DEPARTMENT OF THE ARMY
U.S. ARMY CRIMINAL INVESTIGATION COMMAND
Camp Cropper CID Office
86th Military Police Detachment (CID), 22nd Military Police Battalion (CID),
Baghdad, Iraq, APO AE 09342

02 Jun 2007

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - FINAL/SSI - 0124-2006-CID789-78479 - 5H6

DATES/TIMES/LOCATIONS OF OCCURRENCES:

1. 06 NOV 2006, 0001 - 21 NOV 2006, 0253; INTENSIVE CARE WARD, 21ST COMBAT SUPPORT HOSPITAL, CAMP CROPPER, BAGHDAD, IRAQ

2. 01 NOV 2006, 1200 - 01 NOV 2006, 1300; MB 431785, CHECKPOINT T80 C, IRAQ

3. 01 NOV 2006, 1200 - 06 NOV 2006, 2359; 28TH COMBAT SUPPORT HOSPITAL, BAGHDAD, IRAQ

DATE/TIME REPORTED: 21 NOV 2006, 0310

INVESTIGATED BY:

SA (b)(6), (b)(7)(C), (b)(7)(F)
SA
SA
SA
SA

SUBJECT:

1. UNKNOWN COALITION FORCES, ; [JUSTIFIABLE HOMICIDE] (NFI)

VICTIM:

1. HUMUD, MOSLEM DAWOOD (DECEASED); CIV; IRAQ; 1 JAN 1988; AL

WEHDA, BAGHDAD, IRAQ; MALE; OTHER; HOSPITAL IDENTIFICATION NUMBER b(6), b(7)(C), IZ; XZ ; [JUSTIFIABLE HOMICIDE]

INVESTIGATIVE SUMMARY:

"This is an Operation Iraqi Freedom Investigation."

The 324th Military Police Battalion (MP BN), Camp Cropper, Baghdad, Iraq APO AE 09342 (CCI) reported Mr. HUMUD died at the 21st Combat Support Hospital (CSH), CCI.

Investigation disclosed Mr. HUMUD was admitted to the 21st CSH, suffering from a gunshot wound to the abdomen received during a combat altercation with unknown Coalition Forces and subsequently died from his injuries. Medical personnel and the Forensic Science Officer, 22nd MP BN (CID), Camp Victory, Iraq, APO AE 09342 (CVI), determine the cause of death to be complications due to a gunshot wound to the abdomen and the manner of death was homicide. Due to Mr. HUMUD being shot during an engagement with Coalition Forces, the homicide was justified.

STATUTES:

N/A

EXHIBITS/SUBSTANTIATION:

ATTACHED:

1. Agent's Investigation Report (AIR) of SA b(6), b(7)(C), 21 Nov 06.
2. Internment Paperwork pertaining to Mr. HUMUD, 1 Nov 06.
3. Photographic Packet compromised of 13 photographs.
   a. Photographic Packet containing photographs 1-13 (Mr. HUMUD).
4. Death Certificate pertaining to Mr. HUMUD, 21 Nov 06.

5. Medical records pertaining to Mr. HUMUD, various dates.

6. Birth Certificate and Iraqi Citizenship Certificate pertaining to Mr. HUMUD, 1 Jan 88.

7. English language translations of Exhibit 6.

8. AIR of SA (b)(6),(b)(7)(C) 28 Nov 06.

9. Medical treatment records pertaining to Mr. HUMUD while at the 28th CSH, various dates.

10. AIR of SA (b)(6),(b)(7)(C) 31 May 07.

11. Compact disc 060124.789 containing all photographic images and the originals of Exhibits 3 (USACRC and file copies only).

NOT ATTACHED:

None

The originals of Exhibits 1, 3, 7, 8, 10 and 11 are forwarded with the USACRC copy of this report. The originals of Exhibit 2, 4, 5, 6 and 9 are retained in the files of Task Force 134, CVI.

STATUS: This is a Final Report.

