(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 26 MONTH Sep YR. 03; TIME 1145

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

CURRENT MEDS. (Include immunization and other data): TENORMIN (?100mg) DIABENESE 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/CHEK	98%	99%

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

ORDERS	INITS.	TIME
CBC w/ diff	[redacted]	1155
Cr, UA	[redacted]	1156
[illegible]	[redacted]	1155
Complete 2 hours after 1st set of VS		
Meal - STAT BS		

ASSESSMENT/DIAGNOSIS: Hyperglycemia, Type 2 DM; Hypertension - BPH

DISPOSITION (Check one or more 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:

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)

62y WM at MAP clinic brought by MP's for evaluation of diabetes, hypertension and lower abdominal discomfort. Patient reports taking Diabenese for DM and Tenormin for high blood pressure. Also taking Ciprofloxacin for difficulty urinating - describes symptoms of BPH - but no dysuria

Meds: Tenormin, Diabenese, Ciprofloxacin, Allergies: NKDA

Meds: Ibuprofen

Neuro: Awake/alert & oriented x 3/4, answers appropriately, strong grip bilat

HEENT: Moist mucous membranes

Neck: Supple

Lungs: CTAB, no w/r/r

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

ABD: S/NT/ND, +BS, no masses, no guarding

Extrem: 0 edema

Labs: 15.6 / 45.3 / 227; 139 / 3.8 / 103 / 30 / 292 / 1.3; 140 / 3.9 / 106 / 25 / 240; 29; Ca 9.1; UA: SG 1.035, 40 mg/dl ketone, >2000 glucose, 0 blood, 0 LE; ABG (2L NC): pH (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. PATENOL 25mg - one orally each morning
2. TERAZOSIN 2mg - one orally each evening
3. GLIPIZIDE 5mg - one orally each morning
4. HYDROCHLOROTHIAZIDE 12.5mg - apply to [illegible] as needed

(b)(6)-4

MEDCOM - 324

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 24 MONTH 9 YR. 03 TIME 2354

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

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

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)
S- Seizures

SEX M AGE 47

POSSIBLE THIRD PARTY PAYER?
☐ YES ☒ NO

TIME SEEN BY PROVIDER
2400

VITAL SIGNS

TIME	2354		
BP	140/82		
PULSE	103		
RESP.	16		
TEMP.	98.4		
WT. (Scale)	179 lb		

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

ORDERS — UNIT — TIME

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: 0015

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: 47 yo F c/o seizure x 5 yesterday x 1 today/ ——— HVCA

PMH - 1 [illegible]
PSH - [illegible]
meds - [illegible]
NKDA
PSH - 0

S- 47 yo F hx epilepsy [illegible] currently seizure free x [illegible] taking meds x 5 days. On 2 tx meds - [illegible] BID + one - [illegible] Now happening short spells with [illegible] she states + [illegible] compared to [illegible] No loss of B/B. No [illegible] No headaches. No trauma [illegible]

6-2

Seizures

[illegible] Tongue deviation to [illegible] facial droop [illegible] asymmetry [illegible] c/w witnessed [illegible] anysmia [illegible] unable to [illegible] guide [illegible]

EDC

Pt had seizure [illegible] during exam. Pt fell to [illegible] appears seizure like. Post ictal [illegible] incontinence. Confused. [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 TREAT-MENT RECORD):

Potus [redacted] B6-4

(b)(6)-4

SIGNATURE OF PROVIDER AND [illegible] (b)(6)-2

plans)

Tonic [illegible] = seizure [illegible] 5 [illegible] on [illegible] baseline [illegible] 1.75" mild [illegible] grasp [illegible] [illegible] [illegible] [illegible]

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT (b)(3)-1 FACILITY (Stamp): 2/s + CSH

LOG NUMBER

ARRIVAL — DATE: DAY 20, MONTH 09, YR: 23 — TIME: 1432

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

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): 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. (Lbs)			

CATEGORY (See reverse)
- EMERGENT
- URGENT
- NONURGENT

ORDERS	UNITS	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 conjuctivitis

58y ♂ local detainee brought in MP custody for evaluation of redness and drainage OS. On interview through interpreter detainee also c/o laceration to scalp sustained ago when apprehended and disorientation and ringing in ears. Pt lay

ASSESSMENT/DIAGNOSIS

Conjunctivitis
Scalp laceration

GEN: awake/alert/oriented x3 answers questions appropriately through translator

HEENT: warm + dry ø rashes

HEENT: Yellow-crusting stellate lac of posterior aspect of subciliary portion of left eyelid ø involvement of globe. Conjunctiva/sclera injected OS. Oral mucosa/throat clear c good dentition. EOMI. PERRLA. 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'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. (b)(6)-2

IMMUNOCOMPROMISED? LIST FACILITY HOLDING TREAT. RECORD:

Iraq EPW # [redacted] B6-4

[redacted] (b)(6)-4

UTI, MRSA

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

Apply Bacitracin ophthal ointment to affected eye 2x/day for 5d
Bacitracin + bandage to scalp

MEDCOM - 326

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 28 Sept 03 (DAY / MONTH / YR.) 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	119/65		
PULSE	85		
RESP.	20		
TEMP.	99.1		
(Repeated)	99		

CATEGORY (See reverse)

- ☐ EMERGENT
- ☐ URGENT
- ☒ NON-URGENT

ORDERS	INITS.	TIME
CBC, Estab 6	[redacted]	1448
CL, UA LA		1449
IV		1448

ASSESSMENT/DIAGNOSIS: Dyswia

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

DATE/TIME 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)

Potus ♂ c/o pain in (R) lower pelvic area [redacted]

37y Iraqi ~~detainee~~ c/o dysuria

Through t/p/stator, 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

GENERAL: AAO x3/Iraqi ♂/NAD/A+OX3

Answers appropriately through interpreter

~~Mouth: tongue + dry ∅ jaundice~~

Neck: Unremarkable

Lungs: CTAB x WI/R

CV: NRRS (-) m/r/g

ABD: soft/NT/ND/∅ mass

∅ suprapubic tenderness

∅ CVA tenderness

Extrem: ∅ edema

6.2	11.3	139	26	WBC = 3.8	AST = 25
	35.7	98	191	HGB = 6.6	TB = 0.8
		4.1	1.4	HCT = 20	BUN = 9
				MCV = 52	TP = 7.6

UA - SG=1025 ∅ glucose/trace ketones ∅ blood ∅ nit ∅ LE

(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; CIVILIAN - LIST FACILITY BUILDING TREAT

POTUS Detainee

B6-4

[redacted]

INSTRUCTIONS TO PATIENT (Medications prescribed, special considerations explained, any limitations and follow-up plans)

Rx for H2 blocker provided at patient request: Zantac 300mg orally 2x/day needed

MEDCOM - 327

21st COMBAT SUPPORT HOSPITAL

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

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

Physician: (b)(6)-2 | Ward: | X 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		22-26 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

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:			

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
	TProteinr	7.6	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	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%

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

N/A Tested

NSN 7540-00-834-4178

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
28Sep03	Patus ♂ c c/o Bleeding from external fixator. —
1449 HMM	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: WA/WD/♂/NAD/Patent
SpO2 97%	Airways appropriately managed w/ nasal
	(L) LE with ex-fix in place
	∅ 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 LTC USA

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
PATIENT'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] 61-4

(b)(6)-4

SSN-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 — TIME: 1845

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): (L) 1st digit and (R) wrist pain

SEX: M AGE: 24

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	1845		
PULSE	77		
RESP.	20		
BP	127/71		
TEMP	97.7		
PAIN	7		

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)

24 y/o M, EPW, patient to EMT c c/o (R) wrist pain and (L) 1st digit pain, 1st digit on foot swollen/reddened & tender post nailbed area with superficial (R) wrist abrasion. Noted -DJN

24 y/o EPW c/o (L) toe pain for [illegible]. Stepped on, ajar x 1 week ago. No FB. 7/10

Also c/o (R) wrist abrasion from fall. 5/10.

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS: R great toe cellulitis

[illegible] toe. Pain to plantar aspect. Red, swollen, tender @ proximal IP

XR

NAD, neurovascularly intact. No FB found

1-D — 1 1/2 down. No FB found

DISPOSITION (Check all that apply)
- HOME — FULL DUTY
- QUARTERS: 24 Hrs. — 48 Hrs. — 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Medical clinic): Ortho Spec
- EMERGENCY — TODAY
- 72 HOURS — ROUTINE
- ADMIT TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- IMPROVED — UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1927

(CONTINUE ON SF 507 IF NEEDED)

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; DEROS; PCS; FACILITY HOLDING TREAT. RECORD

[redacted] B6-4

b(6)-4

b(6)-2

[illegible] any limitations and follow-up:

Refer to

Return if no better in 7 days

Tylenol

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (b)(3)-1 CAMP CROPPER

LOG NUMBER

ARRIVAL — DATE: DAY 14 MONTH OCT YR 03 — TIME: 11:13

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

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

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): BAHRAIN 287 DETAINEE

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT (S) (Include symptom(s), duration): HYPERTENSION LEFT ARM

SEX: M AGE: 30

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1130

VITAL SIGNS

TIME	1130		
BP	145/90		
PULSE	84		
RESP	16		
TEMP	100.0		
WT (Lbs)	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)

Stg IRAQI DETAINEE brought from detention requesting medication refill. Taking unknown dosage of captopril. MD's report detainee reciving medications. Detainee also requesting medication for "stomach upset"

Pulse. HTN ? DERS — meds: Captopril — allergies: NKDA — Habits: nonsmoker

ASSESSMENT/DIAGNOSIS: Hypertension, controlled

GENERAL: WNWN/thinset IRAQI/NAD answers questions appropriately through translator
SKIN: warm + dry ⊖ rashes
HEENT: unremarkable
LUNGS: CTAB & w/RR
CV: RRR ⊖ M S1/S2
ABDO: normoactive / soft/NT/ND ⊖ HSM
EXTREM: ⊖ edema
NEURO: nonfocal.

Hypertension - currently controlled. Some confusion about why detainee is receiving medications. Will provide medications to detainee's medics

(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

DATE OF RELEASE: 20 OCT

PATIENT'S IDENTIFICATION (Mechanical imprint) (b)(6)-2
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle initial; SSN or DOB, service status, name and relation of sponsor or unit (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

STATUS: [redacted] (detainee)

(b)(6)-4 B6-4

CO-0201

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

CAPTOPRIL 25mg 1 p.o. q.d. #15 NR
TRAZODONE 100mg 1 p.o. H.S. #20 NR
discuss other medications

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 1752

VITAL SIGNS

TIME	1711		
BP	118/77		
PULSE	80		
RESP.	20		
TEMP.	99.9 °F		
WT. (Child)	180 lb		

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 4d bloody stools for 3 days. Pt. c/o pain to rectum. 1 episode/d
bled stools. ↓ bleeding stools
Also decreased urination
No n/v/f/implications SX;
On Keflex - unclear why
c wound/abscess.
abd - soft NT, ND, +bowel sounds
rectal - painful
↑ rectal tone
↓ prostate
brown hemorrhoid

F/U

S/Ø

ASSESSMENT/DIAGNOSIS: Anal fissure

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) Prod
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE

Prod fissure
Hemorrhoids

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 1800

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

(b)(6)-4

SIG (b)(6)-2

INSTructions and follow-up plan

Eat more fiber

Anal fissure

my limitations and follow-up

B6-4

MEDCOM - 332

556-103 (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 1220

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 1220

VITAL SIGNS

TIME	1220		
BP	129/78		
PULSE	84		
RESP.	20		
TEMP.	98.5		
WT. (Child)	180		

CATEGORY (See reverse)

- ☐ EMERGENT
- ☒ URGENT
- ☐ NON-URGENT

ORDERS	INITS.	TIME
X-Rays (R) face		1315
(R) femur		
(R) humerus		
Pelvis		1315
CBC, Type & Cr		1305
IV NS @ KVO		1310

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 c pain, shrapnel wounds to (R)face, (R)humerus, (R)femur/pelvic area, pt. ambulatory on arrival, A&Ox3, LS CTA bilat, pedal pulses intact, GCS 15, [illegible]

33yo c/p GSW x 4 FW. Pt [illegible] (R)eye) T/C Stable en route. Size 5 ETT [illegible] by EMS 6.5 Balloon.

[illegible] Xrays/procedures by EMT, [illegible] - (R) hand FX, humerus FX: clean [illegible] clean wound

16 1316 1610 1319 1336 1 C.C

Urgent - Fx (R) hand splinted bandages [illegible] abd - STAT abdominal [illegible] NAD

(R) leg - 2 GSW (FW) (R) lateral thigh, medial + lateral (R) humerus - MFW [illegible] proximal humerus - Acute appearing nerve GCS 15.

