crm

abd - s/nt ↓ sprains

GU ↓ several trauma

perineal abrasions

(L) foot pulses

(L) femur - marrow st decreasing at thigh c exposure of quad

Intact DP - 2+ pulse. MFWs - foot

(L) forearm - wrist disarticulation

(L) thigh

abd s/nt/nd burns to lower abd

pelvis - stable

back - atraumatic

XR

(L) wrist/forearm traumatic amp @ wrist (4) FB

(L) femur - comminuted mid shaft fx

(L) tib/fib - MF ↓ of fx

(4) (B) foot - multiple small frags ↓ fx

(L) pelvis - ↓ fx

(4) penile FB

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: OR → ICU

CONDITION UPON RELEASE

IMPROVED	UNCHANGED
DETERIORATED	

TIME OF RELEASE: 2122

(CONTINUE ON SF 507, IF NEEDED)

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: ASK) FACILITY HOLDING TREAT. PATIENT RECORD).

Iraqi # [redacted] B6-4 EPW

[redacted]

SIGNATURE OF PERSON MAKING ENTRIES: (b)(6)-2

INITIALS:

MAT, MC

(Include medications ordered, any limitations and follow-up plans)

Tetanus c antitox

IVF - given - 2 L NS

HR ↓ to 110s

MEDCOM - 277 ENT STANDARD FORM 558 (Rev. 6-82)

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21st CSH (FWD)

LOG NUMBER

ARRIVAL — DATE: DAY 21 | MONTH 6 | YR. 03 — TIME: 1912

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Walk-in

CURRENT MEDS. (tetanus immunization and other data): 0

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Mosul Iraq

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S): (Include symptom(s), duration): Swelling R hand 2nd digit

SEX: Male | AGE: 21

POSSIBLE THIRD PARTY PAYER? ☐ YES ☒ NO

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	1930		
BP	134/65		
PULSE	94		
RESP.	16		
TEMP.	100.9		
WT. (Kg)	98 1/2		

CATEGORY (See reverse)

- ☐ EMERGENT
- ☐ URGENT
- ☒ NON-URGENT

ORDERS	INITS.	TIME

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

S: 21 y/o ♂ c/o swelling 2nd digit of R hand — Sgt [illegible]

PMH: 0
PSH: 0
Smoker (+)

Admitted

See SF 539

ASSESSMENT/DIAGNOSIS: Fever

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

CONDITION UPON RELEASE

- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

DATE OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

PATIENTS IDENTIFICATION (Mechanical imprint)

WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; service status; name and relation of sponsor or next of kin

(IMPORTANT: LIST FACILITY HOLDING TREAT— RECORD)

[redacted] B6-4

(b)(6)-4

(b)(6)-2

SIGNATURE OF PROVIDER AND ID STAMP

etc, etc

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (R...

MEDCOM - 278

SSR-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): 71st CSH

LOG NUMBER:

ARRIVAL — DATE: DAY 30, MONTH NOV, YR 03 — TIME: 2045

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): ∅

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: ∅

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): Unable to Urinate

SEX: M AGE: 63

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	2056	2200
BP	207/113	165/92
PULSE	67	61
RESP	20	20
TEMP	98.3°	97.9°
WEIGHT	214	216

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS — INITS — TIME

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 2045

63 yo M c hx urinary retention. Seen here 9 days ago for same. Had foley placed + removed c 400cc UOP. Pt states he has only been able to urinate very small amounts over past 3 d. Tonight + pain lower abdomen. No dysuria. No fc or systemic sxs. Rec'd 1 PRN, no CP/SOB/HA

No other Rx

ASSESSMENT/DIAGNOSIS: Retention

Guaiac cards (A) Prostate

CN 2 thru 12 intact

CV (2/2) RRR no M/R/G

lungs - clear (B) equal BL

abd - soft, NT, ND, +BS, no HSM, no masses

CVA - no tenderness

rectal - no tenderness, prostate 40gm, no nodules

neuro - AOx3, normal

147 / 4.1 / 166 / 24 / 45 / 9.2

UA, UO30

EKG, CXR

Eblood

DISPOSITION (Check all that apply)
☐ HOME QC ☐ FULL DUTY
QUARTERS
☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: MONTH ____ YEAR ____
☐ REFERRED TO (Indicate clinic)
☐ EMERGENCY ☐ TODAY
☐ 24 HOURS ☐ ROUTINE
☐ ADM. TO HOSP. UNIT/SERVICE

ED course - foley placed x 1000cc dark urine out. Will replace foley in. Will rx for suburethral prostatitis + start α blocker

(CONTINUE ON SF 507, IF NEEDED)

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
DATE/TIME OF RELEASE:

PATIENT'S IDENTIFICATION (Mechanical imprint)
WRITTEN ENTRIES GIVE: Name - last, first, middle; Home/service unit; Name and relation of sponsor or next of kin
IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD)

[redacted] B6-4

[redacted]

S(b)(6)-2

WAT, MC

INSTRUCTIONS (Include medications ordered, any limitations and follow-up plans)

Keflex / Levaquin

Foley catheter in place until Tuesday.

Go to Urology (Specialty Clinic)

EMERGENCY CARE AND TREATMENT

STANDARD FORM

Prescribed by GSA

MEDCOM - 279

ACLU-RDI 1025 p.12

DOD 003406

6

(See Instructions on Back of this Sheet)

558-103

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 20th CSH "N"

LOG NUMBER

ARRIVAL — DATE: DAY 27, MONTH 08, YR. 03; TIME: 0028

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) MPs

CURRENT MEDS. (tetanus immunization and other data): NKDA

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): S - Pain in abdomin, Cant urinate

SEX: M AGE: 63

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0130

VITAL SIGNS

TIME	0028	0135		
BP	185/88	170/98		
PULSE	96	63		
RESP.	14			
TEMP.	100.3			
WT. (Est)	97%	90%		

CATEGORY (See reverse)

☐ EMERGENT
☒ URGENT
☐ NON-URGENT B6-2

ORDERS	INITS.	TIME
[redacted]		
[redacted]		0038
[redacted]		
[redacted]		
[redacted]		

ASSESSMENT/DIAGNOSIS: Urinary retention

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

PT 63 YO (M) stating that he has a pain in his abdomin and can't urinate. Pain when trying to urinate.

63y male of detained Strength by MPs c/o suprapubic discomfort and inability to void. Also c/o urinary symptoms, fevers or abdominal pain since prior similar problems.

PMHx: Ø meds: none

PSHx: Ø Allergies: NKDA

GENERAL: WNWD/Adult of NAD/AAOx3 answers questions appropriately through translator

HEENT: Unremarkable

LUNGS: CTAB & WNL

CV: RRR & (M) no s/s/s2

ABD: soft/NT/ND/Ø mass

EXTREM: Ø edema

GU: NL Ø/testes WNL Ø mass

RECT: Prostate NOT enlarged/NT

(14.5) 16.6 / 50.9 (254) 144 / 110 / 4.2 / 17 / 11.8 / 1.3

UA - SG - 1.024
Ø glucose Ø ketone trace
trace blood Ø nit Ø LE
0-5 WBC/0-5 RBC

ED called IV started
NS 500 bolus c/o discomfort, palpable bladder distension
Foley placed, 400 cc urine obtained. No resistance to foley

(CONTINUE ON SF 507, IF NEEDED)

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): Urol

☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☒ ROUTINE

ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 0200

PATIENT IDENTIFICATION (Mechanical imprint)

TYPED OR PRINTED ENTRIES GIVE: Name - last, first, middle; DOB; service status; name and relation of sponsor or next of kin

IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD

(b)(6)-2

[redacted]

(b)(6)-4

B6-4

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

Impression: Urinary retention, ? BPH
no evidence of acute prostatitis, urine clear, prostate not enlarged. No pyuria/leukocytosis. Foley removed, patient instructions to return for

MEDCOM - 280 REATMENT

STANDARD FORM 558

ACLU-RDI 1025 p.13

DOD 003407

B6-4

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

Last (b)(6)-4	# 200 Detainee	UNIT Detainee	RANK —	SSN [redacted]	
Physician: (b)(6)-2	Ward: 3MT	STAT / Routine	Date and Time: 8/22/03 0040	Reported by: (b)(6)-2	Date and Time: 23/8/03 0135

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	144	128-145 mmol/L
	K	4.2	3.3-4.7 mmol/L
	Cl	110	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	17	7-22 mg/dL
	Glu	118	73-118 mg/dL
	Creat	1.3	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color	Yellow	Straw/Yellow
Clarity	Clear	Clear
Glucose	Neg	Negative
Bilirubin	Neg	Negative
Ketone	trace	Negative
SG	1.024	1.010-1.025
Blood	trace-lysed	Negative
pH	5.5	5.0-8.0
Protein	trace	Negative-Trace
Urobili	Neg	Negative
Nitrite	Neg	Negative
Leuko	Neg	Negative

Urine Microscopic

WBC	6-5	Epi	5-10 RARE
RBC	0-5	Mucus	HEAVY
Bacteria	LIGHT	Yeast	
Casts:			
Crystals:			
Other:			
Other:			

Chemistry (Ricco lo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	14.5	4.8-10.8 x10(3)/uL
	RBC	5.82	4.2-6.1 x10(6)/uL
	Hgb	16.6	12.0-18.0 g/dL
	Hct	50.9	35.0-60.0%
	MCV	87.5	80.0-99.0 fl
	MCH	28.5	27.0-31.0 pg
	MCHC	32.6	33.0-37.0 g/dL
	Plt	234	130-400 x10(3)/uL
	LY%	11.8	15.0-55.0%
	LY#	1.7	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

558-103 (See Instructions on Back of the Sheet) NSN 7540-01-075-37

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21ST CSH MASH IRAQ

LOG NUMBER

ARRIVAL: DATE: DAY 28, MONTH Aug, YR 03; TIME: 1445

TRANSPORTATION TO HOSPITAL (If each care provider sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): NONE

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify) MASH STAFF

ALLERGIES: Sulfa

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): FT CAMPBELL, KY

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration): PT in c/o abd cramps

SEX: M AGE: 42

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: On arrival

VITAL SIGNS			
TIME	1445	1555	
BP	117/74	104/36	
PULSE	117	110	
RESP.	32	24	
TEMP.	96.0		
WT. (Lbs)	99	99	

CATEGORY (See reverse)
- EMERGENT
- URGENT — Cat I
- NON-URGENT — B6-2

ORDERS	INITS.	TIME
Lytes, 6+12 CBC		1510
Flutter Bolus		1540
Valium 2.5mg IV		1520
CXR		1600
NPO, TKO		1545

ASSESSMENT/DIAGNOSIS: Renal insufficiency

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: ICU2
- CONDITION UPON RELEASE: IMPROVED / UNCHANGED / DETERIORATED
- TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

- This Iraqi EPW c/o ~~dx~~ a 15-18 hr h/o malaise and diffuse muscle cramps. Today the cramps became markedly more severity and he was brought in by EMT. He reports having drunk 4 bottles of H2O today and urinated ~~2-3~~ 2-3 times. ⊕ subjective fevers, ⊕ recent cough, ⊖ diarrhea, ⊖ N/V, ⊖ hematuria. Also BM this morning (very) constipation and straining during BM.

PMH ⊖
PSH ⊖
TOB 1/2 ppd
ETOH Smoke
LOI - OTC

EXAM: HEENT, PERRL, EOMI, OP clear. CV: RRR, S1, S2, ⊖ murmurs. Pulm: CTA ⓑ. Abd: soft, diffusely tender, NABS. Ext: ⊖ C/C/E

LAB/XRay: 131 | 97 | 39 | 170 | 3.6 | 21K | 22.6 | 340 | 55.6 | Ca 1.05

Chest: ⊖ effusion, cardiomegaly, acute infiltrative process.

Imp/Plan: Acute renal insufficiency - likely pre-renal given his confinement outdoors, evidence of hemoconcentration, and ↑ BUN/Cr ratio. Admit to ICU for IV hydration, monitoring of UOP, renal fcn. D/W Dr. Mendragon.

(CONTINUE ON SF 507, IF NEEDED)

RECIPIENT'S IDENTIFICATION (Mechanical imprint) OR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; branch of service; status; name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4 [redacted] B6-4

(b)(6)-4 [redacted]

SIGNATURE OF PROVIDER AND ID STAMP: (b)(6)-2 MD (b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) 21st CSH (b)(3)-1

LOG NUMBER

ARRIVAL
DATE: DAY 1 | MONTH Oct | YR. 03 | TIME 1413

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS: (Tetanus immunization and other data) ~~NKA~~ Asthma med "ventol"

HISTORY OBTAINED FROM: ☑ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration): ASTHMA

SEX: M | AGE: 39

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	1420		
BP	123/92		
PULSE	107		
RESP.	14		
TEMP.	99.5		
WT. (Child)	170		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 1430

Pt 39 y/o states he had trouble breathing while HA. Pt. also states he had nose bleed. He took an inhaler around 1200. Pt. states he felt better after dose.

39 y male ♂, in US custody brought by MP's for evaluation of asthma. Through translator, individual reports that he was recently treated (about 5d ago) for asthma exacerbation with ventolin/aminophylline/steroids and oral prednisone. Has used ventolin MDI as needed in past, uses 5min 2 to multiple times per day. Denies prior hospitalizations for asthma - passibly with ICU stay and intubation.

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☑ NON-URGENT — 86-2

ORDERS	INITS.	TIME
Albuterol neb x1	[redacted]	1445
Albuterol neb x2	[redacted]	1500

ASSESSMENT/DIAGNOSIS: ASTHMA EXACERBATION

Past Hx: Asthma (chronic, mild)

Plan: nasal surgery, consult ENT

Meds: Ventolin MDI, Aminophylline, Keflex, Prednisone

Allergies: NKDA

Hx of: Abscess

Pt. is A&Ox3, NAD, resp unlabored, speaks in complete sentences

Lungs: CTA b/l, no w/r/r

Abd: soft, NT/ND, +BS, no mass

Ext: no edema

Plan: CXR - pending

Long discussion with pt. regarding importance of compliance with medications and follow-up with PCP. Pt. verbalized understanding.

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): Ward Medicine
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☑ ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE:
- CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED
- TIME OF RELEASE: 1430

(CONTINUE ON SF 507, IF NEEDED)

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 TREATMENT RECORD).

(b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

1. Albuterol MDI - two puffs from ___ times per day as needed
2. Fluticasone (44mcg) - two puffs from ___ times per day
3. Discontinue all other medications

86-4

(b)(6)-4

MEDCOM - 283 STANDARD FORM 558

ACLU-RDI 1025 p.16

DOD 003410

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 2ld CSH

LOG NUMBER

ARRIVAL
DATE: DAY 01 MONTH 09 YR. 03 TIME 1413

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data)
Valium (Request 1) Ativan

HISTORY OBTAINED FROM
☒ PATIENT ☐ OTHER (Specify)

ALLERGIES
NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)
Mosul, Iraq

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)
Anxiety problems

SEX 3.7 AGE M

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

VITAL SIGNS

TIME	1416		
BP	125/75		
PULSE	116		
RESP.	20		
TEMP.	99.9		
WT. (Lbs)	96.96		

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS | INITS. | TIME
Ativan 1gm po

ASSESSMENT/DIAGNOSIS
Anxiety

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER
1445

37 y/o Iraqi Civilian c/o anxiety problems — KAL 9/6
37y IZRI DETAINEE brought by MPs for evaluation of problems with anxiety. Individual reports onset anxiety problems following injuries sustained in operation Iraqi Freedom. Prescribed various benzodiazapines at some point by host nation physician, now in custody and presents to unit requesting medical intervention to secure release.
PX- Ativan
PSx- Biopsy 9/4
Tob.- 0
Etc.- Gym, 31 Aug 03
PMHx: 0 Meds: Diazepam Lorazepam Unknown medicine
Masters Nonsmoker
PSxHx: Hemorrhoidectomy Allergies: NKDA
Gen Appr: Anxious & in NAD/AAOx3/pleasant & cooperative Speaks in English
Vitals: Conv + dry 0 rashes
Neuro: Unremarkable
Extrem: CTAB S w/R/R
CV: NRR S (1+) rad 2+/2
Abdo: Soft/NT/ND/+BS/0 mass
Extrem: 0 edema

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)
Mental Hygiene
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☒ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☐ IMPROVED ☒ UNCHANGED ☐ DETERIORATED
TIME OF RELEASE: 1500

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREAT. PATIENT RECORD).

[redacted] B6-4

(b)(6)-2 [redacted]

(b)(6)-4 [redacted]

15 Mar. 65

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)
1. RETURN TO DETENTION
2. RECOMMENDS USE OF MEDICATIONS PREVIOUSLY PRESCRIBED, BUT WILL NOT REFILL MEDS AT CSH
3. DISPOSITION TO MP CUSTODY

EMERGENCY CARE AND TREATMENT STANDARD FORM 558

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL
DATE: DAY 4 | MONTH 00 | YR. 03 | TIME 2136

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data)
Ibprax

HISTORY OBTAINED FROM
☐ PATIENT ☐ OTHER (Specify)

ALLERGIES
NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)
Avilan

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)
Stomach Pain

SEX: M | AGE: 12

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

TIME SEEN BY PROVIDER
2144 7131

VITAL SIGNS

TIME	0135		
BP	124/75		
PULSE	91		
RESP.	18		
TEMP.	98.1		
WT. (Lbs)	120		

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☑ NON-URGENT

ORDERS	INITS.	TIME

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

1740 Epw c/o abd pain.
Hx of chronic abd pain x 7 yrs.
usually at times of stress
Tonight began with ago.
No dysuria. No F/C.
Pain c/s wandering.

P/E
Chronic abd pain
S/E

abd - soft
No tenderness
No rebound
No guarding
Exam otherwise

A - Likely GERD by hx + exam
No evidence of significant pain on exam now.

(CONTINUE ON SF 507 IF NEEDED)

ASSESSMENT/DIAGNOSIS
abdominal pain

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)
EPW MEDIC
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☑ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☑ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 2144

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 TREATMENT RECORD)

[redacted] Detainee B6-4

[redacted]

b(6)-2

(Include medications ordered, duty limitations and follow-up plans)

Ranitidine
Drink plenty of fluids

MEDCOM - 285 TMENT STANDARD FORM 558 (Rev. 6-82)

1

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL: DATE (DAY 07, MONTH JUN, YR 03) TIME 1825

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): Q

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: PCN

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Detainee

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Dehydration

SEX: M AGE: 38

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: On arrival

VITAL SIGNS

TIME	1833		
BP	140/92		
PULSE	101		
RESP.	44		
TEMP.	100.2		
WT. (Child)	98%		

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT B6-2

ORDERS	INITS.	TIME
Macrobid PO	[redacted]	1830
CBC, Diff, CMP		1830
UA		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Pt recieved 1500 cc NS @ admission @ EFW Camp

PMH - Ø
PSH - Ø
IDB - Ø
ETOH - Ø

D/W Dr. (b)(6)-2
Admitted
See SF 539

9.3 / 16.2 / 285 / 140 / 108 / 2 / 101
50.2 / 2.3 / 1.0

ASSESSMENT/DIAGNOSIS: Vertigo

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

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED
- TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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 TREATMENT RECORD):

ISN US # [redacted] Iraqi Detainee B6-4

(b)(6)-4

(b)(6)-2 CRC, RN

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans).

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): 21CSH Mosul

LOG NUMBER:

ARRIVAL — DATE: DAY 10 MONTH 09 YR 03; TIME: 1412

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): Glibsyn 2, Captopril 25

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Iraqi Civilian

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration):

SEX: M AGE: 59

POSSIBLE THIRD PARTY PAYER: ☐ YES ☐ NO

TIME SEEN BY PROVIDER: ON ARRIVAL

VITAL SIGNS

TIME	1414	1630	1815
BP	173/95	148/77	134/73
PULSE	124	117	109
RESP.	28	24	20
TEMP.	100.0	98.5	100.4
WT.(Child)	95	94%	96%

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☒ NON-URGENT B6-2

ORDERS	INITS.	TIME
1L IVF BOLUS	[redacted]	1420
CBC/chem/LFT/CK		1420
CXR		1610
Repeat CK 2 hours		1630
2nd 1L IVF		
Foley cath/UA/UCx		

ASSESSMENT/DIAGNOSIS
1. Rhabdomyolysis
2. Dehydration
3. Acute renal failure

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): Detention/CMT
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☒ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE: 1830

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

59y IRAQI 3RD DETAINEE brought from detention area p collapsing while waiting for interrogation. MP escorts upon that detainee forced to stand for extensive period as preparation for interrogation. No LOC, but detainee h/o DM2, hypertension and asthma, prompting MP's to bring him to CSH for evaluation. Through translator, obtained H/P: no recent illness, has supply of medications with him.

PMHx: DM2 (on glibenclamide and hypoglycemics), HTN, Asthma. PSxHx: Ø. Meds: Captopril, Glibenclamide, ? long acting steroid (for asthma). Allergies: NKDA

GENERAL: WN/WD Iraqi 3RD MP/detainee, answers questions appropriately thru interpreter
INTEG: warm + dry, Ø rashes
NECK: supple, Ø nodes
PERL/EOMI/sclera clear
Nares patent
Oral mucosa/throat clear, TMs obscured by cerumen
LUNGS: CTAB, no wheezes
CV: RRR, (no) m/r/g
ABD: soft/NT/ND/(+) BS, Ø masses
EXTREM: Ø edema/cords/tenderness, Homan's negative
NEURO: non-focal

(CONTINUE ON SF 507, IF NEEDED)

PMHx: DM2, HTN, Asthma
PSHx: -
Smoker: -
Lia: -

15.2 / 50.7 (7.4 / 30.4 / 5.3) 138 | 106 | 16 / 245 / 1.2
UA - SG = 1.020, Glucose ≥ 2000, 3 large blood, Ø nit, Ø LE, 0-5 WBC, 0-5 RBC
repeat chem 5 2500cc IVF
179 | 105 | 12 / 4.0 / 14.5 / 1.1 | 16 / 48

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 TREATMENT RECORD).

[redacted]
Pvt SSN [redacted]
B6-4

EPW

SIGNATURE OF PROVIDER AND (b)(6)-2 STAMP: LTC, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans):
CONTINUE MEDICATIONS AS PRESCRIBED
DRINK PLENTY OF WATER
AVOID SUGAR, HIGH CARBOHYDRATE MEAL CONSUMPTION

SF 558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): 21ST CSA

LOG NUMBER:

ARRIVAL — DATE: DAY 15 Sep, MONTH 03, YR. ; TIME: 1425

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) EPW

CURRENT MEDS. (Tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Detainee

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): fever, chills, +/A

SEX: M AGE: 23

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 2000 AW

VITAL SIGNS		
TIME	1830	2010
BP	131/85	118/65
PULSE	120	92
RESP.	16	16
TEMP.	103.6	101.9
WT. (Lbs)	145	98%

CATEGORY (See reverse): ☐ EMERGENT ☐ URGENT ☒ NON-URGENT B6-2

ORDERS	INITS.	TIME
ISHT 6 Cx	[redacted]	1840
CBC UA		1840
2L Bolus IV		
Motrin 800mg PO		1905

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

(S) T_o >24° (R) facial HA, chills, ± nausea, ØemesisØ, ↓ PO intake, malaise & myalgias ØUOP today noted. C/O ↓BP x 1 day. (+) Sens. Ø chills at BMTS, Dry cough, sinus drainage, non-productive. ØCP/SOB. Abd pain.

AMH Ø Meds Ø NKDA

(O) T_max febrile, tachy, normotensive. HEENT - Op clear ± exudate/erythema. WNL sclerae (B) ECRJ, WNL thyroid. ØNeck stiffness, A to x 4. Lungs - CTA (B) ± W/R/R. CV - Tachy, WNL S_1 + S_2 (M). Back - ØCVAT/flank tend. Mild

FH - NC

ECG - NSR, sinus tach, WNL intervals

9.9 / 5.1 / 191

1.38 | 103 | 12 / 3.4 | 1.4 | 137

UA - 1025, 6.5, 1+ LE, 1+ Esc, 5-10 WBC, 1-4 RBC

ASSESSMENT/DIAGNOSIS: Viral Syndrome; Mild Dehydration

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): Sick call

☐ EMERGENCY ☐ TODAY ☐ 72 HOURS ☐ ROUTINE

ADMIT TO HOSP. UNIT/SERVICE:

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

DATE OF RELEASE:

PERSONS IDENTIFICATION (Mechanical imprint). IF WRITTEN ENTRIES GIVE: Name - last, first, middle; DOD service, status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREAT. RECORD)

[redacted] B6-4

(b)(6)-2

(b)(6)-4

TREATMENT (Include medications ordered, any limitations and follow-up plans):

- Motrin 800 Ø PO TID PRN
- Increase oral fluid intake
- Return to routine sick call if no better in 2-3 days or if not improving regularly.

EMERGENCY CARE AND TREATMENT

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): 21st CSH - North

LOG NUMBER:

ARRIVAL — DATE: DAY 18 | MONTH Sep | YR 03 | TIME 2000

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) walk in

CURRENT MEDS. (tetanus immunization and other data): Oral diabetes med. ASA NTG x3 today @ 1800 [illegible]

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): Chest pain radiating to neck SOB

SEX: Male

AGE: 58 DOB

POSSIBLE THIRD PARTY PAYER? ☐ YES ☒ NO

TIME SEEN BY PROVIDER: 2010

VITAL SIGNS

TIME	2005	2115	2145
BP	144/88	133/77	127/82
PULSE	75	65	65
RESP.	28	20	18
TEMP.	97.2		
WT. (Clin)	96.1 kg		198 lbs

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT B6-2

ORDERS

ORDERS	INITS.	TIME
NTG x1	[redacted]	2030
[illegible]		2016
[illegible]		2040
[illegible]		2020
[illegible]		P 135/71
[illegible]		P 130/
[illegible]		P 126/72

ASSESSMENT/DIAGNOSIS: Chest pain, R/o MI

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
CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

19 SEP 03

58 y/o EPW Potus brought to ER by MPs, pt. states c/p that began earlier today, radiating to neck & SOB with it. states pain 9/10. Pt. NAOx3, skin W/D/Y, NAD.

PMH - Diabetes MI x5
PSH - Angiocath 4-5-2001

S- 58 yo c/p known hx CAD (s/p cath x 7, PTCA x 1 of LAD) presents c O on original pattern. Pt has hx daily angina relieved by SL NTG. Today had pain since ~1700 not relieved c SL NTG x 1. 1st episode of pain today). Presents c detainee (since today). Patients c full medical records with them.

P/
CAD s/p PTC
DM
HTN
↑ chol.

S/
PTCA

c wdwn, d duties
neck & JVD
lungs: c/a/b, crackles
CV: Reg rhythm
abd - S/NT/ND
neuro - Alert & oriented.

That —

GCU - 233
135 | 104 | 13
U.C. 25 0.7
78 / 50 CR
CK - 176

EKG - No acute ischemic Δs
CXR -

EDC - Pain free c NTG SL x1 and MSO4 + depressor. Although no EKG Δs, will admit for R/o MI.
That

GRADERS
Levaquin 750mg PO DJN 2110
NTG paste 2in. DJN 2112

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint). FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SS#, DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

[redacted] B6-4

SI (b)(6)-2

MP MM1 MC

IN[illegible] TREATMENT (Include medications ordered, any limitations and follow-up plans)

Admit

(b)(6)-4

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 23 MONTH 9 YR. 03 — TIME: 1850

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): Cardiac meds

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration): Tightness of chest x 24 hrs

SEX: M AGE: 58

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1850

VITAL SIGNS

TIME	1850	2010
BP	129/77	119/73
PULSE	71	80
RESP.	13	16
TEMP.	97.1	98.1
PAT. (Oral)	96	good

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

58 y/o M presents to EMT c c/o CP, abd discomfort that began yesterday after eating. Pain 7/10 to chest, A&Ox3, ambulatory, [illegible]

S - Same as known hx CAD (SP PTCA + recent MI) presents to ED c/o chronic CP today, consistent SSCP (tightness since yesterday afternoon (unchanged)). Nausea (+) N, vomiting (unchanged). To ED today, pt. Recent admit to CMT for NSTEMI (neg trops, dc to FMC complete). Pt has been taking meds given. No SOB / cough. No fevers. No abd pain (N+D only). [illegible]

O - WDWN, ↓ distress.
HEENT - [illegible]
Neck - ↓ JVD
CV - Rg / ↓ m
Lungs - CTAB ↓ wheezes
Abd - SNT/ND ↓ guarding
Ext - ↓ edema
Neuro - AOx3, GCS 15

A - Sxs c/w probable NSTEMI. Chest tightness resolving s pt. c PTCA / known CAD, hemodynamically stable, trop P >12 hrs CP, no acute ischaemic changes on ECGs. Hydrated in ED. Labs c/w mild dehydration. Will f/u labs, Rg/u pm. No indication ? for antibiotic therapy. Effects given c/o.