Report Prepared By:

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

Special Agent

Report Approved By:

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

Special Agent in Charge

DISTRIBUTION:
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CDR, 86TH MP DET (CID), 22ND MP BN (CID), CAMP SLAYER, BAGHDAD, IRAQ, APO AE 09342 (email only)
CDR, 22ND MP BN (CID)(FWD), CAMP VICTORY, BAGHDAD, IRAQ, APO AE 09342 (email only)
FILE

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

AGENT'S INVESTIGATIVE REPORT
CID Regulation 195-1

ROI NUMBER 0124-06-CID789-78479

BASIS FOR INVESTIGATION:
About 0310, 21 Nov 06, this office was notified by SGT b(6), b(7)(C) Headquarters & Headquarters Company (HHC), 324th Military Police Battalion (MP BN), Camp Cropper, Baghdad, Iraq APO AE 09342 (CCI) that an unknown local national (LN) had died at the 21ST Combat Support Hospital (CSH), CCI.

About 0335, 21 Nov 06, SA b(6), b(7)(C) coordinated with SSG b(6), b(7)(C) Military Police Desk, 21st CSH, CCI and obtained copies of the capture paperwork and identification card pertaining to the unknown local national. (See Capture Paperwork and identification card for details)

About 0345, 21 Nov 06, SA b(6), b(7)(C) verified and photographed the body. (See Photographic Packet and Compact Disc for details)

About 0345, 21 Nov 06, SA b(6), b(7)(C) coordinated with PFC b(6), b(7)(C) Patient Administration Division (PAD), 21st CSH, CCI and obtained a copy of the preliminary death certificate pertaining to the unknown LN. (See Death Certificate for details)

About 0400, 21 Nov 06, SA b(6), b(7)(C) coordinated with PFC b(6), b(7)(C) and obtained copies of the medical treatment records pertaining to the unknown LN. (See Medical Records for details)

About 0405, 21 Nov 06, SA b(6), b(7)(C) interviewed CPT (DR) b(6), b(7)(C) 21ST CSH, CCI who stated the unknown LN was brought to the 21ST CSH from the 28TH CSH where a Whipple Procedure was used to repair and alleviate significant trauma of the abdominal area. CPT b(6), b(7)(C) stated a Tracheal Tube and Chest Tubes were inserted into the unknown LN to assist the LN in breathing and relieving fluid from his chest cavity. Sequential Compression Devices (SCD) were placed on the unknown LN's legs to assist with blood flow and prevent blood clotting in the lower extremities. CPT b(6), b(7)(C) stated the unknown LN's vitals dropped very quickly and life saving measures taken consisted of a "Chemical Code" which consisted of use of blood products and Vasopressors, Dopamine and Albuminol. CPT b(6), b(7)(C) stated that chest compressions related to Cardio Pulmonary Resuscitation (CPR) were not used due to the injury to his abdominal area and the unknown LN was pronounced dead at 0253 due to complications from a gunshot wound (GSW) to the abdomen.

About 0410, 21 Nov 06, SA b(6), b(7)(C) coordinated with SGT b(6), b(7)(C) IHA, 324th MP BN, CCI who stated the unknown individual would not be assigned an Internment Serial Number as the capture paperwork was incomplete in that it did not list the individuals name. Further, SGT b(6), b(7)(C) stated when the individual arrived at the hospital the IHA was not made aware there was an identification card (ID) and they could not use the ID card since the individual was unconscious and the information on the ID could not be verified.

TYPED NAME, SEQUENCE NUMBER	ORGANIZATION
SA b(6), b(7)(C), b(7)(F)	76TH MP Det (CID)(FWD)(-), CCI, APO AE 09342
SIGNATURE	DATE: 21 Nov 06 / EXHIBIT:

CID FORM 94-E
(Automated)

AGENT'S INVESTIGATIVE REPORT
CID Regulation 195-1

ROI NUMBER 0124-06-CID789-78479

BASIS FOR INVESTIGATION:
About 1000, 21 Nov 06, SA b(6), b(7)(C), with the assistance of b(6), b(7)(C) Interpreter, L3 Communications, translated the identification card belonging to unknown LN and discovered the name of the LN as Mr. Moslem Dawood HUMUD, 1 Jan 1988, Al Wehda, Baghdad, Iraq. (See Birth Certificate, Iraqi Citizen Certifcate and English translations of both for details)