[illegible] 1320

[illegible] by Chaplain (Technical) [illegible]

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) OR WRITTEN ENTRIES GIVE: Name - last, first, middle; [illegible] (IMPORTANT: LIST FACILITY HOLDING TREASURE)

Status # [redacted] B6-4

[redacted]

(b)(6)-2

(b)(6)-2

(b)(6)-4

[illegible] NEEDED)

[illegible] MMJ, MC

[illegible] medications ordered, any limitations and follow-up

- [illegible] face, (R) [illegible] humerus, (R) femur, pelvis
- MFWs. GWFs. Fxs.

d/c to EPW FACILITY

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 (R) face, (R) humerus, (R) femur/pelvis areas, Pt. ambulatory on arrival, airway intact, LS CTA bilat., skin PW/Dry c dried blood noted to above areas. Pts. face, (R) femur TTP. Pedal pulses strong equal bilat, Pts. GCS 15/15. Pt. recieved IV 18G to (R) 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 [b](6)-2 infusing @ this time. CHT/AN
2350	Pt. returned from radiology. [b](6)-2 CHT/AN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTENANCE
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.

POTUS # [redacted] B6-4

[b](6)-4

CHRONOLOGICAL RECORD [illegible]

Manual [illegible]

STANDARD FORM [illegible]

Prescribed by GSA/[illegible]

FIRMR 101-11.4 [illegible]

B6-2

B6-4
21st COMBAT SUP [redacted] HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI	UNIT	RANK	SSN
Doe, [redacted] B6-4			

Physician: (b)(6)-2	Ward: 9 MT	X STAT / Routine	Date and Time: 02 Oct 03 23:08	Reported to: (b)(6)-2	Date and Time: 2 Oct 03 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	99	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

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

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%

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
Urobill		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

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

ESR / 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

I-Stat 6 use

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 (b)(3)-1 status 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	119/91	130/79	128/79
PULSE	93	95	89
RESP.	16	22	15
TEMP.	97.8	97.8	
WT. (Lbs)	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
Type & Cross		2335
Trauma Surgery Cons		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 y/o CPW s/p GSW c m-4 to (L) lat neck. Stable en route. Speaking c airway involvement.

Pmh: Ø
PSH: 15 years ago [illegible]
Tob: Ø
Last Oral Intake 24hrs

O: A: w/ c-collar
B: B/sym w/ crepes BS lvl B lv
C: CR<2s, DP 2+
D: GCS 15, PERRL
E: HEENT - lat post 3cm c neck GSW c significant hematoma ecchymosis
Chest - (L) shoulder joint pain c crepitus c humerus
(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 UEs. Reflexes 2+

A: GSW (L) neck with (L) shoulder involvement

P: Sed (Sandoz) and 'd pr. & airway involvement & hdx/ptx.
Abx given.

Cx-c spine & chest
C-spine
Humerus

(CONTINUE ON SF 507, IF NEEDED)

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:

PATIENT'S IDENTIFICATION (Mechanical imprint) (WHEN 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. 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)

F. Cl

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] 21 CSH

LOG NUMBER

ARRIVAL
DATE: DAY 10 | MONTH OCT | YR. 07 | TIME 1632

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) Detroit

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	1633		
BP	108/72		
PULSE	97		
RESP.	18		
TEMP.	97		
WT. (Est)	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 leg injury. Pt caught in hand light night (crew). Had MVC 10 days ago c (L) leg injury + 3 (R) rib fxs. Brought by MPs p/ amputee 3 w/ 6 hr (L) leg inj. 2° leg wound.

Ambulatory but unsteady. Had XR + sutures @ civilian facility - no lacs to wound reviewed c/ leg wound. CT chest & abdomen

(L) leg - well healing 2° wound c some areas of re-infection

DP 1 - CR < 2"

2+ DP pulse

MOMS tres

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

observation in ER

No evidence of infection

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

xr done - stat rpt pending

frag: hosp

(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.

Active # [redacted] B6-4

[b)(6)-2]

[b)(6)-4]

ordered, any limitations and follow-up

MEDCOM - 337

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

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Specify) ACSF Mosul

LOG NUMBER

ARRIVAL DATE (DAY / MONTH / YR.)	TIME	TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (Tetanus immunization and other data)	HISTORY OBTAINED FROM
17 Oct 03	1310	☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify) VMP Escort	None	☐ PATIENT ☐ OTHER (Specify) ALLERGIES: 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

TIME SEEN BY PROVIDER: On arrival

VITAL SIGNS

TIME	1310		
BP	114/74		
PULSE	94		
RESP.	13		
TEMP.	97.7		
WT. (Child) OR	180		

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 with follow-up)

S. pt is from EPW camp. Escort states pt was stung by scorpion bite 24 hrs ago to (R) FA which is slightly swollen & red.

PSHx: 0
Tobacco: smokeless

10 y male pt brought by MP's concerned about alleged envenomation (R) forearm. MP's under impression that envenomation acute, but through translator detailed reports that he was stung or bitten by unknown or alleged yesterday

GENERAL = well nourished young adult male - does not appear to be in any pain
SKIN = warm + dry ∅ rashes
NECK: no oropharyngeal edema
LUNGS: CTAB ↕ a/x 12
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 TREATMENT RECORD).

(b)(6)-2

(EPW Camp) Plans:

Potus# [redacted] B6-4

Motrin 800mg orally 3x/day as needed
Benadryl 50mg orally 4x/day as needed
Isolation precautions reviewed

DNA Sco

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Etamp): 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: 44 16

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: On arrival

VITAL SIGNS

TIME	1310		
BP	119/74		
PULSE	94		
RESP.	18		
TEMP.	97.6		
WT. (Kilo)	180 lb		

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: Pt is from EPW Camp escorted by MPs. Hx Scorpion bite 24 ago to (R) FA which is slightly swollen & red. [b](6)-2 wt/r

PMHx: NKA
PSHx: NKA
Tobacco: smokeless ppd

Pt (EPW) detainee brought by MP's concerned about an injured extremity on (R) forearm. MP's under impression that circumstances acute, but through translator, detainee reports that he was stung or bitten by unknown animal/insect yesterday

ASSESSMENT/DIAGNOSIS: Arthropod envenomation

GENERAL: WNWD/WN adult male - does not appear to be in any pain
SKIN: warm + dry @ extremes
HEENT: No oropharyngeal edema
LUNGS: CTAB
EXTREM: Ten mm of induration (R) forearm surrounding what appears to be insect bite @ circle 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 TREATMENT RECORD).

[b](6)-2

(EPW Camp)

Potus# [redacted] B6-4

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

MOTRIN 800 mg orally 3x/d pc as needed
BENADRYL 50mg orally q4 prn as needed
SEDATION precautions reviewed

DATE 4-06

1308
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 TELEPHONE NO. (Inc. area code)

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

SEX: M AGE: [illegible]

POSSIBLE THIRD PARTY PAYER? ☑ YES ☐ NO

TIME SEEN BY PROVIDER: ON ARRIVAL

VITAL SIGNS			
TIME	0910		
BP	129/73		
PULSE	91	46	
RESP.	27		
TEMP.	[illegible]	[illegible]	
WT. (Child)	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)

adult ♂ Pedal pt. [illegible] age [illegible] urine 950.
transferred from FSB at TALIFAR P
sustaining injuries in grenade attack.
Subject is alleged perpetrator of attack,
arrived [illegible] custody of [illegible] will
not [illegible] answer questions, Rec'd 4L crystalloid
AMPLE history - unobtainable - prior to transfer

A- patent and maintained (+ bilateral trumpet [illegible] (Hct 34 / 32.4) 16.4 (279
B - Breath sounds symmetric
C - Small amount of bleeding from frequent [illegible] sounds
BP normal, pulse [illegible]
D- GCS - 12 + (? sedation) PERL, MAE
E - Completely exposed, rolled

GENERAL: Pt is ♂ adult ☹ sedated, [illegible] or occasionally non communicative
HEENT: NC ☺ small [illegible] wound 130/Hg
(R) temporal area
PERRL/EOMI/sclera clear 0-P13
(L) nostril ☺ nasal trumpel
[illegible] well visualized
blood in ear
small penetrating wound [illegible]
anterior neck
LUNGS: CTAB
CV: HRR ☺ (no murmurs)
GU: Foley in place, [illegible]
EXT: Movements equal, [illegible]
BACK: [illegible]

ORDERS | INITS. | TIME
[illegible]
Foley to gravity
CBC, UA, T+S
X-rays - chest, KUB
Abdomen, scalp

ASSESSMENT/DIAGNOSIS
MULTIPLE FRAGMENTATION WOUNDS

DISPOSITION (Check all that apply)
HOME | FULL DUTY
QUARTERS: 24 Hrs. | 48 Hrs. | 72 Hrs.
MODIFIED DUTY UNTIL: DAY [illegible] MONTH [illegible] YEAR
REFERRED TO (Indicate clinic): [illegible]
EMERGENCY | TODAY
72 HOURS | ROUTINE
ADMIT TO HOSP. UNIT/SERVICE: ICU

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).

POTUS # [redacted] (Deturnee)

B6-4

DX(S)-2

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)
EXT REM - Examination and (L) shoulder
(L) Thumb - open laceration at distal pad
(L) 3rd digit laceration sutured
closed prior to arrival
Foley in place, glans & cath site
Scrotum & true small areas of
[illegible] & scrotal edema

B6-4

ps #1 of 2

3 OCT 03 0730

UNKNOWN UNKNOWN

M UNK

ON ARRIVAL

0750
96/43
94
30 60% / fingertip
NON PALP

"Trapped" of unknown age brought to CSH via FLA in custody of 3/327 BNE Scouts (SPC MUNRO Nicholas) ? sustaining GSW to chest, Hemothorax valve and chest wound, no IV access on arrival

"AMPLE" History unobtainable

A - patent, grunting respirations
B - Breath sounds, chest rise symmetric, tachypnic
C - Intermittent thready peripheral pulses, active bleeding from
(L) posterior thoracic chest wound
D - Moving upper extremities only; flaccid + unresponsive
E - Completely exposed, rolled and examined.

Succinocholine 100mg IV - 0142/man
Versed 2mg IVPB 0155/man
Dopamine 3 ttt - 0155/man
Ancef 1 gm IV sent to OR
Tetanus

Ventilations assisted by BVM, 16ga IV cath (L) FA, 8.5 F cordis placed (R) femoral vein by Dr. [redacted]

RSI ε 100mg succinylcholine, intubated by SGT Colwell ε 8.5 ET tube via OL

(L) chest tube thoracostomy placed by Dr. Eastman
ε 500 cc crystalloid and 2 units emergency release blood administered and transferred to OR

Medical Hx: Unknown, unknown, unknown

(1 of 2)

Patient: [redacted] B6-4
SSN: [redacted]

Penetrating trauma to chest - (L) hemothorax
Abdo - (L) paraspinal muscle fragment
Back - tears of psoas shadow

CUT PAGE 1 OF 2

22 y/o M/C/S/W/A

GENERAL: Minimally responsive
Moving upper extremity; moving, unsteady
SKIN: Pale, cool, clammy
HEENT: No obvious injuries
OS anisocoria (old injury)
OD pupil dilated, reactive
LUNGS: Tachypneic, grunting
Chest tube, breath sounds symmetric
Penetrating wounds ② anterior, posterior
② posterior-lateral thoracic
CV: Heart sounds distant
ABDOMEN: Penetrating wound ② posterior/lateral only
EXTREMITIES: Right tenderness
GU: ~~wet~~ of EC ~~of~~ foley
BACK: ~~of~~ blood, flaccid tone
NEURO: ~~of~~ obvious trauma,
UE's apparently accessible
MOVES: Moving upper extremities only, initially, while, purposeful movements

19.2 → 13.8 / 40.1 → 414

134 / 4.3 → 100 → 3.8 / 16

1.9

UA - SG = 1.030 ~~of~~ glucose ~~of~~ ketone
Large blood 0-5 WBC/HPF RBC

(2 of 2) TO OR

Redacted

B6-4

(See Instructions on Back of this Sheet) (b)(3)-P

NSN 7540-01-375-3736

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21st Combat Support Hospital

ID NUMBER

ARRIVAL DATE (DAY / MONTH / YR.)	TIME	TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (Status immunization and other data)	HISTORY OBTAINED FROM
26 / 10 / 03	0402	☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)	Diabetic Medications	☐ 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 wounds

SEX: F AGE: 46

POSSIBLE THIRD PARTY PAYEE? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS		
TIME	0403	0540
BP	167/91	144/74
PULSE	117	103
RESP.	24	20
TEMP.		100.6 (38)
WT. (Child)	190 lbs	100.6 kg

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

ORDERS	INITS.	TIME
IV	[redacted]	0410
MDS, SGK, Nitrous, TMS		0410
Foley & UA		0435
Vent "One shot"		0500
Antibiotics		0425
Analgesia per Flow Sheet		

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)

46 yo [illegible] civilian female s/p [illegible] wounds from [illegible] blast. Reportedly [illegible] by wounds that [illegible] instantly killed another [illegible]. Wounds noted to [illegible] chest and [illegible] lateral [illegible] thigh. No [illegible] abd pain. Symptomatic pain only. VS stable en route. [illegible]

[illegible] chest tube [illegible] CXR [illegible] BS = BS [illegible] abd [illegible] NAD [illegible] pelvis - [illegible] for [illegible] wounds [illegible] OSS [illegible] back [illegible]

[illegible] for [illegible] CT [illegible] for [illegible] to [illegible] from [illegible]

ASSESSMENT/DIAGNOSIS: MFW [illegible] chest tube [illegible] thigh/buttocks

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: 0500

(CONTINUE ON SF 507, IF NEEDED)

(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 THIS AT-MEDIC RECORD)

POTUS #[redacted] EPW

B6-4

NO. ID STAMP

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

To Exam on [illegible] pelvis [illegible] tracks from [illegible] SVC - [illegible] bleeding and [illegible] No [illegible] may [illegible] Will possibly [illegible]

SSN-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 12 | MONTH NOV | YR 03 — TIME: 0422

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

CURRENT MEDS. (Include 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 complaint(s), duration) GSW (B) Forearms.