P - [illegible]

(CONTINUE ON SF 507, IF NEEDED)

CATEGORY (See reverse)
EMERGENT
URGENT B6-2
NON-URGENT

ORDERS | UNITS | TIME

DISPOSITION (Check all that apply)
HOME — Pt. Ref. to Sick Call
QUARTERS — 24 Hrs. — 48 Hrs. — 72 Hrs.
MODIFIED DUTY UNTIL: DAY — MONTH — YEAR
REFERRED TO (Indicate clinic): FMC
EMERGENCY — ROUTINE
72 HOURS
ADMIT TO HOSP. UNIT — SERVICE
CONDITION UPON RELEASE
IMPROVED — UNCHANGED
DETERIORATED
TIME OF RELEASE: 1900

PATIENT'S IDENTIFICATION (Mechanical imprint). FOR WRITTEN ENTRIES GIVE: Name (last, first, middle); SSN; DOB; service (state); name and relation of sponsor or next of kin. IMPORTANT - PUT PATIENT'S HOLDING/TREAT-MENT RECORD:

[redacted] B6-4

(b)(6)-4

(b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

Drink plenty of fluids. Continue all current medications. Start Benzonatate for cough. Return as needed for worse[illegible]. Return if worsening symptoms or [illegible]

MEDCOM - 290

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21st CSH

LOG NUMBER:

ARRIVAL — DATE: DAY 18 MONTH 09 YR. — TIME: 2210

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) walk in

CURRENT MEDS: (Tetanus immunization and other data) None

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): Multiple abrasions lacerations

SEX: M AGE: 27

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 2215

VITAL SIGNS

TIME	1710		
BP	110/72		
PULSE	100		
RESP.	16		
TEMP.	98.1°		
WEIGHT	170 lb		

CATEGORY (See reverse)

- EMERGENT
- URGENT
- ☒ NON-URGENT

ORDERS	INITS.	TIME
CXR		

ASSESSMENT/DIAGNOSIS: multiple lacs + abrasions

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

27 yo ♂ c/o (R) rib pain throbs, increased pain w/ breathing, laceration (L) eyebrow, laceration to post head — Amanda Cact, 91W

PMH: none
smoke: yes

27 y/o c/p s/p physical assault. Unclear exact mechanism of injury. Pt is A&Ox3, c/o multiple [illegible] Brought by MPs to get checked out. Unknown LOC

P/E

Ambulatory

S/E

(+) smoke

c - wbar & dilute

MSCNT - 2x lacs c 7cm of scalp c full recon. & HP

CXR

CT/Lungs - B = BS, CTH

Window

Chest - HP inf c/s of crepits

FAST

Abd - S/NT/ND & hsm

Ext - multiple abrasions/contusions

& FREE FLUID

TDC — Wounds deemed [illegible] Tetanus is current — Refer to ENT in 1 wk for sutured LS

(CONTINUE ON SF 507, IF NEEDED)

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): Ortho
- EMERGENCY / TODAY
- 72 HOURS / ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

- IMPROVED / UNCHANGED
- HOSPITALIZED
- DEATH

TIME RELEASE: 2340

PATIENT IDENTIFICATION (Mechanical imprint) WRITTEN ENTRIES GIVE: Name - last, first, middle; Rank or service status, name and relation of sponsor or next of kin. IMPORTANT - LIST FACILITY HOLDING TREAT. RECORDS

[redacted]

B6-4

SIGN (b)(6)-4

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

Tylenol for pain

Staples removed in 10 days

Return for signs of infection

MEDCOM - 291 TMENT STANDARD FORM 558 (Rev. 6-82)

4

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 21st CSH

LOG NUMBER

ARRIVAL
DATE: DAY 1 | MONTH Sep | YR 03
TIME: 2305

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data)

HISTORY OBTAINED FROM
☑ PATIENT ☐ OTHER (Specify)

ALLERGIES
NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration)
ABD Pain

SEX: M | AGE: 53

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

VITAL SIGNS

TIME	2307		
BP	126/84		
PULSE	83		
RESP.	20		
TEMP.	98.6		
PULSE OX. (Circle)	97%		

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT B6-2

ORDERS	INITS.	TIME
CXR		
CBC		

ASSESSMENT/DIAGNOSIS
Contusions/abd

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)
ER
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
PERMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE: 1345

PATIENT'S IDENTIFICATION (Mechanical imprint)
IN WRITTEN ENTRIES GIVE: Name, last, first, middle; grade, service status, name and relation of sponsor or next of kin.
IMPORTANT: LIST FACILITY HOLDING TREAT. RECORD.

B6-4

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 2337

53 y/o Iraqi EPW.
Brought for check of IP assailed by pts / Nurses c/o (B) side / sub pain. No head injury.
No LOC. No other c/c

P/
O
S/C

Ecchymosis & distension
Pannic. Neck supple
NCAT
CV - Reg rhm
Lungs - CTA B
abd + BS + ND & tym.
Extrem Atr x 4
Neurol. wnl

FAST US
(-)
CXR
48 T.

A) Multiple contusions of c/s (B). No evidence of ptx
RACPD
of thoracic or abd inj

(b)(6)-2

(EEDED)

MP

WNL, MA

plans)

Tylenol for pain
Return for vomiting / worse pain

(b)(6)-4

MEDCOM - 292 TMENT STANDARD FORM 558 (Rev. 6-82)

(3)

558-109 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 21st CSH

LOG NUMBER

ARRIVAL — DATE: DAY 19 | MONTH 9 | YR. 03 — TIME: 2310

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☑ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): 0

HISTORY OBTAINED FROM: ☑ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): HA/ABD Pain

SEX: M AGE: 39

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 2310

VITAL SIGNS

TIME	2315		
BP	131/74		
PULSE	69		
RESP.	16		
TEMP.	97.1		
(OTHER)	97		

CATEGORY (See reverse)
EMERGENT
URGENT
NON-URGENT B6-2

ORDERS	INITS.	TIME
CMP	[redacted]	23
CBC		23
UA		
~~ASA~~		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

S: 39 y/o ♂ c/c Head & abdominal pain x 9hrs. (+)nausea
Pt also has (L) Elbow pain and chest pain — sat Ank Shld

39 y/o CM c/c head/abd pain s/p assault. Was hit/punched/kicked all to pt. c/c (L) parietal scalp pain. Ambulatory. Nauseated

C- unremarkable.

HEENT - PERRL. Fom.
Head - Atraumatic. TMs - clear (B)
Oropharynx - moist. MMM
neck - FROM. No LAD
CV - RRR
Lungs - CTA (B)
Abd - soft, ND. Hyperactive BS
Extremities - FROM. Grip strength normal

ASSESSMENT/DIAGNOSIS
Pain

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

CONDITION UPON RELEASE
IMPROVED — UNCHANGED
DETERIORATED
RELEASE: 2353

P/
F
S/
A

First free fluid

CXR

EKG normal

IV/IO: (b)(6)-2

30g

NAME (Mechanical imprint) / WHEN ENTRIES GIVEN: Name — last, first, middle; rank; service status, name and relation of sponsor or next of kin. IMPORTANT: LIST FACILITY HOLDING TREAT. RECORD:

B6-4

SIGNATURE

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans):

Tylenol for pain
Return for persistent vomiting or worse pain.

MEDCOM - 293 — STANDARD FORM 558 (Rev. 6-92)

558-103 (See Instructions on Back of this Sheet) & SAVE THIS COPY & PINK NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL
DATE: DAY 30 | MONTH 09 | YR. 03 | TIME 1220

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data). None

HISTORY OBTAINED FROM
☐ PATIENT ☐ OTHER (Specify)

ALLERGIES NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration) "passed out"

SEX M | AGE 25

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

TIME SEEN BY PROVIDER 1422

VITAL SIGNS		
TIME	1230	1422
BP	115/63	117/63
PULSE	72	60
RESP.	16	24
TEMP.	100.7	99.3
OXYGEN SAT.	97%	100

CATEGORY (See reverse)
☐ EMERGENT
☒ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
IV Access		
Labs: CBC		
Urinalysis + Bcx		
CXR: PA & LAT		
Rocephin 30mg/kg IV		1500
Observe 2 hours		

ASSESSMENT/DIAGNOSIS
Syncopal episode

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

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE: 1445

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

27y male student at [redacted] brought from school in area after syncopal episode. During transfer, individual reports that he was standing during episode for 2-3 days PTA. Since prior to evaluation, has had poor appetite, poor oral intake and generalized malaise.

Family Hx: [illegible] Habits: Smokes 2 cigarettes/day, EtOH

Exam: Pleasant in NAD x3. Dry mucous membranes, otherwise benign HEENT exam. Lungs CTA. Heart RRR. Abd soft, NT/ND. No rebound or guarding. No CVA tenderness. No lesions or rashes.

Labs: WBC 9.1, Hct 45.8, Plt 169, Na 134, K 4.3, Cl 102, CO2 24, BUN 11, Cr 1.0, Glucose 96. UA: Glucose trace, otherwise unremarkable. CXR: Clear. EKG: NSR, no ischemic changes.

Assessment: Syncope, likely vasovagal in nature. Dehydration.

Plan: Observe for 2 hours. Rocephin 30mg/kg IV given. Encouraged PO hydration. Will discharge if remains stable.

(CONTINUE ON SF 507, IF NEEDED)

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. ENT RECORD)

[redacted] B6-4

SIGNATURE OF PROVIDER [redacted]

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

1. Motrin 800mg orally 3x/day as needed
2. Drink plenty of fluids, eat regular meals as tolerated

EMERGENCY CARE AND TREATMENT STANDARD FORM 558 (Rev. 6-82)

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	DOB	RANK	SSN
potus # [redacted] B6-4				

Physician (b)(6)-2	Ward: EMT	STAT / Routine	Specimen Date and Time: 20sept03e 1235	Reported by: (b)(6)-2	Date and Time: 20sept e 12xx

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	134	128-145 mmol/L
	K	5.3	3.3-4.7 mmol/L
	Cl	103	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	14	7-22 mg/dL
	Glu	91	73-118 mg/dL
	Creat	0.6	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color	dk y	Straw/Yellow
Clarity	clear	Clear
Glucose	neg	Negative
Bilirubin	neg	Negative
Ketone	moderate (40)	Negative
Sp. Gr	1.019	1.010-1.025
Blood	trace	Negative
pH	6.0	5.0-8.0
Protein	trace	Negative-Trace
Urobili	norm	Negative
Nitrite	neg	Negative
Leuko	Neg	Negative

Urine Microscopic

WBC	0-2	Epi	occasional
RBC	0-3	Mucus	trace
Bacteria	light	Yeast	
Casts		Spermatozoa	

Chemistry (Piccolo Analyzer)

Chem 12 Met Lyte 8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	11	7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK	15594	30-170 U/L
	CL	102	98-108 mmol/L
	TCO2	24	18-33 mmol/L
	Creat	1.0	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	92	73-118 mg/dL
	K	4.8	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	133	128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	7.0	4.8-10.8 x10(3)/uL
	RBC	4.99	4.2-6.1 x10(6)/uL
	Hgb	14.9	12.0-18.0 g/dL
	Hct	46.0	35.0-60.0%
	MCV	92.1	80.0-99.0 fl
	MCH	29.8	27.0-31.0 pg
	MCHC	32.4	33.0-37.0 g/dL
	Plt	169	130-400 x10(3)/uL
	LY%	9.8	15.0-55.0%
	LY#	0.7	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh	
T&C	

MEDCOM - 295

Crystals		Amorph Sed	Urine		Negative	T&S	
Other 1			Serum		Negative		
Other 2							

CBC, Istat 6, CE, metlyte 8, UA

FORM BEARLAB 20 23 July 2003

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 20, MONTH Sep, YR 03 — TIME: 2030

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Walk in

CURRENT MEDS. (tetanus immunization and other data): DM - insulin - HTN med (?) - Antiinflam meds

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): c/o nausea, drug A for ® foot

SEX: Male AGE: 56

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	2030		2200
BP	181/109		180/97
PULSE	114		98
RESP.	18		20
TEMP.	99.2		
WT. (Child)	97 lb		98 k

CATEGORY (See reverse)
- EMERGENT
- ✓ URGENT
- NON-URGENT B6-2

ORDERS	INITS.	TIME
I.V. lac'd	[redacted]	2095
CXR		2115
CBC, lytes, Cr		2040
Tylenol #3		2040

ASSESSMENT/DIAGNOSIS: Renal failure

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

56y/o male c/o nausea & vomiting & SOB. (Hands brought pt here to have drug A on ® foot.

56 yo m c/o ↑ SOB x 10 d. Worse over ↑ 4 hrs. Hand chest tightness x > 6 hrs. Had recent ® 5TH toe Amp 10 d ago for DM/PVD. SOB worse c exertion c/w st tightness. Intermittent. No F/C/Recent illness. VSS, ↑ P. PO tenuous. No other c/c.

c - chest trag. CV & distress of SOB

CV - reg & ↓m

Lungs - (+) CTA, ↓ rales bibasilar ↓w

abd - obese - NTTP

ext - ↓ edema - ® 5TH toe amp healing well & no s/s infection

A/P: Renal Failure. Pt denies hx renal failure/problems in past. Will admit. Nonoliguric output.

PMH - Diabetic sacral decubitus ulcer, HTN

PSH - Surgical removal of ® toe ta 10 days ago @ Bhy Surgery

P/
IDDM
HTN
PVD ? DM
↓ CAD
↑ MI

12 × 327

131 | 91
4.5 | 6.3

TVCP - x5 G

EKG - NSR ↓ ischemic c/s

CXR - ↑ fluid ® effusion (small).

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

CONDITION UPON RELEASE
- IMPROVED / UNCHANGED
- DETERIORATED
- MEDS RELEASED

PATIENT'S IDENTIFICATION (Mechanical imprint) WRITTEN ENTRIES GIVE: Name - last, first, middle; Service status, name and relation of sponsor or next of kin. IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD

[redacted] B6-4

(b)(6)-4

SIGN (b)(6)-2 MAT, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

Admit

MEDCOM - 297 TMENT STANDARD FORM 558 (Rev. 6-82)

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL
DATE: DAY 25 | MONTH Sept | YR 03 | TIME 1425

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Humvee

CURRENT MEDS. (Tetanus immunization and other data)
1. Lasix 80 PO
2. Insulin HPH/Reg. 40 HPH bid Honey bid

HISTORY OBTAINED FROM
☐ PATIENT ☐ OTHER (Specify)

ALLERGIES
NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)
Headache / N/V

SEX: Male | AGE: 56

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

VITAL SIGNS		
TIME	1445	1816
BP	121/89	143/65
PULSE	78	89
RESP.	16	16
TEMP.	97.6	10
WT. (Child)	94.0 KG	100%

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT BB-2

ORDERS	INITS.	TIME
IV, NS @150cc/hr	[redacted]	done

ASSESSMENT/DIAGNOSIS

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

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER

Pt Complaining of headache and throwing up.

This 56 yo patient well known to us c CHF, DM, HTN, ESRD, recently D/C'd from 21 CSH after treatment for his multiple health problems. Returns today c/o HA and 1 episode of vomiting following breakfast this morning. He attributes the HA to the sun in his eyes. He has an indwelling foley catheter - cannot tell me when the bag was last emptied, but the bag is full of light yellow urine.

Exam: CV: nl S1, S2, ϕ murm/g Pulm: Good (B) air exchange - (L) basilar rales.

Abd: Soft, NT, ND. NL BS. NA BS.

Ext: ϕ c/c/E

Rectal: not done

Impt Hx: which may be attributable to uremia, electrolyte abnormalities, or the meds he is taking. Headache which the pt. attributes to photosensitivity and nausea. Pt. once in loop?

Plan: D/C back to Epw component

Spoke c Co. commander of MPs and agreed for expedited transfer

LABS:
135 | 102 | 82 / 99
3.7 | 25 | 5.4
8.7 / 10.5 / 32.8 / 350

(CONTINUE ON SF 507, IF NEEDED)

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 TREATMENT RECORD).

Potus #[redacted]

BB-4

[redacted]

(b)(6)-4

(b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

to Regional prison where they have an infirmary.

MEDCOM - 298

(3)

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 24 MONTH Sep YR 03 TIME 1555

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) walk in

CURRENT MEDS. (tetanus immunization and other data): See below

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (Include symptom(s), duration): (R) Flank pain, Headache

SEX: Male AGE: 56

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: On Arrival

VITAL SIGNS		
TIME	1600	1800
BP	139/73	126/77
PULSE	83	80
RESP.	20	20
TEMP.	98.3	96.5°
WT. (Lbs)	94½	88#

CATEGORY (See reverse)
☐ EMERGENT
☒ URGENT B6-2
☐ NON-URGENT

ORDERS	INITS.	TIME
IV NS @ 125 cc/hr	[redacted]	1620
CBC, METOPROLOL, BC		1620
CREATININE, CMP		1620
CXR, MAGNETIC		1650
ECG and		1600
FLOW MEASURES		1600

ASSESSMENT/DIAGNOSIS: Congestive CHF, Renal failure, HTN, DM-2, Anemia, COPD

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): Nl Cardiology
☐ EMERGENCY ☒ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE: 1930

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

56 y/o M EPW presents to EMT c/o HA, (R) flank pain since this AM. Pt. A/Ox3, ambulates c crutches, LS CTA, pt. c dry dressing to foot — [redacted] CVA/AN
Stay @ c SOB, HTN, CHF and renal failure discharged from OSH yesterday & treatment for CHF + renal failure brought back by MPS from detention c/o chest pain. On interview through translator, detainee reports c/o headache, back/flank pain (L) x (12) and chest discomfort. No dyspnea or respiratory symptoms. No orthopnea. Lies flat without difficulty.

PMHx: HTN, DM, CHF, Renal failure, Neuropathy, Retinopathy, NSVD's
PSHx: Sacral dislocation — (R) hip surgery
Meds: Ciprofloxacin, Isordil, Amlodipine, Lasix, Clonidine, Insulin
Allergies: NKSA
Meds: Unknown

GENERAL: Obese Iraqi @ in NAD, responds appropriately through translator
INTER: Seldom complain, pale
NECK: ↑ JVD
LUNGS: Good air movement, fine rales b/l (w) Heart sounds distant, RRR, nl S1/S2 ↑ (w)
ABD: Obese, soft/NT/↑ BS mass
EXTREM: Trace b/l dusky discoloration in, hardness b/l knees, (L) TMOE negative without drainage, open wound c dry granulation tissue

Troponin 1620 → 0.1
Procrit 10000cc sc
Tylenol 650 mg p.o. 1830
Lasix 40 IV 1830

IMPRESSION: Musculoskeletal problems, headache likely 2° to stress, back pain possibly related to DJD, and bladder infection with UTI

(CONTINUE ON SF 507, IF NEEDED)

8.9 → 383
8.1 (28.9)
134 | 101 | 93
4.1 | 21 | (5.3)
CK = 122
TROPONIN - NEG

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 TREATMENT RECORD).

Potus [redacted] B6-4 EPW

[redacted]

SIGNATURE OF PROVIDER (Typed or Stamped): [redacted] CPT, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans):
Increase insulin to 10U in AM and 4U in PM
Increase Lasix to 40mg BID
Return to Troop Medical Clinic each day

PA/LAT CXR - mild PVR; cardiomegaly
ECG - HR 70-80's

Medical

MEDCOM - 299

[redacted] B6-4

DOD 003426

513-110 NSN 7540-00-634-4127

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO: Internal medicine

FROM: (Requesting physician or activity) LTC (b)(6)-2

DATE OF REQUEST 24 Sep 03

REASON FOR REQUEST (Complaints and findings)

56 y renal & RETAINER discharged from 21ST CSH yesterday after evaluation and treatment for CHF and renal failure returns (brought by MP's from detention area) for c/o headache, back/flank pain and chest discomfort.

PROVISIONAL DIAGNOSIS

Renal failure, CHF

(b)(6)-2	APPROVED	PLACE OF CONSULTATION	ROUTINE / TODAY
(b)(6)-2 CPT, MC		BEDSIDE / ON CALL	72 HOURS / EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☑ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO

Imp: ① Headache may be 2° dehydration, but another possibility is relative hypoglycemia since blood sugars were in 200's x now low 100's. (now 87). Impress Tx c Tylenol

② Recurrent ② CHF primarily, P/T #3. ↑ Lasix to 80 mg PO x 3 days

③ C/O of back & flank pain earlier, but may be 2° bladder outlet obstruction & UTI

Tx: ① ↓ NPH to 1/2 unit SQ QD x 1 week & D/C 5 reg. 1 unit SQ QD

② ↑ Lasix to 80 mg p.o. QD x 3 days — speak with G.A. re: plan for F/U, Dem. 28 Sep 1700

③ Foley in place. IV Lasix before pick leaves.

(Continue on reverse side)

SIGNATURE AND TITLE (b)(6)-2 (b)(6)-2 Lieutenant Colonel, Medical Corps (b)(3)-1 DATE 24 Sep 03

IDENTIFICATION NO. ORGANIZATION SERVICE NO. WARD NO

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

Potus # [redacted] B6-4

[redacted]

(b)(6)-4

CONSULTATION SHEET
Medical Record

MEDCOM - 300

STANDARD FORM 513 REV. 8-80
Prescribed by USA HCMR AR 40-400

[redacted]
Lieutenant Colonel, Medical Corps
[redacted]

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 25, MONTH [illegible], YR. 03 — TIME: 1425

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Ltr Amb

CURRENT MEDS. (tetanus immunization and other data): 1. Lasix 80 PO 2. Insulin HPH 10 U SQ HS HPH 10 U SQ Q AM

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Headache / N/V

SEX: Male AGE: 56

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS		
TIME	1425	1516
BP	150/80	142/65
PULSE	78	56
RESP.	16	16
TEMP.	97.6	98.6
WT. (Stat)	[illegible]	[illegible]

CATEGORY (See reverse)
- EMERGENT
- URGENT
- NON-URGENT 86-2

ORDERS	INITS.	TIME
IV, NS @ KVO, [redacted]	[redacted]	[redacted]

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Pt complaining of headache and vomiting

J.D.

[redacted] is a patient well known to us [illegible] CHF, DM, HTN, ESRD, recently [illegible] from 21 days after treatment for his complex health problems. Returns today c/o HA and episode of vomiting following breakfast this morning. He attributes the HA to the sun in his eyes. He has an indwelling foley catheter - cannot tell urine bag was last emptied, but urine has a puff of light yellow color.

Exam: Eyes PERRL, [illegible] Neuro: Grossly [illegible] Pulm: Good BS x 4 quads - [illegible] bases. CV: RRR, S1, S2, [illegible] MA BS. Abd: Soft, NT/ND, [illegible] BS. Ext: [illegible] Rectal: [illegible]

Impression: Headache which may [illegible] to uncontrolled HTN, electrolyte abnormalities, or [illegible]. Headache which [illegible] to pt's chronic [illegible] and resolved [illegible] in ED.

Plan: D/C back to ED [illegible]. Pt to follow up with PCP for [illegible] and recheck of BP. Pt given strict return precautions for worsening symptoms.

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

CONDITION UPON RELEASE
- IMPROVED / UNCHANGED
- DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint). FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB; service status, name and relation of sponsor; next of kin. (IMPORTANT: LIST FACILITY HOLDING THIS RECORD).

Pt's # [redacted] 86-4

[redacted]

(b)(6)-4

(b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

To Expedite prison where there is any [illegible]

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974) BB-4

LAST, FIRST, MI.	UNIT	RANK	SSN
(b)(6)-4 257			[redacted]

Physician:	Ward:			Date and Time:	Reported by:	Date and Time:
MAJ	(b)(6)-2	X	STAT		(b)(6)-4	
			Routine	25 Sep 03 1600		25 Sep 03

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	137	128-145 mmol/L
	K	3.7	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.422	7.35-7.45
	PCO2	39.0	35-45 mmHg
	PO2	72	80-90 mmHg
	TCO2	27	18-33 mmol/L
	HCO3	25	22-28 mmol/L
	sO2	95	95-99%
	BEecf	1	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.12	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu	102	73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobil		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:			
Crystals:			
Other:			
Other:			

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	8.2	4.8-10.8 x10(3)/uL
	RBC	3.99	4.2-6.1 x10(6)/uL
	Hgb	10.5	12.0-18.0 g/dL
	Hct	32.8	35.0-60.0%
	MCV	82.0	80.0-99.0 fl
	MCH	26.2	27.0-31.0 pg
	MCHC	31.9	33.0-37.0 g/dL
	Plt	350	130-400 x10(3)/uL
	LY%	15.6	15.0-55.0%
	LY#	1.3	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 303

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974) B6-4

LAST, FIRST, MI: Iraqi, 251 | UNIT | RANK | SSN [redacted]

Physician: | Ward: [b)(6)-2] | X STAT / Routine | Date and Time: 25 Sep 03 1600 | Reported by: [b)(6)-2] | Date and Time: 25 Sep 03

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	137	128-145 mmol/L
	K	3.7	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.422	7.35-7.45
	PCO2	39.0	35-45 mmHg
	PO2	72	80-90 mmHg
	TCO2	27	18-33 mmol/L
	HCO3	25	22-28 mmol/L
	sO2	95	95-99%
	BEecf	1	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.12	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu	102	73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

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

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:			
Crystals:			
Other:			

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	Cl		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh	
T&C	
T&S	

HCG

Urine	Negative
Serum	Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	8.2	4.8-10.8 x10(3)/uL
	RBC	3.99	4.2-6.1 x10(6)/uL
	Hgb	10.5	12.0-18.0 g/dL
	Hct	32.8	35.0-60.0%
	MCV	82.0	80.0-99.0 fl
	MCH	26.2	27.0-31.0 pg
	MCHC	31.9	33.0-37.0 g/dL
	Plt	350	130-400 x10(3)/uL
	LY%	15.6	15.0-55.0%
	LY#	1.3	0.7-4.3 x10(3)/uL

Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp Ly		Imm	

RBC Morph:

Plt verify:

Spun Crit: 35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate	1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 304

358-103 [See Instructions on Back of this Sheet] NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL
DATE: DAY 25 | MONTH Sept | YR. 03 | TIME 1425

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Humvee

CURRENT MEDS. (tetanus immunization and other data)
1. Lasix 80 QD
2. Insulin Hpt/Reg. 40 HPH bid
Honey bid

HISTORY OBTAINED FROM
☐ PATIENT ☐ OTHER (Specify)

ALLERGIES
NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration)
Headache / N/V

SEX Male | AGE 56

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	1425	1816
BP	101/59	143/65
PULSE	78	89
RESP.	16	14
TEMP.	97.6	10
WT. (Lbs)	94 kg	100.7

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT Bb-2
☐ NON-URGENT

ORDERS	INITS.	TIME
CV, NS @150cc/hr	[redacted]	done

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Pt complaining of headache and throwing up.

This 56 yo patient well known to us c CHF, DM, HTN, ESRD, recently d/c'd from 2 CSH after treatment for his multiple health problems. Returns today c/o HA, and 1 episode of vomiting following breakfast this morning. He attributes the HA to the sun in his eyes. He has an indwelling foley catheter - cannot tell me when the bag was last emptied, but the bag is full of light yellow urine.

Exam: CV: nl S1, S2, ϕ murm/g/r Pulm: Good (B) air exchange - (L) basilar rales.
Abd: Soft, NT, ND, NABS
Ext: ϕ c/c/e
Rectal: not done

Impr: Nausea which may be attributable to uremia, electrolyte abnormalities, or the meds he is taking. Headache which the pt attributes to photosensitivity and resolved once in room.

Plan: D/c back to Epw compound
Spoke c Co. commander of MPs and asked for expedited transfer

LABS:
135 | 82 | 99 | 8.2 | 350
3.7 | 5.4 | 32.8

(CONTINUE ON SF 507, IF NEEDED)

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
CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE:

PATIENT'S IDENTIFICATION (Mechanical imprint) OR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB; service status, name and relation of sponsor or next of kin; (DEPOSITION) AND FACILITY HOLDING TREATMENT RECORD):
Patus # [redacted] B6-4
[redacted]

SIGNATURE OF PROVIDER AND ID STAMP
(b)(6)-2 (b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)
→ to Baghdad prison where they have an infirmary.

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
24 SEP 03 1600 139/73 83 20 98.3 94% RA	56 y/o M EPW presents to EMT c c/o Headache, (R) flank pain since this AM. Pt. A/O x3, ambulation c crutches, airway intact, LS CTA, HRR, pt. c dry dressing to (R) foot. Pt. has Mhx of Diabetes, (R) 5th digit/foot surgical amputation, wound appears dry, ø drainage noted. Weak dorsal pedal pulses bilat noted. Pt. given 18G IV to (L) wrist infusing NS @ TKO, blood drawn and sent to lab, 12 lead EKG (b)(6)-2 completed, continue to monitor. — 6 CPT
24 SEP 03 1730	Pt. was taken to Radiology @ 1650, returned @ 1705. 16F Foley cath. placed/secured, 1100 cc light-yellowish urine output. urine specimen sent to lab. CPT
1820	Pt. given 40mg IV Lasix and 650mg Tylenol (b)(6)-2 PO @ this time CPT/AN

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.