About 1200, 21 Nov 06, SA b(6), b(7)(C) interviewed MAJ (DR) b(6), b(7)(C) b(6), b(7)(C) 21ST CSH, CCI, who stated Mr. HUMUD was transported to the 21ST CSH with a gunshot wound to the abdomen from the 28TH CSH where he received initial treatment. MAJ b(6), b(7)(C) stated that Mr. HUMUD's condition had steadily deteriorated and his vitals dropped. MAJ b(6), b(7)(C) stated that life saving measures consisted of intubation and placement of chest tubes to assist in breathing and alleviating pooling of blood in the chest cavity. MAJ b(6), b(7)(C) also stated they conducted a "Chemical Code" which consisted of using blood pressure enhancers and antibiotics to stimulate his system as CPR could not be conducted due to injuries to the abdominal area. MAJ b(6), b(7)(C) pronounced Mr. HUMUD dead at 0253, 21 Nov 06, and stated the cause of death to be a gunshot wound to the abdomen.///Last Entry///

TYPED NAME, SEQUENCE NUMBER
SA b(6), b(7)(C), b(7)(F)

ORGANIZATION
76TH MP Det (CID)(FWD)(-), CCI, APO AE 09342

SIGN

DATE
21 Nov 06

EXHIBIT
1

CID FORM 94-E
(Automated)

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

☐ **Offense against Civilian(s) [check one] If "Other" then describe:** _____

- ☐ Arson (I.P.C. 342)
- ☐ Solicitation of Fornication/Prostitution (I.P.C. 399)
- ☐ Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- ☐ Murder (I.P.C. 405)
- ☑ Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- ☐ Maiming (I.P.C. 412)
- ☐ Simple Assault (I.P.C. 415)
- ☐ Kidnapping (I.P.C. 421)
- ☐ Burglary or Housebreaking (I.P.C. 428)
- ☐ Extortion/Communicating Threats (I.P.C. 430)
- ☐ Theft (I.P.C. 439)
- ☐ Destruction of Property (I.P.C. 477)
- ☐ Obstructing a Public Highway/Place (I.P.C. 487)
- ☑ Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- ☑ Riot or Breach of Peace (I.P.C. 495(3))
- ☐ Other

☐ **Offense against Coalition Forces [check one] If "Other" then describe:** _____

- ☐ Violation of Curfew
- ☐ Illegal Possession of Weapon
- ☑ Assault/Attack on Coalition Forces
- ☐ Theft of Coalition Force Property
- ☐ Trespass on Military Installation or Facility
- ☐ Photographing/Surveilling Military Installation or Facility
- ☑ Obstructing Performance of Military Mission
- ☐ Other

Apprehending Unit: D. Co. 2/506 TH		Location Grid: MB 431 785	
Date of Incident: (D/M/Y)	Time of Incident:	Date of Report: (D/M/Y)	Time of Report:
01 NOV 06 to	1200 hrs to 1300 hrs	01 NOV 06	1540 hrs

Detainee # _____			Key Connected Person: ☐ Victim ☐ Witness		
Last Name:			Last Name:		
First Name:	Given Name:		First Name:	Given Name:	
Hair Color:	Scars/Tattoos/Deformities:		Hair Color:	Scars/Tattoos/Deformities:	
Eye-Color:	Weight: lb	Height: in	Eye-Color:	Weight: lb	Height: in
Address:			Address:		
Place of Birth:			Place of Birth:		
Ethn/Tribe/ Sect:	Sex: ☐ M ☐ F	Phone#: DOB D/M/Y: ☐ Mobile ☐ Regular	Ethn/Tribe/ Sect:	Sex: ☐ M ☐ F	Phone#: DOB D/M/Y: ☐ Mobile ☐ Regular
☐ Passport ☐ Dr. license ☐ Other (specify) Document #:			☐ Passport ☐ Dr. license ☐ Other (specify) Document #:		

Total Number of Persons Involved _____(list names/identifying info on reverse under "Additional Helpful Information")

☐ Vehicle Information Vehicle Number _____ of _____ Vehicle(s)

Make:	Color:	License No.:	Owner:
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

☐ Property/Contraband ☐ Weapon Photo Taken of Suspect with Weapon/Contraband: Yes/ No

Type:	Model:	Color/Caliber:
Serial No.:	Quantity: Make:	Receipt Provided to Owner: Yes/ No
Other Details:	Where Found:	Owner:

Name of Assisting Interpreter: b(6), b(7)(C) Email, Phone, or Contact Info:

Detaining Soldier's Name (Print): b(6), b(7)(C)	Supervising Officer's Name (Print): Last, First MI
Signature:	Signature:
Email:	Email:
Unit Phone: Date: 01 / NOV / 06	Unit Phone: Date: / /

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? identified as one of the shooters against coalition forces.