SEX: M | AGE: 30

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: ~~0422~~ 0420

VITAL SIGNS

TIME	0421		
BP	122/39		
PULSE	90		
RESP.	18		
TEMP.	98.2		
WT. (Lbs)	100		

CATEGORY (See reverse)

- EMERGENT
- URGENT
- NONURGENT

ORDERS	INITS.	TIME
(B) Forearm XR		
Pelvis XR		
(L) hip XR		
Ancef 1g IV		
MSO4 5mg IV		
UA		

ASSESSMENT/DIAGNOSIS

(B) forearms

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 yo M/P GSW to (B) forearms.

Also c complaint of pain to forearm - (L) hip. Occurred just PTA

2° combatant = US troop.

PI: ESW

R - 22 - 10.6 - n.l.

C: A&Ox3. Very anx

HEENT -

Chest -

Abd soft NT/ND +BS

Back -

Ext - GSW (B) forearm - 2+ RP/DP/PT bilat

GSW (B) mid FA

- pt on operating c hand surgery

- XRs: 2+ Rad pulse, (B) forearm comparisons, pelvis - small FX (L) hip

EDC - Given Ancef, MSO4, Cleaned - dressed GW's (B) forearms

2° real OR workload - Cx for surgery possibly to generate (L) elbow splint

chest tubes

routine foley in @ FA

GSW (B) FA

- reduced hip

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: CR/ORTHO

CONDITION UPON RELEASE

- IMPROVED | UNCHANGED
- DETERIORATED

TIME OF RELEASE: 0600

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 FACILITY HOLDING TREAT. MENT RECORD)

(b)(6)-2

Plans: Admit to ortho for elbow

Patient #

B6-4

Civ / Trauma

MEDCOM - 344

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) | OG NUMBER

ARRIVAL	TRANSPORTATION TO HOSPITAL (If class care enroute sheet)	CURRENT MEDS. (Include immunization and other data)	HISTORY OBTAINED FROM
DATE: DAY 22 MONTH Nov YR. 03 TIME 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)
EMERGENCY
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: on arrival

63y Iraqi ♂ DETAINEE brought in custody of MPs for wound check/sutures 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 baytrin.

ASSESSMENT/DIAGNOSIS: (1) URINARY RETENTION (2) LACERATIONS WOUND (3) TRAUMA (4) SUTURE REMOVAL

TREATMENT: Pt is Iraqi DETAINEE in MPs/CONTAINERS guesting through translator

(1) medical hx c healing wound approx 10 cm long, clean, dry ø erythema or drainage. Sutures in place (sutured 1 wk ago)

Foley removed
Sutures removed
c gauze dressing
Wound covered

(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 (Medical 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)-4

(b)(6)-2

INSTRUCTIONS TO PATIENT (Including medications prescribed, any limitations and follow-up visits)

(1) KEEP WOUNDS CLEAN DRY COVERED
(2) CONTINUE BAYTRIN AS PRESCRIBED
(3) RETURN IF UNABLE TO VOID
(4) RETURN FOR SCHEDULED F/U
FOLEY SCHEDULE TO BE CHANGED

Patient II [redacted] B6-4

MEDCOM - 345

ATTENDING

B6-4

21st COMBAT SUPPORT HOSPITAL

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

LAST, FIRST, MI	UNIT	DOB	RANK	SSN
Potus # [redacted]	21st CSH		N/A	[redacted]

Physician:	Ward:			Specimen Date and Time:	Received by:	Date and Time:
	EMT	X	STAT	16 Nov 03 1525		16 NOV 03 1526
			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	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		

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): (b)(6)-1 21ST CSH

LOG NUMBER:

ARRIVAL — DATE: DAY 19, MONTH Nov, YR 03; TIME: 1530

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

CURRENT MEDS. (Include immunization and other data): Anti-inflamatory Antibiotic

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: Dust- NKDA

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

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

CHIEF COMPLAINT(S) (Indicate 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

ORDERS | INITS | TIME

ASSESSMENT/DIAGNOSIS: BRONCHITIS, RESOLVING

DISPOSITION (Check all that apply)

- HOME ☒ FULL DUTY
- QUARTERS: 24 HRS. | 48 HRS. | 72 HRS.
- MODIFIED DUTY UNTIL: DAY | MONTH | YEAR
- REFERRED TO (Ambulance Case): MP CUSTODY
- EMERGENCY | TODAY
- 72 HOURS | ☒ ROUTINE
- ADMIT TO HOSP. UNIT | ☒ SERVICE

CONDITION UPON RELEASE

- IMPROVED | ☒ UNCHANGED
- DETERIORATED

TIME OF RELEASE: 1610

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

2140 Pt states he was seen by doctor x 2 week ago. Pt states doctor told him he had pulmonary infection. Pt states he has been having a pain in Lower (R) side of chest. Pt states he has pain when he breathes. SEE NOTES

SMOKE x 20yr x hx

PMHx:

PSHx: Foo

24y/M/AA brought from detainment for cough x 2 weeks, possible TB. On interview by translator at 21st CSH, individual reports no history of TB. Reports that he was seen by another physician two weeks ago for retrosternal chest discomfort and treated with antibiotic and anti-inflammatory medication. Still has midsternal retrosternal chest discomfort with deep inhalation. Reports occasional cough; also has cough productive of yellow or green sputum. Also complains of night sweats, loss of appetite, weight loss, fevers, night sweats. Also c/o occipital headache. Pain 2° trauma sustained in arrest. No LOC

Pain: 0 Meds: Unknown Allergies: NKDA Results: Normal

Psych: minor distress Antibiotic Anti-inflammatory

Procedure (R) Smoker Stopped

Gen: awake/alert/oriented x 3 in NAD

HEENT: MMM/no lymphadenopathy

Neck: supple, no JVD, no LAD

Resp: CTA b/l, no W/R/R

CV: RRR, no M/R/G

Abd: soft, NT/ND, +BS x 4

Ext: no C/C/E, 2+ DP pulses b/l

Neuro: AAOx3, CN II-XII grossly intact, no focal deficits

Skin: warm, dry, no rashes

MSK: no TTP, full ROM

Plan: CXR, Labs, Sputum AFB x 3, Mantoux PPD

Labs: CBC w/ diff, CMP, UA

CXR PA/Lat: Right upper lobe infiltrate with cavitation

Sputum AFB x 3: Negative

Mantoux PPD: 15 mm induration

Diagnosis: Pulmonary tuberculosis, right upper lobe

Treatment: Isoniazid 300 mg PO daily, Rifampin 600 mg PO daily, Pyrazinamide 1500 mg PO daily, Ethambutol 1200 mg PO daily x 2 months, then Isoniazid 300 mg PO daily and Rifampin 600 mg PO daily x 4 months

Follow-up: Return to clinic in 1 week for labs and medication refill

Patient counseled on importance of medication compliance and isolation precautions

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Typed/Label 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

POW [redacted] 86-4

[redacted]

(b)(6)

MEDCOM - 347

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 Rev. 6-85

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 20 | MONTH NOV | YR. 03 | TIME 1615

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

CURRENT MEDS. (Tetanus 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 symptom(s), duration): EPILEPTIC

SEX: M AGE: 36

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	1615		
BP	113/75		
PULSE	115		
RESP.	16		
TEMP.	100.0		
WT. (Lbs)	99		

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

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS: Epilepsy, unspecified

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 HE CANNOT SPECIFY 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 MONTHS. PT STATES HE HAS HAD DISORDER 1990's PRC MEDICS. PMH: seizure disorder PSH x 4 Tobacco: yes (3 ppd)

The patient reports that he has suffered from generalized seizures since the early 1990's when he learned that his brother had been killed. He has taken an anticonvulsant called the interpreter identifies as Lomenel (Gp-?). 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.

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

Impression: 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, pt. was instructed to return 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]

SIGNATURE (b)(6)-2

ADDRESS STAMP (b)(6)-2

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

(b)(6)

SSS-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. (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): Fever ± HA, generalized bodyaches

SEX: M | AGE: 40

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	1612
BP	123/67
PULSE	124
RESP.	18
TEMP.	103.5
WT. (Child)	

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

ORDERS | INITS. | TIME

1 L NS TO [redacted] 1623

IM Phen + MS [redacted] 1625

ASSESSMENT/DIAGNOSIS: Viral Syndrome

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

40 y/o M presents to EMT 2° c/o fever, HA, bodyaches for [b)(6)-] 1 day. Pt A&Ox3, LS CTA, skin W/W/Dry. states ø N/V/D. -.

The pt. first developed HA and fever 2 days ago, followed by generalized myalgias and malaise. ØN/V, ↓ anorexia, ↑ cough ↑ mild stiffness. Denies ST, CP, SOB, abd pain, rash, dysuria, diarrhea, constipation, hematuria.

PMHx: ø

PSHx: ø

Tobacco: Tpr

HEENT: OP - mild erythema, no exudate.

Neck: supple, non-tender, no LAD

HEART: RRR (+) S1, S2, ø murmurs, rubs, gallops

LUNGS: CTA B/L, ø c/c/e

Imp: viral syndrome

Plan: - Tylenol 4-4-6°

- 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)

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

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]

DOD ID STAMP [b)(6)-2]

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

[b)(6)-4]

SSN-100 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

(b)(3)-1 FACILITY (Sheep) 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): EPW

CURRENT MEDS. (Patients immunization and other data): INSULIN V (D UNITS) IDM

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) (Include symptom(s), duration): Diabetes

SEX: M AGE: 37

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS		
TIME	1620	1900
BP	104/61	118/60
PULSE	96	83
RESP.	18	20
TEMP.	99.8	97.2
WT (Kilo)	98	99 KG

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

ORDERS	INITS.	TIME
2L Bolus NS	[redacted]	00
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 dose and follow-up

49 YO MALE CSM PLANS OF EPI GASTRIC PAIN X 1 DAY. PT STATES HE BELIEVES IT IS BECAUSE OF HIS SUGAR LEVEL. PT STATES HE HAS BEEN NON COMPLIANT WITH HIS INSULIN (b)(6)-1. PT STATES HE PAIN IS IN UPPER QUAD.

PMHx: Diabetes
PSHx: Ø

Pt brought unresponsive. He is an ID patient who is new to my area. His regimen is 10u lente QD (before supper during Ramadan). He is determined 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: VBG, 7.28/40/36/26/69-10~~

Lab: 2+ 5h / large ketones

Gluc SL: 367

Temp w/ kussmaul's? ~~No~~ Will start full-blown DKA. Will give 10u NPH, 2L bolus, and transport to ED for further eval. Pt to remain with 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 / 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, rank and relation of sponsor or next of kin. IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORDS.