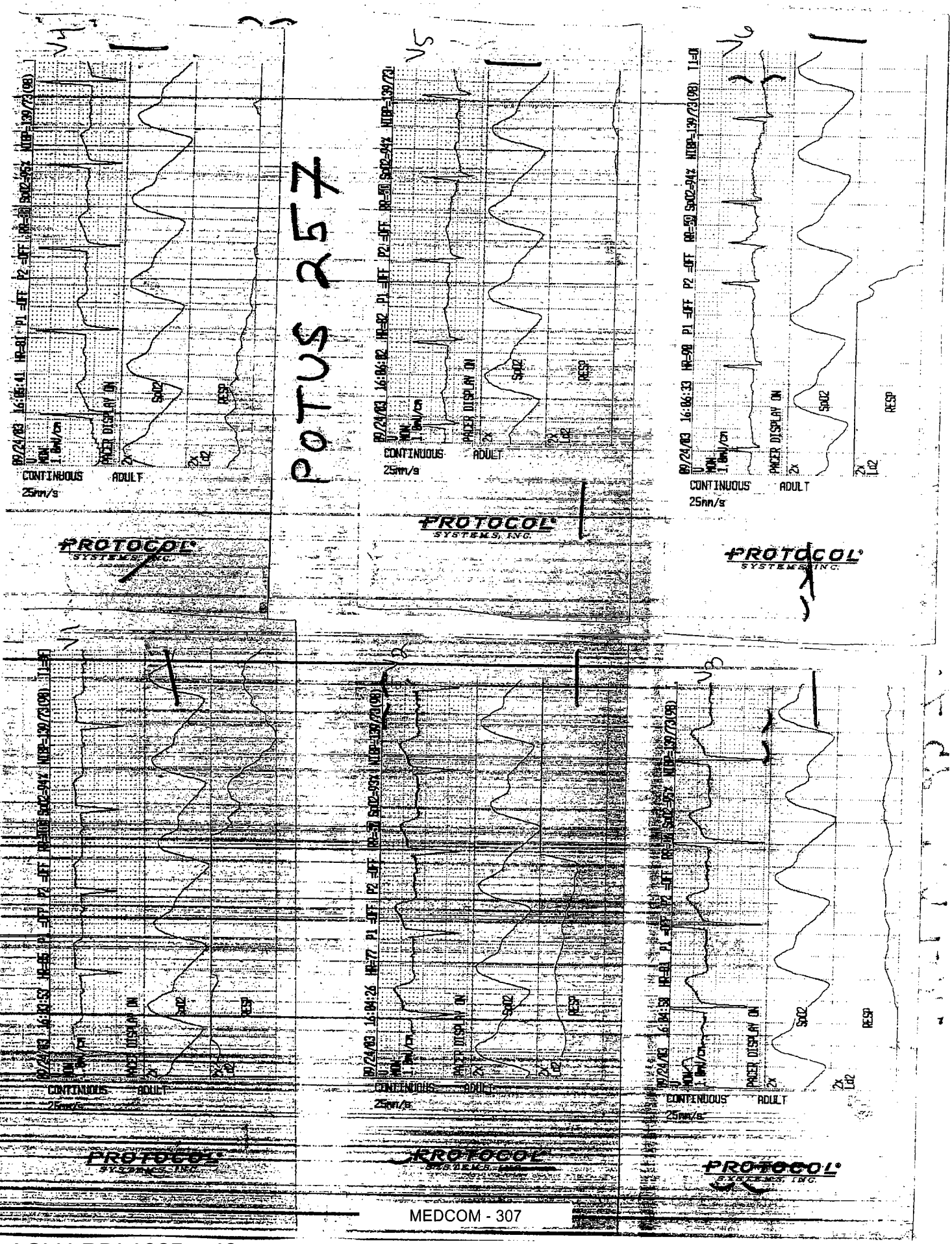
POTUS [redacted] EPW B6-4

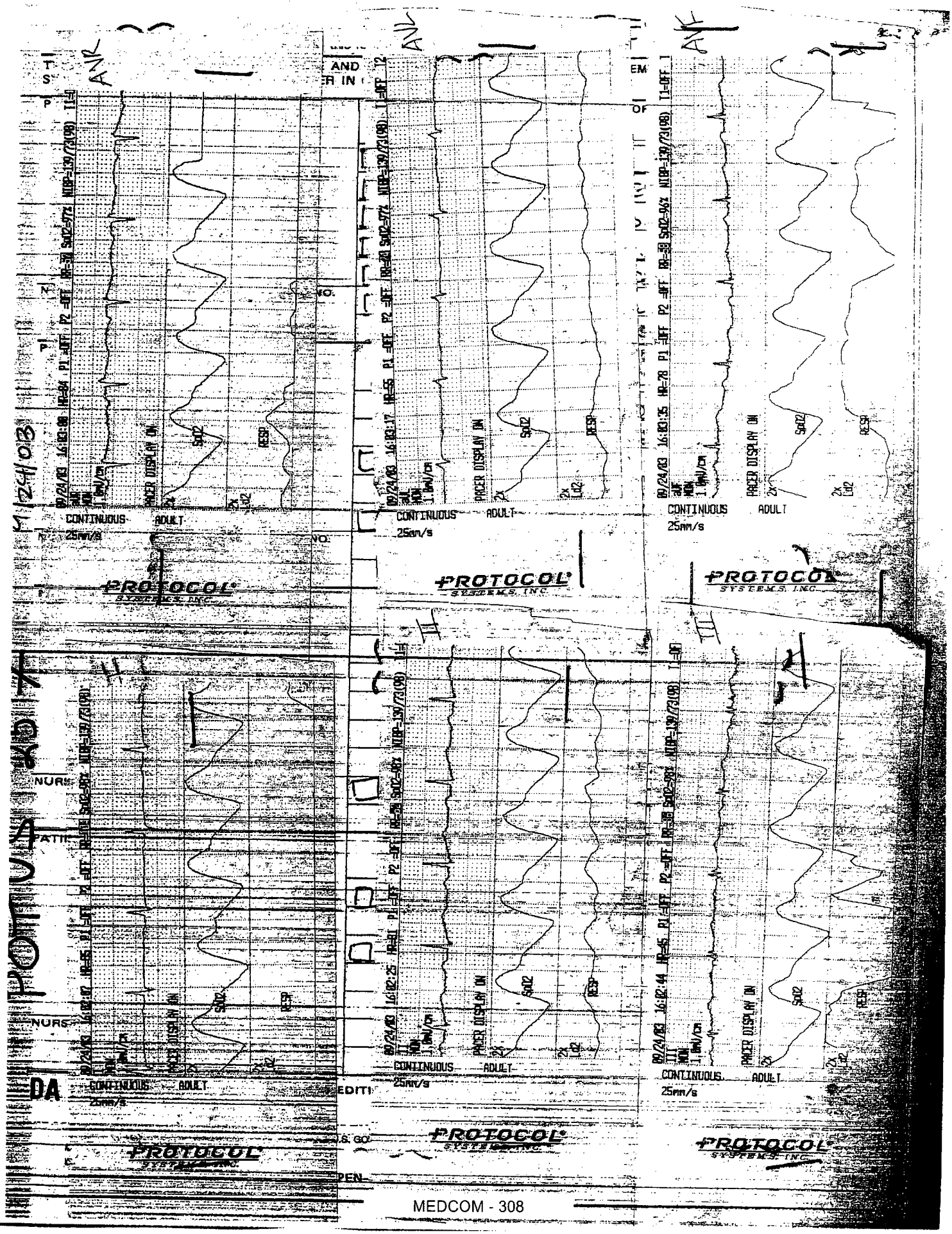
(b)(6)-4

[redacted] B6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201.9.202-1

MEDCOM - 306


POTUS 257
PROTOCOL SYSTEMS, INC.
CONTINUOUS ADULT
25mm/s
PACER DISPLAY ON
SpO2
RESP


PROTOCOL SYSTEMS, INC.
CONTINUOUS ADULT
25mm/s
PACER DISPLAY ON
SpO2
RESP

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) 21st CSH (b)(3)-1

LOG NUMBER

ARRIVAL — DATE: DAY 23 MONTH Sep YR 03 — TIME: 2025

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Taxi

CURRENT MEDS. (Tetanus immunization and other data): Unknown meds

HISTORY OBTAINED FROM: ☒ PATIENT ☒ OTHER (Specify)

ALLERGIES: NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code) (b)(6)-4

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Pt was mediating [illegible] when he had [illegible]

SEX: Male AGE: 64

POSSIBLE THIRD PARTY PAYER? ☐ YES ☒ NO

TIME SEEN BY PROVIDER: 2025 Arrived

VITAL SIGNS

TIME	2025		2158
BP	177		157/78
PULSE	175/80		79
RESP	20		20
TEMP	97.2		
WT. (Child)	98.1		100%

CATEGORY (See reverse)
EMERGENT
URGENT
NON-URGENT BB-2

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

64yo c/ hx CP [illegible] Pt was undergoing interrogation + developed L-sided, aching, CP today in the afternoon. Then felt lightheaded + blacked out. No palpitations. [illegible] vitals taken. No [illegible] given. [illegible] Pt was transported by [illegible] to ED. Pt has hx of [illegible] years. [illegible] ECG [illegible] ST segs [illegible] c - troponin [illegible] & cardiac [illegible] CXR [illegible] Pt was monitored + observed. [illegible] CONTINUE ON SF 507, IF NEEDED)

PMH - HTN
Diabetes
Heart [illegible]
1975 - [illegible]
PSH - [illegible]

ORDERS — INITS. — TIME

ORDERS	INITS.	TIME
EKG Post B	[redacted]	2035
CXR		2132
[illegible]		[illegible]
ASA 325 PO		2048
[illegible]		2048
[illegible]		2048

ASSESSMENT/DIAGNOSIS: CP/Syncope c/ HTN / dyslipidemia

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: MED
CONDITION UPON RELEASE
IMPROVED — UNCHANGED
DETERIORATED
TIME OF RELEASE: 2145

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 TREATMENT RECORD)

[redacted]

BB-4

SIGN (b)(6)-2

INST plans — [illegible] ordered, any limitations and follow-up

(b)(6)-4

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 27 | MONTH Sep | YR. 03 | TIME 1000

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): Meds for HTN

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Mosul

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): chest pain x 4 days

SEX: M | AGE: 62

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1038

VITAL SIGNS

TIME	1000		
BP	177/75		
PULSE	66		
RESP.	18		
TEMP.	98.6		
WT. (Child)	95%		

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT — B6-2
- ☐ NONURGENT

ORDERS	INITS.	TIME
EKG		
PALPAT CAP [redacted]		1020
Metoprolol 6		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

62 y old M complains of left chest pain and blood pressure

pt states he has had pain in chest X 4 days [illegible]

62y male was referred admitted 21st CSW for syncope and chest discomfort [illegible] 23-24 SEP brought to EMT for evaluation of episodes of palpitations. History obtained through translator. Describes spells 30 minute episode of palpitations yesterday evening. Also concerned that he must sleep flat in detonation (although completely comfortable on supine position in EMT.) Asymptomatic at time of presentation to EMT

PMHx: HTN - meds
DVT — Tenormin Surgery
Syncope — Clopidogrel Surgery

PSHx: Eye surgery Allergies: ASA → GI upset

GENERAL: unremarkable c/o/N/A/S/ on exams - approximately through interpreter
INTEG: warm, dry, no rashes
HEENT: PERRL
LUNGS: CTA B/L
CV: RRR s1/s2
ABD: soft/NT/ND/+ bowel sounds
EXTREM: no edema

FPG - NSR @ 70
? new ST wave inversions V3-V6
otherwise normal

139 | 102 | 73
41 | 21 | 302
CK: 383 0.9
TROP - NEG

PALPAT CAP NAD

(CONTINUE ON SF 507 IF NEEDED)

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
- CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED
- DESIGNATED
- TIME RELEASE:

PATIENT'S IDENTIFICATION (Mechanical imprint)
IF WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; service status, name and relation of sponsor or next of kin.
IMPORTANT: LIST FACILITY HOLDING TREAT RECORD

(b)(6)-2

(b)(6)-4 [redacted] B6-4

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

(1) [illegible] EKG

(2) INCREASE ATENOLOL TO 50mg PO QD

MEDCOM - 310

MEDCOM - 311

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21st [illegible]

LOG NUMBER

ARRIVAL — DATE: DAY 25, MONTH 09, YR. 07 — TIME: 1500

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): ϕ

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Blood In Stool

SEX: M AGE: 75

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up):

75 yo EPW presents c melena x 4 days. Also c/o diffuse suprapub. c pain. ϕ HTN. GI bleed. ϕ N/V. ϕ meds.

Social: [illegible] heavy smoker - ϕ etoh

PMHx: ϕ

PSHx: ϕ

RDS:

- ϕ neuro.

- Cv: ϕ CP, ϕ PMD, ϕ syncope.

Ex: [illegible] consult assess

Pulm: ϕ SOB, (+) cough c yellow sputum (chronic)

Abd: GI (+) diarrhea (tarry), ϕ N/V, (+) suprapubic pain.

Exam: General - overweight elderly gentleman c severe distress from tremor.

HEENT: PERRL, OP - dark red material in OP?

Chest: nl S1, S2, ϕ murmur, breath sounds, Lungs: diminished breath sounds, bibasilar rales.

Abd: distended + BS, + heard. Ext: ϕ C/E/E

suprapubic TTP.

CXR: [illegible] equivocal radiopacity, nl S, no free air, (R) hemidiaphragm elevation.

Labs: 12.7 / 15.7 / 1.03 / 74.1

LABS: 12.4 | 99 | 2.0 / 24 | 21 | 118

Alb 2.7 Alk Ph 58 Alt 38 Tbili 1.0

CK 1004 PT 17.8 PTT 50.1

Rx: [illegible] started SQ heparin.

(CONTINUE ON SF 507, IF NEEDED)

VITAL SIGNS

TIME	1510	1900	
BP	121/82	155/88	
PULSE	111	87	
RESP.	18	33	
TEMP.	100.1	101.2	
O2 SAT. (Circle)	87%	93% RA	

CATEGORY (See reverse): EMERGENT 1A; URGENT; NON-URGENT B6-2

ORDERS	INITS.	TIME
Place Foley catheter	[redacted]	Rec'd
Keflex / IVR	[redacted]	1615
CXR: chest R.F. L.F. [illegible]	[redacted]	1530
Urine C+S Exp Dr [redacted]	[redacted]	1530

ASSESSMENT/DIAGNOSIS

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

CONDITION UPON RELEASE: IMPROVED | UNCHANGED | DETERIORATED

TIME OF RELEASE:

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 TREATMENT RECORD):

Potus [redacted] B6-4

[redacted] (b)(6)-4 (b)(6)-2

SIGNATURE OF PROVIDER AND ID STAMP: (b)(6)-2 (b)(6)-4

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

(b)(6)-4

MEDCOM - 312

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 24, MONTH Sep, YR 03; TIME 1556

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) MP escort

CURRENT MEDS. (tetanus immunization and other data): Ventolin Inh, Beclomethasone Inh, Prednisone

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify) interpreter

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): CP / Difficulty breathing

SEX: M AGE: 49

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	1610	1800
BP	180/85	
PULSE	101	91
RESP.	14	
TEMP.	99.2	
WT. (Child)	97%RA	97%RA

CATEGORY (See reverse): ☐ EMERGENT ☒ URGENT ☐ NON-URGENT

ORDERS	INITS.	TIME
CBC, LFT, MULTE,	[redacted]	
CXR, EKG	[redacted]	1630
IV NS TKO	[redacted]	
FULL MEDICATIONS	[redacted]	
PA/LAT CXR	[redacted]	
TROPONIN-I	[redacted]	

ASSESSMENT/DIAGNOSIS: ASTHMA EXACERBATION

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): MP CUSTODY

☐ EMERGENCY ☐ TODAY ☐ 72 HOURS ☐ ROUTINE

ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE: 1730

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: ON ARRIVAL

49y/o Iraqi detainee brought by MPs for evaluation of chest pain. On interview through translator, detainee reports hx of lung dz, asthma and recent difficulty breathing at night similar to prior asthma exacerbations. Seen by U.S. medical personnel at some point prior to transfer for detention at Camp Bucca last night and given Ventolin and beclomethasone MDIs and prednisone, but patient taking only ventolin MDI x 2 per day.

PMHx: Asthma - frequent exacerbations

PSHx: Ø

Meds: Ventolin, Beclomethasone, Prednisone } NOT using

Allergies: NKDA

Habits: Nonsmoker.

GENERAL: awake/oriented x2 (place/date) x3 (speaks in complete sentences answering questions through interpreter.

HEENT: unremarkable

NECK: supple, no JVD

CV: RRR, S1 S2 no m/r/g

RESP: Bilateral exp wheezes, no crackles

ABD: Benign

EXTREMITIES: warm, no edema

NEURO: Cooperative, pleasant, no focal findings on auscultation

9.9	17.1	192
	149.6	
142	102	91
4.4	24	0.9

UA = 1000

TROPONIN - NEGATIVE

PA/LAT CXR - WNL

ECG - NSR @ probable early repol V2 + V3

Impression: 49y/o Iraqi detainee with hx of asthma and findings c/w exacerbation. Doubt acute cardiac etiology. Will tx c steroids, nebs.

(CONTINUE ON SF 507, IF NEEDED)

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 TREATMENT RECORD).

POTUS # [redacted] b6-4

(b)(6)-2

(b)(6)-4

DISCHARGE INSTRUCTIONS (Include medications ordered, any limitations and follow-up plans):

1. Prednisone 60mg orally each day for five days
2. Ventolin MDI 2 puffs 4x/day
3. Beclomethasone MDI 2 puffs 4x/day
4. [redacted] instructions

MEDCOM - 313

09/24/03 16:31:28
MDN
1.0mV/cm
PACER DISPLAY ON
2x
Lo2
SpO2
RESP
RR=24 SpO2
09/24/03 16:31:57
09/24/03 16:41:11
09/24/03 16:45:16
09/24/03 16:49:46
09/24/03 16:44:46
MEDCOM - 314

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

B6-4

LAST, FIRST, MI: POTUS, [redacted] B6-4 | UNIT: EPW | RANK: — | SSN: [redacted]

Physician: (b)(6)-2 | Ward: | ☒ STAT ☐ Routine | Date and Time: 24 Sep 03 @ 1660 HR | Reported by: (b)(6)-2 | Date and Time: 24 Sep

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

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

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other		
Other:	MRINYTE & CBC, LFT & CR + TROPONIN	

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB	4.4	3.3-5.5 g/dL
	ALP	89	26-84 U/L
	ALT	28	10-47 U/L
	AMY	23	14-97 U/L
	AST	49	11-38 U/L
	Tbil	1.6	0.2-1.6 mg/dL
	BUN	10	7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK	1000	30-170 U/L
	CL	102	98-108 mmol/L
	TCO2	24	18-33 mmol/L
	Creat	0.9	0.6-1.2 mg/dL
	GGT	31	5-65 U/L
	Glu	91	73-118 mg/dL
	K	4.4	3.3-4.7 mmol/L
	TProtein	8.7	6.4-8.1 g/dL
	Na	142	128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh	
T&C	
T&S	

HCG

Urine	Negative
Serum	Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	9.9	4.8-10.8 x10(3)/uL
	RBC	5.66	4.2-6.1 x10(6)/uL
	Hgb	17.1	12.0-18.0 g/dL
	Hct	49.6	35.0-60.0%
	MCV	87.8	80.0-99.0 fl
	MCH	30.2	27.0-31.0 pg
	MCHC	34.4	33.0-37.0 g/dL
	Plt	192	130-400 x10(3)/uL
	LY%	31.5	15.0-55.0%
	LY#	3.1	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin	No Plasmodium Seen
Thick	No Plasmodium Seen

Sed Rate

Sed Rate	1hr = 0-20 mm

Coagulation

PT	10-13 seconds
APTT	22.1-33.7 seconds
FDP	Negative

Misc. Chemistry

Mono	Negative
RPR	Negative
HIV	Negative
Meningitis	Negative
Tropin	Negative

MEDCOM - 315

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) | LOG NUMBER

ARRIVAL — DATE: DAY 24, MONTH Sep, YR 03 | TIME 1556

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) MP escort

CURRENT MEDS. (tetanus immunization and other data): Ventolin Inh, Beclomethasone Inh, Prednisone

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify) interpreter

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration): CP / "Difficulty breathing"

SEX: M | AGE: 49

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1600

VITAL SIGNS

TIME	1610	1900	
BP	180/95		
PULSE	101	91	
RESP.	14		
TEMP.	98.2		
WT. (Clothed)	97%RA	97%RA	

CATEGORY (See reverse)
- ☐ EMERGENT
- ☒ URGENT
- ☐ NON-URGENT

ORDERS	INITS.	TIME
CBC, DIFF, MCV/PLT		
CXR, EKG		1630
IV, VS TKO		
[redacted]		
ABG/VBG, CBC		
[illegible]		

ASSESSMENT/DIAGNOSIS: [illegible] Chest Pain

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): MH clinic 0800
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED
- TIME OF RELEASE: 1730

PATIENT'S IDENTIFICATION (Mechanical imprint OR WRITTEN ENTRIES GIVE: Name—last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD):

[redacted] B6-4

(b)(6)-4

49 yo male detainee brought by MP's for evaluation of chest pain. On interview through translator, detainee reports hx of asthma and recent difficulty breathing at night similar to prior asthma exacerbations. Seen by MP's medical personnel at some point prior to transfer for detention at which time he received albuterol and given breathing treatments and beclomethasone inh's and prednisone, but patient taking only albuterol inh 1 x 2 per day.

PMHx: Asthma — frequent exacerbations
Meds: Albuterol, Beclomethasone, Prednisone — NOT using
PSHx: Ø
Allergies: NKDA
Habits: Nonsmoker
SH: Detainee, unable to speak English, speaks in complete sentences requiring questions through interpreter.

INTERN: Worn + dry Ø rales
RECENT: Unremarkable
EKG: NSR @ 91 bpm, WNL
CXR: Clear
ABG: Benign
EXTREM: Ø edema
LUNGS: Coarse wheezes throughout, no focal findings on auscultation

Impression: 49 y male with hx asthma and findings c/w exacerbation due to environmental allergy. Could be steroids, will

(CONTINUE ON SF 507, IF NEEDED)

SIGNATURE OF PROVIDER AND ID TYPE: (b)(6)-2

(plans)

1. Prednisone 60 mg orally each day for five days
2. Ventolin HFA - two puffs 4x/day
3. Albuterol HFA - two puffs 4x/day

MEDCOM - 316

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): 21st CSH

LOG NUMBER

ARRIVAL — DATE: DAY 24 MONTH Sep YR 03; TIME 2310

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): none

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKAD

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW (L) Thigh

SEX: M AGE: 22

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	2310		
BP	111/65	50	
PULSE	71		
RESP.	24		
TEMP.			
WT. (Child)	100 %		

CATEGORY (See reverse): ☐ EMERGENT ☐ URGENT ☒ NON-URGENT

ORDERS

ORDERS	INITS.	TIME
CBC, T+T (L)	[redacted]	
CR,		
X-mats x4		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

S. 22 y/o male pt c gun shot to (L) thigh

22y/o Iraqi civ s/p GSW (L)

b. thigh. Ent scene, had entered

bldgs for (L) groin ext wound

c 1L blood loss A+O, VS stable +

wnl Tourniquet placed.

P

Tobacco 8-10 per day

PMH 0

PMS 0

C - clear A3C ✓

ACx3

ASSESSMENT/DIAGNOSIS: (L) GSW to thigh

(L) possible bladder

+ femoral art injury

CV - Reg ☐m

lungs - clear (B) = BS

abd - S/NT/ND

neuro - ACx3 nonfocal

MSK - ☐ grossly intact

pelvis - (L) groin hematoma

ext - tourniquet on (L) prox thigh

entrance wound to (L) thigh c + ew under

tourniquet (L) groin

2+ DP pulse on (L) moves all toes

neuro - ☐ gross bladder/rectal

(CONTINUE ON SF 507, IF NEEDED)

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: OR

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE: 2

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 TREATMENT RECORD).

Patus # [redacted]

B6-4

[redacted]

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

ESC 1 Tetanus booster - gross hematoma c

300cc (L) femur fx s xrt Fx

(L) tibia x-rays F/U 1+ fb's

+ CBC, T+T, Cx + Enema

SSN-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

(b)(3)-1

FACILITY (Stamp) 31st CSH

LOG NUMBER

ARRIVAL: DATE (DAY 26, MONTH SEP, YR 03) TIME 1140

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): GLIPIZIDE 5mg BID

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): LOW BLOOD SUGAR

SEX M AGE 62

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	1147		
BP	141/68		
PULSE	99		
RESP.	16		
TEMP.	98.6		
WT. (Child)	94		

CATEGORY (See reverse)

- ☐ EMERGENT
- ☐ URGENT
- ☒ NON-URGENT

ORDERS	UNITS	TIME
CBC DIFF GLU	CHEM	1250

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures/Medications (Immediate follow-up)

PT WAS SEEN 25SEP03 FOR LOW BLOOD SUGAR. PT

62y male detained c hx diabetes seen ER yesterday for elevated glucose (7300) and (R) great toe lesion and started on oral hypoglycemic w/ hx of blood sugar. Mingo translator, detainee relates good understanding of dietary recommendations, MPs administering medications as directed.

GENERAL: WN/WD/C adult/NAD/answers appropriately Mingo translator

SKIN: warm + dry c rashes

HEENT: Unremarkable

LUNGS: CTAB c WFR

CV: RRR c (M) murmur

ABD: BS(+)

EXTREM: Healing callus (R) great toe c drainage or evidence infection c LE edema

9.7 / 44.5 / 16.4 / 206 | 139 / 106 / 24 / 162 | 4.4 / 1.1

Great toe debrided c bacitracin + gauze

ASSESSMENT/DIAGNOSIS: DM-2, hyperglycemia

DISPOSITION (Check all that apply)

- ☐ HOME
- ☐ FULL DUTY
- ☐ QUARTERS
- ☐ 24 HR. ☐ 72 HR.
- ☐ MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- ☐ REFERRED TO (Individual or clinic)
- ☐ EMERGENCY ☐ ROUTINE
- ☐ 72 HOURS ☐ ROUTINE
- ☐ ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

- ☒ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE: 1200

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... MEDICAL RECORDS.

(b)(6)-4

(b)(6)-2

(CONTINUE ON SF 600 IF NEEDED)

etc, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

CONTINUE MEDICATIONS AS PRESCRIBED 4 STEROIDS

MPs TO RETURN TO CSH FOR RECHECK AS NEEDED

b6-4

MEDCOM - 318

ACLU-RDI 1025 p.51

DOD 003445

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

(b)(3)-1 [redacted] ENT FACILITY (Stamp) 21ST CSH (b)(3)-1 [redacted]

LOG NUMBER

ARRIVAL: DATE DAY 15 MONTH MAR TIME 1355

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: PCN

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (Enter brief symptom(s), duration): High Blood Pressure

SEX: M AGE: 60

POSSIBLE THIRD PARTY PAYER? ☐ YES ☒ NO

VITAL SIGNS				
TIME	1355	1500	1600	
BP	164/88	154/86		
PULSE	64	58		
RESP.	18	18		
TEMP.	98.4			
WT. (Child)				

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

(b)(6)-2 [redacted]

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS	TIME
[redacted]		

(ASSESSMENT) DIAGNOSIS
1. [redacted]
2. Chronic otitis media

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

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE:

(CONTINUE ON SF 507 IF NEEDED)

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)

[redacted] B6-4

(b)(6)-4 [redacted]

SIG (b)(6)-2 [redacted]

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

[redacted] B6-4

MEDCOM - 319

ACLU-RDI 1025 p.52

DOD 003446

(See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY / MONTH / YR. — TIME

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data)
ATENOLOL

HISTORY OBTAINED FROM
☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration)

SEX: M AGE: 45

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

VITAL SIGNS

TIME	1116		
BP	160/92		
PULSE	62		
RESP.	20		
TEMP.	97.5		
WEIGHT	75		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 1130

S) 65 y male ♂ detainee brought in MP custody for blood pressure medications.