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

SSG [redacted] b(6) b(7)(C) D. Co. 2/506TH
SSG "
SSG "

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

Who was with this person? ~~a small kid looked after the man about 7 year old~~ A group of local civilians brought him to us carried in a blanket.

What weapons was this person carrying? none at the time we received him

What contraband was this person carrying? none at the time we received him

What other weapons were seized? N/A

What other information did you get from this person? I.D.

Additional Helpful Information: We received him wounded and he matched the description of one of the shooters.

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is PMG.

PRIVACY ACT STATEMENT

AUTHORITY:	Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 *(SSN)*.
PRINCIPAL PURPOSE:	To provide commanders and law enforcement officials with means by which information may be accurately identified.
ROUTINE USES:	Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE:	Disclosure of your social security number is voluntary.

1. LOCATION	2. DATE *(YYYYMMDD)*	3. TIME	4. FILE NUMBER
MOLLALA 826 T80 C	20061101	1500	

5. LAST NAME, FIRST NAME, MIDDLE NAME	6. SSN	7. GRADE/STATUS
b(6), b(7)(C)	b(6), b(7)(C)	E6 - SECTION LDR

8. ORGANIZATION OR ADDRESS
D Co 2/506 INF

9.

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

ON 11 NOV 06 AT 1200 HRS WE WERE ASSISTING b(6), b(7)(C) 27, 2/506 IN A SMALL ARMS CONTACT AT CHECK POINT T80C. THEY GAVE US THE DESCRIPTION OF THE TWO SHOOTERS. WE BEGAN PATROLING THE IMMEDIATE AREA AND FOUND ONE OF THE SHOOTERS, POSITIVELY IDENTIFIED BY THE PATROL IN CONTACT. THE SECOND SHOOTER WAS BROUGHT TO US BY A LOCAL NATIONAL, WITH A GUN SHOT WOUND IN HIS BACK, ALSO POSITIVELY IDENTIFIED BY THE PATROL LEADER AS BEING ONE OF THE GUN MEN ATTACKING THE U.S CONVOY. THE PATROL SAID THAT IT WAS A TEENAGE IRAQI KID, WITH A BASE SHIRT, AND b(6), b(7)(C) THE YOUNG BOY SUFFERED A BULLET WOUND THAT ENTERED IN HIS BACK AND OUT HIS ABDOMINAL AREA.
MP (Q) IS THERE ANYTHING YOU WOULD LIKE TO ADD?
(A) NO b(6), b(7)(C)
/// NOTHING FOLLOWS ///

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT b(6), b(7)(C)	PAGE 1 OF 3 PAGES