Potus #[redacted]

[redacted] B6-4

SIG (b)(6)-2 PROVIDER (b)(6)-2 MD

INS

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

(b)(6)-1

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

[redacted]	UNIT EPW	DOB 1JUL68	RANK	SSN 86-4 [redacted]		
Physician: [redacted]	Ward: EMT	STAT / Routine	Specimen Date and Time: 1655 20NOV08	Reported by: [redacted]	Date and Time: 20NOV08 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	1.19	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		35.9-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color	yellow	Straw/Yellow
Clarity	clear	Clear
(2) Glucose	2+	Negative
Bilirubin	NEG	Negative
(2) 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:			

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

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		35-50%

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		

558-1(3) (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 DATE (DAY / MONTH / YR.)	TIME	TRANSPORTATION TO HOSPITAL (Attach care transfer sheet)	CURRENT MEDS. (Tetanus immunization and other data)	HISTORY OBTAINED FROM
22 NOV 96	415	☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER (Specify)		☐ PATIENT ☑ OTHER (Specify)

ALLERGIES: NKDA

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

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

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

SEX: M AGE: 37

POSSIBLE THIRD PARTY PAYER?: ☐ YES ☐ NO

VITAL SIGNS	
TIME	1415
BP	149/80
PULSE	92
RESP.	16
TEMP.	95.4
WT. (Kilo)	96/AT

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:

37 y/o ZIMPAT c/o R/L FLANK WT, (D) FLANK PN x 2 HRS S/P KIDNEY STONE

(D) FLANK PN x 4 DAYS RADIATES TO THIGH, N/V/D, DYSURIA, HX PRESENT (HPI = KIDNEY STONE PSH: Q Sx, Back

ht stable, through interpreter that pain is worse standing, prolonged period of time, States pain slowly down to L/E, Denies gross hematuria - Repeat Stone - (A) kidney

O: 37.0 afeb lungs nl/clear bil NAD, A&Ox3 VS as noted (A) (B) CVA (C) TTP to central abdomen area, (D) Popliteal reflexes 2+ (E) LE strength 5/5 neuro intact

6.8	15.6 / 42.4	288
131	95	8 / 86
3.5	22	0.9

UA Ketone 80 Urobil 1 otherwise WNL

A: LBP

(B) Ureteral stone - urine

P: (A) Toradol 30 mg IV now - SR

(B) Toradol 30 mg PO TID x 5 days then Motrin 800 mg PO TID PRN

(C) Drink 1 fluids

(D) Ht/Wt, LE Exam r/t ketones Pt report blood in urine - f/u with UA

(E) RTC prn for f/u or persistent pain

End stuff - Precautions and prognostic study results and s/s renal colic. Symptoms likely musculoskeletal in etiology. Continue Toradol Rx x 5 days, RTC prn

(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 (Institution/clinic):

EMERGENCY	TODAY
72 HOURS	ROUTINE

ADMIT TO HOSP. UNIT/SERVICE:

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE:

SIGN (b)(6)-2

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

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)(2)-1 [redacted] B6-4

1996 OCTOBER 17

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

POTUS #370

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI: [redacted] | UNIT: CV | DOB: 26 OCT 73 | RANK: | SSN: [redacted] B6-4

Physician: [redacted] | Ward: EMT | ☑ STAT ☐ Routine | Specimen Date and Time: 28 Nov 1830 | Reported: [redacted] | Date and Time: 22 Nov 03 1526

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	1+	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	TIME	TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT ILLNESS, (Include immunization and other data)	HISTORY OBTAINED FROM
DAY 24 MONTH Nov YR 03	1600	☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) MP CUSTODY	UNKNOWN ANTIBIOTIC	☒ PATIENT ☐ OTHER (Specify) MP

ALLERGIES NKDA — TRANSLATOR

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	POSSIBLE THIRD PARTY PAYER?
	M	24	☐ YES ☐ NO

VITAL SIGNS		
TIME	1610	0130
BP	127/82	136/74
PULSE	110	77
RESP	16	14
TEMP	100.5	100.5
WT. (Lbs)	95	94

CATEGORY (See reverse)
EMERGENT
☒ URGENT
NON-URGENT

ORDERS	INITS.	TIME
[redacted]	[redacted]	1620
IV NSC BMP	[redacted]	1620
Bolus to KVO @ [redacted]	[redacted]	1700
Percocet 5/325	[redacted]	1730
Tylenol 325 PO q6h	[redacted]	PRN
[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)

TIME SEEN BY PROVIDER: on arrival

Pt. was hit by a Datsun in the spinal. Patient stood up without trembling.
24y/o male who detained brought by MPs c/o difficulty ambulating. Detained 4d ago (? by civilian police) and custody transferred to FOB Diamond Brgde. MPs today. Individual alleges that he was beaten when initially detained and now is too weak to walk. When asked specifically what is happening he answered through translator to go to Landstuhl + lower r/s pain, weakness, back pain

PMHx: Ø meds: Unknown Holistic
PSHx: Ø ambulatic
for otitis
Allergies: NKDA
PSHx: Ø
Exam: Thin male (Arab) cooperative throughout translation) non toxic appearing, unsteady and almost 5/5 strength
Injuries: Numerous contusions + abrasions
Imp/Plan: ruled out fx/dislocations
Ø battles or wrist/hand FTP
(R) (L) mild FTP/mid/face soft tissue injected
Pearl/Equal/Round Ø malocclusion
Ø nystagmus
Thin walled 3/L ear bilaterally
Neuro: CN II-XII intact MS 4-5/5 all major groups (no focal weakness) DTR's symmetric Ø Babinski's
Chest: CTA B s-w/R/R
CV: RRR s (m) rub/gs/52
Abd: soft/NT/ND/+BS x4
Pelvis: stable
Back: Tender c/spine T-spine (L) lateral lumbar r/s
(R) Tender

UA-SG: 1.030 Ø glucose Ø blood Ø ketones Ø nitrites Ø LE

10,1 / 16.2 / 48.0 / 326 / Ca=10

138 / 98 / 17 / 86 / 45 / 23 / 12

No Claims

(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: 1800

ASSESSMENT/DIAGNOSIS
WEAKNESS,
DESATURATION

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)
ICDO: [redacted]

B6-4

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 stand unsupported
Custody to follow
Cannot complete Klonberg

MEDCOM - 354 ATMENT STANDARD FORM 558 (Rev. 5-82)

(See instructions on back of this Sheet)

NSN 7540-01-075-2784

EMERGENCY CARE AND TREATMENT
(Medical Record)

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

LOG NUMBER

ARRIVAL — DATE: DAY 25 MONTH Nov YR 03 TIME 1310

TRANSPORTATION TO HOSPITAL (Action care enroute (see))
☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CORPSE (Location 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 TEL. NO. (Incl. Area Code)

CHIEF COMPLAINT (S) (Include symptom(s), duration) Sp GSW @ arm → abd

SEX M AGE 16

POSSIBLE TRIAD PATIENT ☐ YES ☐ NO

VITAL SIGNS

BP	136	131	135
P	105	96	91
RE	54	80	100
R	18		22
AP	99%	✓	✓
WGHT	162 lbs		

DESCRIBE (1) Subjective data (Pertinent History) (2) Objective data (Examination - include results of lab and x-rays) (3) Assessment (Diagnosis) (4) Plan (Treatment/Procedure - include medication given and disposition)

TIME SEEN BY PROVIDER: On ARRIVAL

No Med Hx
No past Surg

Brought to 21st SH EMT by SFC Robert L. Navra C/Co 3/4 IN

16y i/RAQ ♂ brought to CSH F sustaining wounds when vehicle he was a passenger in was engaged as hostile by U.S. personnel. Accompanied by father and aunt. Father detained.

A- Patent + maintains C-Spine
B- Breath sounds, chest rise symmetric
C- BP, pulse normal, distal pulses intact, bleeding controlled + direct pressure
D- GCS=15, PERRL
E- Completely exposed for exam

A- NKDA
M- Ø
P- Ø
L- 1000 - breakfast
E- Events as above

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

ORDERS — INITS. — TIME
CXR AP/Lat/Axial — [redacted] — 1345
[redacted] — [redacted] — 1340
[redacted] — [redacted] — 1340

b7

ASSESSMENT/DIAGNOSIS
GSW R forearm, R abd
(1) ExAM

GENERAL: well/well nourished adolescent ♂ in NAD, alert/interactively stable in appearance, answers questions through interpreter
SKIN: warm + dry Ø rashes
HEENT: unremarkable Ø injury
EYES: CTAB w/o R/R
NECK: FROM + Ø JVD
CV: RRR + (2+) radial pulses
RESP: Scattered/intermittent guarding diffusely bilateral (R) parasternal hyperaeration
BACK: Ø tenderness/crepitus
EXTREM: Entry/exit wounds at (1) distal forearm and (2) abdomen
NEURO: GCS=15, PERRL

14.8 / 10.9 / 42.5 / 237
AB - POS
UA - pending
PT/PTT - WNL
XR dx: (1) comminuted fractured ulna (2) ileum + mesentery fragments, Ø Sx

(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
☐ ROUTINE
☐ ADMITTED TO (Hospital, Unit, Service)
☐ RETURN TO DUTY/RELEASE
☐ IMPROVED ☐ UNCHANGED

(b)(6)-2

B6-4

Pt transferred to General Surgery at 1350

(b)(6)-2

MEDCOM - 355

PATIENT

STANDARD FORM 558 (Rev. 7-90)

Def Exh 1

(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 / MONTH / YR.)	TIME	TRANSPORTATION TO HOSPITAL (Attach care envelope sheet)	CURRENT MEDS. (Include immunization and other data)	HISTORY OBTAINED FROM
25 NOV 03	17.00	☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)	Prednazone	☐ 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

TIME SEEN BY PROVIDER

VITAL SIGNS	
TIME	1700
BP	146/82
PULSE	90
RESP.	18
TEMP.	98.2
WT. (Lbs)	98

CATEGORY (See reverse)
EMERGENT
URGENT
NON-URGENT

ORDERS / UNITS / TIME

DESCRIBE (1) Significant Interval 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)

43 y/o ♂ Presents to Emt C injuries sustained from Shooting. Pt. had wounds in ⓐ hand, Left Side of neck + ⓛ Ear. Pt injured ⓡ cheek injury + ⓛ hand. No other injuries

Med hyst
Rumatoid Arthritis
Spc [redacted]
Med prednisolone
Allerg NKDA
Smg ✗ ∅

EXAM:
HENT: NC ⓛ small shallow cut approx and ⓡ cheek. EOM PERRLA = EACTM clear Canal TM ✗ fluid or erythema lungs CTA bilat w/ heart RRR ⓐ radial and DP 2+ bilat abd soft NTND + guarding ext FROM - ✗ strong pedals

Xray - fracture ⓛ hand

Tet: ① time of injury trauma ⓛ hand ② shrapnel to ⓡ cheek

(b)(6)-2 [redacted]

① TO dr for washout / Rx ⓛ hand ② Dr. Hendrix here to see on call for OR

DISPOSITION (Check all that apply)	
HOME	FULL DUTY
QUARTERS	
MODIFIED DUTY UNTIL (Month / Year)	
REFERRED TO (Indicate clinic)	
EMERGENCY	TODAY
24 HOURS	ROUTINE
PROMPT TO HOSP. UNIT/SERVICE	

CONDITION UPON RELEASE: IMPROVED / UNCHANGED / DETERIORATED

TIME OF RELEASE:

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - Gp, first, middle; SSN - DOB, service (rank), name and relation of sponsor or next of kin. (IMPORTANT: POST-FINAL HOLDING TREATMENT RECORD):

Potus # [redacted]

B6-4

[redacted]

(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 06 MONTH Dec YR 03 TIME 735

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

CURRENT MEDS. (Tetanus immunization and other data): Dilantin 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): 23

SEX: M AGE: ~~20~~

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME	0140	0857
TEMP	102.5	101.4
PULSE	95	80
RESP	20	16
BP	97/3	
SaO2	100	99.2

CATEGORY (See reverse)

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS	TIME
NPO, telemetry, IVF		
Ativan 2mg q 4hr prn IV [redacted]	DH2	
CBC, chem 7, LFT's, CK, UA		
Tylenol 3 prn		

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 & packed bandage placed in mouth by MP's. 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

~~DEMERGENT~~ 23y IRAQI ♂ brought c clonic activity, subsequently postictal + combative

INTRO: - bedrest + dry Ø fistules

NEURO: NCAT/PERRL/EOMI/tongue midline x5

CVS: HRR 3/6 nl S1/S2

ABDO: Soft/NT/ND

EXTREM: Ø contusions, ~~deformities~~ Chronic joint deformities of feet

NEURO: Gradually cleared, follows commands, answers questions, MAE, DTR's symmetric

82 | 15.2 / 459 | 360

137 | 10.3 / 4.2 | 20 / 9.3 / 28

UA - specimen lost

result pending

DISPOSITION (Check all that apply)

☐ HOME ☐ FULL DUTY
☐ QUARTERS
☐ ADMIT ☐ 48 HR. ☐ 72 HR.
☐ MODIFIED DUTY UNTIL: DAY ___ MONTH ___ YEAR ___
☐ REFERRED TO (Institution/clinic)
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☐ ROUTINE
☐ ADMIT TO (Ward, unit, service)
☐ CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED
☐ DECEASED

(CONTINUE ON SF 507, IF NEEDED)

PATIENT IDENTIFICATION (Typewritten or printed) FOR YOUR ELECTRONIC ENTRIES GIVE: Name - last, first, middle; SSN; DOB; service, status, name and relation of sponsor or next of kin. (IMPORTANT - LIST FACILITY HOLDING TREATMENT RECORDS.)

[redacted]

[redacted] B6.14

[b)(6)-4]

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

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

Admitted

N/W [b)(6)-2]

EMERGENCY CARE AND TREATMENT

STANDARD FO

(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.) 02 Dec 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): SEIZURE

SEX: M AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS: TIME 2000; BP 130/80; PULSE 88; RESP 20; TEMP 100.4; WT (KG) 100 %

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

ORDERS | INITS. | TIME

~~From the battlefield~~ [illegible] with head, [illegible] Oxygen, phenytoin to IV, Tylenol NG @ 1500, Keppra IV

ASSESSMENT/DIAGNOSIS

Seizure, r/o stroke, r/o TIA, not 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): ☐ 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)

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

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, PERRLA, fundi visualized, ↓papilledema, edema c/w/ vasoplegia, ↓ lt/ex

Large CABG scar

heart RRR c/w/o m/r/g

abd soft, NDNT, no masses, no HSM

DTR's 2+ throughout, plantars ↓/c/c

neuro: CN II-XII grossly intact, ⊕ 2-3 beat clonus ⊕ foot ⊕ ⊕ high arch feet (as if paralytic contractures), ⊕ full ROM

137 | 105 | 17 (12)
4.0 | | 8
10.7 | 14.6 | 339
42.9

Med Hx: ⊕ seizure ⊕ "angina"

Surg Hx: appy, lap

Meds: (something for seizure)

[b(6)-2]

ORDERED:

Conditions ordered, any limitations and follow-up

[b(6)-2]

Pt's #: [redacted] B6-4

[redacted]

① Also - medicine
② Ration, load phenytoin

(See Instructions on Back of this Sheet)

NSN 7530-01-[redacted]-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21CSH, [redacted] Mosul Iraq

LOG NUMBER

ARRIVAL — DATE: DAY 06, MONTH Dec, YR 03 — TIME: 1846

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: 17

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS

TIME: 1846
BP: 122/82
PULSE: 110
RESP.: 45
TEMP.: 98.9
WT. (KG): 99%

CATEGORY (See reverse)

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS — INITS. — TIME

CBC, Bmp — [redacted] — 1900
CXR — 1900
EKG — 1900
ABG — 1900
Atrovent TUX — [redacted] — 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

5-17 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 1 time for 1-2 days. Now he reports these episodes are happening 2-3x/day with the same symptoms.