Meds: Tenormin
Allergies: Penicillin
Habits: occ. cigar

PMHx - HTN
Exam: obese elderly ♂ in NAD
Pleasant guarded responses, poor translator
HEENT: normocephalic, PERRLA, EOMI, poor dentition
CV: RRR ⓜ no s3/s4
A: BP: anemia/stiff/HT/possible CHF
Extrem: ♀ edema
Neuro: alert

Impression: HTN

Plan: took Rx atenolol 50mg po daily x two weeks quantity

(CONTINUE ON SF 507, IF NEEDED)

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NONURGENT

ORDERS	INITS.	TIME

TREATMENT/DIAGNOSIS
HYPERTENSION

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

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE: 1200

PATIENT'S IDENTIFICATION (Mechanical imprint)
IF MORE THAN ONE PATIENT ENTRIES GIVE: Name - last, first, middle; SSN; DOB; service status; name and relation of sponsor or
IMPORTANT: LIST FACILITY HOLDING TRE
OF RECORD)

[redacted]

SIGNATURE OF PROVIDER AND ID STAMP
(b)(6)-2

(b)(6)-4

B6-4 Atenolol 50mg - 1 po QD #15 NR

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974) B6-4

LAST, FIRST, MI: Polos # [redacted] B6-4 | UNIT: Detainee | RANK: CIV | SSN: 000-[redacted]

Physician: (b)(6)-2 | Ward: EMT | STAT: X | Routine: | Date and Time: 27 Sep 03 1 | Reported by: (b)(6)-2 | Date and Time: 27 Sep 03

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		- (-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobil		Negative
Nitrite		Negative
WBC		Negative

Urine Microscopic

Epi	
Mucus	
Yeast	

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	23	7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK	383 *	30-170 U/L
	Cl	102	98-108 mmol/L
	TCO2	21	18-33 mmol/L
	Creat	0.9	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	302 *	73-118 mg/dL
	K	4.1	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	139	128-145 mmol/L
	Troponin	<0.05 ng	Neg

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh	
T&C	
T&S	
*	

HCG

Urine	Negative
Serum	Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 7 CSH

LOG NUMBER

ARRIVAL — DATE: DAY 27 MONTH SEP YR. 03 TIME 1000

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): [illegible] Nitro SL

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: ~~Asa~~ ASA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Mosul Irq

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom (s), duration): Arrest Meds

SEX: M AGE: 65

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 01 [illegible]

VITAL SIGNS

TIME	1000		
BP	133/75		
PULSE	67		
RESP.	20		
TEMP.	100 F		
WT. (Child)	98 #'s		

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT

ORDERS	INITS.	TIME

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

65y male detainee brought in custody of military police requesting prescription of medications. Detainee c hx HTN and ASCAD reportedly takes

INDERAL 20mg po Bid
ISORDIL 10mg po Bid
Nitro SL

GENERAL: Elderly [illegible] male Awake, appropriately [illegible] translator

HEENT: Warm + dry ○ Rales
NECK: ○ JVD
LUNGS: CTAB & unlabored
CV: RRR & (M) ~~dl~~ s1/s2
ABDO: Benign
EXTREM: ○ edema

Impression: Completely asymptomatic.

Plan: Medications as requested.

PSH - ○
PMH - MI ?
Stroke - 1990

ASSESSMENT/DIAGNOSIS: ASCAD

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): MP CUSTODY
- EMERGENCY | TODAY
- 72 HOURS | ☒ ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- IMPROVED ☒ | UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1032

(CONTINUE ON SF 507 IF NEEDED)

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 TREATMENT RECORD).

(b)(6)-2

Pats.

(b)(6)-4

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans):

1. ~~INDERAL 40mg~~ SL for use prn CP
2. ISORDIL 40mg, ½ tab 2x/day
3. ~~Cancel 10mg one tab each day~~

MEDCOM - 322

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 27 | MONTH 09 | YR. 03 — TIME: 1000

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data)

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX M | AGE 62

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	1000		
BP	145/73		
PULSE	61		
RESP.	18		
TEMP.			
WT. (Clothed)	91		

CATEGORY (See reverse)
- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS	TIME
1 stat C	[redacted]	

ASSESSMENT/DIAGNOSIS

DM-2

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Seen yesterday i hyperglycemia brought back today to include serum glucose electrolytes, BP ↑ starting on glipizide, atenolol and lyrica

140 | 102 | 21 / 229

4.1

Impression:

hyperglycemia, hypertension tolerating atenolol, lyrica, glipizide and increased glipizide to 5 mg bid.

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) MP custody

EMERGENCY | TODAY

72 HOURS | ☒ ROUTINE

ADMIT TO (Hosp. Unit/Service)

CONDITION UPON RELEASE

IMPROVED ☒ UNCHANGED

DETERIORATED

TIME OF RELEASE: 1030

(CONTINUE ON SF 507 IF NEEDED)

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 TREATMENT RECORD).

Potus [redacted] -B64

(b)(6)-4

(b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

increase glipizide to 5 mg twice per day

MEDCOM - 323

(4)

558-109 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL: DATE DAY 26 MONTH Sep YR 03; TIME 1145

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): TENORMIN (?10mg) DIABINESE CIPROFLOXACIN

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Mosul, Iraq

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): C/O hyperglycemic symptoms + ABD pain

SEX: M AGE: 62

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: on arrival

VITAL SIGNS

TIME	1145	1317
BP	165	139/69
PULSE	80	69
RESP.	20	20
TEMP.	101.1°	100.3°
WT (Lbs)	98%	98%

CATEGORY (See reverse)

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

ORDERS	INITS.	TIME
CBC w/ Diff	[redacted]	1158
Cr, UA		
[illegible]		1153
Complete 2 hour OGTT w/ 75 gm load		
Obtain 1-stat-B+		

ASSESSMENT/DIAGNOSIS: Hyperglycemia ? Type 2 DM ? Hyperlipidemia ? BPH

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): MAP CLINIC TODAY

☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☒ ROUTINE

ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

☒ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE:

62y male DEPLOYED brought by MEDS for evaluation of diabetes, hypertension and lower abdominal discomfort. DEPLOYED reports taking diabenese for DM and Tenormin for high blood pressure. Also taking ciprofloxacin for diverticulitis - describes symptoms of BPH - but no dysuria

Meds: Tenormin, Diabenese, Ciprofloxacin

Allergies: NKDA

Meds: Tenormin

Diabenese

Ciprofloxacin

Allergies: NKDA

PMHx: DM-2

? HTN

? BPH

PSHx: Ø

GENERAL: comfortable Iraqi adult male, answers appropriately through translator

HEENT: conj + dry, O/P clear

NECK: supple

LUNGS: CTA B's w/o r/r/w

CV: RRR s S1/S2

ABDO: s/NT/ND/+BS, Ø mass

EXTREM: Ø edema

CBC 15.6 / 45.3 / 227

BMP 139 / 3.8 / 103 / 30 / 242 / 1.3

UA: SG 1.035

Hemoglobin A1c >2000 glucose

Ø blood Ø LE

Lipid panel 140 / 106 / 25 / 240 / 3.9

PM (venous) = 7.326

(CONTINUE ON SF 507, IF NEEDED)

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 TREATMENT RECORD)

(b)(6)-2

LTC, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

1. TENORMIN 25mg - one orally each morning
2. TERAZOSIN 2mg - one orally each evening
3. GLIPIZIDE 5mg - one orally each morning
4. NITROGLYCERIN SUBLINGUAL apply to [illegible] as needed

DOTMS # [redacted] B6-4

[redacted]

(b)(6)-4

MEDCOM - 324

ACLU-RDI 1025 p.57

DOD 003451

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21st CSH (b)(3)-1

LOG NUMBER: N/A

ARRIVAL — DATE: DAY 26 MONTH 9 YR. 03; TIME: 2354

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Walk in

CURRENT MEDS. (tetanus immunization and other data): ARTHM - CELIB -

HISTORY OBTAINED FROM: ☐ PATIENT ☒ OTHER (Specify) [illegible]

ALLERGIES: NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code): N/A

CHIEF COMPLAINT(S) (Include symptom(s), duration): S. Setting —

SEX: M AGE: 47

POSSIBLE THIRD PARTY PAYER? ☐ YES ☒ NO

TIME SEEN BY PROVIDER: 1 GCCC

VITAL SIGNS

TIME	2355		
BP	[illegible]		
PULSE	125		
RESP.	16		
TEMP.	[illegible]		
WT. (Child)	97 lb		

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☒ NON-URGENT

ORDERS — INITIALS — TIME

Ativan 2 mg IV
IVCC NS
MCT 8 cm

ASSESSMENT/DIAGNOSIS: Seizures

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): EDC
- ☐ EMERGENCY — ☐ TODAY
- ☐ 72 HOURS — ☐ ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE: FCC

CONDITION UPON RELEASE
- ☐ IMPROVED — ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE: 0114

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):

Potus [redacted] B6-4

(b)(6)-4

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medications given and follow-up)

S: 47 yo M c/o seizure x 5 yesterday x 1 today

PMH - [illegible]
PSH - [illegible]
med - [illegible]
none
PSH - 0

S - 47 yo [illegible] hx epilepsy [illegible] seizures currently [illegible] + [illegible] taper and [illegible] 5 days. On 2 [illegible] meds - one BID + one - [illegible] Now hospitalized after [illegible] with [illegible] he stays + [illegible] [illegible] prompted [illegible]

No [illegible]
No [illegible]
No headaches. No trauma [illegible]

[illegible] Comm. Tongue [illegible] [illegible] facial droop [illegible] arm [illegible] symmetric [illegible] c/w witnessed [illegible] - Cute - Bicep / [illegible] strength - symmetric [illegible] grip [illegible] symmetric

[illegible] P. had several [illegible] during exam. Pt fell [illegible] team [illegible] appeared [illegible] several times. Post ictal. [illegible] incontinence. Confused. Given [illegible] Ativan

(CONTINUE ON SF 507, IF NEEDED)

SIGNATURE OF PROVIDER AND TITLE: (b)(6)-2 [illegible] MD

Plans) [illegible] medications ordered, any limitations and follow-up

Total [illegible] time - reversed [illegible] 5 Resolution [illegible] baseline amnesia 1 15" until Ativan given / [illegible] Given [illegible] about [illegible] [illegible] [illegible]

MEDCOM - 325

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 21st CSH

LOG NUMBER

ARRIVAL: DATE DAY 18 MONTH 04 YR 03; TIME 1432

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) CAV

CURRENT MEDS. (Tetanus immunization and other data): 0

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): CIV Mosul / Iraq

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration)

SEX: M AGE: 58

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: on arrival

VITAL SIGNS

TIME			
BP			
PULSE			
RESP.			
TEMP.			
WT. (Child)			

CATEGORY (See reverse)
EMERGENT
URGENT
NON-URGENT

ORDERS	INITS.	TIME

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

58y/o EPW # [redacted] B6-4 presents c possible contusions

58y ♂ IRAQI DETAINEE brought in MP custody for evaluation of redness and drainage OS. On interview through interpreter detainee also c/o laceration to scalp sustained 2d ago when apprehended and dizziness and ringing in ears since UXO

ASSESSMENT/DIAGNOSIS

CONTUSIONS
SCALP LACERATION

GEN: WNWD/WD IRAQI male answers questions appropriately through translator

MUSC: warm + dry c/ rashes

RESP: CTA

ABDOMEN: NT/ND/+BS

EXT: FROM throughout, steady gait

HEENT: PERRL/EOMI/sclera injected OS
ONL moist/throat clear
C-spine NT
VA grossly normal (counts fingers)

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): MP CUSTODY
EMERGENCY TODAY
72 HOURS ☒ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
IMPROVED UNCHANGED
DETERIORATED
TIME OF RELEASE: 1445

(CONTINUE ON SF 507 IF NEEDED)

PATIENT IDENTIFICATION (Mechanical imprint) OR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB; service status, name and relation of sponsor or next of kin. IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD:

(b)(6)-2

UTL/MK

(Include medications ordered, any limitations and follow-up plans)

Apply Bacitracin ophtal ointment to affected eye 2x/day for 5d
Bacitracin + bandage to scalp

Lead EPW # [redacted] B6-4

(b)(6)-4 [redacted]

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ACLU-RDI 1025 p.59

DOD 003453

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Station): 21st CSH (b)(3)-1

LOG NUMBER

ARRIVAL — DATE: DAY 28, MONTH Sept, YR 03; TIME: 1430

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): NONE

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: ~~NKDA~~ PCN

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Potus Detainee

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX: M AGE: 37

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: On arrival

VITAL SIGNS

TIME	1433		
BP	118/65		
PULSE	85		
RESP.	20		
TEMP.	99.1		
WT (Kilos)	99		

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☒ NON-URGENT

ORDERS	INITS.	TIME
CBC, Istat 6	[redacted]	1448
CL, UA LFT		1449
IV		1448

ASSESSMENT/DIAGNOSIS: DySuria

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): MP custody
- EMERGENCY | TODAY
- 72 HOURS | ☒ ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- IMPROVED ☒ UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1530

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

(b)(6)-2

Potus 37 s/o pain in (R) lower pelvic area.

37y Iraqi detainee c/o dysuria

Through translator, reports he was told that he has many bladder stones currently asymptomatic. Also requests Rx for Zantac

PMHx: GERD Meds: Zantac Allergies: PCN

PSHx: ∅ Allergies: PCN

Meds: Nexium

GENERAL: AAO x3/Iraqi detainee/NAD/A+Ox3 answers appropriately through interpreter

~~HEENT: WDWN, dry, ∅ jaundice~~

NECK: Unremarkable

CHEST: CTAB x4 w/R/R

CV: NRRR x (W) all S1/S2

ABDOMEN: Soft/NT/ND/∅ mass ∅ suprapubic tenderness ∅ CVA tenderness

EXTREMITIES: ∅ edema

6.2	11.3 / 35.7	139 / 105 / 9.1	26 / 1.2 / 191 / 1.4	AMB = 3.8	AST = 25
				AMP = 66	TB = 0.8
				ALT = 20	BUT = 9
				AMY = 52	TP = 7.6

UA - SG=1025 ∅ glucose/trace ketones ∅ blood ∅ nit ∅ LE

(CONTINUE ON SF 507, IF NEEDED)

PERSON'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; CONFINEMENT; LIST FACILITY HOLDING TREATMENT RECORD

(b)(6)-2

Potus Detainee

B6-4

(b)(6)-4

INSTRUCTIONS (Operative, Dietary, Medications ordered, any limitations and follow-up plans)

Rx for GERD & Zantac provided

Pt patient request: Request 40mg orally 2x/day refills

MEDCOM - 327

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974) B6-4

LAST, FIRST, MI: POTUS # [redacted] B6-4 | UNIT: Detainee | RANK | SSN [redacted]

Physician: (b)(6)-2 | Ward: | STAT / Routine | Date and Time: 28 Sept 03 | Reported by: (b)(6)-2 | Date and Time: 28 Sept 03 1515

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	139	128-145 mmol/L
	K	4.1	3.3-4.7 mmol/L
	Cl	102	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	26	7-22 mg/dL
	Glu	141	73-118 mg/dL
	Creat	1.4	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB	3.8	3.3-5.5 g/dL
	ALP	66	26-84 U/L
	ALT	20	10-47 U/L
	AMY	52	14-97 U/L
	AST	25	11-38 U/L
	Tbil	0.8	0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT	9	5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	7.6	6.4-8.1 g/dL
	Na		128-145 mmol/L

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	6.2	4.8-10.8 x10(3)/uL
	RBC	5.41	4.2-6.1 x10(6)/uL
	Hgb	11.3	12.0-18.0 g/dL
	Hct	35.7	35.0-60.0%
	MCV	66.0	80.0-99.0 fl
	MCH	20.9	27.0-31.0 pg
	MCHC	31.7	33.0-37.0 g/dL
	Plt	185	130-400 x10(3)/uL
	LY%	20.2	15.0-55.0%
	LY#	1.3	0.7-4.3 x10(3)/uL

Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp Ly		Imm	
RBC Morph:			
Plt verify:			
Spun Crit		35-60%	

Urinalysis

Color	Yellow	Straw/Yellow
Clarity	CLEAR	Clear
Glucose	NEG	Negative
Bilirubin	NEG	Negative
Ketone	TRACE	Negative
SG	1.025	1.010-1.025
Blood	NEG	Negative
pH	6.0	5.0-8.0
Protein	TRACE	Negative-Trace
Urobili	NEG	Negative
Nitrite	NEG	Negative
Leuko	NEG	Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	1
Casts:			
Crystals:			
Other:			

Microbiology

Source:		
Fecleuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 328

ACLU-RDI 1025 p.61

DOD 003455

NSN 7540-00-834-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
18 Sep 03	Patus ♂ c/o Bleeding from external fixator. —
1415	37y Iraqi ♂ sent from detainee for
BP 111/57	evaluation of possible bleeding from
P 51	external fixator. Placed 7 months ago
R 16	by local civilian physician
T 98.9	O: WD/WN/♂/NAD/Alert
SpO2 97%	Answers appropriately through interpreter
	(L) LE with ex-fix in place
	Ø drainage or bleeding
	Distal neurovascular intact
	Ambulates c full weight bearing
	A: No evidence of infection
	P: F/U civilian physician when appropriate

(b)(6)-2

(b)(6)-2 , USMC

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.

[redacted] B6-4

(b)(6)-4

MEDCOM - 329

CHRONOLOGICAL RECORD OF MEDICAL RECORD

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 18 MONTH 4 YR 03 — TIME: 1945

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Include immunization and other data): Ø

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s)-duration): Rt foot and (R) wrist pain, Ø

SEX: M AGE: 24

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1960

VITAL SIGNS

TIME				
PULSE	88			
RESP.				
BP				
TEMP.				
WT.				
PAIN				

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

24 y/o M, EPW, presents to ER c/o (R) wrist pain and (R) foot 1st digit pain, 1st digit on foot swollen/reddened & visible just noted near nail. Superficial (R) wrist abrasions noted - DJN

24 yo EPW c/o (R) foot pain for [illegible]. P/E Skin: clean, dry, and intact. [illegible] to foot. Pain to plantar aspect. Red swollen, tender Ø nail bed (R) great toe. XR (R) foot, wrist. FB in wrist? FB in foot? Ø FB

Rx: Motrin 800 mg PO TID x 10 days. No FB found. Cast applied to (R) wrist. Ortho f/u in 1 week. Return to ER if worsening symptoms. Crutches given. Pt verbalized understanding. DJN

CATEGORY (See reverse)
- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS: Ø Great toe [illegible]

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): Ortho Dec 22
- EMERGENCY — TODAY
- 72 HOURS — ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- IMPROVED — UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1977

PATIENT'S IDENTIFICATION (Mechanical imprint) OR 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 RECORDS

(b)(6)-4 [redacted] B6-4

(b)(6)-2 [redacted]

(CONTINUE ON SF 507 IF NEEDED)

[illegible] any limitations and follow-up

Ortho

Return if no better in 7 days

Crutches

MEDCOM - 330

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
[Medical Record]

TREATMENT/FACILITY (b)(3)-1 21ST CSH

LOG NUMBER

ARRIVAL — DATE: DAY 12 MONTH DEC YR 03 — TIME: 11:13

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): CAPOTEN

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): CAMP ARIFJAN #287 DELAWARE

HOME TELE. NO. (Inc. area code)

BRIEF COMPLAINT(S) (Include symptom(s), duration): HYPERTENSION RECHK

SEX: M AGE: 30

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1130

VITAL SIGNS

TIME	11:20		
BP	145/90		
PULSE	74		
RESP	16		
TEMP.	100.9		
PULSE (Oxim)	98		

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Sby IRAQI & DETAINEE brought sick call detainee requesting medication refill. Taking unknown dosage of capotril. MP's report detainee receiving medications. Detainee also requesting medication for "stomach upset"

PMHx: HTN
? GERD
Meds: Capotril
Allergies: NKDA
Habits: nonsmoker

GENERAL: WNWN/cheerful IRAQI D/NAD answers questions appropriately through translator
SKIN: warm + dry ⊘ rashes
ACCENT: Unremarkable
LUNGS: CTAB & CVR/R
CV: RRR ⊘ M/R/G
ABD: active BS/soft/NT/⊘ mass
EXTREM: ⊘ edema
NEURO: WNL/oc

Hypertension - currently controlled. Some confusion about where detainee is receiving medications. Will provide new Rx & instructions to discontinue

(CONTINUE ON SF 507, IF NEEDED)

ASSESSMENT/DIAGNOSIS
Hypertension, controlled

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): MP CUSTODY
☐ EMERGENCY ☐ TODAY
☒ 72 HOURS ☐ ROUTINE
ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE: 1200

PATIENT'S IDENTIFICATION (Mechanical imprint) OR WRITTEN ENTRIES GIVE: Name - last, first, middle initial; SSN; DOB; service status; Name and relation of sponsor or IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD). (b)(6)-2

STATUS: [redacted] (detainee)

(b)(6)-4 B6-4

00-0021

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)
CAPTOPRIL 25mg 1 po qd #15 NR
TRICHLORMETHIAZIDE 4mg 1 po BID #20 NR
Discontinue other medications

MEDCOM - 331

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) 21st CSH (b)(3)-1

LOG NUMBER

ARRIVAL — DATE: DAY 02 MONTH 10 YR. 03 — TIME: 1750

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): Keflex

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: Ø

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Bloody Stools

SEX: M AGE: 39

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1755

VITAL SIGNS

TIME	1755		
BP	116/71		
PULSE	80		
RESP.	18		
TEMP.	98.9 tA		
WT.(Child)	180		

CATEGORY (See reverse)
- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

39 y/o M, EPW, presents to EMT c 4/0 bloody stools for 3 days. Pt. c/o pain to rectum. 1 episode/d

Red stools. ↓ bleeding stools

Also discomfort w rectum F/U

No c/f/implications SX;

On Keflex - unclear why c worsening diarrhea. S/Ø

abd - soft NT, ND, (+)BS

rectal - pumpkin

↓ rads

↓ fiber

brown hemorrhoid stool

ASSESSMENT/DIAGNOSIS: Anal fissure

Prob fissure

Hemorrhoids

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): 7th

- EMERGENCY
- 72 HOURS
- TODAY
- ROUTINE

ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1800

PATIENT'S IDENTIFICATION (Mechanical imprint) OR 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. PATIENT RECORD)

(b)(6)-4

SIG (b)(6)-2

INST plan

dull MC

my limitations and follow-up

Eat more fiber

US B6-4

MEDCOM - 332

ACLU-RDI 1025 p.65

DOD 003459

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 02 MONTH 10 YR 03 — TIME: 2220

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data)

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Shrapnel injuries to (R) face, (R) humerus, (R) femur — SEX: M — AGE: 33

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 2220

VITAL SIGNS

TIME	2225		
BP	126/78		
PULSE	84		
RESP.	20		
TEMP.	98.8		
WT. (Child)	180		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

33 y/o M, EPW presents to EMT. T pos. shrapnel wounds to (R) face, (R) humerus, (R) femur/pelvic area, pt. ambulatory on arrival, A/Ox3, 4E CTA b/l ext, pedal pulses intact, GCS 15, [illegible]

33 y/o c/p GSW (-) FH. P: IV x 2 (18g) RFA (EPW) T/9
Shrapnel wounds to face, humerus & femur
L/S Saline
[illegible] - (R) humerus
Trms: clean
CMS WNL
Chest: FW (R) lat chest under (R) arm
Back: FW (R) lat chest under (R) arm
Abd: SMT wounds
Pelvis: FW (R) buttock
(R) leg - 2 GSW (FW) (R) lat thigh, thru & thru
(R) humerus - MFW (L) entry
Femur - Acts as if can't move RLE. GCS 15.
Pain control given
EPW Statement taken by Cmdr (Retired) [illegible]
Abx given

CATEGORY (See reverse)
- ☐ EMERGENT
- ☒ URGENT
- ☐ NON-URGENT

ORDERS	INITS.	TIME
X-Rays (R) face		2315
(R) femur		
(R) humerus		
Pelvis		2315
CBC, T&S, UA, Lytes		2345
Morphine IV		2310

ASSESSMENT/DIAGNOSIS
MFW (Small)

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): EPW
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE: [illegible]

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED
- TIME OF RELEASE: 0000

PATIENT'S IDENTIFICATION (Mechanical imprint)
OTHERWISE ENTRIES GIVE: Name - last, first, middle; DOB, service status, name and relation of sponsor or next
IMPORTANT: LIST FACILITY HOLDING TREAT RECORD).

[redacted] Status # [redacted] B6-4

(b)(6)-4

(b)(6)-2

(b)(6)-2

EEDED)

MP

MMJ, MC

lications ordered, any limitations and follow-up

- Face, (R) [illegible] humerus, (R) femur, pelvis
- MFWs. MFs. & Txs.

d/c to EPW FACILITY

MEDCOM - 333

ACLU-RDI 1025 p.66

DOD 003460

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
20 OCT 03 2230	33 y/o M EPW presents to EMT c pos. GSW/shrapnel injuries to ®face, ®humerus, ®femur/pelvis areas, Pt. ambulatory on arrival, airway intact, LS CTA bilat., skin PW/Dry c dried blood noted to above areas. Pts. face, ®femur TTP. Pedal pulses strong equal bilat. Pts. GCS 15/15. Pt. recieved IV 18G to ® bicep, infusing LR 150cc/hr, blood drawn sent to lab, X-Rays ordered. - [b)(6)-2]
2310	Pt. taken to Radiology for X-Rays, Ancef 1g IVPB infusing @ this time. [b)(6)-2] CPT/AN
2350	Pt. returned from radiology. [b)(6)-2] CPT/AN

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.

POTUS #[redacted] B6-4

[b)(6)-4]

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical [illegible]

STANDARD FORM 600

Prescribed by GSA/ICMR

FIRMR (41 CFR 201-45.505)

MEDCOM - 334

B6-2

B6-4
21st COMBAT SUP [redacted] HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	RANK	SSN
DOUS # [redacted] B6-4			

Physician: (b)(6)-2	Ward: CMT	X STAT / Routine	Date and Time: 020CT03 23:07	Reported By: (b)(6)-2	Date and Time: 20Oct03 2330

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	140	128-145 mmol/L
	K	4.0	3.3-4.7 mmol/L
	Cl	110	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	9	7-22 mg/dL
	Glu	118	73-118 mg/dL
	Creat	0.9	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

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

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:			
Crystals:			
Other:			
Other:			

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	16.7	4.8-10.8 x10(3)/uL
	RBC	4.59	4.2-6.1 x10(6)/uL
	Hgb	14.7	12.0-18.0 g/dL
	Hct	43.6	35.0-60.0%
	MCV	95.0	80.0-99.0 fl
	MCH	32.0	27.0-31.0 pg
	MCHC	33.6	33.0-37.0 g/dL
	Plt	306	130-400 x10(3)/uL
	LY%	7.4	15.0-55.0%
	LY#	1.2	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Istat 6 ISE

MEDCOM - 335

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21st CSH (b)(3)-1

LOG NUMBER

ARRIVAL
DATE: DAY 2 | MONTH 10 | YR. 03
TIME: 2225

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT ... tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: PCN

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW neck.

SEX: M | AGE: 37

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 2256

VITAL SIGNS

TIME	2225	2315	2330
BP	149/91	130/79	125/79
PULSE	93	95	89
RESP.	16	22	15
TEMP.	97.8	97.9	
WT.(Child)	97	97%RA	95%

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☑ NON-URGENT

ORDERS	INITS.	TIME
CBC, Istat 6, Cr	[redacted]	2235
UA		2305
CXR, C-spine		2300
Immunos		2300
T+C x-ray		2235
Fluoroscein exam		2300

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

S: 37 y/o ♂ GSW to neck and shoulder.

37 yo EPW s/p GSW c M-4 to (L) lat neck. Stable en route. Speaking c airway intact.

C - A. wound
1° B - B: symmetric BS bilat
C. CR<2s, DP 2+
D - GCS 15, PERL
E - HEENT - 1cm post 3cm c neck GSW c significant hematoma ecchymosis.
Chest - (L) shoulder joint pain c decreased ROM
(L) Shoulder - GSW c FB palp post, small EW
Cv - RRR
lungs - CTAB
abd - S/NT/ND
pelvis stable
back - deferred
neuro symmetric MM 5/5 UE/LE. Reflexes 2+

PMH - Ø
PSH - 15 years ago (unknown)
Tob - Ø
Last Oral Intake 24 hrs

Plan - CXR, C-spine, thoracic spine, humerus

ASSESSMENT/DIAGNOSIS: GSW (L) neck

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

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
DATE OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) OR WRITTEN ENTRIES GIVE: Name - last, first, middle; grade, service status, name and relation of sponsor or next of kin. IMPORTANT: LIST FACILITY HOLDING TREAT. RECORD).

[redacted] B6-4

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP (b)(6)-2

TREATMENT (Include medications ordered, any limitations and follow-up plans)

Fx CR

MEDCOM - 336

ACLU-RDI 1025 p.69

DOD 003463

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 2+6SH

LOG NUMBER

ARRIVAL
DATE: DAY 10 | MONTH OCT | YR. 03 | TIME 1672

TRANSPORTATION TO [illegible]AL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data)

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)
Detainee

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)
(L) Leg injury

SEX M | AGE 54

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	1733		
BP	138/78		
PULSE	97	[redacted]	
RESP.	18		
TEMP.	99		
WT (LBS)	95		

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

54 y/o c/m brought by MPs. GSW to leg injury. Pt caught in hand lgt night (1 AM). Had MVC 10 days ago c (L) leg injury + 3 (R) rib fxs. Brought by MPs p/ 2° leg wound.

Ambulatory but unsteady. Had XR + sutures @ civilian facility — no leg fx — wound reopened (L) leg — with healing 2° to (L) leg injury.

angiocath 3 x 5 fx

ASSESSMENT/DIAGNOSIS
2° Reopening of (L) leg wound.