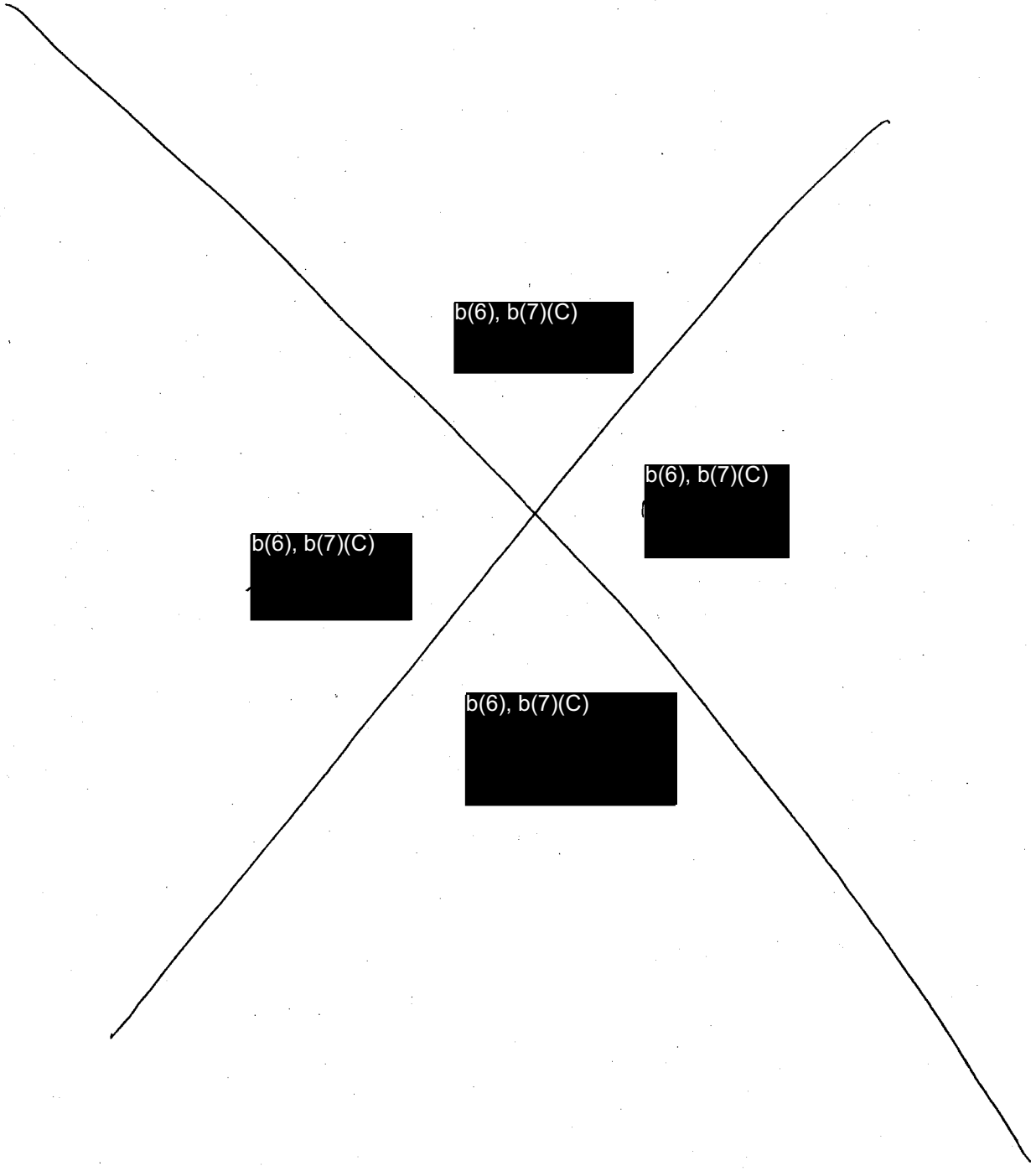
ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF _____ TAKEN AT ____ DATED ____"

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

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

STATEMENT OF SSG b(6), b(7)(C) AKEN AT 1500 b(6), b(7)(C) DATED 1 NOV 0 b(6), b(7)(C)

9. STATEMENT *(Continued)*



INITIALS OF PERSON MAKING STATEMENT b(6), b(7)(C)