Denies [illegible]

PMHx - ∅ PSHx - ∅ meds - ∅ NKDA

ASSESSMENT/DIAGNOSIS: Hyperventilation Episode with ER Pt had a few episodes of hyperventilation [illegible] no neurological deficits, no real toxic clinical concern no potential etc

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
C-CTA bil 98% RA CXR - clear
CV RRR S1S2 (-)
Abd - NABS, soft nontender ∅ HSM/masses
Ext - 5/5/5 grips [illegible]
Neuro - NAD grossly DTR's 2+ throughout

16.9 / 52.3 / 176 / 281K

134 / 5.8 / 102 / 30 / 14 / 0.9 / Cl 100

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

[redacted]

Non us # [redacted]

B6-4

Admit to TCW for Observation

[redacted]

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

7

558-100 (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): FOB Q-Star 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	130/86		
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 [b](6)-2 ICU until JAG available

2000: JAG here to question + speak with pt. [b](6)-2 <PTA

2140 Pt returned to ENT Ambulatory resp even + translator JAG officer, friend/family member here. Discharge instructions given per interpreter. Denies questions or concerns. Instructed to return 24 Jan @ 0900am w all paperwork + Xrays. Condition stable. Pt smiling + happy to see family. D/Ced home. [b](6)-2 <PTA

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

(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): ϕ

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): c/o Possible Trauma to ⓛ side

SEX: M AGE: 43

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	1807		
BP	129/86		
PULSE	89		
RESP.	16		
TEMP.	97.9		
WT. (Lbs.)	160		

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

ORDERS | INITS. | TIME

~~Tetanus toxoid 0.5 ml IM~~ done
~~to Ward 6~~
~~CXR (PA & Lat) Ward 6~~
~~Tylox #20 to Ward 6~~

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)

43 y/o c/o possible trauma to ⓛ side x 5 days PT states pain. p/o "as severe" ⓛ inferior PSH-ϕ PMH-ϕ "sticky" CP. Reports being punched 5 d. ago. fever 56.6 x 2 days ago. ⊖ meds.

PE: VS noted. T/Lungs c shallow wheezing throughout. L c upper airway sounds x ? ? pleural rub. ⊖ HK tenderness ⓛ c/w ⓛ ⊖ tenderness ⓛ ⊖ tenderness ⓛ PA x lat CXR ⊖ for infiltrate. ⊖ for effusion. ⊖ for pneumothorax. ⊖ for fluid maj. fissure ? ⓛ on lat. ⊖ for obvious fracture. ⊖ for soft tissue injury. ⊖ for foreign body. ⊖ for abnormal soft tissue calcification. ⊖ for bony abnormality. ⊖ for abnormal soft tissue density. ⊖ for abnormal bony density. ⊖ for abnormal soft tissue shadow. ⊖ for abnormal bony shadow. ⊖ for abnormal soft tissue opacity. ⊖ for abnormal bony opacity. ⊖ for abnormal soft tissue lucency. ⊖ for abnormal bony lucency. ⊖ for abnormal soft tissue radiolucency. ⊖ for abnormal bony radiolucency. ⊖ for abnormal soft tissue radiopacity. ⊖ for abnormal bony radiopacity. ⊖ for abnormal soft tissue hyperdensity. ⊖ for abnormal bony hyperdensity. ⊖ for abnormal soft tissue hypodensity. ⊖ for abnormal bony hypodensity. ⊖ for abnormal soft tissue isodensity. ⊖ for abnormal bony isodensity. ⊖ for abnormal soft tissue mixed density. ⊖ for abnormal bony mixed density. ⊖ for abnormal soft tissue calcification. ⊖ for abnormal bony calcification. ⊖ for abnormal soft tissue ossification. ⊖ for abnormal bony ossification. ⊖ for abnormal soft tissue mineralization. ⊖ for abnormal bony mineralization. ⊖ for abnormal soft tissue demineralization. ⊖ for abnormal bony demineralization. ⊖ for abnormal soft tissue atrophy. ⊖ for abnormal bony atrophy. ⊖ for abnormal soft tissue hypertrophy. ⊖ for abnormal bony hypertrophy. ⊖ for abnormal soft tissue hyperplasia. ⊖ for abnormal bony hyperplasia. ⊖ for abnormal soft tissue hypoplasia. ⊖ for abnormal bony hypoplasia. ⊖ for abnormal soft tissue aplasia. ⊖ for abnormal bony aplasia. ⊖ for abnormal soft tissue dysplasia. ⊖ for abnormal bony dysplasia. ⊖ for abnormal soft tissue neoplasia. ⊖ for abnormal bony neoplasia. ⊖ for abnormal soft tissue metastasis. ⊖ for abnormal bony metastasis. ⊖ for abnormal soft tissue inflammation. ⊖ for abnormal bony inflammation. ⊖ for abnormal soft tissue infection. ⊖ for abnormal bony infection. ⊖ for abnormal soft tissue abscess. ⊖ for abnormal bony abscess. ⊖ for abnormal soft tissue cellulitis. ⊖ for abnormal bony cellulitis. ⊖ for abnormal soft tissue osteomyelitis. ⊖ for abnormal bony osteomyelitis. ⊖ for abnormal soft tissue septic arthritis. ⊖ for abnormal bony septic arthritis. ⊖ for abnormal soft tissue tuberculosis. ⊖ for abnormal bony tuberculosis. ⊖ for abnormal soft tissue fungal infection. ⊖ for abnormal bony fungal infection. ⊖ for abnormal soft tissue parasitic infection. ⊖ for abnormal bony parasitic infection. ⊖ for abnormal soft tissue viral infection. ⊖ for abnormal bony viral infection. ⊖ for abnormal soft tissue bacterial infection. ⊖ for abnormal bony bacterial infection. ⊖ for abnormal soft tissue gangrene. ⊖ for abnormal bony gangrene. ⊖ for abnormal soft tissue necrosis. ⊖ for abnormal bony necrosis. ⊖ for abnormal soft tissue sloughing. ⊖ for abnormal bony sloughing. ⊖ for abnormal soft tissue ulceration. ⊖ for abnormal bony ulceration. ⊖ for abnormal soft tissue fistula. ⊖ for abnormal bony fistula. ⊖ for abnormal soft tissue sinus tract. ⊖ for abnormal bony sinus tract. ⊖ for abnormal soft tissue foreign body reaction. ⊖ for abnormal bony foreign body reaction. ⊖ for abnormal soft tissue granuloma. ⊖ for abnormal bony granuloma. ⊖ for abnormal soft tissue keloid. ⊖ for abnormal bony keloid. ⊖ for abnormal soft tissue hypertrophic scar. ⊖ for abnormal bony hypertrophic scar. ⊖ for abnormal soft tissue contracture. ⊖ for abnormal bony contracture. ⊖ for abnormal soft tissue adhesion. ⊖ for abnormal bony adhesion. ⊖ for abnormal soft tissue scar. ⊖ for abnormal bony scar. ⊖ for abnormal soft tissue deformity. ⊖ for abnormal bony deformity. ⊖ for abnormal soft tissue malformation. ⊖ for abnormal bony malformation. ⊖ for abnormal soft tissue congenital anomaly. ⊖ for abnormal bony congenital anomaly. ⊖ for abnormal soft tissue developmental anomaly. ⊖ for abnormal bony developmental anomaly. ⊖ for abnormal soft tissue acquired anomaly. ⊖ for abnormal bony acquired anomaly. ⊖ for abnormal soft tissue traumatic anomaly. ⊖ for abnormal bony traumatic anomaly. ⊖ for abnormal soft tissue iatrogenic anomaly. ⊖ for abnormal bony iatrogenic anomaly. ⊖ for abnormal soft tissue nosocomial anomaly. ⊖ for abnormal bony nosocomial anomaly. ⊖ for abnormal soft tissue occupational anomaly. ⊖ for abnormal bony occupational anomaly. ⊖ for abnormal soft tissue environmental anomaly. ⊖ for abnormal bony environmental anomaly. ⊖ for abnormal soft tissue toxic anomaly. ⊖ for abnormal bony toxic anomaly. ⊖ for abnormal soft tissue allergic anomaly. ⊖ for abnormal bony allergic anomaly. ⊖ for abnormal soft tissue autoimmune anomaly. ⊖ for abnormal bony autoimmune anomaly. ⊖ for abnormal soft tissue idiopathic anomaly. ⊖ for abnormal bony idiopathic anomaly. ⊖ for abnormal soft tissue unknown anomaly. ⊖ for abnormal bony unknown anomaly.

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). IF HAND 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).

Pvt US ET [redacted] B6-4

SIGNATURE OF PROVIDER AND IN CAPS [b](6)-2 MD
Lieutenant Colonel, Medical Corps

INSTRUCTIONS [b](3)-1 (Include any limitations and follow-up plans)

① Tylox 1 capsule 250mg by mouth every 6 hrs. as needed for pain. Dispense #20

② Tylox 2 tablets by mouth every 6 hrs. as needed for pain. Dispense #40

Return to duty with no restrictions.

(CONTINUE ON SF 507, IF NEEDED)

EMERGENCY CARE AND TREATMENT STANDARD FORM 558 Back (Rev. 7-85)

IVON - [redacted] B6-4

GEMS IT MAC1200 , 21ST COMBAT SUPPORT HOSPITAL, [redacted]

HR 54bpm

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

Interpretation:
Sinus bradycardia
~~Nonspecific ST abnormality~~
~~Abnormal ECG~~

[redacted]

Order Physician

[redacted] MD

Unconfirmed report

MEDCOM - 362

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21CSH, (0X3)-1, Mosul Iraq

LOG NUMBER:

ARRIVAL — DATE: DAY 15, MONTH 12, YR 03; TIME: 1443

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

CURRENT MEDS. (Tetanus immunization and other data): NKA Tylenol 2 days

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: 0045

BP: N/A

PULSE: 72

RESP.: 16

TEMP.: 98.4

WT. (Kilos): 90

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 ROOM, UNIT/SERVICE: PACU

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 0115

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

TIME SEEN BY PROVIDER: 0045

S: 24 y/o M/C/O Saint Mary's History [illegible] B6-4 [redacted] Left wrist abscess? Sent from 526 for eval. Dx: Cellulitis vs Abscess

Left dorsal wrist abscess
Ecchymosis and edema noted to dorsal aspect of left wrist. Fluctuance noted to ulnar aspect of left wrist. Tenderness to palpation noted to left wrist. Full ROM of left wrist. Left radial pulse palpable. Capillary refill < 2 seconds to left hand. Sensation intact to left hand.

Cellulitis vs abscess

Continue abx
Consult for I+D - if abscess

PATIENT'S IDENTIFICATION: (Typed or printed) 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)

Pvt. [redacted] B6-4
Iraqi Detainee

SIGNATURE AND TITLE OF PERSON MAKING ENTRIES

INSTRUCTIONS (Including any limitations and follow-up plans):

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

NSN 7540-01-075-3786

(See Instructions on Back of this Sheet)

SF 600

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp) 21 CSH, [redacted] Mosul Iraq

LOG NUMBER

ARRIVAL — DATE: DAY 16 MONTH Dec YR 03 TIME 1107

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

CURRENT MEDS. (Tetanus immunization and other data): ? Diovan

HISTORY OBTAINED FROM: ☐ PATIENT ☑ OTHER (Specify) [redacted]

ALLERGIES: PCN

HOME TELE. NO. (Inc. area code)

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

POSSIBLE THIRD PARTY PAYER: ☐ YES ☐ NO

SEX: M AGE: 53

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

TIME SEEN BY PROVIDER: 1130

VITAL SIGNS

TIME	1110	1513		
BP	134/72	132/68		
PULSE	130	107		
RESP.	18	17		
TEMP.	97.7	99.8		
WT. (Lbs)	95#	96#		

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

ORDERS	INITS	TIME
IV Lopidac at [redacted]		1142
NS/LR TKO		1142
CBC, I-STAT-6+		1142
CHEM 7 OR BMP		1142
LFTs, UA &		1142
PAT EAT CAR		1205

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 ____ MON ____ 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

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

[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)

53yo F/IRAQI DETAINEE c hx HTN and DIABETES brought from Confinement to the upper and lower extremity edema, edema, malaise, tiredness.