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): ER camp.
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

Observation in ER.
No evidence of infection
4 x XR done - that neg for fx or frag. bone

TIME OF RELEASE

(CONTINUE ON SF 507, IF NEEDED)

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)

CAT US# [redacted] B6-4

(b)(6)-2

ordered, any limitations and follow-up

, WHT, WMC

(b)(6)-4

Stable

MEDCOM - 337

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-675-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Specify) ACSF, MDSU, TFBSO | LOG NUMBER

ARRIVAL — DATE: DAY 17, MONTH Oct, YR. 03; TIME 1310

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ MP Escort ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): None

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Scorpion bite (R) FA

SEX: M | AGE: 18

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1320

VITAL SIGNS

TIME	1310		
BP	114/74		
PULSE	94		
RESP.	18		
TEMP.	99.3 (O)		
WT. (Child) OR	180 lbs		

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☑ NON-URGENT

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS: ARTHROPOD ENVENOMATION

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow up)

S. pt is from EPW Camp Security with scorpion bite 24" ago to (R) FA which is slightly swollen & red. [illegible] PSHx: 0 Tobacco: smokeless

18 y male & dependent brought by MP's concerned about an dropped envenomation (R) forearm. MP's under impression that envenomation is acute, but through translator details reports that he was stung or bitten by unknown or dropped yesterday.

GENERAL: WD/WN/ 18 y/o young adult/NAD - does not appear to be in any pain
SKIN: warm + dry ∅ rashes
HEENT: no oropharyngeal edema
LUNGS: CTAB ∴ a/p/l R
EXTREM: 1cm area of induration (R) forearm surrounding what appears to be insect bite ∅ evidence of infection or abscess and not tender to palpation

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): Clinic at MP's
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- ☐ IMPROVED ☑ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE: 1320

(CONTINUE ON SF 507, IF NEEDED)

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 TREATMENT RECORD.)

(b)(6)-2

(EPW Camp)

CRF sent F

(Medications ordered, any limitations and follow-up plans)

Potus# [redacted] B6-4

Motrin 800 mg orally 3x/day as needed
Benadryl 50 mg orally 4x/day as needed
Standard precautions reviewed

ANA SCO

MEDCOM - 338

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): 21CSH, Mosul Iraq

LOG NUMBER

ARRIVAL — DATE: DAY 17 MONTH Oct YR 03; TIME 1310

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify) MP escort

CURRENT MEDS. (Tetanus immunization and other data): None

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: PCN, eggs

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Scorpion bite (R) FA

SEX: M AGE: 18

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	1310		
BP	114/74		
PULSE	94		
RESP.	18		
TEMP.	97.6		
WT. (Clothes)	180 lb		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: on arrival

S: Pt is from EPW Camp escorted by MPs. Hx scorpion bite 24° ago to (R) FA which is slightly swollen & red. (b)(6)-2 LT/A

PMHx: 0
PSHx: 0
Tobacco: smokeless ppd

CATEGORY (See reverse)

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

ORDERS	INITS.	TIME

By IRAQI DETAINEE brought by MP's concerned about arthropod envenomation (R) forearm. MP's under impression that envenomation acute, but through translator, detainee reports that he was stung or bitten by unknown arthropod yesterday

ASSESSMENT/DIAGNOSIS

ARTHROPOD ENVENOMATION

O: GENERAL: WD/WN/AA young adult/NAD - does not appear to be in any pain
MUCOUS: warm + dry & pinkish
EYES: PERRL
LUNGS: CTA B 3 w/ RR
EXTREM: 1cm area of induration (R) forearm surrounding what appears to be insect bite & evidence of infection or abscess and not tender to palpation

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): custody of MP's
☐ EMERGENCY ☐ TODAY ☐ 72 HOURS ☐ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

☐ IMPROVED ☒ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE: 1320

(CONTINUE ON SF 507, IF NEEDED)

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).

(EPW Camp)

Potus# [redacted] B6-4

(b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

MOTRIN 800 mg orally 3x/d ac as needed
BENADRYL 50mg orally 4x/day as needed
SEDATION precautions reviewed

MEDCOM - 339

AT 308
Bed 2

558-103

(See Instruction on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 19 MONTH OCT YR. 03 — TIME 0900

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): PRIVATE VEHICLE / AMBULANCE / ☑ OTHER (Specify)

CURRENT MEDS (tetanus immunization and other data): UNKNOWN

HISTORY OBTAINED FROM: PATIENT / OTHER (Specify)

ALLERGIES: UNKNOWN

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX: M

AGE: UNK

POSSIBLE THIRD PARTY PAYER? ☒ YES ☐ NO

TIME SEEN BY PROVIDER: ON ARRIVAL

VITAL SIGNS		
TIME	0910	
BP	121/73	
PULSE	91	
RESP.	29	
TEMP.		
WT. (Child)	97%	

CATEGORY (See reverse)
- ☒ EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME
Maintain IV NS at 42 [redacted]		
2nd IV NS at 42 [redacted]		
Foley to gravity		
CBC, UA, T&S		
X-rays - chest, abdo, pelvis, skull		

ASSESSMENT/DIAGNOSIS: MULTIPLE FRAGMENTATION WOUNDS

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Adult ♂ local national of unknown age transferred from FST at TALIFAR ? sustaining injuries in grenade attack. Subject is alleged perpetrator of attack, arrived in custody of US personnel, will not speak or answer questions. Rec'd 4L crystalloid prior to transfer
AMPLE history - unobtainable - urine 450

A- patent and maintained
(nasal trumpet in R) 11.4 / 32.4 (279
B - Breath sounds symmetric
C - small amount of bleeding from fragmentation wounds
BP normal, pulse ~ 102
D - GCS - 12+ (? sedation) PERL, MAE
E - completely exposed, rolled ... = 1.022 large blood 20-30 RBC

GENERAL: Thin ♂ adult ♂ sedated, arousable but noncommunicative
INTEG: warm + dry
HEENT: NC ē small penetrating wound (R) temporal area A30/RA
PERRL/EOMI/sclera clear 0-P13
(L) nostril ē nasal trumpet
... not well visualized
⊖ blood in EAC
(L) small penetrating wound (R) anterior neck
LUNGS: CTAB ⊖W/R/R
CV: RRR ⊖ m/r/g
CHEST: numerous small penetrating ... fragments
ABD: ... small fragments ...
... wounds and ...

(CONTINUE ON SF 507, IF NEEDED)

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): General Surgery	
EMERGENCY / TODAY	
72 HOURS / ROUTINE	
ADMIT. TO HOSP. UNIT/SERVICE	

CONDITION UPON RELEASE: IMPROVED / UNCHANGED / DETERIORATED

TIME OF RELEASE:

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 TREATMENT RECORD).

(b)(6)-2

POTUS # [redacted] (detainee)
[redacted]
B6-4
POTUS # [redacted]

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

EXTREM - fragmentation wound (L) shoulder
(L) thumb ē open laceration at distal pad
(L) 3rd digit laceration sutured closed prior to arrival
Foley in place, glans ē contusion
Scrotum ē two small areas of trauma & scrotal edema

B6-4

MEDCOM - 340

PS #1 of 2

3 OCT 03 0730 UNKNOWN UNKNOWN

M UNK

ON ARRIVAL

0750
96/43
94
30
100% Bvm

60" / Franklin

Trauma of unknown age brought to CSH via FLA in custody of 3/327 INF Scouts (SPC MURRAY Hopkins) S sustaining GSW to chest, Hemlock valve over chest wound, no IV access on arrival

"AMPLE" History unobtainable

A - patent, grunting respirations
B - Breath sounds, chest rise symmetric, tachypneic
C - Intermittent thready peripheral pulses, active bleeding from
(L) posterior thoracic chest wound
D - Moving upper extremities only; flaccid + unresponsive all other extremities
E - Completely exposed, rolled and examined.

2 L NS O.C LR
monitors [redacted] 1130
BP, T+C, LR [redacted] 0743
EKG, ABLO [redacted] 0743
Foley [redacted] 0743

Sux succinocholine 100mg IV - 0743/5mg
Versed 2mg IV 0750/1mg
Dopamine gtt - 0757/mcg
Ancef 1 gm IV stat to OR/1gm
Tetanus

Intubations assisted by BVM, 16ga IV cath (L) FA, 8.5 E cord & placed (R) femoral by Dr. [redacted]

RSI c 100mg succinylcholine, intubated by MAJ Colwell c 8.5 ET tube via DL

(L) chest tube Thoracostomy placed by Dr. Eastman
2,500 cc crystalloid and 2 units emergency release blood administered and transfused to OR

Unilateral fingertips lacerations, etc, noted

post - (L) subscapular muscle fragment
Abdo - (L) paraspinal muscle fragment loss of psoas shadow

(1 of 2)

Patient [redacted] B6-4
SSN [redacted]

MEDCOM - 341

GCS PAGE 1 OF 2

2° SURVEY -

GENERAL: Minimally responsive
Moving upper extremity only, unable
HEENT: Pale, cool, clammy
NECK: No obvious injuries
OS anticipated (old surg)
ad pupil dilated, reactive
LUNGS: Tachypneic, grunting
chest rise, breath sounds symmetric
Penetrating wounds ① anterior paraxiphoid
② posterior-lateral thoracic
CV: Heart sounds distinct
ABDOMEN: Back: Penetrating wound ② posterior/lateral only
GU: Rigid tender
EXT: wk of EC ϕ trauma
NEURO: ϕ blood, flaccid tone
EXTREM: ϕ obvious trauma,
2E's apparently consensual
MOVES: Moving upper extremities only
initially, withdraw, purposeful movements

19.2 | 13.8 / 4.14 / 40.1 | 134 / 4.3 | 100 | 3.8 / 16 | 1.9

WB - 3C = 1.030 ϕ glucose ϕ ketone
(Large blood) 0-5 WBC/HPF RBC

(b)(6)-2

(2 of 2) TO OR

K. CHRIST DEPARTURE

[redacted]

B6-4

(See Instructions on Back of this Sheet)

NSN 7540-01-075-5736

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21st Combat Support Hospital

G NUMBER:

ARRIVAL				TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (Tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE			TIME	☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)	Orabutic Meds (c)	☐ PATIENT ☐ OTHER (Specify)
DAY	MONTH	YR.				ALLERGIES
26	10	03	0402			?

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): shrapnel wounds

SEX: F AGE: 46

POSSIBLE THIRD PARTY SAVES? ☐ YES ☐ NO

VITAL SIGNS			
TIME	0403	0540	
BP	167/91	144/94	
PULSE	117	103	
RESP.	24	20	
TEMP.		*100.6 (OT)	
WT. (Child)	190 lb	100.6 kg	

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT

ORDERS	INITS.	TIME
IV	[redacted]	0410
Labs: CBC, Metcmp, T&S		0410
Foley + UA		0435
Vicodin, Motrin		0500
Ancef 1gm IVPB		0425
Ancef 1gm IVPB		[redacted]

ASSESSMENT/DIAGNOSIS: MFW (L) chest + (L) flank/back

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: 0506

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 0410

46yo Iraqi civilian female S/P Fuel wounds from nearby GI - battle. Reportedly hit by rounds that had already killed another [illegible] wounds noted to (L) chest + (L) lat pelvis / flank. No SOB or abd pain. Superficial pain only, VSS stable en route, [illegible]

(L) chest MFW (L) lat pelvis - (L) lat FW

[illegible] back wounds

EDC - Pt [illegible] to [illegible] tracks from (L) SCC - [illegible] may [illegible] Pt [illegible]

(CONTINUE ON SF 507, IF NEEDED)

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 TREATMENT RECORD)

POTUS # [redacted]

B6-4

EPW

(b)(6)-2

UNIT ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans):

To [illegible] tracks from (L) SCC - [illegible] may [illegible] Pt [illegible]

SF 558-1C3 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): 21st CSH

LOG NUMBER

ARRIVAL — DATE: DAY 12 | MONTH NOV | YR 03 — TIME: 0422

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Status immunization and other data): ∅

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: ∅

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration): GSW (B) Forearms.

SEX: M AGE: 30

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: ~~0440~~ 0420

VITAL SIGNS

TIME	0427		
BP	132/39		
PULSE	90		
RESP.	18		
TEMP.	98.2		
WT. (Lbs)	200	74	

CATEGORY (See reverse)

- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME
(B) Forearm XR		
Pelvis XR		
(L) hip XR		0440
Ancef 1g IV		
MSO4 5mg IV		
UA		

ASSESSMENT/DIAGNOSIS: GSW (B) forearms

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: CRITICARE

CONDITION UPON RELEASE

- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE: 0630

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.

Status #: [redacted]

[redacted]

B6-4

(b)(6)-2

DESCRIBE: (1) Subjective data (Pertinent history); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

S: 30 c/o SIP GSW to (B) forearms.
Also c/o small FB to forearm - (L)
hip. Occurred just PTA in
2° confirmation c US troops.
PI is EBW. (R) - 22 - Tac - Inf.

O: NAD. Drsy - wnl
HEENT
chest
CV
lungs
abd - soft, NT, ND, +BS
ext - GSW (B) forearm
GSW (L) hip FA

P/ ∅ S/ chest 6 sutures

INF -

UA LA+ -

- 2 multiple frags
- (B) FA
- @ x5
- Pelvis/hip
- @ frags

- Pt uncooperative - hand motion - @ frags
- Exam
- Pulses - 2+ Rad Pulses (B) 16 x 385
- Compartments soft

Pelvis - small FB (L) hip

EDC - Given Ancef 1g IVPB.
Cleans + dressed (B) forearm.
2 need OR workup + CVC for access
possibly to penetrate (L) elbow joint

(b)(6)-2

Will go to OR for (B) elbow

(L) TRAUMA

(See Instructions on Back of this Sheet) NSN 7540-01-075-3736

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) | OG NUMBER

ARRIVAL DATE (DAY / MONTH / YR.)	TIME	TRANSPORTATION TO HOSPITAL (If class care enroute sheet)	CURRENT MEDS. (Tetanus immunization and other data)	HISTORY OBTAINED FROM
22 Mar 03	1345	☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)		☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code) | HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration) | SEX: M | AGE: 63 | POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS	
TIME	
BP	
PULSE	
RESP.	
TEMP.	
WT. (Child)	

CATEGORY (See reverse)
EMERGENT
URGENT
NON-URGENT

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS:
1) OUTPATIENT REFERRAL
2) INFECTED WOUND (L) TOE
3) SUTURE REMOVAL

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: on arrival

63y Iraqi ♂ DETAINEE brought in custody of MPs for wound check/suture removal and foley catheter removal. Seen approx one week ago for urinary retention, foley catheter placed and PVR > 500 cc. Discharged c foley in place and c Rx for levofloxacin and bactrim.

Interpreter: [redacted] Iraqi ♂ in MPs/answers questions through translator

(1) medial right c healing wound approx 1cm long, clean, dry ø erythema or drainage - Sutures in place (sutured 1wk ago)

Foley removed
Sutures removed
wound cleaned c gauze dressing

(CONTINUE ON SF 507, IF NEEDED)

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)
MCF CLINIC
EMERGENCY | TODAY
24 HOURS ☑ | ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☒ IMPROVED | UNCHANGED
DETERIORATED
TIME OF RELEASE: 1400

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-

(b)(6)-2

(b)(6)-4

Patus II [redacted] B6-4

INSTRUCTIONS TO PATIENT (Including medications prescribed, any limitations and follow-up plans)
(1) KEEP WOUNDS CLEAN, DRY & COVERED
(2) CONTINUE ANTIBIOTICS AS PRESCRIBED
(3) RETURN TO CLINIC IN 10 DAYS
(4) RETURN FOR SIGNS OF INFECTION (REDNESS, SWELLING, DRAINAGE)

MEDCOM - 345

B6-4

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974) B6-4

LAST, FIRST, MI	UNIT (b)(3)-1	DOB	RANK	SSN
Potus # [redacted]	21st CSH		N/A	[redacted]

Physician: (b)(6)-2	Ward:			Specimen Date and Time:	Re(b)(6)-2 by:	Date and Time:
	EMT	X	STAT	16 Nov 03 1525		16 Nov 03 1526
			Routine			

Chemistry (i-STAT)

8+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color	Yellow	Straw/Yellow
Clarity	Clear	Clear
Glucose	Neg	Negative
Bilirubin	Neg	Negative
Ketone	Neg	Negative
SG	1.020	1.010-1.025
Blood	Neg	Negative
pH	6.0	5.0-8.0
Protein	Neg	Negative-Trace
Urobili	Normal	Negative
Nitrite	Neg	Negative
Leuko	Neg	Negative

Urine Microscopic

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

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin-I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:

Plt verify:

Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

MEDCOM - 346

(See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): (b)(3)-1 21ST CSH

LOG NUMBER

ARRIVAL — DATE: DAY 19, MONTH Nov 03, YR.; TIME: 1530

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

CURRENT MEDS. (Include immunization and other data): Anti-inflamatory Antibiotic

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: Dust- MRSA

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): Pain w/ Breathing

SEX: M AGE: 21

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	1540
BP	143/58
PULSE	96
RESP.	16
TEMP.	100.7
WT. (Lbs)	98%

CATEGORY (See reverse)

- EMERGENT
- URGENT
- ☒ NON-URGENT

DESCRIBE: (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 1545

21/0 M states he was seen by doctor x 2 week ago. Pt states doctor told him he had pulmonary inflamation. Pt states he has been having a pain in Lower (R) side of chest. Pt states he has pain when he breathes. SOB increases

21 y/o M brought from detention for cough, reporting possible TB. On interview by translator at 21st CSH, individual reports no history of TB. Reports that he was seen by civilian physician two weeks ago for retrosternal chest discomfort and treated with antibiotic and anti-inflammatory medication. Still has midsternal retrosternal chest discomfort on deep inhalation. Reports sensitivity to dust, causing cough; also has cough productive of yellow-green sputum. No hemoptysis, night sweats, loss of fevers, night sweats. Also c/o constipation, poor po intake past 5d. Also c/o occipital headpain 2° trauma sustained in arrest. No LOC

SMOKE x 20y x PPD

PMH: x

PSH: x Foo

Pain Mx: Ø meds: tylenol, ambien, motrin

PSYCH: minor anti-inflamatory procedure (R) Allergies: MRSA

Results: "Heavy" Sputum Zzpod fast

GEN: awake/alert/oriented/NAD/pleasant/cooperative

HEENT: MMM/EOMI/PERRL/sclera injected

NECK: supple/FROM/no JVD/no LAD

RESP: CTAB/no W/R/R

CV: RRR/no M/R/G

ABD: soft/NT/ND/+BS

EXT: WWP/no C/C/E

NEURO: AAOx3/CN II-XII grossly intact/5/5 strength throughout/sensation intact

PSYCH: appropriate affect/mood

A: Bronchitis, resolving

P: CXR PA/Lat - WNL

Continue Q6h PRN cough

Motrin 800mg orally 3x/day as needed

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): MP CUSTODY
- EMERGENCY | TODAY
- 72 HOURS | ☒ ROUTINE
- ADMIT TO HOSP. UNIT | ☒ SERVICE

CONDITION UPON RELEASE

- IMPROVED | ☒ UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1610

(CONTINUE ON SF 507, IF NEEDED) TW's signed

PATIENT'S IDENTIFICATION (Strip/metal 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 TREATMENT RECORD)

(b)(6)-2

POTUS [redacted] B6-4

[redacted]

(b)(6)

MEDCOM - 347

EMERGENCY CARE AND TREATMENT STANDARD FORM 558 (Rev. 6-85)

ACLU-RDI 1025 p.80

DOD 003474

558-103 [See Instructions on Back of this Sheet] NSN 7540-01-015-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 21st CSH

LOG NUMBER

ARRIVAL
DATE: DAY 20 | MONTH NOV | YR. 03 | TIME 1615

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

CURRENT MEDS. (Include immunization and other data)
LOMINEL (-)

HISTORY OBTAINED FROM
☐ PATIENT ☒ OTHER (Specify) Translator

ALLERGIES
NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)
EPW

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptoms), duration)
Epileptic

SEX M AGE 30

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

VITAL SIGNS

TIME	1615		
BP	113/75		
PULSE	75		
RESP.	16		
TEMP.	100.0		
WT. (LBS)	99		

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS | INITS. | TIME

ASSESSMENT/DIAGNOSIS
Seizure disorder

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
CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE: 1798

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER

30 Y/O MALE C/O SEIZURES. PT STATES IF HE CANNOT SMOKE HIS SEIZURES BECOME MORE FREQUENT. PT STATES HE TAKES MED FOR HIS DISORDER BUT THEY DO NOT WORK. PT STATES HIS LAST SEIZURE WAS x 1 WEEK AGO. PT STATE HE HAS SEIZURES EVERY 10 DAYS TO EVERY SIX MONTS. PT STATES HE HAS HAD DISORDER 1990's. PMH: SEIZURE DISORDER. PSH: NONE. FH: NONE.

The patient reports that he has suffered from generalized seizures since the early 1990s when he heard that his brother had been killed. He has taken an anticonvulsant called the interpreter identifies as Lomine (sp?). His last seizure was approx 10 days ago. He reports that he has been unable to smoke since being detained and that when he cannot smoke he tends to seize. His anti-convulsant could not be obtained.

PSH x 4
Follow up: yes (3 PM)

Tmp Plan - long standing seizure disorder - has seizures with the frequency of 1-2/month. - will send the pt back to the detainee center and monitor him for seizure activity. If a seizure occurs, MTS are instructed to return him here for treatment.

(CONTINUE ON SF 507 IF NEEDED)

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 TREATMENT RECORD)

Potus # [redacted] B6-4

[redacted] (b)(6)

SIGNATURE (b)(6)-2 AND ID STAMP (b)(6)-2

INSTRUCTIONS (Include medications ordered, any limitations and follow-up plans)

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-5786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) | LOG NUMBER

ARRIVAL — DATE: DAY 20 / MONTH 11 / YR. 03 — TIME: 1609

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Fever c HA, generalized bodyaches

SEX: M | AGE: 40

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	1612		
BP	108/67		
PULSE	124		
RESP.	18		
TEMP.	103.5		
WT. (Child)	90 lbs		

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT

ORDERS | INITS. | TIME
- Tylenol 1g PO [redacted] 1623
- IV Bolus NS [redacted] 1625

ASSESSMENT/DIAGNOSIS: viral syndrome

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
- CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED
- TIME OF RELEASE: 1748

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

40 y/o M presents to EMT c c/o fever, HA, bodyaches for [b)(6)-2] 1 day. Pt A&Ox3, LS CTA, skin PWD/Dry, strep O-/U/D. -.

- The pt endorsed HA and fever 2 days ago, followed by generalized myalgias and malaise. ØHIV, ↓ anorexia, ↓ cough. Ø N/V. Ø stiff neck. Ø rash.
- PE - mild erythema [illegible] exudate.
- CV: unremarkable.
- HEENT: mild LAD (cervical) (+) TTP
- CV: nl S1, S2, Ø murmurs, [illegible]
- Plan: CTA (B) Pt d/c'd

PMHx: Ø

PSHx: Ø

Tobacco: Ø

Imp: viral syndrome

Plan:
- Tylenol 4-6 g
- Aggressive po hydration
- F/u in 3-5 days if no improvement or sooner if condition worsens, e.g. unable to tolerate oral intake.

(CONTINUE ON SF 507, IF NEEDED)

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 TREATMENT RECORD)

POTUS # [redacted] B6-4

SIGNATURE [b)(6)-2] | MD ID STAMP [b)(6)-2]

INSTRUCTIONS (Include medications, limitations and follow-up plans)

[b)(6)-4]

SSB-1C3 (See Instructions on Back of this Sheet) NSN 7540-01-075-5786

EMERGENCY CARE AND TREATMENT (Medical Record)

(b)(3)-1

FACILITY (Stamp): 21st CSH

LOG NUMBER

ARRIVAL DATE (DAY / MONTH / YR)	TIME
20 / NOV / 03	1615

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify): EPW

CURRENT MEDS. (Tetanus immunization and other data): INSULIN Y 10 UNITS x1DM

HISTORY OBTAINED FROM: ☐ PATIENT ☒ OTHER (Specify): Translator

ALLERGIES: NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT (S) (Actual symptom(s), duration): Diabetes

SEX: M AGE: 37

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS		
TIME	1620	1900
BP	104/61	118/60
PULSE	96	83
RESP.	18	20
TEMP.	99.8	97.2
WT. (Clothed)	98	99 KG

CATEGORY (See reverse): ☐ EMERGENT ☐ URGENT ☐ NON-URGENT

ORDERS	INITS.	TIME
2L Bolus NS	[redacted]	1700
10u NPH SQ		1720

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER

PT IS A MALE COMPLAINS OF EPIGASTRIC PAIN X 1 DAY. PT STATES HE BELIEVES IT IS BECAUSE OF HIS SUGAR LEVEL. PT STATES HE HAS BEEN NAUSEA X 2 DAYS. PT STATES HIS PAIN IS IN UPPER QUAD.

PMHx Diabetes
PSHx Ø

Pt is thought unreliable he is an ID diabetic x approx 6 years. His regimen is 10u lente QD (before supper during Ramadan). He is detained on post by the MPs and has not had insulin for almost 2 days. He c/o mild epigastric pain (this usual symptom when he misses his insulin). He does not appear toxic

Labs: WBC 7.5 / 12 / 36 / 26 / 69-10

Ur: 2+ gluc / large ketones

Gluc: 167

Imp: Ketosis ? DKA. Initial intervention but not full-blown DKA. Will give 1 unit NPH and recheck at end of route for 10 u SQ QD, and have him f/u in am with Dr L in EMT.

ASSESSMENT/DIAGNOSIS: Hyperglycemia

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 / 72 HOURS	TODAY / ROUTINE
ADMIT TO HOSP, UNIT/SERVICE:	

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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):

Potus # [redacted]

[redacted] B6-4

(b)(6)-4

SIG (b)(6)-2

PROVIDER (b)(6)-2

INS

PATIENT (Include medications ordered, any limitations and follow-up plans).