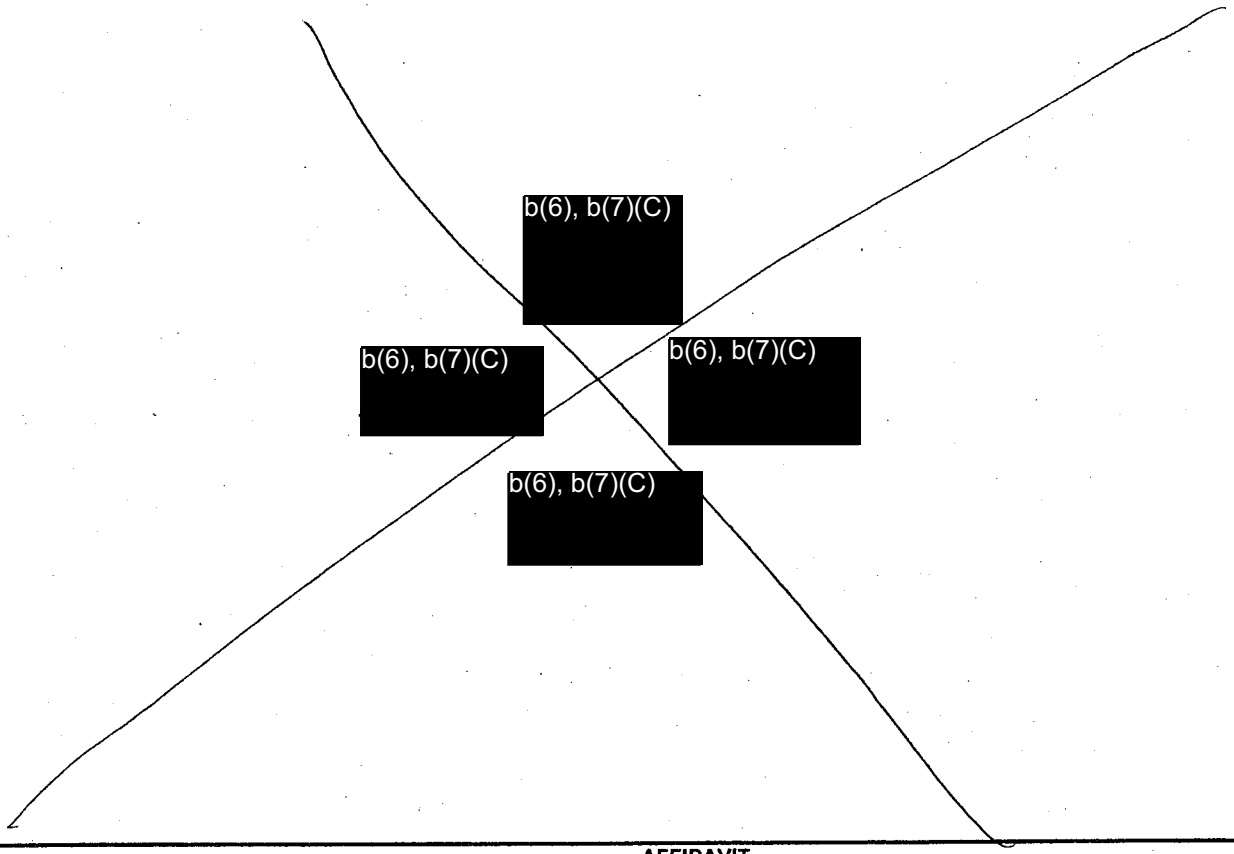
PAGE 2 OF 3 PAGES

PAGE 2, DA FORM 2823, DEC 1998

APD PE v1.01

STATEMENT OF SSG b(6), b(7)(C) TAKEN AT 1500 b(6), b(7)(C) DATED 1 NOV 06 b(6), b(7)(C)

9. STATEMENT *(Continued)*



AFFIDAVIT

I, SSG b(6), b(7)(C), HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS O 3. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL IN b(6), b(7)(C)

WITNESSES:

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

ORGANIZATION OR ADDRESS 28th CSH

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 01 day of NOV, 2006 at 28th CSH

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

(Typed Name of Person Administering Oath)

Art 134 (b)(4) UCMJ

(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT

PAGE 3 OF 3 PAGES

PAGE 3, DA FORM 2823, DEC 1998

APD PE v1.01

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is PMG.

PRIVACY ACT STATEMENT

AUTHORITY:	Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 *(SSN)*.
PRINCIPAL PURPOSE:	To provide commanders and law enforcement officials with means by which information may be accurately identified.
ROUTINE USES:	Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE:	Disclosure of your social security number is voluntary.

1. LOCATION	2. DATE *(YYYYMMDD)*	3. TIME	4. FILE NUMBER
Muhalla 826 CP T80C	20061101	1500	

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

8. ORGANIZATION OR ADDRESS

D. Co. 2/506 TH

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

At approximately b(6), b(7)(C) 200 we linked up with B27 element to assist them. They were receiving small arms fire from their west and east side of their position. We were sent to grid MB 431 785 where we detained one of the shooters and had positive ID on him. The other wounded detainee was brought to us by a group of locals, he was carried in a blanket. He fit the description of one of the shooters that b(6), b(7)(C) was shooting at U.S. forces. Our medics cared for him after he was treated we then got orders to bring him to the CASH. He was wounded on his lower back and had an exit wound in his abdomen area b(6), b(7)(C) (Q) Is ther anything you would like to add? (A) NO b(6), b(7)(C)

/// Nothing Follows ///

10. EXHIBIT	b(6), b(7)(C) ON MAKING STATEMENT	PAGE 1 OF 3 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STA[redacted] TAKEN AT ____ DATED ____