PMHx: DM-2, HTN, Chronic LBP

Meds: Diovan

Allergies: PCN

PSxHx: Ø

PMHx: Diabetes, Chronic Back Pain (Ctrl Prolapse)

PSHx: Ø

Tobacco (+)

Meds: Smokes cigarettes

GENERAL: Thin IRAQI Ø in NAD/alert answers questions and follows commands through interpreter, appears stated age sub/extremely older than stated age

HEENT: Warm + dry [redacted] hairs of feet

CV: RRR s MRG

ABD: Soft/NT/ND/+ BS

EXTREM: Feet erythema/thickened c pitting but [redacted] edema

Ø wrist abrasions c/ glycerin c mild surrounding erythema

LUNGS: CTAB s wheeze s rales

NEURO: AAOx3 CN II-XII grossly intact

SKIN: Warm/dry/intact

4:30 pm Ancef 1gm IV

165 (22.2) 5008 (23) 3.8 (P23) 88 (24) 225 1.2

ALB = 3.5 ALK = 44

ALP = 76 AST = 36

ALT = 55 TB = 1.3

UA = SG = 1.020 Large glucose, large ketone & blood, Orth Ø LE

(CONTINUE ON SF 507, IF NEEDED)

INSTRUCTIONS TO PATIENT (Include follow-up plans)

1. Education: Soak feet daily once daily x10d
2. Keflex 500mg orally four times per day x10d
3. Advised to elevate feet, drink fluids and eat regular meal. Report for re-evaluation in two days, sooner if worse

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

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: 130/72 P: 87 PO2: 97% Temp: 96.7° RESP: 14 PMH: DIABETES BACK PN PSH: Ø TOB Ø ØDM	53 y/o ♂ E/V c DIABETES/UPPER & LOWER EXTREMITY EDEMA, REDNESS & MALAISE. was seen 12/16/03 in 21CSH: North EMT - 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 Fluoroquinolones. started on Kefflex. pt voices less pain & swelling in his feet. felt cold & night but no fevers Allergies: A- WD WM NAD mild erythema medially. 1+ pitting edema to mid shins. clear effect 7.2/47 5/24 132 91 7/272 4.8 24 6.0 Rx: PO, Flu of cellulitis. for 10 days started to 1 tab po BID. (#30) ② Cont Keflex 1 po @ HS ③ Elev p.r.n.

[b)(6)-2]

Practice Staff

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

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

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

[b)(6)-4]

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

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM

(Subject to Privacy Act of 1974) B6-4

LAST, FIRST, MI		UNIT	DOB	RANK	SSN
NONMEMBER [redacted]	(b)(6)-4	Detainee		CIV	[redacted]

Physician:	Ward:		STAT	Specimen Date and Time:	Report:	Date and Time:
B6-4 (b)(6)-2	EMT	X	STAT	12/19/03 0845	(b)(6)-2	19Dec03 09:1
			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

		REF. RANGE
	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	

Chemistry (Piccolo Analyzer)

Chem 12 Mell yte8 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
X	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

		REF. RANGE
	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

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

HCG

		REF. RANGE
	Urine	Negative
	Serum	Negative

Hematology

CBC Malaria U/A

X	TEST	RESULT	REF. RANGE
	WBC	9.2	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 See
Thick		No Plasmodium See

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		

Other: CBC, BMP

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:
	Emr	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	128-146 mmol/L
	K	3.8	3.3-4.7 mmol/L
	Cl	98	96-108 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)
	iCap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	24	7-22 mg/dL
	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

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

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	22.2	4.8-10.8 x10(3)/uL
	RBC	5.97	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)
	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%

Urinalysis

Color	Dark Yellow	Straw/Yellow
Clarity	clear	Clear
Glucose	1200	Negative
Bilirubin	neg	Negative
Ketone	trace	Negative
SG	1.020	1.010-1.025
Blood	neg	Negative
pH	5.50	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	

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

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		

Other: Par. Istat 6zcr. [illegible]

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT (Medical Record)

ARRIVAL TIME: 2130	TREATMENT FACILITY (Stamp): 21CSH (b)(6)-1 Mosul Iraq		LOG NUMBER
	TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): PRIVATE VEHICLE [ ] AMBULANCE [X] 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)
COMPLAINTS (Include symptom(s) duration): [illegible] GSW to (L) 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); (4) Plan (Treatment/Procedures - include medication given and follow-up)		TIME SEEN BY PROVIDER: upon arrival

Male Iraqi civilian brought to EMT by soldiers who were in gunfight with PT.

PT arousable to verbal stimuli, moaning

Resp rapid. O2 sats 93% Dsg to (L) chest, both hands,

(L) hip & thigh. Central line, foley.

2 unit of blood. To OR @ 2205. (b)(6)-2 CPTA

NIBP TREND [redacted] 12/16/03

NORUS

TIME HR MN	HR/PR BPM	SpO2 %	SYS / DIA mmHg	MEAN	RR RPM
22:00	OFF	OFF	ERR# 2		OFF
21:58	114	[illegible]	101 / 72	85	[illegible]
21:57	114	98	101 / 56	74	[illegible]
21:54	105	SRCH	ERR# 15		26
21:52	106	92	94 / 64	76	[illegible]
21:51	116	87	103 / 57	73	[illegible]
21:50	114	SRCH	89 / 62 ×	72	[illegible]
21:48	[illegible]	96	89 / 45	68	30
21:46	103	89	87 / 49	62	OFF
21:44	[illegible]	SRCH	91 / 54	67	OFF
21:42	110	96	88 / 57	73	OFF
21:41	[illegible]	SRCH	[illegible] / 43	64	OFF
21:40	[illegible]	SRCH	ERR# 15		OFF
21:38	[illegible]	SRCH	[illegible] / 37	[illegible]	[illegible]
21:35	[illegible]	SRCH	ERR# 2		[illegible]
21:34	[illegible]	[illegible]	ERR# 2		[illegible]
21:33	[illegible]	[illegible]	ERR# 2		[illegible]
21:32	116	[illegible]	[illegible] / 48	52	OFF

ADULT

PROTOCOL SYSTEMS, INC.

B6-4

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; DETERIORATED

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) (For typed or written entries give: Name - last, first, middle; grade; rate; service status, name and relation of sponsor or next of kin). IMPORTANT: LIST FACILITY HOLDING TREAT. RECORD.

[illegible] # [redacted] B6-4

[redacted]

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

MEDCOM - 368

STANDARD FORM 558 (Rev. 9-82)

(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): 24 Dec 05; TIME: 1030

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

CURRENT MEDS. (Tetanus 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	[redacted]/78
PULSE	15
RESP.	20
TEMP.	[redacted]103
WT. (Child)	[redacted]

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

ORDERS	INITS.	TIME
IV NS @ 2L	[redacted]	1040
BMP, CBC, LFT		1040
Discuss the case with Dr [redacted]		
Repeat VS		

ASSESSMENT/DIAGNOSIS
(1) Seizure disorder
(2) Drug reaction
(3) Schizophrenia

DISPOSITION (Check all that apply)
☐ HOME: ☐ FULL DUTY
QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
MODIFIED DUTY UNTIL: DAY ____ MONTH ____ YEAR ____
REFERRED TO: (Specialty, clinic) MP clinic 1053
☐ EMERGENCY ☐ TODAY
☐ 72 HOURS ☒ ROUTINE
ADMIT TO HOSP. UNIT/SERVICE
CONDITION UPON RELEASE
☐ IMPROVED ☒ UNCHANGED
☐ DETERIORATED
TIME OF RELEASE: 1145

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 ordered, advice given)

TIME SEEN BY PROVIDER: 1040

Medics report that patient has Iraqi citizenship, stopped eating + drinking. Refuses to speak. Incontinent of urine this morning.

34 y o male detained brought from detention for evaluation of bizarre behavior. MP medics report detained refusing medications, soiling self with urine. Also, MI's 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's, one detained family member translator and records from admit (12 Dec 05)

PMH: Seizure d/o, Schizophrenia
Meds: Dilantin 300 mg qd (reportedly previously on Risperdal)
Allergies: NKDA (from record)
Fam Hx: ∅
Soc Hx:

ALB = 4.2 AMY = 27
AP = 90 AST = 72
PROT = 8.1 TB = 1.1

GENERAL: Male Iraqi appears stated age/guidelle/non toxic
INTEG: Scattered hemorrhagic erythematous raised lesions scattered on extremities and trunk
HEENT: NC/AT/MMM/sclera clear/neck supple/no thyromegaly
LUNGS: CTAB ∴ w/o R/R
CV: RRR ∴ no M/R/G
A-3 20: Soft/NT/ND/+BS
EXTREM: ∅ edema, cords, tenderness

14-6 | 14.3 | 356 | 48.2
137 | 93 | 1.3 | 1 HY | 9
4.5 | 21

(CONTINUE ON SF 502, IF NEEDED)

(b)(6)-4

PATIENT'S IDENTIFICATION (Fingerprint): 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 US # [redacted] B6-4

EPW # [redacted] B6-4

(b)(6)-4

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)
(1) DISCONTINUE DILANTIN
(2) BEGIN TEGRETOL 200mg orally 2x/day
(3) BEGIN OLANZEPINE 10mg orally each day at bedtime (add at bottom of side effects)
(4) RETURN IF DETAINEE DEVELOPS FEVER, BLISTERS OR SKIN LESIONS SIMILAR TO LARGE BLISTERS

STANDARD FORM 558

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	RANK	SSN
Mendez # [redacted] B6-4	CIV Patient	CIV	B6-4 [redacted]

Physician:	Ward:		Date and Time:	Report	Date and Time:
LTC (b)(6)-2	CMMT	STAT / Routine	29 Dec 03 1046	(b)(6)-2	29 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	5-85 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

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

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp) [b)(3)-1] RICSH, Mosul Iraq

LOG NUMBER

ARRIVAL — DATE: DAY 13 MONTH YR. — TIME: 1516

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): [ ] PRIVATE VEHICLE [ ] AMBULANCE [X] OTHER (Specify) Up Escort

CURRENT MEDS. (Include 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)

SEX: M AGE: 31

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

TIME SEEN BY PROVIDER: 1700

VITAL SIGNS

TIME	1520	1700
BP	114/70	124/65
PULSE	65	45
RESP.	16	16
TEMP.	99.1	99.8
WT. (Indicate kg or lb)		

CATEGORY (Check one)

- [ ] EMERGENT
- [ ] URGENT
- [ ] NON-URGENT

ORDERS — INITS. — TIME

Tylenol 650mg PO now

Ativan 2mg IV now

ASSESSMENT/DIAGNOSIS

Possible Seizures R/O

Head

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

METHOD OF RELEASE:

PERSON IDENTIFICATION (Mechanical imprint)

TYPED OR PRINTED ENTRIES GIVE: Name - last, first, middle; Rank; Service status, name and relation of sponsor or next of kin. IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORDS

[b)(6)-4]

[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)

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 Iraq at that facility. Per pt is he was taking 60mg valium, b/c - an implausible dose. ⊖ recollection of event or wife ⊖ FHx ⊖ HTN ⊖ DM or hypoglycemia ⊖ HA ⊖ chest pain, palpitations ⊖ presyncope. Does not report "remembering seizures" → report it was witnessed → also reports back pain since not here → also reports bowel incontinence ⊖ PMHx

EXAM: NCAT, PERRLA b/c, EACFTM clear bilat, no JVD, no LAN, neck supple, trachea midline, lungs CTA b/l, no wheezing/rhonchi/rales, RRR, no MRG, abd soft, NTND, normoactive BS, no HSM, no CVAT, no peripheral edema, strength 5/5 throughout, sensation intact DTR 2/4 no clonus, can heel walk

Impression: Pseudoseizures
- not postictal
- no common symptoms

R/O infection
- cardiac - unlikely
- neurologic - unlikely
- metabolic

VS: real seizure disorder

Plan:
1. Admit for observation
2. Consult + manage
3. Keep pt calm - stop valium
4. Seizure precautions

Valium dose conversion: 60mg PO = 10mg IV

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)

MEDCOM - 371

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

SSN TOP

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Stamp) 32 CSH, Mosul Iraq

LOG NUMBER

ARRIVAL DATE 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

HOME TELE. NO. (Inc. area code)

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

POSSIBLE THIRD PARTY PAYER ☐ YES ☐ NO

CHIEF COMPLAINT(S) (Record symptom(s), duration) N/V (L) sided weakness

SEX M AGE 30

TIME SEEN BY PROVIDER 1415

VITAL SIGNS			
TIME	1410	1635	1750
BP	170/91	113/83	118/68
PULSE	111	107	111
RESP.	20	20	20
TEMP.	99 AX	99.4 AX	99 C
WT. (Stat)	96 a	96	96 a

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

ORDERS — INITS. — TIME

[redacted] — 1439

[redacted] — 1500

ASSESSMENT/DIAGNOSIS
Stroke
Dehydration

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) 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).

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)

30 y/o male Iraqi EPW brought to EMT Ambulatory assist. Medic report that pt was brought to him with N/V x 4 days & progressive weakness in (R) extremities + face. [redacted] PMH - Htn, ↑chol
PSH - ∅
TOB - yes
ETOH - ∅

S - BP 110 or 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 denies N/V x 4d, no appetite per pt. Pt reports previously healthy.