MEDCOM - 350

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	DOB	RANK	SSN
(b)(6)-4	EPW	1JUL68		86-9 [redacted]

Physician:	Ward:		Specimen Date and Time:	Reported by:	Date and Time
(b)(6)-2	EMT	X STAT / Routine	1655 20NOV03	(b)(6)-2	20NOV03 1706

Chemistry (i-STAT)
6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.398	7.35-7.45
	PCO2	40.1	35-45 mmHg
	PO2	36	80-90 mmHg
	TCO2	26	18-33 mmol/L
	HCO3	25	22-28 mmol/L
	sO2	69%	95-99%
	BEecf	0	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.18	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
(H)	Glu	267	73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Chemistry (Piccolo Analyzer)
Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Hematology
CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:

Plt verify:

Spun Crit		35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

Urinalysis

Color	Yellow	Straw/Yellow
Clarity	clear	Clear
(2+) Glucose	2+	Negative
Bilirubin	Neg	Negative
(4+) Ketone	Large	Negative
SG	1.030	1.010-1.025
Blood	Neg	Negative
pH	5.0	5.0-8.0
Protein	trace	Negative-Trace
Urobili	normal	Negative
Nitrite	Neg	Negative
Leuko	Neg	Negative

Urine Microscopic

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

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
Fec Leuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine	Negative

MEDCOM - 351 ative

SF 558-100 See Instructions on Back of this Sheet NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Specify): 21st CSH Mosul Iraq

LOG NUMBER

ARRIVAL	TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (Patients immunization and other data)	HISTORY OBTAINED FROM
DATE: DAY 22, MONTH NOV, YR. 03 — TIME 415	☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER (Specify)		☐ PATIENT ☑ OTHER (Specify)
			ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Mosul Iraq — HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): FLANK PN — SEX: F — AGE: 23 — POSSIBLE THIRD PARTY PAYER(S): ☐ YES ☐ NO

VITAL SIGNS		
TIME	1415	
BP	149/80	
PULSE	92	
RESP.	18	
TEMP.	95.4	
WT. (Child)	96/61	

CATEGORY (See reverse): ☐ EMERGENT ☐ URGENT ☐ NON-URGENT

ORDERS	INITS.	TIME
NS @ 200 cc/hr		
Toradol 30 mg IV		
CBC, BMP, UA, UCG		

ASSESSMENT/DIAGNOSIS: ① LBP ② Pyelo - urine

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:

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE:

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 TREATMENT RECORD):

DOTUS# [redacted] B6-4

(b)(2)-1

1996 OCTOBER 17

DESCRIBE: (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER

37 y/o ZUNFQI c/o R+L FLANK WT, ⓐ FLANK PN x 2 hrs c kidney stone
ⓑ FLANK PN x 4 DAYS radiates to thigh. N/V/D, dizziness, HA present
(PMH = kidney stone
PSH = D Sp. Bann
pt states through interpreter that pain is worse standing, prolonged period of time, states pain slows down bc of
ⓒ LE. Denies gen pain. Repeat stone - ⓓ kidney
O: 37.0 ↑ found lying restfully in bed. NAD, A&Ox3
VS as noted ⓔ ⓕ CVA ⓖ TTP to central L
ⓗ Lumbar area, ⓘ Popliteal pulses 2+
ⓙ LE strength 5/5 neurologically intact

6.8 | 15.1 / 41.4 | 258
131 | 95 | 8 | 86
3.5 | 22 | 0.9

UA Ketone 80 Urobil 1 otherwise NONL

P: ① Urine 800 cc PO today then
② Toradol 30 mg now - IV
③ Diet ↑ fluids
④ HA CT Spine r/t ketones
Pt reports been ↑ fluids and PO
⑤ RTC prn SOB ↑ or persistent
Ext stuff - Precautions and diagnostic study results and f/u recommended. Symptoms likely musculoskeletal in etiology. Continue
Motrin Rx SLC

(b)(6)-2 also, etc, wc

(CONTINUE ON SF 507, IF NEEDED)

SIGNATURE: (b)(6)-2

INSTRUCTIONS/MEDICATIONS: (Include medications ordered, any limitations and follow-up plans)

POTUS #370

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

21st COMBAT SUPPORT HOSPITAL

LAST, FIRST, MI.	UNIT	DOB	RANK	SSN
(b)(6)-4	CV	26 OCT 07		[redacted] B6-4

Physician:	Ward:			Specimen Date and Time:	Date and Time:
(b)(6)-2	EMT	✓	STAT	22 Nov 07 1520	22 NOV07 1520
			Routine		

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dl
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color	Yellow	Straw/Yellow
Clarity	CLEAR	Clear
Glucose	NEGATIVE	Negative
Bilirubin	NEGATIVE	Negative
Ketone	80	Negative
SG	1.020	1.010-1.025
Blood	NEGATIVE	Negative
pH	6.0	5.0-8.0
Protein	NEGATIVE	Negative-Trace
Urobili	1	Negative
Nitrite	NEGATIVE	Negative
Leuko	NEGATIVE	Negative

Urine Microscopic

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

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	8	7-22 mg/dL
	Ca	8.9	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL	95	98-108 mmol/L
	TCO2	22	18-33 mmol/L
	Creat	0.9	0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu	86	73-118 mg/dL
	K	3.5	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	132	128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	6.8	4.8-10.8 x10(3)/uL
	RBC	5.35	4.2-6.1 x10(6)/uL
	Hgb	15.6	12.0-18.0 g/dL
	Hct	46.4	35.0-60.0%
	MCV	86.7	80.0-99.0 fl
	MCH	29.2	27.0-31.0 pg
	MCHC	33.7	33.0-37.0 g/dL
	Plt	288	130-400 x10(3)/uL
	LY%	27.7	15.0-55.0%
	LY#	1.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:

Plt verify:

Spun Crit 35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT	10-13 seconds
APTT	22.1-33.7 seconds
FDP	Negative
D-Dimer	Negative
Fibrinogen	200-400 mg/dL

Blood Bank

ABO/Rh	
T&C	
T&S	

(See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp) 21st CSH (b)(3)-1

LOG NUMBER

ARRIVAL — DATE: DAY 24 MONTH Nov YR 03 — TIME: 1600

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) MP CUSTODY

CURRENT MEDS., immunization and other cu: UNKNOWN ANTIBIOTIC

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify) TRLO TRANSLATOR

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE NO. (Inc. area code)

BRIEF COMPLAINT(S) (Include symptom(s), duration)

SEX: M AGE: 24

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: on arrival

VITAL SIGNS

TIME	1610	1630
BP	127/82	136/74
PULSE	110	77
RESP.	16	14
TEMP.	100.5	100.5
WT. (Child)	75	99

CATEGORY (See reverse)
- EMERGENT
- ☒ URGENT
- NON-URGENT

ORDERS	INITS.	TIME
UA, C/S, Preg	[redacted]	1620
IV, TKO, Bmp	[redacted]	1620
Bolus 2L NS @	[redacted]	1700
Repeat VS @	[redacted]	1930
Tordol 30mg SUPP IVSU	[redacted]	
[redacted]	[redacted]	

ASSESSMENT/DIAGNOSIS: WEAKNESS, DEHYDRATION

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): MP CUSTODY
- EMERGENCY TODAY
- 72 HOURS ☒ ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- ☒ IMPROVED UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1800

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 TREATMENT RECORD!

Potus #[redacted] (DETAINEE)

DOB [redacted]

B6-4

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Pt. was bit by a Cobra in the spinal. Patient [illegible] without trembling.

24y [illegible] DETAINEE brought by MPs c/o difficulty ambulating. Detained 4d ago (? by civilian police) and custody transferred to FOB Diamond Back. MPs to day. Individual alleges that he was bited abnormally detained and now is too weak to walk. When asked specifically what is bothering him through translator he [illegible] pointed flank + lower rib pain, weakness, back pain

PMHx: Ø Meds: Unknown Hospit: Unknown antibiotic for otitis

Allergies: NKDA

Genl: Alert, oriented x3 (interviewed through translator) comfortable appearance, unsteady and almost [illegible] gait

Integ: Numerous contusions + abrasions c/w/ hyperextended elbows

HEENT: NC/AT PERRLA, EOMI, sclera anicteric, MMM, OP clear, no exudates or erythema, TM intact bilat

CV: RRR s S1/S2 no m/r/g

Resp: CTAB s wheezes/rales/rhonchi

Abd: Soft/NT/ND +BS no mass

Pelvis: Stable

Back: Tender upper T-spine (+) Tender (+) lateral lumbar ribs

Neuro: CN II-XII intact MS 4-5/5 all major groups (no focal weakness) DTRs symmetric (no clonus) Babinski (-) Romberg (-) Coordination intact

Labs: UA-SG: 1.030, Glucose Ø, blood Ø, ketones Ø, nitrite Ø, LE Ø

10.1 / 16.2 / 48.0 / 326

Ca = 10

130 / 98 / 45 / 23 — 17 / 86 / 12

(CONTINUE ON SF 507 IF NEEDED)

INSTRUCTIONS TO PATIENT: Include medications ordered, any limitations and follow-up plans:

① Regular diet as tolerated

② Motrin 800 mg orally 3x/day as needed

Cannot sign unsupported custody in fact. Cannot complete Romberg

MEDCOM - 354 ATMENT STANDARD FORM 558 (Rev. 08-2...)

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 2ISH CSH (b)(3)-1

LOG NUMBER

ARRIVAL — DATE: DAY 25 MONTH Nov YR 03 — TIME 1310

TRANSPORTATION TO HOSPITAL (Action taken enroute (see)): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT (Location and other data): HOME

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TEL. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): SP GSW (L) arm → abd

SEX: M AGE: 16

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: ON ARRIVAL

VITAL SIGNS

BP	130/70	131/	135/
P	105/95		95/51
RESP	57	80	100
TEMP	18		22
WT (Lbs)	97 lbs		
	96.2-99%	100%	

CATEGORY (See reverse)

- EMERGENT
- URGENT
- NON-URGENT

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and disposition)

16y Iraqi ♂ Brought to CSH 5 sustaining wounds when vehicle he was a passenger in was engaged as hostile by U.S. personnel. Accompanied by father and aunt. Father detained.

No Med Hx
No past Surg

Brought to 2ISH EMT by SFC Robert L. Navra C/CO 3/7 IN

A- Patient + maintaining c-c
B- Breath sounds, chest rise symmetric
C- BP, pulse normal, distal pulses intact, bleeding controlled c direct pressure
D- GCS=15, AVPU
E- Completely exposed for exam

A- NKDA
M- Ø
P- Ø
L- 1000 - breakfast
E- Events as above

ORDERS* — INITS. — TIME

- CBC, Abd xray — [redacted] — 1315
- IVF — [redacted] — 1307
- Tet, CBC, T&S
- Urine — [redacted] — 1340

ASSESSMENT/DIAGNOSIS

GSW Abdomen, (L) Elbow

GENERAL: anxious 14-16 y/o adolescent ♂ appears alert/subjectively stable in appearance, answers questions through interpreter — 14.8/425 — 237

SKIN: warm + dry Ø rashes — AB - POS

HEENT: Unremarkable Ø injury — NKA - penicillin

LUNGS: CTAB's w/o R/R

CV: RRR c (-) MM c S1S2

ABD: Soft/voluntary guarding entry wound (L) paraclavicular region

BACK: Ø discoloration/bruising

EXTREM: Entry/exit wounds at (L) elbow, pulses present distal

NEURO: GCS=15, AVPU

PMHX - NKMH

MEDS: (L) abdominal fragment

(L) elbow - numerous fragments, Ø Sx

DISPOSITION (Check all that apply)

HOME ☐ FULL DUTY

QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.

MODIFIED DUTY UNTIL: DAY ____ MONTH ____ YEAR ____

REFERRED TO (If desire clinic): General Surgery

- EMERGENCY
- TODAY
- 24 HOURS
- ROUTINE

ADMIT TO HOSP. UNIT/SERVICE

RETURN TO DUTY/QUARTERS: ☐ UNCHANGED

DATE

(CONTINUE ON SF 557, IF NEEDED)

IDENTIFICATION (Mechanical imprint)

(b)(6)-2

PRINT OR TYPE ENTRIES BELOW: Name (Last, first, middle); Name and location of sponsor or next of kin; SERVICE NUMBER; HOLDING TREATMENT FACILITY

B6-4

INSTRUCTIONS (Including transportation plans)

Pt transferred to General Surgery at 1350

(b)(6)-4

MEDCOM - 355

STANDARD FORM 558 (Rev. 7-82)

ACLU-RDI 1025 p.88

DOD 003482

(See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

21st CSH (b)(3)-1 LOG NUMBER

ARRIVAL — DATE: DAY 25 MONTH NOV YR. 03 — TIME: 17:00

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Include immunization and other data): Prednazone

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): B6-4

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Potus # [redacted] / Shot

SEX: M AGE: 43

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	1700
BP	144/88
PULSE	90
RESP.	18
TEMP.	99.2
WT. (Lbs)	98

CATEGORY (See reverse)

- EMERGENT
- URGENT
- NON-URGENT

ORDERS — INITS. — TIME

ASSESSMENT/DIAGNOSIS

DISPOSITION (Check all that apply)

- HOME
- FULL DUTY
- QUARTERS
- 24 Hrs. / 48 Hrs. / 72 Hrs.
- MODIFIED DUTY UNTIL: MONTH / YEAR
- REFERRED TO (Indicate clinic)
- EMERGENCY / TODAY
- 72 HOURS / ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

- IMPROVED / UNCHANGED
- DETERIORATED

TIME OF RELEASE:

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 ALL ... HOLDING TREATMENT RECORD):

Potus # [redacted]

B6-4

[redacted]

DESCRIBE (1) Significant data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan, Treatment/Procedures - include medication given and follow-up)

43 y/o ♂ presents to EMT c injuries sustained from shooting. Pt has wounds in ⓡ hand, Lt side of neck + ⓛ ear. Pt injured ⓡ cheek injury + ⓛ hand. No other injuries

Meds: Methyst, Rumatard, Arthritis

Spec (b)(6)-2

Meds: Prednisolone

Allgy: NKDA

Surg x ∅

EXAM:

HENT: NC ⓛ small shallow entry wound ⓡ cheek. EOMI PERRLA, EACTM clear ~~Gingivae & Fluid oropharynx~~

Lungs CTA BBS w/ equal breath sounds bilat

Abd soft NTND + active BS, no rebound

Ext FPP + strong pedals

Xray - fracture ⓛ hand

Imp: ① Hand injury ⓛ hand

② Shrapnel to ⓡ cheek

(b)(6)-2

① TO ok for window fix ⓛ hand

② Dr Hendrix here to see on call for ⓡ

MEDCOM - 356

STANDARD FORM

(See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): 21CSH, [redacted] Mosul Iraq

LOG NUMBER:

ARRIVAL — DATE: 06 DEC 03 TIME: 735

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): Di Lantin PO 100mg 3 PO @ HS.

HISTORY OBTAINED FROM: ☑ PATIENT ☐ OTHER (Specify)

ALLERGIES:

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

HOME TELEPHONE NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration):

SEX: M AGE: 23 (20)

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	0740	0851
BP	102/55	107/47
PULSE	95	80
RESP	20	16
TEMP	99.3	
Chill	100	99.9

CATEGORY (See reverse)

- ☒ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT

ORDERS — INITS. — TIME

ANTIBIOTICS [redacted] OTH2

drug [redacted] IV

CBC, ESTAT, CR, UA

Portocath, pm

ASSESSMENT/DIAGNOSIS

Seizure

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: on arrival

23y IRAQI ♂ brought from detention by MP's for seizure. Recently admitted 21ST CSH for seizure, started on dilantin, which patient has been receiving. On arrival at CSH, patient with clonic activity & packaged bandage placed in mouth by MPs. No urinary or fecal incontinence, apparently postictal and combative at time of arrival at EMT, given 2mg IV Ativan.

PMHx: Epilepsy
Back/disc
? kidney

Meds: Dilantin 300mg q HS

Allergies: NKDA

PSxHx: Appendectomy

CONTENT: 23y IRAQI ♂ brought c clonic activity s/o seizure postictal + combative

INTAKE: - [redacted] + dry ø fashes

WOUND: - UC/AT/neck supple
- PERRL/EOMI/pterygium medial OS

LUNGS: CTAB s w/e/r

CV: HRR s (m) no s1/s2

ABDO: Soft/NT/ND

EXTREM: ø contusions, [redacted] ROM
Clonus at joint definitions of feet

NEURO: Gradually cleared, follows commands answers questions MAE, DTR's symmetric

8.2 | 15.2 | 360 / 459

137 | 103 | 20 / 4.2 | 93 / 0.8

UA - specimen sent, result pending

(CONTINUE ON SF 507, IF NEEDED)

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
- CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED
- TIME OF RELEASE:

PATIENT 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 TREATMENT RECORD)

[redacted]

MOM LES [redacted]

[redacted] B6 14

[redacted]

SIGNATURE OF PROVIDER AND ID STAMP

[redacted]

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations, and follow-up plans)

Admitted

N/W

[redacted]

EMERGENCY CARE AND TREATMENT — STANDARD FORM

MEDCOM - 357

ACLU-RDI 1025 p.90

DOD 003484

(See Instructions on Back of this Sheet) NSN 7540-01-675-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): 21CSH, (b)(3)-1, Mosul Iraq

LOG NUMBER:

ARRIVAL — DATE: DAY 02, MONTH Dec, YR 03; TIME: 2000

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data):

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration):

SEX: M AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER:

VITAL SIGNS

TIME 2000
BP 132/80
PULSE 88
RESP 20
TEMP 100.4
OXYGEN SAT 100 %

CATEGORY (See reverse)
EMERGENT
URGENT
NON-URGENT

ORDERS — INITS. — TIME

~~Start IV NS~~ TKO
~~Tramadol 100mg IV load,~~
~~then 50mg q6h~~
Keppra 1000mg PO load, then 500mg BID
Promethazine 25mg IV/IM/PO NOW @ 1504
Zofran 4mg IV NOW
Valium 10mg IV NOW

ASSESSMENT/DIAGNOSIS

Admit, undiff
Not stabilized.

DISPOSITION (Check all that apply)

HOME ☐ FULL DUTY ☐
QUARTERS ☐ 24 HR. ☐ 48 HR. ☐ 72 HR.
MODIFIED DUTY UNTIL: DAY MONTH YEAR
REFERRED TO (Indicate clinic):
EMERGENCY ☐ TODAY ☐
72 HOURS ☐ ROUTINE ☐
ADMIT TO HOSP: UNIT/SERVICE

CONDITION UPON RELEASE
IMPROVED ☐ UNCHANGED ☐
DETERIORATED ☐
TIME OF RELEASE:

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

20 yo Iraqi POW c hx of witnessed (by another prisoner) "fell in a funny way" and "was shaking". Pt reports urinary incontinence. Cannot remember the episode. Has had epilepsy for many years "on medicine" but can't remember name. Hasn't taken for 13 days

EXAM: NCAT EOMI PERLA fundi visualized ↓ papill edema cor/reg/no m/r/g ; lu/ex

Large CABLE SCM
Heart RRR @ clear
abd soft NTND + masses
LE pulses strong b/l/e
neuro: CN II-XII grossly intact @ 2-3 beat clonus @ foot @ B/L hip and feet (as if paralytic contractures) @ full ROM

Meds Hx: ⊕ seizure ⊕ "angina"
Surg Hx: appy 1990
Meds: (something for seizure)

139 | 103 | 17 / 8 (12)
4.0 | 14.6 / 339
10.7 | 427

[redacted]

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 TREATMENT RECORD):

Potus #[redacted] B6-4

[redacted]

Orders, cons ordered, any limitations and follow-up:

(b)(6)-2

@ ATSO - medicine
@ valium load phenytoin

TREATMENT

STANDARD FORM 558 Rev.

MEDCOM - 358

(See Instructions on Back of this Sheet) NSN 7530-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) 21CSH, (b)(3)-1, Mosul Iraq

LOG NUMBER

ARRIVAL DATE (DAY, MONTH, YR.)	TIME	TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (Returns immunization and other data)	HISTORY OBTAINED FROM
06 Dec 03	1846	☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)		☑ PATIENT ☐ OTHER (Specify)

ALLERGIES

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration)

SEX	AGE
M	17

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	1846
BP	122/82
PULSE	110
RESP.	45
TEMP.	98.9
WT. (Child)	99%

CATEGORY (See reverse)

- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME
CBC, Bmp	[redacted]	1901
CXR		1900
EKG		1900
ABG		1901
Atovaquone TUX		1915

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: Upon arrival

S-17 y/o male pt c c/o

17yo Iraqi male (detainee) brought in via medic c c/o "spells". Pt relates he has had episodes where he can't control his body - it shakes and he can't move. He has been admitted x 1-2 days. Unsure how much truth/validity the cause of his spells are.

Denies medical/surgical hx.

Hx - ø PSHx - ø meds - ø NKDA

ASSESSMENT/DIAGNOSIS

Hyperventilation Episode with ? Elevated Prolactin - a gen episode of hyperventilation [illegible] Panicky d/t lack of knowledge and lack of training, no real toxic clinic symptoms, no Postictal state.

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: TCW
- CONDITION UPON RELEASE
- IMPROVED / UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1930

PS - NEENT - unremarkable

Neck - nontender

L-CTA 98% RA CXR - clear

CV - RRR S1S2 no M/R/G

Abd - NABS, soft, nontender, ø HSM, no masses

Ext - s/c/c/e, grossly intact

Neuro - nonfocal DTRs 2+ throughout

(16.9) 17.6 / 52.3 281K

134 | 102 | 14
5.8 | 30 | 0.9
Ca 10.0

Plan: Admit to TCW for observation

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name (last, first, middle initial), SSN; DOB, service status, name and relation of sponsor, if kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-2

Non us # [redacted] B6-4

[redacted]

(b)(6)-4

EMERGENCY CARE AND TREATMENT STANDARD FORM 558 (Rev. 6-92)

MEDCOM - 359

ACLU-RDI 1025 p.92

DOD 003486

7

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21st Combat Support Hosp

LOG NUMBER:

ARRIVAL — DATE: DAY 4 | MONTH 1 | YR 03 — TIME: 1745

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data):

HISTORY OBTAINED FROM: ☐ PATIENT ☒ OTHER (Specify) Translator

ALLERGIES: NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Mosul Iraq

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT (S) (Include symptom(s), duration):

SEX: M AGE: 20

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: upon arrival

VITAL SIGNS

TIME	1751		
BP	130/96		
PULSE	127		
RESP.	16		
TEMP.	—		
O2 SAT. (RA)	100%		

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Arrived from 28th CSH to be released to family after being seen by JAG. Will admit to ICU until JAG available

(b)(6)-2 CPT

2000: JAG here to question + speak with pt.

(b)(6)-2 CPT

2140 Pt returned to ENT Ambulatory respiration & unaccompanied JAG officer, friend/family member here. Discharge instructions given per interpreter. Denies questions or concerns. Instructed to return 24 Jan @ 0900am w all paperwork & X-rays. Condition stable. Pt smiling & happy to see family. D/Ced home.

(b)(6)-2 CPT

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
- CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED
- TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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 TREATMENT RECORD).

Non US [redacted] B6-4

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

EMERGENCY CARE AND TREATMENT STANDARD FORM

MEDCOM - 360

(See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) 21CSH, (b)(3)-1 Mosul Iraq

LOG NUMBER

ARRIVAL: DATE (DAY, MONTH, YR.) 11 12 03 TIME 1807

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data) ∅

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration) c/o Possible Trauma to (L) side

SEX M AGE 43

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	1807
BP	129/66
PULSE	59
RESP.	16
TEMP.	97.9
WT. (Lbs.)	160

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS | INITS. | TIME

~~Tetanus Toxoid 0.5 ml IM~~ ~~12 Ambien~~ ~~CXR (PA + Lat) Acquired~~ ~~Tylenol #3 po Q4-6h prn~~

ASSESSMENT/DIAGNOSIS
Left contusion

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); 4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER

S: 43 y/o c/o possible trauma to (L) side x 5 days ago. PT states as pain. c/o "as severe" (L) inferior "colicky" CP. Reports being punched Tab-∅. 5 d. ago. ? fevers 5 d. ago. ∅ N/V/D. PSH-∅ PMH-∅

PE: VS WDWN. Thin shallow splinting breathing. L C upper airway sounds + 2 subcostal rub. PERRLA EOMI ∅ nystagmus. ~~No~~ ∅ tenderness (L) (L) tenderness (L) inferior. ~~No~~ crepitus palpated. ? (L) CVA ∅ ~~tenderness~~ ~~CXR (PA + Lat)~~ ∅ ~~infiltrate~~ ~~effusion~~ ~~pneumothorax~~ ~~fracture~~ ~~Left sided~~ ~~chest tube~~ ~~in place~~ ~~suture~~ ~~staple~~ ~~line~~ ~~clean~~ ~~dry~~ ~~intact~~ ~~Abdomen~~ ~~soft~~ ~~non-tender~~ ~~bowel sounds~~ ~~present~~ ~~GU~~ ~~foley~~ ~~in place~~ ~~draining~~ ~~clear~~ ~~yellow~~ ~~urine~~ ~~Extremities~~ ~~full~~ ~~ROM~~ ~~strength~~ ~~intact~~ ~~distal~~ ~~pulses~~ ~~palpable~~ ~~bilateral~~ ~~Skin~~ ~~warm~~ ~~dry~~ ~~pink~~ ~~Neuro~~ ~~A&O x 3~~ ~~GCS 15~~ ~~PERRLA~~ ~~EOMI~~ ~~CN II-XII intact~~ ~~Motor~~ ~~5/5 bilateral~~ ~~Sensory~~ ~~intact~~ ~~Gait~~ ~~steady~~ ~~Romberg~~ ~~negative~~

A: Left sided rib fx

P: ~~Ice~~ ~~Pain control~~ ~~Ambulate as tolerated~~ ~~Follow up in clinic~~ ~~Return to ER if worsening pain~~ ~~SOB~~ ~~fever~~ ~~chills~~ ~~nausea~~ ~~vomiting~~ ~~Tylenol #3 1-2 tabs po Q4-6h prn pain~~ ~~Rx x 10~~ ~~Motrin 600 mg po Q6h prn pain~~ ~~Rx x 20~~ ~~Ambulate as tolerated~~ ~~Follow up in clinic~~ ~~Return to ER if worsening pain~~ ~~SOB~~ ~~fever~~ ~~chills~~ ~~nausea~~ ~~vomiting~~

(CONTINUE ON SF 507, IF NEEDED)

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

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE:

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 TREATMENT RECORD).

DEA US # [redacted] B6-4

SIGNATURE OF PROVIDER AND IR STAMP (b)(6)-2 MD
Lieutenant Colonel, Medical Corps

INSTRUCTIONS (b)(3)-1 (Medications prescribed, any limitations and follow-up plans)

① Tylenol #3 1-2 tabs by mouth every 4 hrs. as needed for pain. Rx x 20

② Motrin 600 mg by mouth every 6 hrs. as needed for pain. Rx x 30

Return to ER if worsening pain, SOB, fever, chills, nausea, vomiting

Follow up in clinic one week

EMERGENCY CARE AND TREATMENT STANDARD FORM 558 (Rev. 7-85)

IVON - [redacted] B6-4

GEMS IT MAC1200 , 21ST COMBAT SUPPORT HOSPITAL, (b)(3)-

HR 54 bpm

Measurement Results:

QRS		80 ms
QT/QTcB	426 /	403 ms
PR		182 ms
P		84 ms
RR/PP	1102 /	1110 ms
P/QRS/T	10/ 9/	32 degrees

< P
< T
< QRS

-90
aVR aVL
0 I

Interpretation:
Sinus bradycardia
~~Nonspecific ST abnormality~~
~~Abnormal ECG~~

(b)(6)-2

Order Physician

III +90 II
aVF

(b)(6)
(b)(3)-

MD

Unconfirmed report.

I aVR V1 V4
II aVL V2 V5
III aVF V3 V6
II

Speed 1 Sens 1
11-Dec-2008 18:47:18 25mm/s 10mm/mV ADS 60Hz 0.05 - 150Hz Ax2 5kl 12-Lead

MEDCOM - 362

ACLU-RDI 1025 p.95

DOD 003489

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21CSH, (b)(3)-1, Mosul Iraq

LOG NUMBER

ARRIVAL — DATE: DAY 15, MONTH 12, YR 03; TIME 1148

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): NKA

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code): N/A

CHIEF COMPLAINT(S) (Include symptom(s), duration): L wrist infection I&D

SEX: M AGE: 24

POSSIBLE THIRD PARTY PAYER? ☐ YES ☒ NO

VITAL SIGNS

TIME	1148
BP	[redacted]
PULSE	72
RESP.	[redacted]
TEMP.	[redacted]
WT.(Child)	[redacted]

CATEGORY (See reverse)

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

ORDERS | INITS. | TIME

ASSESSMENT/DIAGNOSIS: cellulitis

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: PACE

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 1315

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: 1216

S: 24 y/o [redacted] B6-4 Sent from 526 for evaluation of L wrist infection x 1 week. Pt denies fever, chills, N/V/D.

O: A&O x 3, NAD, HEENT: PERRLA, EOMI, anicteric sclera, MMM, oropharynx clear, neck supple, no LAD, CV: RRR, no m/r/g, Lungs: CTA bilat, Abd: soft, NT/ND, +BS, Ext: no c/c/e, Skin: warm, dry, L wrist: erythema, induration, TTP, ROM intact, no fluctuance, no drainage, sensation intact, 2+ radial pulse, Neuro: CN II-XII grossly intact, sensation intact to light touch, strength 5/5 throughout, DTR's 2+ throughout, gait steady

A: L wrist cellulitis

P: Continue abx
Recommend I&D - if no improvement in 24-48 hrs
Pt to return to clinic in 24 hrs for recheck
Pt given return precautions

[redacted] MD

PATIENT IDENTIFICATION (Machine 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 TREATMENT RECORD)

Non-US [redacted] B6-4 Iraqi Detainee

SIGNATURE: [redacted] (b)(6)-2

INSTRUCTIONS (Medications, diet, any limitations and follow-up plans):

Pt to return to clinic in 24 hrs for recheck

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 (Rev. 6-82)

NSN 7540-01-075-3786

(See Instructions on Back of this Sheet)

558-101

LOG NUMBER

EMERGENCY CARE AND TREATMENT (Medical record)

TREATMENT FACILITY (Stamp) 21 CSH (b)(3)-1 Mosul Iraq

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)

ARRIVAL — DATE: DAY 16 MONTH Dec YR 03 — TIME: 1107

PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify) ☑

CURRENT MEDS. (Include immunization and other data): 7 Dionyl

HISTORY OBTAINED FROM: PATIENT ☒ OTHER (Specify): Interpreter

ALLERGIES: PCN

HOME TELE. NO. (Inc. area code)

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): N/A Iraq

POSSIBLE THIRD PARTY PAYER? YES ☐ NO ☐

SEX: M AGE: 53

CHIEF COMPLAINT(S) (Include symptom(s), duration): Left Swelling

TIME SEEN BY PROVIDER: 1130

VITAL SIGNS		
TIME	1110	1513
BP	119/70	132/68
PULSE	150	107
RESP.	18	17
TEMP.	97.7	99.8
WT. (Child)	98#	96#

CATEGORY (See reverse)
EMERGENT
URGENT
☒ NON-URGENT

DESCRIBE (1) Subjective data (Pertinent history); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

53 y/o IRAQI DETAINEE c hx HTN and DIABETES brought from compound c/o BLE upper and lower extremity edema, edema, malaise, tiredness.