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

DA FORM 2823, DEC 1998 DA FORM 2823, JUL 72, IS OBSOLETE APD PE v1.01

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

STATEMENT OF b(6), b(7)(C) TAKEN AT 1500 b(6), b(7)(C) TED 01 NOV 06 b(6), b(7)(C)

9. STATEMENT *(Continued)*

Nothing Follows

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

INITIALS OF PERSON MAKING STATEME b(6), b(7)(C)

PAGE 2 OF 3 PAGES

PAGE 2, DA FORM 2823, DEC 1998

APD PE v1.01

STATEMENT OF b(6), b(7)(C) TAKEN AT 1500 DATED 01 NOV 06 b(6), b(7)(C)

9. STATEMENT *(Continued)*

Nothing Follow

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

AFFIDAVIT

I, b(6), b(7)(C), HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE 3. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE [illegible] THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLA

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

(Si

WITNESSES:

b(6), b(7)(C)
28th CSH

ORGANIZATION OR ADDRESS 28 CSH

b(6), b(7)(C)
28th CSH

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 01 day of November 2006 at 28th CSH

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

(Typed Name of Person Administering Oath)

Art 134 (b)(4) UCMJ

(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT b(6), b(7)(C)

EXHIBIT 9

Pages 125 thru 181 referred to:

CDR USAMEDCOM
ATTN: FOIA OFFICE, STOP 76
1216 STANLEY RD 2D FL
FT. SAM HOUSTON, TX 78234-5049

0124 06 [illegible] 78479

Front of Birth Certificate

Republic of Iraq
Interior ministry

Certificate # 785253 Serial # 1544M
133

Birth certificate and general service director

Personnel Certificate

Issue according civil law number 60 dated 1972

Name: Moslem

Father & Grand father Name: Dawood Humud

Last Name: N/A

Mother & Grand Mother Name: Fatuma Hassan

Sex: Male

Official Signature

Organize Date: N/A

Organizer Signature:

Complete Name: Abraham Hassan

EXHIBIT 7

0124 06 CID 78479

Back of Birth Certificate

785253

Religious: Moslem

Date OF Birth 1/1/1988

Place of Birth: Al Wehda /Al Mada'an/Baghdad

Any mark: None

Single

Registration Place: Al Mada'an

Eye Color: Brown

Interpreted by:
b(6), b(7)(C)
Mr. b(6), b(7)(C)
Camp Cropper CID Office
Category II Interpreter
US Contractor, L3 Communications

~~FOR OFFICIAL USE ONLY~~
~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT 122

0124 06 UL789 78479

Serial Number: 73/45937

Birth Certificate # 647815

Dated 4/24/1973

Iraqi Citizen Certificate

We certify that Dawood Humud Salum Iraqi citizen which his picture Above according with number (114) from Iraqi citizen law For this he was issue this certificate.

Place of birth for Certificate holder: Selman Back

Previous Certificate: Iraqi

Religion: Moslem

Any Remark: None

Complete Father Name: Humud Salum

Place of Birth: Selman Back

Complete Mother: Faytum Ali

Place of Birth: Selman Pack

Original Father Citizenship: Iraqi

Original Mother Citizenship: Iraqi

Interpreted by:
b(6), b(7)(C)
Mr. b(6), b(7)(C)
Camp Cropper CID Office
Category II Interpreter
US Contractor, L3 Communications

~~FOR OFFICIAL USE ONLY~~
~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT 123

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0306-06-CID899

PAGE 1 OF 1 PAGES

DETAILS

BASIS FOR INVESTIGATION: About 0845, 24 Nov 06, this office received a request for assistance from Camp Cropper CID Office, Badhdad, Iraq, APO AE 09342, to obtain the medical records of Mr. Moslem Dawood HUMUD, Hospital Identification Number (HIN) b(6), b(7)(C) 21st Combat Support Hospital (CSH), Camp Cropper, Baghdad, Iraq, APO AE (CCI).

About 1200, 26 Nov 06, SA b(6), b(7)(C) and SA b(6), b(7)(C) this office, coordinated with SFC b(6), b(7)(C) b(6), b(7)(C) Hospital Administration, Medical Records, 28th CSH, International Zone (IZ), Iraq, APO AE, and obtained the medical records of Mr. HUMUD.