O - WD EW NAD, resting comfortably in bed but "shivering" on (L) arm only. L arm @ 90° angle @ elbow. (L) leg not spontaneously moving while (R) moves though he can feel (L) leg stimulated while dragging (L) leg. TM's clear, throat 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 carotid or bruit bruit. L - CTA (R) S1 H1 P M - MMS WNL. abd - S/NT/ND, NABS, ∅ HSM. Pelvis WNL. Testicles WNL. Rectal - Guaic (+), PST, nodule prostate on (R). Neuro - A&O x 3, CN II - XII intact on best pt would cooperate. (R) arm → full strength, WNL reflexes, (L) arm → hyperreflexia pt state unable to use muscles. Can passively straighten arm to 180° but slowly returns to 90° - good tone. (R) leg → WNL strength + reflexes. (L) leg. >20 beats clonus on ankle reflex, hyperreflexia (R) patella. Contracture @ all. Poor tone. Pt did not cooperate w/ sensory

(CONTINUE ON BACK IF NEEDED)

SIGNATURE OF PROVIDER [redacted]

INSTRUCTIONS TO PATIENT (Diet, activity, medications ordered, any limitations, follow-up clinic, etc.)

Stroke w/ Dr. [redacted] Dehydration w/ IVF. Pt to be transported to Baghdad for further treatment w/ ASA (once tolerated will start) & CT scan eval. Await transport to 28th CSH.

EMERGENCY CARE AND TREATMENT (Medical Record) STANDARD FORM 558 (Rev. 7-85) MEDCOM - 372

[redacted] 10/930 7/57

B6-4 147 101 5.2 104 alb - 3.5 alb 4 - 3.3

b6-2

NSN 7540-00-834-4178 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@Case 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 c (R) AC labs drawn & sent Hme. Portable CXR done. Attempt to insert [b](6)-2 cath 3 times. Dr. [b](6)-2 Urologist consulted. Ref inserted by Dr. [b](6)-2 approx 300cc dk Coffee Colored urine returned. UA spec to lab. Ketoprin 50mg IVPB [b](6)-2 as ordered. Will cont to monitor [b](6)-2 cont
	addendum
	[b](6)-2 in - returned dark, concentrated urine Spec Grav 1.028. Pt has responded well to 3L NS IV bolus, now at 150 cc/hr & is even much more cooperative than before but still unable to move (R) leg. (R) arm & hand weak. Pt able to feel the sensation in legs & arms but no motor. Slight facial droop

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 [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

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

await answer to 28 yr CS Hosp CT Scan. Suspect stroke, ischemia in nature a TIA 2° dehydration/Sludge. await CT Scan and Treatment options from neurologist. T LFTs + T CBC. likely 2° Hemoconcentration but will need re-eval as hydration status stabilize.

(b)(6)-2

Reduce Staff

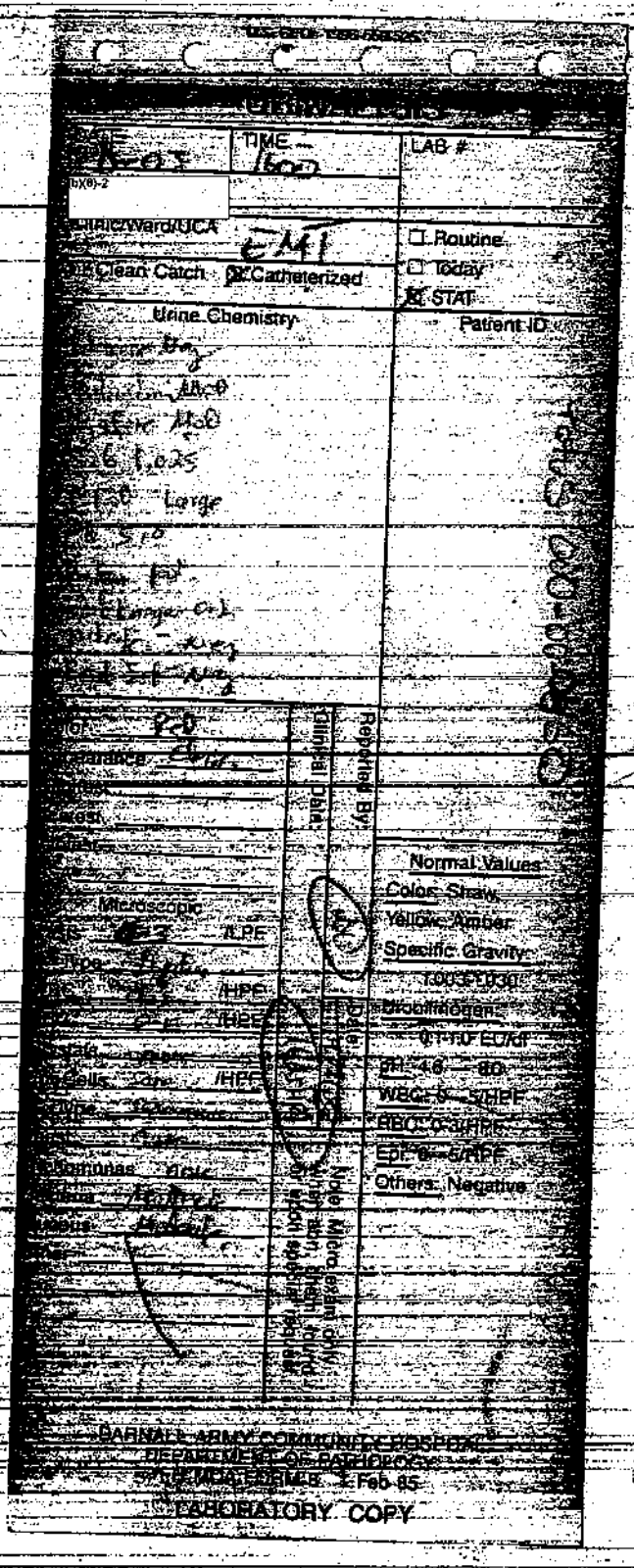
J/S	1410	1635	1730
BP	120/91	113/83	116/64
	111	109	111
	20	20	22
	99 RA	99 2LNC	99 2LNC
	96% RA	96% LA	96% RA

1740: IV fluids - 300cc

1740: Urine - 500cc

Meds: Levaquin 500mg IV @ 1515

Phenergan 25mg IV @ 1745



TIME
LAB #
(b)(6)-2
Routine
Today
STAT
Patient ID
Clean Catch
Catheterized
Urine Chemistry
Reported By
Date
Normal Values
Color: Straw, Yellow, Amber
Specific Gravity:
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
Microscopic
/HPF
Cells
Bacteria
Mucus
Amorphous
Urate
Phosphate
Oxalate
Casts
Hyaline
Granular
Waxy
Epithelial
Other
BARNALL ARMY COMMUNITY HOSPITAL
DEPARTMENT OF PATHOLOGY
DA FORM 8 Feb 85
LABORATORY COPY

(See Instructions on Back of this Sheet) NSN 7540-01-375-5734

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,	HISTORY OBTAINED FROM
21 Dec 03	1300	PRIVATE VEHICLE; X AMBULANCE; OTHER (Specify)	No MEDS	PATIENT; OTHER (Specify)

ALLERGIES: NKDA

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

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

REASON FOR VISIT: Gunshot wound to (R) arm

SEX: M AGE: 28

POSSIBLE THIRD PARTY PAYER: YES / NO

TIME SEEN BY PROVIDER:

VITAL SIGNS: TIME 1340; BP 97/70

DESCRIBE (1) Subjective Care (Pertinent History), (2) Objective (Exam), (3) Assessment (Diagnosis), (4) Plan (Treatment/Procedures):

... shot ... crossfire to (R) arm ... (b)(6)-2

...

LOCAL DISPOSITION:

INJURY ... (R) arm ... complexity closed

(b)(6)-2

TREATMENT ... OR

(b)(6)-4 B6-4

[redacted]

[redacted]

EMERGENCY CARE AND TREATMENT STANDARD FORM

b6-4

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT: 21CSH, (b)(3)-1 Mosul Iraq

TRANSPORTATION TO HOSPITAL (If ambulance 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

HOME TEL. NO. (Inc. area code)

POSSIBLE THIRD PARTY PAYER: ☐ YES ☐ NO

TIME: 1030

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

SEX: M AGE: 40

COMPLAINT(S) (Include symptom(s), duration): Coughing blood

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, including medication given and follow-up)

b-2

DISPOSITION (Check all that apply): ☒ OUTPATIENT

ROUTINE

(b)(6)-2

IMPORTANT: LIST FACILITY HOLDING TREAT

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558

B6-4

(See Instructions on Back of this Sheet)

SSB-103

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1 21CSH, Mosul, Iraq

ARRIVAL — DATE: DAY 30, MONTH Dec, YR 03 — TIME 1640

TRANSPORTATION TO HOSPITAL (If each 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 TEL. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s); duration): S/P GSW x Talk to R thigh referred from Camp [illegible]

SEX: Male

AGE: 36

POSSIBLE THIRD PARTY PAYER: ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1700

VITAL SIGNS

TIME	1650
BP	121/79
PULSE	98
RESP.	26
TEMP.	99.6
WT. (Lbs)	99 (A)

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

ORDERS	UNITS	TIME
CSC		1700
Tetanus Toxoid IM		1715

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 Reg. Male Sustained GSW @ ® medial thigh 7 days ago. T'd at C.S.H. 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: 6 Rx. Pt. has been able to bear wt. on ® leg.

PMH - Ø
PSH - Ø
TOB - heavy smoker
ETOH -

Most of Medial half of thigh covered c ecchymoses 6-10 cm wound anteromedial & posteromedial thigh c active bleeding, c exudate. Lower leg compartments -> soft & non-tender @ edema lower leg. No pain c active or passive motion of knee/hip/ankle. LT sens. intact all dermatomes ® LE. 5/5 DF, PF, Quads, HS. DP pulse 2+/4

ASSESSMENT/DIAGNOSIS: @ Thigh GSW c ecchymoses

AP ® Thigh Low Vel GSW, c large ecchymoses. No evidence of Compartment Syndrome. Cont. c Meds. CONTINUE [illegible] NSAIDs.

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): X Back to EPW Facility
- EMERGENCY | TODAY
- ROUTINE | ROUTINE
- HOME TO UNIT/SERVICE

CONDITION UPON RELEASE
- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

PATIENT'S IDENTIFICATION (Permanent imprint) FOR WHEN 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

[redacted]

B6-4

SI (b)(6)-2

[illegible] plans)

Return to Q. Cross EPW Facility

Hemoglobin & Serums @ no of the static symptoms.

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): [b(3)-1] Ft Irwin

LOG NUMBER:

ARRIVAL — DATE: DAY 05, MONTH OCT, 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 TRINE MEDS

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

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

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

CHIEF COMPLAINT(S) (Include symptom(s), duration): Poss. Hydro

SEX: M AGE: 52

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1320

VITAL SIGNS

TIME	1301		
BP	131/77		
PULSE	102		
RESP.	20		
TEMP.	101.1		
WT. (Lbs)	196		

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

ORDERS	INITS.	TIME
UA, CBC, BMP	[redacted]	1402
CET, CXR		1402
NS TKO		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: 1690

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

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/O & Referral from to Ft Irwin Hydro — IVF given IV-8 PSV-8 Foley placed Lido-TC.

S: Pt c/o difficulty breathing r/t stomach swelling. States has a hx of TB and ascites. Pt reports was being tapped for abdominal pressure & fluids q weekly for about last procedure 6 days ago. States had been taking TB medications up to time of incarceration.

O: 52yo AAM (non-toxic/chronically ill appearing) in NAD. Pt is A&Ox3, cooperative, pleasant. Skin warm and dry. Pupils equal, round, reactive to accommodation. EOMI. Lungs CTA bilaterally. Heart RRR, no murmurs, rubs or gallops. Abdomen soft, distended, tympanic to percussion, hypoactive BS, diffuse tenderness to palpation. Lower legs 2+ edema. Foley patent draining clear yellow urine.

EMT STAFF: Patient interviewed and examined. EMT Weldon, Shelby, 52yo AAM from Hydro reported hx of TUBERCULOUS ASCITES now in detention at MOAB Airfield x 68 days, off TB medication regimen for approx 8 weeks, has had his abdominal volume paracentesis (tapping) on weekly basis. Presents c/o increasing abdominal girth and dyspnea. PROCEDURE NOTE: Abdomen prepped and draped in usual sterile fashion and approx 4L attempted at 5US explant location with sterile technique. Patient tolerated procedure well.