PMHx: DM-2, HTN, Chronic LBP

Meds: Dionyl

Allergies: PCN

PSHx: Ø

Tobacco: (+)

Habits = Smokes cigarettes

PSxHx: Ø

GENERAL: Thin IRAQI ♂ in NAD/alert answers questions and follows commands through interpreter, appears stated age but extremely older than stated age

HEENT: Brown + dry hair/hairs of feet erythematous ⊖ exudate nares

NECK: Supple, (+) JVD, (+) edema

LUNGS: CTA B's w/ R

CV: RRR s (III) no s/s/r

ABDO: S/NT/ND/(+) BS x 4

EXTREM: Feet erythematous/blistered ⊖ pitting but (+) edema ⊖ ulcerations ⊖ abrasions ⊖ (+) dry scaling erythema (+) mild surrounding erythema

ORDERS — INITS — TIME

IV keflex q 6h		1192
NS/RLIV TKO		1142
CBC, I-STAT-6+		1192
CREAT (CR BUN)		1142
LFTs, UA		IN ✓
PA/LAT CXR		FILES

1430 DCS
Accept Tgm
LV

ASSESSMENT/DIAGNOSIS: DIABETES; feet and hand swelling

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): MP CUSTODY

EMERGENCY ☐ TODAY ☐

72 HOURS ☐ ☒ ROUTINE

ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE:

IMPROVED ☐ ☒ UNCHANGED

DETERIORATED ☐

TIME OF RELEASE: 1500

165	(22.2)	(23)	50.6	123	88	24	225	38	1.2		

ALB = 3.5 TP = 7.6 ALP = 55 AST = 36 TB = 1.3 AMY = 49

(CONTINUE ON SF 507, IF NEEDED)

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 TREATMENT RECORD). (DETAINEE)

(b)(6)-2

INSTRUCTIONS TO PATIENT (Including follow-up plans):

1. Cefuroxime 500mg 1 tab orally bid x 10d
2. Keflex 500mg orally four times per day x 10d
3. Avoid restricted to elevate feet, provide regular meal and water
4. Return for recheck in two days, sooner if worse

(b)(6)-4

STANDARD FORM 558 (Rev. 5-

EMERGENCY CARE AND TREATMENT

MEDCOM - 364

ACLU-RDI 1025 p.97

DOD 003491

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
19 DEC 2003 0813 ARRIVED BP: 120/72 P: 87 POx: 97% Temp: 96.7° RESP: 14 PMH: DIABETES BACK PN PSH: Ø TOB Ø Ø DM	53 y/o Ø F/U c DIABETES/UPPER LOWER EXTREMITY EDEMA REDNESS MALAISE was seen 12/16/03 in 21CSH. North ENT - see SF558. Labs drawn CBC, BMP per Dr [b)(6)-2] order. Medic escorting patient states that patient's feet are less swollen than 48° ago. 5 Flu of cellulitis. Started on Keflex. Pt notes less pain + swelling in his feet. Gets cold @ night but no fevers or rigors. Ø wd w/ NAD mild erythema medially + pitting edema to mid shin. glucose offset 9-2-97 Ø 241 132 91 7 272 4.8 21 1.0
	Dx: DM, Flu of cellulitis. ① Glucotrol to 1 tab po BID. (#30) ② Cont Keflex 1 po QID ③ Flu p/n.

[b)(6)-2]

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

[b)(6)-4]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (4) CFR) 201-9.202-1

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

B6-4

LAST, FIRST, MI: NONNS, [redacted] (b)(6)-4 | UNIT: Detainee | DOB | RANK: CIV | SSN: [redacted]

Physician: B6-4 | Ward: EMT | STAT / Routine | Specimen Date and Time: 12/19/03 0845 | Report (b)(6)-1 | Date and Time: 19 Dec 03 0915

(b)(6)-2

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

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

Urine-Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts		Spermatozoa
Crystals		Amorph Sed
Other		
Other	CBC, BMP	

Chemistry (Piccolo Analyzer)

Chem 12 Metlyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	Tbil		0.2-1.6 mg/dL
	BUN	7	7-22 mg/dL
	Ca	9.8	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL	91	98-108 mmol/L
	TCO2	21	18-33 mmol/L
	Creat	1.0	0.6-1.2 mg/dL
	GGT		5-65 U/L
K	Glu	272	73-118 mg/dL
	K	4.8	3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na	132	128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		< 4.3 ng/mL
Troponin I		< 0.19 ng/mL
Myoglobin		< 107 ng/mL

Microbiology

Source		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	9.1	4.8-10.8 x10(3)/uL
	RBC	5.46	4.2-6.1 x10(6)/uL
	Hgb	15.7	12.0-18.0 g/dL
	Hct	47.4	35.0-60.0%
	MCV	86.8	80.0-99.0 fl
	MCH	28.8	27.0-31.0 pg
	MCHC	33.1	33.0-37.0 g/dL
	Plt	261	130-400 x10(3)/uL
	LY%	15.2	15.0-55.0%
	LY#	1.4	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin	No Plasmodium Seen
Thick	No Plasmodium Seen

Sed Rate

Sed Rate	1hr = 0-20 mm

Coagulation

PT	10-13 seconds
APTT	22.1-33.7 seconds
FDP	Negative
D-Dimer	Negative
Fibrinogen	200-400 mg/dL

Blood Bank

ABO/Rh	
T&C	
T&S	

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974) B6-4

LAST, FIRST, MI	UNIT	DOB	RANK	SSN
NONUSF [redacted] B6-4	Detainee		CIV	[redacted]

Physician (b)(6)-2	Ward:	STAT / Routine	Specimen Date and Time:	Reported by: (b)(6)-2	Date and Time:
	EMT	X STAT	12/16/03 11:20		16 Dec 03

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	125	128-145 mmol/L
	K	3.8	3.3-4.7 mmol/L
	Cl	98	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
X	BUN	24	7-22 mg/dL
X	Glu	225	73-118 mg/dL
	Creat	1.2	0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color	DARK Yellow	Straw/Yellow
Clarity	clear	Clear
Glucose	2000	Negative
Bilirubin	Neg	Negative
Ketone	Large	Negative
Sp. Gr	1.020	1.010-1.025
Blood	Neg	Negative
pH	5.0	5.0-8.0
Protein	Trace	Negative-Trace
Urobili	Neg	Negative
Nitrite	Neg	Negative
Leuko	Neg	Negative

Urine Microscopic

WBC:	Epi
RBC:	Mucus
Bacteria	Yeast
Casts:	Spermatozoa
Crystals:	Amorph Sed
Other:	
Other:	CBC Istat bzcv. [illegible]

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB	3.5	3.3-5.5 g/dL
	ALP	76	26-84 U/L
	ALT	55	10-47 U/L
	AMY	44	14-97 U/L
	AST	36	11-38 U/L
	Tbil	1.3	0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT	22	5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein	6.9	6.4-8.1 g/dL
	Na		128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative
DOA		Negative
CK-MB		<4.3 ng/mL
Troponin I		<0.19 ng/mL
Myoglobin		<107 ng/mL

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

HCG

Urine		Negative
Serum		Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	22.2	4.8-10.8 x10(3)/uL
	RBC	5.87	4.2-6.1 x10(6)/uL
	Hgb	16.5	12.0-18.0 g/dL
	Hct	50.8	35.0-60.0%
	MCV	86.6	80.0-99.0 fl
	MCH	28.1	27.0-31.0 pg
	MCHC	32.4	33.0-37.0 g/dL
	Plt	231	130-400 x10(3)/uL
	LY%	4.7	15.0-55.0%
	LY#	1.0	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative
D-Dimer		Negative
Fibrinogen		200-400 mg/dL

Blood Bank

ABO/Rh		
T&C		
T&S		

(See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp) 212CSH (b)(3)-1 Mosul Iraq

LOG NUMBER

TIME 2130

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet) ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data) unknown

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES unknown

ADDRESS OF DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

INJURIES (Include symptoms of surgeon) GSW to chest both hands, L thigh

SEX Male AGE

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); & Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER

Male Iraqi civilian brought in by EMT by soldiers who were in gunfight with PT. PT ambulated in verbal status, moaning pain, rapid O2 sats 93% Dsg on L thigh, both hands & L chest. Central line, 2 units of blood. To OR @ 2305

(b)(6)-2

CPTA

INITS. TIME

PRIMARY DIAGNOSIS

DISPOSITION (Check all that apply)

FULL DUTY

QUARTERS

48 Hrs. 72 Hrs.

MODIFIED DUTY UNTIL: MONTH YEAR

REFERRED TO (Indicate clinic)

EMERGENCY TODAY

HOURS ROUTINE

ADMITTED TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

IMPROVED UNCHANGED

HOSPITALIZED

DATE RELEASE:

PATIENT IDENTIFICATION (Attach label, imprint)

ADDITIONAL ENTRIES GIVE: Name - last, first, middle; Service status, name and relation of sponsor or next of kin

IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD

[redacted] B6-4

[redacted]

PRO TOCOL SYSTEMS, INC.

ADULT

VITALS TREND

12/16/03

TIME	HR/PR	BP	SaO2	SYS / DIA - MEAN	RR
	M-NM	EPM	%	mmHg	RPM
21:32	116	116			
21:33	120	116			
21:34	120	116			
21:36	120	116			
21:40	120	116			
21:41	120	116			
21:42	118	116	94	88 / 57	23
21:44	120	116	SRCH	91 / 54	67
21:46	103	116	89	87 / 49	62
21:48	104	116	96	89 / 45	68
21:50	114	116	SRCH	89 / 62 × 72	28
21:51	106	116	87	103 / 52	72
21:52	105	116	92	94 / 64	76
21:54	105	116	SRCH	98 / 181 / 56	74
21:57	114	116	96	181 / 72	85
21:58	114	116	89	181 / 72	85
22:12	86	OFF	OFF	OFF	OFF

ERR# 2 ERR# 15 26

ERR# 2 ERR# 2 ERR# 2 ERR# 15 54 OFF 52 OFF

ERR# 2 ERR# 37 ERR# 43 54 OFF 23 OFF

CONTINUE ON SF 507, IF NEEDED)

SIGNATURE OF PROVIDER AND ID STAMP (b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 368

ACLU-RDI 1025 p.101

DOD 003495

(See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): 21CSH, (b)(3)-1, Mosul Iraq

LOG NUMBER:

ARRIVAL — DATE: DAY 24, MONTH Dec, YR 03; TIME: 1030

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

CURRENT MEDS. (Include immunization and other data): DILANTIN

HISTORY OBTAINED FROM: ☐ PATIENT ☒ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): behavioral Δs

SEX: M AGE: 34

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	1045
BP	144/78
PULSE	75
RESP.	20
TEMP.	98.3
WT. (Child)	220

CATEGORY (See reverse)
☒ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
IV NS @ KVO	[redacted]	1040
BMP, CBC, LFT	[redacted]	1040
Recheck Dilantin level		
Repeat VS		

ASSESSMENT/DIAGNOSIS
1. SEIZURE D/O
2. DRUG REACTION
3. SCHIZOPHRENIA

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medications given, advice given/follow-up)

TIME SEEN BY PROVIDER: 2100

Iraqi detainee brought in by Medics, report that patient has stopped eating + drinking. Refuses to speak. Incontinent of urine this morning.

34y o Iraqi detainee brought from detention for evaluation of bizarre behavior. MP medics report detained refusing medications, soiling self with urine. Also, MPs express concern regarding skin lesions on arms and trunk. Patient will not cooperate with examination, but does not resist efforts to examine him. Reported history obtained from detained family members through MP translators and records from admit (12 Oct 2)

PMHx: Seizure D/O, Schizophrenia
PSHx: Ø
Meds: Dilantin 300mg qd (reportedly previously on restarted, not yet received)
Allergies: NKDA (from record)

AM labs: WBC 9.2, HGB 14.3, HCT 42.6, PLT 356, MCV 90.1, MCH 31, MCHC 34.7, RDW 12.3, MPV 7.2, NEUT 72, LYMPH 16.1

GENERAL: Thin Iraqi ♂ NAD/guidable/non-toxic
INTEG: Scattered annular erythematous raised lesions scattered on extremities and trunk
NEURO: MS/MP intact/equal, sclera clear, PERRL, EOMI, CNs grossly intact
LUNGS: CTAB s W/R/R
CV: RRR s M, no MRG
A-B-D: Soft/NT/ND/Ø mass
EXTREM: Ø edema, cords, tenderness

137 | 93 | 134
4.5 | 21 | 14

(CONTINUE ON SF 507, IF NEEDED)

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): MP custody
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☒ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE:

CONDITION UPON RELEASE
☐ IMPROVED ☒ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 1145

PATIENT'S IDENTIFICATION (Typed/check 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 TREATMENT RECORD).

(b)(6)-4

MNF-US # [redacted] B6-4

EPW # [redacted] B6-4

(b)(6)-4

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up)
1. DISCONTINUE DILANTIN
2. BEGIN TEGRETOL 200mg orally 2x/day
3. BEGIN OLANZAPINE 10mg orally each day at bedtime (add atypicals to Rx)
4. RETURN IF DETAINEE DEVELOPS SEIZURES OR SKIN LESIONS FORM CARE GIVERS

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 Rev. 6-97

MEDCOM - 369

ACLU-RDI 1025 p.102

DOD 003496

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI:	UNIT	RANK	SSN
Non US # [redacted] B6-4	CIV Detainee	CIV	B6-4 [redacted]

Physician: (b)(6)-2	Ward:		STAT / Routine	Date and Time:	Reporter (b)(6)-2	Date and Time:
LTC	Camp		Routine	24 Dec 03 1046		24 Dec 03 1111

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

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

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:			
Crystals:			
Other:			

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB	4.2	3.3-5.5 g/dL
	ALP	90	26-84 U/L
	ALT	31	10-47 U/L
	AMY	27	14-97 U/L
*	AST	72	11-38 U/L
	Tbil	1.1	0.2-1.6 mg/dL
	BUN	19	7-22 mg/dL
	Ca	9.4	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL	93	98-108 mmol/L
	TCO2	21	18-33 mmol/L
	Creat	1.3	0.6-1.2 mg/dL
*	GGT	139	5-65 U/L
	Glu	134	73-118 mg/dL
	K	4.5	3.3-4.7 mmol/L
	TProtein	8.8	6.4-8.1 g/dL
	Na	137	128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	14.6	4.8-10.8 x10(3)/uL
	RBC	4.79	4.2-6.1 x10(6)/uL
	Hgb	16.3	12.0-18.0 g/dL
	Hct	48.2	35.0-60.0%
	MCV	100.6	80.0-99.0 fl
	MCH	34.0	27.0-31.0 pg
	MCHC	33.8	33.0-37.0 g/dL
	Plt	356	130-400 x10(3)/uL
	LY%	7.2	15.0-55.0%
	LY#	1.0	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr. = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 370

(See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) 21CSH, (b)(3)-1 Mosul Iraq

LOG NUMBER

ARRIVAL — DATE: DAY 03, MONTH, YR. | TIME: 1516

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) Hp Exc. A

CURRENT MEDS. (Include immunization and other data): Θ

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): SEIZURE

SEX: F | AGE: 34 M

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1700

VITAL SIGNS

TIME	1520	1700
BP	114/76	124/85
PULSE	65	85
RESP.	20	16
TEMP.	97.1	98.8
WT. (Stretcher)		

CATEGORY (Circle one): EMERGENT | URGENT | NON-URGENT

ORDERS | INITS. | TIME

Keppra 1000 mg oral load
Ativan 2 mg IV
Urinalysis → Culture
Serum toxicology

ASSESSMENT/DIAGNOSIS
Recurrent Seizures ?
New

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

CONDITION UPON RELEASE
IMPROVED | UNCHANGED
DETERIORATED

TIME OF RELEASE:

PATIENT IDENTIFICATION (Mechanical imprint)
OR WHEN TYPED ENTRIES GIVE: Name - last, first, middle; service status, name and relation of sponsor or next of kin. IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORDS

(b)(6)-4 [redacted] Bb-4

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

34 y/o old male brought patient in for possible seizures
Pt oriented x 3, no post-ictal symptoms. Had "diagnosis of seizures" made by Doctor here in Mosul + reports he was taking Keppra 1000 mg BID from pcp in the US. Pt is unsure of dose. 60 mg valium, PR - an implausible dose. Θ
Incontinence of stool or urine Θ F/C Θ HA Θ chest pain, SOB or hypoglycemia Θ N/V Θ chest pain, palpitations or presyncope. Does not report "remembering" seizures → report if was witnessed but found person not here → also records
EXAM: NCAT, PERRLA b/c, EAC/TM clear, MMM, no JVD, neck supple, lungs CTAB, anterior chest wall TTP, RRR (no clicks, rubs, murmurs), abd soft, NTND, normoactive BS, no rebound or guarding, no HSM, no CVA TTP, FullROM ext, no clubbing, cyanosis, or edema, 2+ radial pulses b/l, A&Ox3, CN II-XII grossly intact, DTR 2+/4 b/l, no clonus, can heard nods
Ativan 2 mg IV does control pt but does not fully control pt
Θ
(b)(6)-2
R/O infection
- Cardiac (unlikely)
- Neurologic (unlikely)
- Metabolic
vs real acute disorder
Dx: Epileptic seizures
- Not postictal
- No common symptoms
(b)(6)-2
(1) Admit for observation
Ref/EP to consult + manage
(2) Seizure precautions
Neuro checks
IV fluids
Seizure precautions
Keppra 1000 mg BID
Ativan 2 mg IV PRN seizure
Ativan 2 mg IV PRN agitation

MH: seizure d/o
SH - Θ
Med Hx Θ
Surg Hx Θ
Meds: valium
Allergies: NKDA

EMERGENCY CARE AND TREATMENT STANDARD FORM 558 (Rev. 6-82)

(See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): 212 CSH, [redacted] Mosul Iraq

LOG NUMBER

ARRIVAL — DATE (DAY-MONTH-YR): 19 Dec 03; TIME: 1410

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): NONE

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Actual symptom(s), Duration): N/V ⓛ sided-weakness

SEX: M AGE: 30

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1415

VITAL SIGNS			
TIME	1410	1635	1750
BP	100/71	113/83	118/68
PULSE	111	101	111
RESP.	20	20	20
TEMP.	99	99.2	99.2
WT. (Kilo)	96/a	96	96.0

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT

ORDERS	INITS.	TIME
chem 8, CBC, [redacted]		1150
IV: LR NS	[redacted]	1430
Cipro 500mg PO BID x 7d	[redacted]	1500
Morphine Sulfate @ 1415: 4.0 mg IV		
Ondansetron 8mg IV now, PRN		
Continue NS bolus, then 150/hr		

ASSESSMENT/DIAGNOSIS: Guillain-Barre Syndrome

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): 28th CSH, Baghdad
  - ☐ EMERGENCY ☐ TODAY
  - ☐ 72 HOURS ☐ ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

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 TREATMENT RECORD).

[redacted]

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

PMH - HTN
PSA - Ø
TOB - yes
ETOH - Ø

30y/o male Iraqi EPW brought to ERT Ambulatory assist. Medic report that pt was brought to her with N/V x 4days & progressive weakness in (R) extremities + face. [redacted]

S - H/O as above - pt reports ↑ weakness of (L) side x 4 days, now unable to walk. Cannot feel or control his bowel & bladder. MP's report patient has been found lying in a pool of his own urine. Pt reports no cough, ⊖ N/V x 4d, NO pertinent PMH per pt. Pt reports previously healthy.

O - WD IM NAD, pleasant, comfortable in bed but "shivering" on (L) arm only w/ arm @ 90° angle @ elbow. (L) leg NT spontaneously, while awake though he came to [redacted] b/c agitated while dragging (L) leg. IM's clear, nose clear, OP - (R) thick, mucus building on teeth of (L) side of mouth only. Uvula ↑ equally. PERRLA, EOMI. No fasciculations. Neck - supple, ⊖ mass or JVD. No icterus or pallor. L-CTA (R) S1&2 H - MMS WNL. abd - SNTND, NABS, ⊖ HSM. groin NL, testicles NL. Rectal - Guac ⊖, ↑ ST, nodular prostate on (R). CN II - XII intact as best pt would cooperate. (R) arm → WNL strength, WNL reflexes, (L) arm → hyporeflexia pt able to move muscles. Can passively straighten arm to 180° but slowly returns to 90° - good tone. (R) leg → WNL strength + reflex, (L) leg. ↑ 2/4 bicep, ↑ 3/4 on achilles reflex, hyperreflexic. (R) patella: Can't elicit @ all. Poor tone. Pt did not cooperate w/ sensory exam.

(CONTINUE ON ____ FOR ADDITIONAL RECORD)

SIGNATURE OF PROVIDER [redacted]

INSTRUCTIONS TO PATIENT (Follow-up, medications ordered, any limitations, etc.): Smoke w/ Pt. Will treat w/ ASA / investigate ... Consult neuro. Await transport to 28th CSH.

[redacted] 18 4/20 4/57

B6-4 147 101 52 104

alb - 3.5 Hb 14 L 3

alb 4 - 3.5

EMERGENCY CARE AND TREATMENT (STANDARD FORM 558)

MEDCOM - 372

5 = Na hydrochloride

NSN 7540-00-634-4178 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19Dec03 1410	Presents to ER ambulatory c assist, dragging (R) foot & leg. Medic@Cage reports Pt has been sick x 4-5days "Not eating & vomiting" "Has had progressive (R) sided weakness. Brought him here for further eval." Alert & answers questions when asked by translator. IV started in (R) AC. Labs drawn & sent to Lab. Portable EKG done. Attempt to insert (b)(6)-2 cath x 2 c success. Dr. (b)(6)-2 Urologist consulted. Pt inserted c by Dr. (b)(6)-2 approx 300cc dk Coffee Colored urine returned. UA spec to lab. Pt began on IVPB (b)(6)-2 as ordered. Will continue to monitor (b)(6)-2 cont
19Dec03	addendum
	(b)(6)-2 ER returned dark concentrated urine Spec Grav 1028. Pt has responded well to 3L NS IV bolus, given an 50 cc/hr & an even much more cooperative pt now, but still unable to move (R) leg. (R) 2/2 weakness. Left arm grip strength - 5/5. Pt confused & responding to questions c delay. Pupils equal, round & reactive to light. Facial droop

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

B6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 8-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 373

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

await an exam to 28th CS Hyfor CT Scan. Suspect stroke, ischemic in nature a TIA 2° dehydration / sludge. await CT Scan and Treatment options from neurologist. ↑ LFTs + ↑ CBC likely 2° hemoconcentration, but will need re-eval as hydration status stabilizes.

(b)(6)-2

Office Staff

J/S	1410	1635	1730
BP	120/91	113/83	118/64
	111	109	111
	20	20	20
	99 RA	99 2LNC	99 2LNC
	96% RA	96% RA	96% RA

1740: IV fluids - 300cc

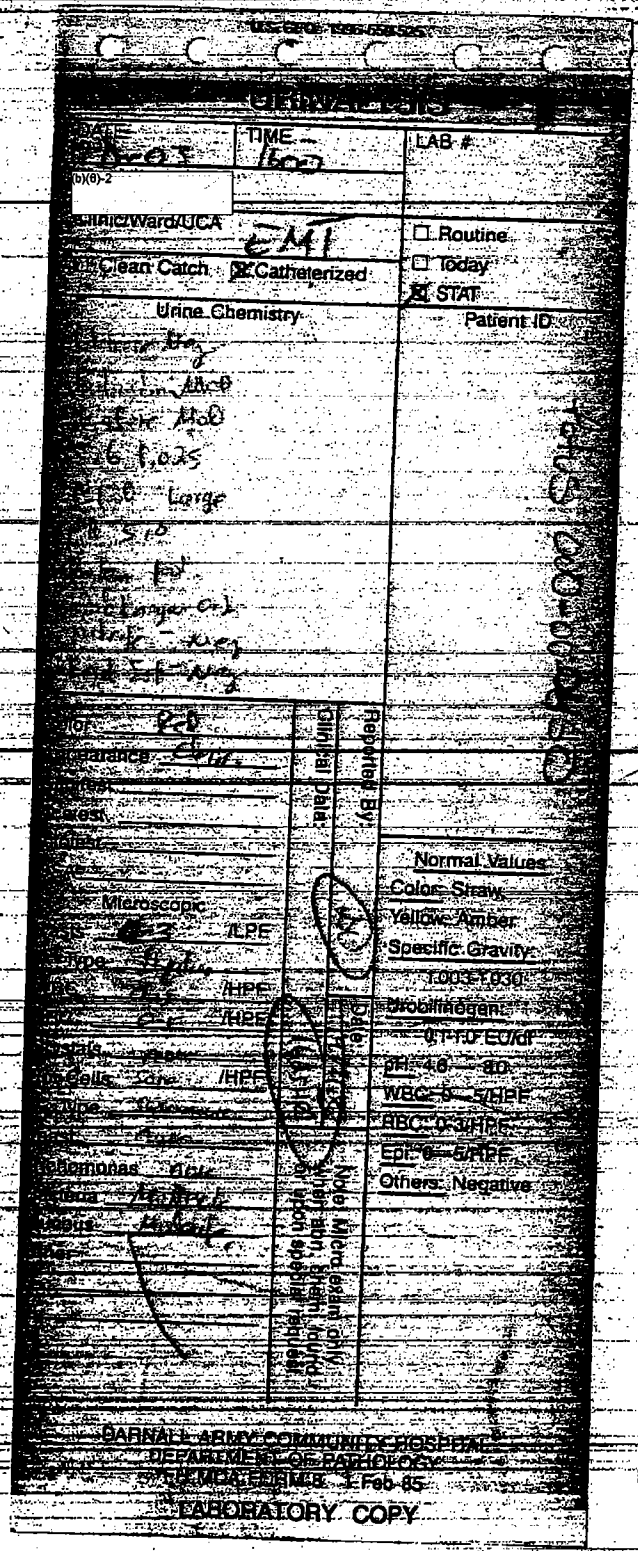
1740: Urine - 500cc

Meds: Levaquin 500mg IV @ 1515

Phenergan 25mg IV @ 1745

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 374



URINALYSIS

TIME

LAB #

(b)(6)-2

Clinic/Ward/UCA

EMT

Routine

Today

STAT

Clean Catch

Catheterized

Urine Chemistry

Patient ID

Microscopic

/LPE

/HPF

/HPF

/HPF

Normal Values:
Color: Straw, Yellow, Amber
Specific Gravity: 1.003-1.030
Urobilinogen: 0.1-1.0 EU/dl
pH: 4.6 — 8.0
WBC: 0 — 5/HPF
RBC: 0-3/HPF
Epi: 0 — 5/HPF
Others: Negative

Clinical Data

Reported By

DARNALL ARMY COMMUNITY HOSPITAL
DEPARTMENT OF PATHOLOGY
FT HOOD, TEXAS 76544-4799

1 Feb 05

LABORATORY COPY

(See Instructions on Back of this Sheet) NSN 7540-01-075-3736

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21CSH, (b)(3)-1 Mosul, Iraq

LOG NUMBER:

ARRIVAL — DATE: 21 Dec 05 — TIME: 1300

TRANSPORTATION TO HOSPITAL: PRIVATE VEHICLE / X AMBULANCE / OTHER (Specify)

CURRENT MEDS.: no meds

HISTORY OBTAINED FROM: PATIENT / OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): NSN US [redacted]

HOME TELE. NO. (Incl. area code):

BRIEF DESCRIPTION: Gunshot wound to (R) arm

SEX: M AGE: 28

POSSIBLE THIRD PARTY PAYER: YES / NO

TIME SEEN BY PROVIDER: on arrival

VITAL SIGNS: TIME 1320 — BP 141/90 — PULSE 117 — RESP 16 — TEMP [illegible]

DESCRIBE (1) Subjective data (Pertinent History) (2) Objective data (Physical Examination — include results of tests and x-rays) (3) Assessment (Diagnosis) (4) Plan (Treatment/Procedure — include medication given and follow-up):

20 ho [illegible] US brought here c GSW shot from crossfire to (R) arm. Pt (b)(6)-2 [illegible]

[illegible] brought by [illegible] from [illegible] [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] and was

shot [illegible] [illegible] [illegible] [illegible] [illegible]

seen by [illegible] who transferred patient to

CSH A NKDA [illegible]

M — Ø B breath sounds clear

P — Ø [illegible] symmetrical

L — [illegible] C — no active bleeding

E — as above [illegible]

[illegible] IV [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] E — completely exposed

[illegible] [illegible]

[illegible] (R) arm [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

(CONTINUE ON REVERSE SIDE IF NEEDED)

PHYSICIAN'S ORDERS / INITIALS / TIME: [illegible]

DIAGNOSIS: [illegible] (R) arm [illegible]

DISPOSITION: HOME / DUTY / ADMITTED / REFERRED TO: [illegible] 1340

PATIENT'S IDENTIFICATION: (b)(6)-2

OR [redacted]

(b)(6)-4

B6-4

[redacted]

To OR

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558

b6-4

MEDCOM - 376

(See Instructions on Reverse Sheet)

NSN 7540-01-075-3788

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FOR: 21CSH (b)(3)-P.L. 86-36 Iraq

LOG NUMBER

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data) N/A

HISTORY OBTAINED FROM ☑ PATIENT ☐ OTHER (Specify)

ALLERGIES NKDA

ARRIVAL TIME 03 1030

HOME ADDRESS OF DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

COMPLAINT(S) (Include symptoms; duration) Coughing of Blood

SEX M AGE 40

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER On arrival

DESCRIBE: (1) Subjective data (Pertinent history); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/procedures - include medication given and follow-up)

VITAL SIGNS

TIME

DIAGNOSIS

DISPOSITION (Check all that apply)

☒ FULL DUTY

☐ ROUTINE

CONDITION UPON RELEASE

UNCHANGED

IMPROVED

RELEASED

IDENTIFICATION (Typed or printed)

ENTRIES MUST BE SIGNED

IMPORTANT: LIST FACILITY HOLDING TREAT-

(b)(6)-2

INSTRUCTIONS FOR TREATMENT AND/OR MEDICATIONS prescribed, any limitations on activity and follow-up plans

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558

MEDCOM - 377

b-2

ACLU-RDI 1025 p.110 B6-4

DOD 003504

(See Instructions on Back of this Sheet)

NSN 7540-01-375-3736

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21CSH, (b)(3)-1 Mosul, Iraq

LOG NUMBER

ARRIVAL — DATE: DAY 20, MONTH Dec, YR 03 — TIME: 1644

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Include immunization and other data): NONE

HISTORY OBTAINED FROM: ☐ PATIENT ☐ (OTHER (Specify))

ALLERGIES: NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): S/P OSW x Talk to R thigh, referred to EPW

SEX: M

AGE: 36

POSSIBLE THIRD PARTY PAYER: ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1700

VITAL SIGNS

TIME	1650
BP	121/74
PULSE	98
RESP.	26
TEMP.	99.6
WT. (Child)	99#

CATEGORY (See reverse)
EMERGENT
URGENT
NON-URGENT

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

36 yo Iraq. Male sustained GSW R medial thigh 7 days ago. Tx'd at civ. hospital & local wound cleaning + Abx. Held at EPW facility. Now c pain (not new) in anterior thigh, & large area of ecchymoses. no pain below knee. Previous x-ray: GR x. Pt has been able to bear wt. on leg.

PMH - Ø
PSH - Ø
TOB - heavy smoker
ETOH -

R thigh GSW c ecchymosis

Most of medial half of thigh caved c ecchymosis 6-10 mm wound circumferential & post-wounded thigh c active bleeding, c exudate.

Lower leg compartments -> soft & non-tender
+ edema lower leg.
ROM & active or passive motion of leg/knee/ankle
LT sens. intact all dermatomes R LE
5/5 DF, PF Quads, HS.
DP pulse 2+/4

ORDERS | LIMITS | TIME
CBC | | 1700
Results in ZM 1715

ASSESSMENT/DIAGNOSIS
R thigh GSW c 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): EPW Facility
EMERGENCY | TODAY
HOURS | ROUTINE
DMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
IMPROVED | UNCHANGED
DETERIORATED

TIME OF RELEASE:

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 TREATMENT RECORD):

(b)(6)-4

EPW

Nonbattle [redacted]

B6-4

[redacted]

AP R Thigh Low Vel. GSW, c large ecchymoses
No evidence of Compartment Syndrome.
Cont. c MCG, CONTINUE PHYSICAL THERAPY AS NEEDED in NSAIDs.

SI (b)(6)-2

IN[redacted] Plans)

Return to Q-West EPW Facility

Hemoglobin & Syrums Ø

No orthostatic symptoms.

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558

MEDCOM - 378

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp): (b)(3)-1 22 15H

LOG NUMBER:

ARRIVAL — DATE: DAY 05 MONTH 01 YR 04 TIME 1300

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify):

CURRENT MEDS. (Tetanus immunization and other data): 2 UNKNOWN THREE MEDS

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): Tikrit, Iraq

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): Poss. Ascites

SEX: M AGE: 52

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	1301		
BP	131/77		
PULSE	102		
RESP.	20		
TEMP.	101.1		
WT. (KG)	96.4		

CATEGORY (See reverse): ☐ EMERGENT ☐ URGENT ☐ NON-URGENT

ORDERS	INITS.	TIME
UA, CBC, BMP	[redacted]	1402
LFT, COAG	[redacted]	1402
NG TUBE		1345
CXR		

ASSESSMENT/DIAGNOSIS: ASCITES

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): MP CUSTODY

EMERGENCY ☐ TODAY ☐ 72 HOURS ☒ ROUTINE

ADMIT TO HOSP. UNIT/SERVICE:

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE: 1630

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up):

TIME SEEN BY PROVIDER: 1320

S/O 5 Detainee presents c/o SOB. Hypoxia — RA sats 90% IV — 18 gauge L AC. Pt c/o difficulty breathing r/t stomach swelling. States has a hx of TB and ascites. Pt reports was being tapped for abdominal peritoneal fluids q weekly for about 1st time procedure 4 days ago. States had been taking 3 TB meds up to time of incarceration. O: 5'4" 96.4 kg (per stated) pt appears comfortable in NAD. Abd soft, mild distended, hyperactive BS x 4 quads, (+) fluid wave, (+) shifting dullness, (+) bilateral LE edema. Lungs CTA bilaterally. Pt ambulates with steady gait. Pt denies pain. Pt denies N/V/D. Pt denies fever/chills. Pt denies CP. Pt denies dizziness. Pt denies HA. Pt denies SOB. Pt denies cough. Pt denies abd pain. Pt denies dysuria. Pt denies hematuria. Pt denies hematochezia. Pt denies melena. Pt denies rectal bleeding. Pt denies vaginal bleeding. Pt denies vaginal discharge. Pt denies penile discharge. Pt denies testicular pain. Pt denies testicular swelling. Pt denies rash. Pt denies pruritus. Pt denies joint pain. Pt denies joint swelling. Pt denies muscle pain. Pt denies muscle weakness. Pt denies numbness. Pt denies tingling. Pt denies dizziness. Pt denies syncope. Pt denies seizures. Pt denies tremors. Pt denies confusion. Pt denies memory loss. Pt denies speech difficulty. Pt denies vision changes. Pt denies hearing loss. Pt denies tinnitus. Pt denies vertigo. Pt denies nausea. Pt denies vomiting. Pt denies diarrhea. Pt denies constipation. Pt denies abdominal pain. Pt denies back pain. Pt denies flank pain. Pt denies urinary frequency. Pt denies urinary urgency. Pt denies urinary hesitancy. Pt denies urinary retention. Pt denies incontinence. Pt denies polyuria. Pt denies polydipsia. Pt denies polyphagia. Pt denies weight loss. Pt denies weight gain. Pt denies fatigue. Pt denies malaise. Pt denies lethargy. Pt denies anorexia. Pt denies diaphoresis. Pt denies chills. Pt denies rigors. Pt denies night sweats. Pt denies recent travel. Pt denies sick contacts. Pt denies recent illness. Pt denies recent hospitalization. Pt denies recent surgery. Pt denies recent trauma. Pt denies recent fall. Pt denies recent injury. Pt denies recent accident. Pt denies recent assault. Pt denies recent exposure to toxins. Pt denies recent exposure to chemicals. Pt denies recent exposure to radiation. Pt denies recent exposure to infectious disease. Pt denies recent exposure to tuberculosis. Pt denies recent exposure to HIV. Pt denies recent exposure to hepatitis. Pt denies recent exposure to STD. Pt denies recent exposure to sexual assault. Pt denies recent exposure to violence. Pt denies recent exposure to weapons. Pt denies recent exposure to explosives. Pt denies recent exposure to fire. Pt denies recent exposure to smoke. Pt denies recent exposure to carbon monoxide. Pt denies recent exposure to asbestos. Pt denies recent exposure to lead. Pt denies recent exposure to mercury. Pt denies recent exposure to pesticides. Pt denies recent exposure to herbicides. Pt denies recent exposure to fertilizers. Pt denies recent exposure to petroleum products. Pt denies recent exposure to solvents. Pt denies recent exposure to paints. Pt denies recent exposure to varnishes. Pt denies recent exposure to lacquers. Pt denies recent exposure to thinners. Pt denies recent exposure to adhesives. Pt denies recent exposure to sealants. Pt denies recent exposure to coatings. Pt denies recent exposure to plastics. Pt denies recent exposure to rubber. Pt denies recent exposure to metals. Pt denies recent exposure to wood. Pt denies recent exposure to paper. Pt denies recent exposure to glass. Pt denies recent exposure to ceramics. Pt denies recent exposure to textiles. Pt denies recent exposure to leather. Pt denies recent exposure to fur. Pt denies recent exposure to feathers. Pt denies recent exposure to animals. Pt denies recent exposure to insects. Pt denies recent exposure to plants. Pt denies recent exposure to fungi. Pt denies recent exposure to bacteria. Pt denies recent exposure to viruses. Pt denies recent exposure to parasites. Pt denies recent exposure to protozoa. Pt denies recent exposure to helminths. Pt denies recent exposure to arthropods. Pt denies recent exposure to mollusks. Pt denies recent exposure to echinoderms. Pt denies recent exposure to chordates. Pt denies recent exposure to vertebrates. Pt denies recent exposure to mammals. Pt denies recent exposure to birds. Pt denies recent exposure to reptiles. Pt denies recent exposure to amphibians. Pt denies recent exposure to fish. Pt denies recent exposure to cartilaginous fish. Pt denies recent exposure to bony fish. Pt denies recent exposure to jawless fish. Pt denies recent exposure to lancelets. Pt denies recent exposure to tunicates. Pt denies recent exposure to hemichordates. Pt denies recent exposure to echinoderms. Pt denies recent exposure to chordates. Pt denies recent exposure to vertebrates. Pt denies recent exposure to mammals. Pt denies recent exposure to birds. Pt denies recent exposure to reptiles. Pt denies recent exposure to amphibians. Pt denies recent exposure to fish. Pt denies recent exposure to cartilaginous fish. Pt denies recent exposure to bony fish. Pt denies recent exposure to jawless fish. Pt denies recent exposure to lancelets. Pt denies recent exposure to tunicates. Pt denies recent exposure to hemichordates.

A: Ascites fluid

P: Patient to follow up with [redacted] for paracentesis of ascitic fluid. Patient tolerated procedure well.

EMT STAFF — Patient interviewed and examined c CAT Weldon briefly. Sgt [redacted] from [redacted] reported hx of TUBERCULOUS ASCITES was in detention at [redacted] x 10 days off three medication regimen. For appx 8 weeks has had his abdominal paracentesis (6L per visit) on weekly basis. Presents c/o increasing abdominal girth and dyspnea. PROCEDURE NOTE: Abdomen prepped and draped in usual sterile fashion and aspiration attempted at 5th L paracentesis. Procedure unsuccessful. Patient refused to be obtained. Discussion and paracentesis of ascitic fluid completed. Patient tolerated procedure well.

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 TREATMENT RECORD):

[redacted] B6-4

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans): Patient and escort dismissed c/s. Pt to follow up with [redacted] for disposal of ascitic fluid and prescription of medications from [redacted] physician. Pt to return for patient at nearest US hospital. RETURN FOR FEVER, ABDOMINAL PAIN, DIFFICULTY BREATHING

Patient to follow up with [redacted] cleared by [redacted]

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 (Back) (b)(3)-1

MEDCOM - 379

WBC 10.1 HCT 39.7 MCV 97 PLT 129 RDW 13.5 MCH 27 MCHC 99 RBC 5.1 HGB 24 PT 19 INR 1.2 PTT 106

ALB = 2.6 AMY = 69 TB = (2.1) Na+ = 140 K+ = 4.0 Cl- = 104 CO2 = 24 BUN = 9 Cr = 0.8 Glu = 106 Ca++ = 8.4 Mg++ = 1.9 Phos = 3.2 AST = 62 GGT = 33 Alk Phos = 90

UA: SG 1.010 pH 6.5 Prot neg Glu neg Ketones neg Bili neg Blood neg Nitrite neg Leuk Esterase neg WBC 0-2 RBC 0-2 Epi 0-2 Bacteria few Hyaline casts 0-2

Urine culture: No growth at 48 hours

Blood cultures x 2: No growth at 5 days

Ascitic fluid culture: No growth at 5 days

Ascitic fluid cell count: WBC 250 (N 10%, L 90%) RBC 1,200

Ascitic fluid protein: 2.1 g/dL

Ascitic fluid albumin: 1.0 g/dL

Ascitic fluid SAAG: 1.1 g/dL

Ascitic fluid LDH: 120 U/L

Ascitic fluid glucose: 110 mg/dL

Ascitic fluid amylase: 30 U/L

Ascitic fluid triglycerides: 40 mg/dL

Ascitic fluid cholesterol: 120 mg/dL

Ascitic fluid pH: 7.4

Ascitic fluid gram stain: No organisms seen

Ascitic fluid AFB smear: No AFB seen

Ascitic fluid AFB culture: No growth at 6 weeks

Ascitic fluid cytology: No malignant cells seen

Ascitic fluid adenosine deaminase: 10 U/L

Ascitic fluid interferon-gamma release assay: Negative

Ascitic fluid PCR for M. tuberculosis: Negative

Ascitic fluid PCR for M. tuberculosis complex: Negative

Ascitic fluid PCR for M. tuberculosis rifampin resistance: Negative

Ascitic fluid PCR for M. tuberculosis isoniazid resistance: Negative

Ascitic fluid PCR for M. tuberculosis ethambutol resistance: Negative

Ascitic fluid PCR for M. tuberculosis streptomycin resistance: Negative

Ascitic fluid PCR for M. tuberculosis pyrazinamide resistance: Negative

Ascitic fluid PCR for M. tuberculosis fluoroquinolone resistance: Negative

Ascitic fluid PCR for M. tuberculosis second-line injectable resistance: Negative

Ascitic fluid PCR for M. tuberculosis ethionamide resistance: Negative

Ascitic fluid PCR for M. tuberculosis para-aminosalicylic acid resistance: Negative

Ascitic fluid PCR for M. tuberculosis cycloserine resistance: Negative

Ascitic fluid PCR for M. tuberculosis linezolid resistance: Negative

Ascitic fluid PCR for M. tuberculosis clofazimine resistance: Negative

Ascitic fluid PCR for M. tuberculosis bedaquiline resistance: Negative

Ascitic fluid PCR for M. tuberculosis delamanid resistance: Negative

Ascitic fluid PCR for M. tuberculosis pretomanid resistance: Negative

Ascitic fluid PCR for M. tuberculosis moxifloxacin resistance: Negative

Ascitic fluid PCR for M. tuberculosis gatifloxacin resistance: Negative

Ascitic fluid PCR for M. tuberculosis levofloxacin resistance: Negative

Ascitic fluid PCR for M. tuberculosis ofloxacin resistance: Negative

Ascitic fluid PCR for M. tuberculosis ciprofloxacin resistance: Negative

Ascitic fluid PCR for M. tuberculosis amikacin resistance: Negative

Ascitic fluid PCR for M. tuberculosis kanamycin resistance: Negative

Ascitic fluid PCR for M. tuberculosis capreomycin resistance: Negative

Ascitic fluid PCR for M. tuberculosis viomycin resistance: Negative

Ascitic fluid PCR for M. tuberculosis ethambutol resistance: Negative

Ascitic fluid PCR for M. tuberculosis streptomycin resistance: Negative

Ascitic fluid PCR for M. tuberculosis pyrazinamide resistance: Negative

Ascitic fluid PCR for M. tuberculosis fluoroquinolone resistance: Negative

Ascitic fluid PCR for M. tuberculosis second-line injectable resistance: Negative

Ascitic fluid PCR for M. tuberculosis ethionamide resistance: Negative

Ascitic fluid PCR for M. tuberculosis para-aminosalicylic acid resistance: Negative

Ascitic fluid PCR for M. tuberculosis cycloserine resistance: Negative

Ascitic fluid PCR for M. tuberculosis linezolid resistance: Negative

Ascitic fluid PCR for M. tuberculosis clofazimine resistance: Negative

Ascitic fluid PCR for M. tuberculosis bedaquiline resistance: Negative

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Ascitic fluid PCR for M. tuberculosis gatifloxacin resistance: Negative

Ascitic fluid PCR for M. tuberculosis levofloxacin resistance: Negative

Ascitic fluid PCR for M. tuberculosis ofloxacin resistance: Negative

Ascitic fluid PCR for M. tuberculosis ciprofloxacin resistance: Negative

Ascitic fluid PCR for M. tuberculosis amikacin resistance: Negative

Ascitic fluid PCR for M. tuberculosis kanamycin resistance: Negative

Ascitic fluid PCR for M. tuberculosis capreomycin resistance: Negative

Ascitic fluid PCR for M. tuberculosis viomycin resistance: Negative

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

21st COMBAT SUPPORT HOSPITAL B6-4

LAST, FIRST, MI: NOIJ - US [redacted] | UNIT: 5MAT | RANK | SSN

Physician: (b)(6)-2 | Ward: | X STAT / Routine | Date and Time: 3 JAN04 1400 | Reported by: (b)(6)-2 | Date and Time: 3 JAN04 2143

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

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

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		
Other:		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB	2.6	3.3-5.5 g/dL
	ALP	90	26-84 U/L
	ALT	9	10-47 U/L
	AMY	69	14-97 U/L
	AST	62	11-38 U/L
	Tbil	2.4	0.2-1.6 mg/dL
	BUN	19	7-22 mg/dL
	Ca	8.4	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	Cl	94	98-108 mmol/L
	TCO2	24	18-33 mmol/L
	Creat	1.2	0.6-1.2 mg/dL
	GGT	14	5-85 U/L
	Glu	106	73-118 mg/dL
	K	3.1	3.3-4.7 mmol/L
	TProtein	5.1	6.4-8.1 g/dL
	Na	137	128-145 mmol/L

Microbiology

Source:		
Fecl euk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	10.4	4.8-10.8 x10(3)/uL
	RBC	4.29	4.2-6.1 x10(6)/uL
	Hgb	13.3	12.0-18.0 g/dL
	Hct	38.7	35.0-60.0%
	MCV	90.1	80.0-99.0 fl
	MCH	30.9	27.0-31.0 pg
	MCHC	34.3	33.0-37.0 g/dL
	Plt	271	130-400 x10(3)/uL
	LY%	9.9	15.0-55.0%
	LY#	1.0	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium
Thick		No Plasmodium

Sed Rate

Sed Rate		1hr 0-20 mm

Coagulation

PT	15.2	10-13 seconds
APTT	35.6	22.1-33.0 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

MEDCOM - 380

(2)

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 04, MONTH Jan, YR. 03; TIME 2040

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): NONE

HISTORY OBTAINED FROM: ☐ PATIENT ☑ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX: Male AGE: 26

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: Upon arrival

VITAL SIGNS

TIME	2040		
BP	116/63		
PULSE	80 (R)		
RESP.	18		
TEMP.			
WT. (Child)	100% AA		

CATEGORY (See reverse)

- ☐ EMERGENT
- ☐ URGENT
- ☑ NON-URGENT

ORDERS	INITS.	TIME
L ankle	[redacted]	2100
L foot	[redacted]	2100
crutches, IV		2100
CXR	[redacted]	2100

ASSESSMENT/DIAGNOSIS

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

26 c/o sp IED. Req. detained PMH-Ø PSH-Ø

Hx very poor, but hospt gross is that he felt victim to this cum, IED. - Seen @ outside BAS.

Facial + L ankle injuries

AOx4. GCS 15.

Stable VS en route

ABCV

C - HEENT - Swollen, ecchymotic, (R) orbit. + eye trauma, pupil 2mm + (R) scleral

No Hyp's facial abnormalities

Thx - (B) bilateral TM's c bleeding, hearing intact / understands interpreter needs - d/w FT

back

Chest - AT - B=BS - abd - benign

pelvis - stable

(L) ankle - 8cm lat ankle lac. + pulses

neuro - AOx4. GCS 15. No focal deficit

(CONTINUE ON SF 507 IF NEEDED)

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

CONDITION UPON RELEASE

- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

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. REC. RECORD)

[redacted] b6-4

(b)(6)-4

(b)(6)-2

STAMP: MAJ MC

medications ordered, any limitations and follow-up

Seen by ortho (Johnson)

Optometry contacted

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 (Rev. 6-93)

MEDCOM - 381

ACLU-RDI 1025 p.114

DOD 003508

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY: 21st CSH (b)(3)-1

LOG NUMBER

ARRIVAL — DATE: DAY 04 MONTH Jan YR 09 — TIME: 1943

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): Nitro x 2, ASA

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): CPW

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Chest pain SOB

SEX: M AGE: 57

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	2050		
BP	140/63		
PULSE	78		
RESP.	16		
TEMP.			
WT. (Lbs)	160#		

CATEGORY (See reverse)
☐ EMERGENCY
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
IVHRC	[redacted]	2015
CBC, Troponin		2015
CRMS	[redacted]	2011
CXR		
12 Lead EKG	[redacted]	2015

ASSESSMENT/DIAGNOSIS: Chest pain - resolved

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

56 yo Iraqi detainee brought to ER for chest pain x 1 hr. Pt. given Nitro x 2 & ASA at detainee facility. Afterwards chest pain has resolved. Pt. only complaining of headache. Hx of CP in the past.

Ex: HEENT - NCAT
Heart - RRR
Lungs - CTA B
Abd - soft, NT, ND
Ext - warm

pmh: ?
meds: ?
allergies: NKDA

EKG: NSR, 177, 446, 84, 37/41
Troponin: neg
CK-MB: neg

A&P: Pt. c/o resolved chest pain. EKG neg. Troponin neg. CK-MB neg. (1) Discharge to detainee facility. (2) Tylenol prn HA. (3) Return for return of chest pain.

(CONTINUE ON SF 507, IF NEEDED)

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

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE:

(b)(6)-2

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 TREATMENT RECORD).

[redacted] B6-4

1947

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, plans)

EMERGENCY CARE AND TREATMENT STANDARD FORM 507 (REV. 4-92)

MEDCOM - 382

ACLU-RDI 1025 p.116

DOD 003510

B6-4

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

B6-4

LAST, FIRST, MI	UNIT	RANK	SSN
ABNER, [redacted]	EPW	CIV	[redacted]

Physician (b)(6)-2	Ward:	STAT / Routine	Date and Time:	Re (b)(6)-2	Date and Time:
	EMC	Routine	06 Jan 0412		6 Jan 04

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na	139	128-145 mmol/L
	K	4.0	3.3-4.7 mmol/L
	Cl	108	98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	12	7-22 mg/dL
	Glu	113	73-118 mg/dL
	Creat		0.8-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

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

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		
Crystals:		
Other:		

Chemistry (Piccolo Analyzer)

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		26-84 U/L
	ALT		10-47 U/L
	AMY		14-97 U/L
	AST		11-38 U/L
	TBil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.8-1.2 mg/dL
	GGT		5-85 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Ne[redacted]
Sram St		
WetPrep		[redacted]
KOH		Ne[redacted]ements
OccBld		[redacted]
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative
[illegible]		

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	8.4	4.8-10.8 x10(3)/uL
	RBC	5.97	4.2-6.1 x10(6)/uL
	Hgb	17.7	12.0-18.0 g/dL
	Hct	51.2	35.0-60.0%
	MCV	85.9	80.0-99.0 fl
	MCH	29.7	27.0-31.0 pg
	MCHC	34.6	33.0-37.0 g/dL
	Plt	446	130-400 x10(3)/uL
	LY%	27.2	15.0-55.0%
	LY#	2.3	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm
RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin	No Plasmodium Seen
Thick	No Plasmodium Seen

Sed Rate

[redacted]

APTT		
FDP		

Misc. Chemistry

Mono		
RPR		
HIV		
Meningitis		
Trop	Neg	
CK/MB	Neg	

MEDCOM - 384

7. CAT

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 21ST CSH

LOG NUMBER

ARRIVAL
DATE: DAY 21 MONTH JAN YR 03 TIME 2315

TRANSPORTATION TO MEDICAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): [redacted] VACCINATION UNKNOWN

HISTORY OBTAINED FROM: ☐ PATIENT ☒ OTHER (Specify)

ALLERGIES: NKA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): STOMACH CRAMPS

SEX: M AGE: 22

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS			
TIME	2315	2345	0020
BP	154/69		126/66
PULSE	147	94	96
RESP.	18		18
TEMP.	98.2		97.3
WT(Clothed)	99		98.6

CATEGORY (See reverse)
☐ EMERGENT
☒ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
CBC, BMP	[redacted]	
UA, LFT's		35
LTIL NS bolus		35
Phenergan 12.5		
Repeat VS 2 bolus	[redacted]	2120
Bolus 2nd L 65 NS		

ASSESSMENT/DIAGNOSIS
[redacted] 340.1 LLE
ACUTE GASTROENTERITIS

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: on arrival

22Y/O MALE C/O NAUSEA, VOMITING, DIARRHEA AND STOMACH CRAMPS. PT STATES HE HAS BEEN ILL x 3 DAYS. SPC (b)(6)

22 y/o IRAQI DETAINEE brought by MP's for evaluation of abdominal pain. History obtained through translator. DETAINEE reports nausea, abdominal cramping and diarrhea now x 3 days. Onset x 3. No F/C, no hematemesis, no hematochezia. Symptoms worse today, evening meal was eaten and tolerated at DETAINEE sick call.

PMH: Ø Meds: Unknown
PSH: Ø
Hemorrhoidectomy Allergies: NKDA.

GENERAL: WN/WD/IRAQI Ø/Ø/Ø/Ø/Ø abdominal pain/non toxic/follows commands

INTEG: warm + dry Ø rashes

HEENT: Unremarkable

LUNGS: CTAB 5 w/ exc

CV: HRR 3 (no) m s1/s2

ABD: +BS/? volitory guarding, soft when distracted Ø rebound Ø Rovsing's Ø evidence guarding

EXTREM: Ø edema

Repeat exam 0015 - Abdomen soft Ø rebound Ø focal abdominal tenderness

Impression: AGE, doubt appendicitis

(CONTINUE ON SF 507, IF NEEDED)

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): MP custody
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☒ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE: 0030

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 TREATMENT RECORD).

[redacted]

B6-4

(b)(6)-4

(b)(6)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

1. Discontinue all medications previously prescribed
2. Ciprofloxacin 500mg orally 2x/day x 3d
3. Loperamide 2mg orally after each diarrhea
4. Phenergan 25mg orally every 6 hours as needed for nausea
5. Clear liquids frequently
6. Return for worsening pain, fevers or vomiting 24-48 hours

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 385

ACLU-RDI 1025 p.118

DOD 003512

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21st CSH MosulLOG NUMBER:

ARRIVAL — DATE: DAY 30 MONTH 01 YR. 04 TIME: 1204

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): Captopril 50mg

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): EPW Detainee Camp

HOME TELE. NO. (Inc. area code):

CHIEF COMPLAINT(S) (Include symptom(s), duration): HA

SEX: M AGE: 51

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: On Arrival

VITAL SIGNS			
TIME	1210	1220	1225
BP	159/112	205/117	217/122
PULSE	81		
RESP.	18		
TEMP.	98.5		
WT. (Child)	179 LBS		

CATEGORY (See reverse)
☐ EMERGENT
☒ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
IVH + KO	[redacted]	1200
CBC, LFT, PT/PTT		1200
ISTAT 6, CK, UA		1200
EKG		1220
CXR PA/LAT		1225
w/c bed-bound		1300

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

51 y.o.♂ Brought in from EPW camp c/o headache
PMH - High Blood pressure, Peptic ulcers
PSH - ∅
Tob - pk/day
EMHx Hypertension. spc. Kiwo A. Viggia 91W
51 yr old EPW Diagnosis in c/o HA - seen/pt
evaluated to have exacerbation of known hypertension, ∅CP, ∅SOB, took it of his Captopril (50mg) today - usually takes it in the am
HA
Gl Chem ∅ 1.010 7.0 pH
PT 13.9 PTT 33.7
30mg toradol IVP
TP 7.4 alb 4.4 glo 2.5 alp 100(↑) ast 34 amy 50 alt 20 Tbili 1.6 Ca++ 9.1
9.0 | 16.0 / 48.2 2371
145 | 100 / 107
4.5 | 26 / 1.2
B6-2

ASSESSMENT/DIAGNOSIS: Hypertension mildly out of control

A+Ox3, coop/pleasant, discussion thru interpreter, skin color good, warm, dry, neck ∅JVD, supple, pupils =, EOMI fundi benign, TM's cl (has tinnitus since 1999 ⊕ exposure loud noises) mouth ∅ lungs CTA, heart RRR ∅(m) heard, abd soft, ext - ∅CCE
1350 sl HA but "fever" of head gone
1350 - BP 170/90 feels better, will ↑ dose of Captopril to 75mg tid & monitor BP for next 24 hrs if does not work will add β Blocker like Atenolol & get medicine consult
CXR no cardiac enlargement
EKG sinus - RSR

(CONTINUE ON SF 507, IF NEEDED)

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): Clinic
EMERGENCY TODAY
72 HOURS ☒ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE: 1400

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 TREATMENT RECORD).

(b)(6)-2

R AND ID STAMP: LTC MC (b)(6)-2

NT (Include medications ordered, any limitations and follow-up)

(b)(6)-4

[redacted] B6-4

① Captopril 50mg ↑ to 3 times/day
② Get 5d BP check
③ if any problems

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 (Rev. 6-82)

[redacted]

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