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans): Patient activity as tolerated. Use walker for ambulation. Use call bell for assistance. Discharge instructions reviewed with patient. Patient verbalized understanding. Patient to follow up with PCP in 1 week. RETURN FOR FEVER, ABDOMINAL PAIN, DIFFICULTY BREATHING

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 (Rev. 7-90)

MEDCOM - 379

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

21st COMBAT SUPPORT HOSPITAL B64

LAST, FIRST, MI: NOTJ - [redacted] UNIT: [illegible] RANK: SSN:

Physician: (b)(6)-2 Ward: X STAT / Routine Date and Time: 3 JAN04 1400 Reported by: (b)(6)-2 Date and Time: 3JAN04 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		22-26 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	2.6	3.3-5.5 g/dL
	ALP	96	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	1.0	0.6-1.2 mg/dL
	GGT	[illegible]	5-85 U/L
	Glu	186	73-118 mg/dL
	K	4.1	3.3-4.7 mmol/L
	TProtein	7.1	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	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 Parasites
Thick		No Parasites

Sed Rate

Sed Rate		1hr 0-15

Coagulation

PT	15.2	10-13 seconds
APTT	35.6	22.1-32.5 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other: [illegible]

(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	116/72		
PULSE	80		
RESP.	18		
TEMP.			
WT (Child)	100% PA		

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

ORDERS	INITS.	TIME
L ankle	[redacted]	2100
L foot	[redacted]	2100
Morphine IV	[redacted]	2100
CXR	[redacted]	2100

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 TREAT. REC. RECORD)

[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 medication given and follow-up)

76 c/o SIP. IED. Ivg. detained PMH-Ø PSH-Ø
Hx very poor, but hist gross is that he fell victim to mass casualty IED. - Seen @ outside BAS.
Facial + L ankle injuries
Ao x 4. GCS 15.
Stable VS en route
ABC ✓
C - HEENT - swollen, ecchymotic L orbit. ↓ eye trauma, pupil 2mm → 2 round
Nl Hyp's facial abrasions
Thx - (B) bilateral hyperechoic bleeding, heart, intact / understands / interpreter needed - DNC TFT
back
Chest - AT. B-BS abd - benign
pelvis - stable
L ankle - 8cm lat ankle lac. ↓ ROM
neuro - Ao x 4 GCS 15. No focal deficit

(CONTINUE ON SF 507 IF NEEDED)

(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.)

MEDCOM - 381

556-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY: 31st CSH (b)(3)-1

LOG NUMBER

ARRIVAL — DATE: DAY 01 MONTH Jan YR 04 — TIME: 1943

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

CURRENT MEDS. (Witness 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

VITAL SIGNS

TIME	2050		
BP	142/63		
PULSE	78		
RESP.	16		
TEMP.			
WT. (Lbs)	160#		

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

ORDERS	INITS.	TIME
IVNS	[redacted]	2015
CBC, Troponin,	[redacted]	2015
CKMB	[redacted]	2011
CXR	[redacted]	
12 Lead EKG	[redacted]	2045

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)

TIME SEEN BY PROVIDER

57yo Iraqi detainee brought to ER for chest pain x 1hr. Pt. given Nitro x 2 & ASA at detainee facility. Afterwards chest pain has resolved. Pain, pt. only complaining of headache. Phx of CP in the past.

Ex: HEENT - NCJ
Heart - RRR
Lungs - CTA B
Abd - soft, ND, NT
Ext - warm

pmhx
0
psh
0
Surgery
Hx:
Trauma
Allergies
NKDA
EKG
PSA
127/44b
8.4/37.1
Troponin - neg
CK-MB neg

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:

A&O x 4. Pt. resolved chest pain. EKG neg. Troponin neg. CK-MB neg.
1) Dc to detainee facility.
2) Tylenol + ASA
3) Return for return of chest pain

(CONTINUE ON SF 507, IF NEEDED)

(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).

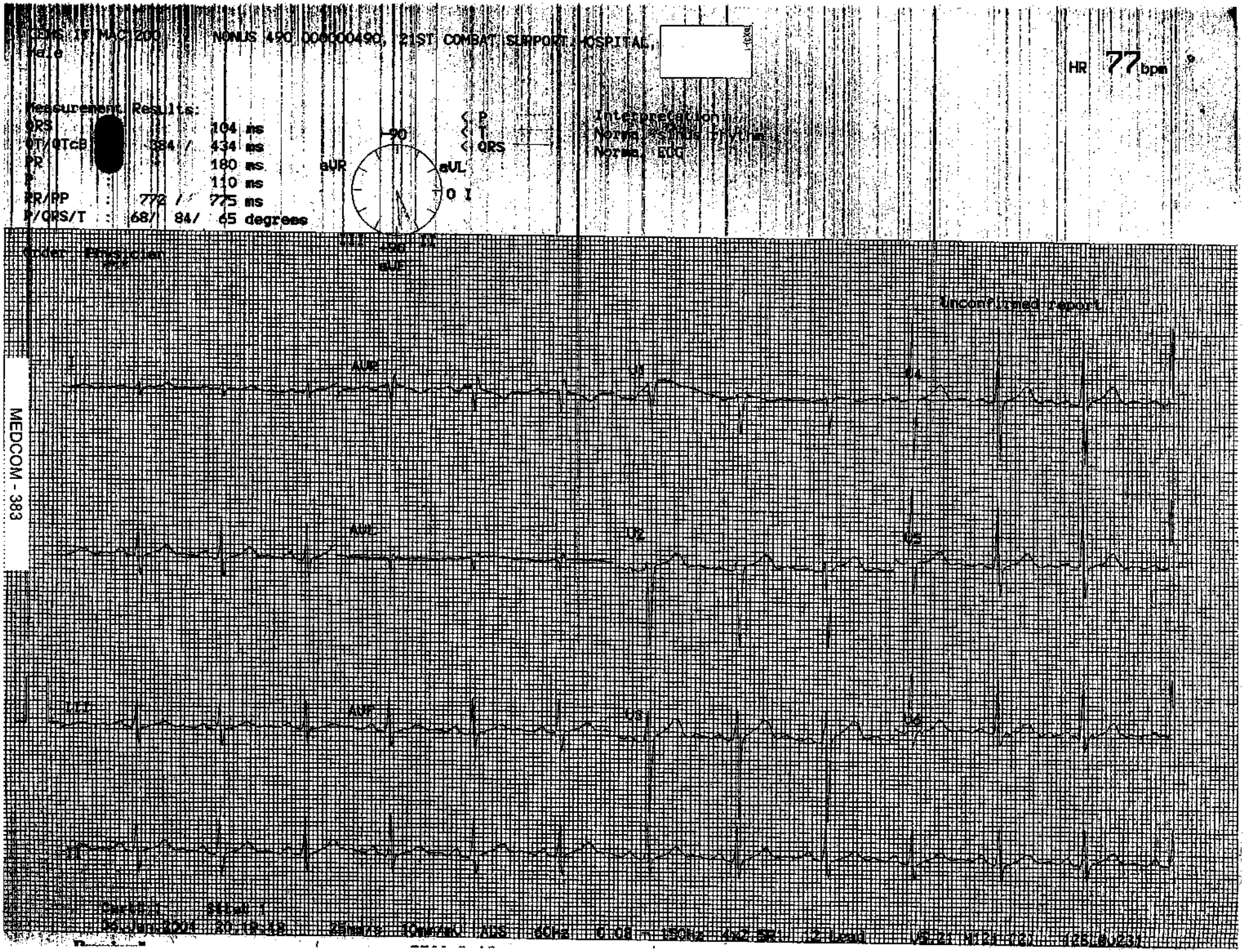
[redacted] B6-4

1947

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications or plans)

EMERGENCY CARE AND TREATMENT STANDARD FORM


Male
HR 77 bpm
Measurement Results:
QRS 104 ms
QT/QTcB 384 / 434 ms
PP 780 ms
PR 110 ms
RR/PP 772 / 775 ms
P/QRS/T 68 / 84 / 65 degrees
Interpretation:
Normal sinus rhythm
Normal ECG
Unconfirmed report
MEDCOM - 383

B6-4

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

B6-4

LAST, FIRST, MI: ABNUS, [redacted] | UNIT: CSH | RANK: CIV | SSN: [redacted]

Physician: [redacted] | Ward: CMC | STAT | Routine | Date and Time: 06 Jan 08 | Requesting: [redacted] | Date and Time: 6 Jan 08

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		22-26 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

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		0.2-1.8 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

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%

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:		

Microbiology

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

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative
Troponin		

Malaria Smear

Thin	No Plasmodium Seen
Thick	No Plasmodium

Misc. Chem

Mono	
RPR	
HIV	
Meningitis	
Trop	Neg
CK/MB	Neg

[redacted]

7. CBG

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 [illegible] (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)

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

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

TIME SEEN BY PROVIDER: on arrival

VITAL SIGNS			
TIME	2315	2345	0020
BP	134/69		129/66
PULSE	147	94	96
RESP.	18		18
TEMP.	98.2		97.3
WT(KG)	99		98.2

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

ORDERS	INITS.	TIME
CBC, BMP	[redacted]	
UA, LFT's		2330
KUB, CXR, 2 views		2335
Phenergan 12.5		2340
Repeat VS 2 hours	[redacted]	0020
Bowel sounds		
ASSESSMENT/DIAGNOSIS		

ICD9 558.9 GE

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)

22 y/o MALE C/O NAUSEA, VOMITING, DIARRHEA AND STOMACH CRAMPS. PT STATES HE HAS BEEN ILL X 3 DAYS. SPC (b)(6)

22y.o. male 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. Denies fever. No F/C, no hematemesis, no hematochezia. Symptoms worse today & vomiting. Meal was eaten at detainee sick call.

PMH: ∅ Meds: Unknown anti-diarrheal

PSH: Hemorrhoidectomy Allergies: NKDA

GENERAL: WN/WD/male in ∅ acute distress, alert, cooperative, pleasant, non-toxic / follows commands

HEENT: NC/AT, PERRL, EOMI, anicteric sclera, MMM, OP clear

NECK: Supple, FROM, no JVD, no LAD

CV: RRR, S1/S2 WNL, no M/R/G

RESP: CTAB, no W/R/R

ABD: NABS, soft, mild diffuse TTP, no R/G, no guarding, no rebound, no masses, no HSM

EXTREM: ∅ edema, ∅ cyanosis, ∅ clubbing, 2+ DP pulses bilaterally

NEURO: AAOx3, CN II-XII grossly intact, sensation intact to light touch, 5/5 strength throughout, gait steady

SKIN: Warm, dry, ∅ rashes

WBC 15.3	RBC 4.8	HGB 13.9	HCT 44.8	MCV 93	MCH 29.0	MCHC 31.1
RDW 15.2	PLT 205	MPV 9.7				
NEUT 54	LYMPH 31	MONO 7.3	EOS 3.8	BASO 1.0		
NEUT# 8.3	LYMPH# 4.8	MONO# 1.1	EOS# 0.6	BASO# 0.2		
AST 22	ALT 23	ALK PHOS 127	TBILI 1.0			
NA 139	K 3.8	CL 100	CO2 23	BUN 9	CREAT 0.8	GLU 127
CA 9.7						

UA: SG 1.030, ∅ ketones, ∅ glucose, ∅ blood

Repeat exam 0015 - Abdomen soft ∅ rebound ∅ focal abdominal tenderness

Impression: AGE, denies 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 outpost
- ☐ 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 [illegible] CRNP

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 not improving 24-48 hours

EMERGENCY CARE AND TREATMENT

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) 21st CSH MoSwl

LOG 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	145/112	21st Hosp
PULSE	81		
RESP.	18		
TEMP.	98.5 @		
WT. (Lbs)	929.RA		

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

ORDERS	INITS.	TIME
IVH0 tko	[redacted]	1200
CBC, LFT, PTT/T		1200
UA/T&C, CX, UA		1206
EKG		1210
CXR PA/LAT		1215
Vs/c betal, 12 hr		1230

ASSESSMENT/DIAGNOSIS: Hypertension Medically out of Control

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

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 yo M brought in from EPW camp c/o headache
Hx HTN hypertension. spec Kiss A. Diagnosis 9/04
51 yo M EPW Diagnosis in c/o HA - seen/PA
noted to have exacerbation of known hypertension, ØCP, ØSOB, took 1/2 of his Captopril (50mg) today - usually takes 1 in the am

PMH – High Blood pressure Past years
PSH – Ø
Tob – 1 pk/day

11A
Lytes PT 13.9 PTT 33.7
Chem 1.010 7.0 pH
30 mg Toradol IMP

TP 8.4 alb 4.4
gt 25 alp 100(↑)
alt 34 amy 50
alt 20 Tbili 1.6
Ca++ 9.1

9.0 / 16.0 / 48.2 — 237
145 | 100 / 107
4.5 | 26 / 1.2

A&Ox3, coop/pleasant, discussion thru interpreter, skin color good, warm, dry, neck ØJVD, supple, pupils =, EOMI fundi benign, TM's cl (has tinnitus since 1999 ⊕ exposure loud noises) mouth Ø lesions CTA, heart RRR Ø⊕ heard, abd soft, ext - ØCCE
1350 sl HA but "fever" & head gone
1350 - BP 170/90 feels better, will ↑ dose of Captopril to 1 (50mg) tid & monitor BP for next 4 days not work will add β Blocker like Atenolol & get medicine consult
CXR no cardiac enlargement
EKG Sinus - RSR

(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

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 1 to 3 times/day
② Get 5d BP check
③ If any problems

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