About 0945, 28 Nov 06, SA b(6), b(7)(C) coordinated with SA b(6), b(7)(C) Camp Cropper CID Office, to determine whether there was any further information needed. SA b(6), b(7)(C) that no further information was needed at this time and the case is closed in the files of this office.///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
SA b(6), b(7)(C)	International Zone CID Office, 86th MP Battalion, USACIDC, APO AE 09348
SIG b(6), b(7)(C)	DATE 28 Nov 06 / EXHIBIT 8

MEDICAL RECORD - PROVIDER ORDERS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Orders completed during the shift in which they are written will be signed off adjacent to the order and do not require recopying on other ITR forms.

DATE/ TIME

ORDERS

(SIGNATURE REQUIRED FOR EACH ORDER/SET OF ORDERS. SIGNATURE MUST BE LEGIBLE; PROVIDER WILL USE SIGNATURE STAMP OR PRINT NAME).

TRAUMA ADMISSION ORDERS (1 of 2)

(b)(6)

(b)(6)

(b)(6)

11/13 Nov 13

Admit/Transfer to ICU 1 or 2/SDU/ICW 1 or 2 Physician: (b)(6)

Diagnosis: SIP GSW to Abd X

Condition: ___ Critical X Stable +

Vital Signs: ___ q1 hrs ___ q2 hrs ___ q4 hrs X q8 hrs ___ q12 hrs +

Activity: ___ Bedrest: HOB to 45 deg X OOB BID ___ Up at Lib +

Allergies: Unknown/NKDA/ → Ambulate twice daily +

Nursing:

1. ___ Accurate I/O ___ Foley to gravity ___ Cardiac Monitor D/C Foley Once Ambulating C

2. ___ NGT/OGT to LCWS/LIS ___ JP to Bulb Suction

3. ___ Vascular Checks q1 hrs ___ Neuro Checks q1 hrs ___ CVP q1 hrs

4. ___ Spinal Precautions ___ Chest Tube to 20 cmH2O suction Clamp ~~ICT~~ C-tube

5. ___ Soft Restraints for personal protection

6. ___ Reinforce Dressing prn ___ Routine Skin Care ___ Clean pins BID (use 1/2 peroxide & 1/2 NS)

~~7. ___ Ventilator: settings per physician, anesthesia, respiratory therapy~~

8. ___ Oxygen: titrate to maintain SaO2 greater than 93% D/C O2 for Sat >90% X

Verified

Diet: NPO/Clear/Regular/Cardiac/2 gm Sodium/ CLEARS

LABS: X CBC, Chem 10, and Coags on arrival and/or X q am ___ q8 hrs ___ q12 hrs X

___ ABG on arrival and q am on all vented patients

RADS: CXR ___ on arrival, and ___ q am

X Call MD if temp >102.5 F; p <60 or >170; SBP <90 or >170; Pulse Ox <90%; I/O <30 ml/hr x 2 hrs X

___ For K+ <3.5 and Phos > 2.5, give 40 meq KCL in 250 ml NS (100 ml NS for patients with central venous access) IV over 4 hours.

___ For K+ <3.5 and Phos <2.5, give 30 mmol of Kphos in 250 ml NS (100 ml NS for patients with central venous access

___ For Mg++<1.5, give 2 gms Mg SO4 in 250 ml NS (100 ml NS for patients with central venous access) IV over 4 hours

40 mEq KCl Dulb now & 2g Mag Sulfate now IVPB

CONTINUE

(b)(6)

(b)(6)

Complete the following information on page 1 of provided orders only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight (lbs): _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.

IV SITE. (Condition Legend: P - Puffy I - Infiltrated In - Indurated R - Reddened OK - No swelling/redness * - Central line)

E: 1230 P3 1130 INITIALS: (b)(6)	TIME: _____ INITIALS: _____	TIME: 1915 INITIALS: (b)(6)	
atency check q ___ hr:	IV patency check q ___ hr:	IV patency check q ___ hr:	
	SITE 1 / SITE 2	SITE 1 / SITE 2	SITE 1 / SITE 2
tion date	Insertion date	Insertion date	
cter size	Catheter size	Catheter size	
tion RIJ	Location	Location RIJ	
tion Intact	Condition	Condition patent	
care provided	Site care provided	Site care provided	
ng changed	Tubing changed	Tubing changed	
te changed	IV site changed	IV site changed	
ment:	Comment:	Comment:	

PAIN. For location of pain, use the anatomical numbering scheme (Figure 1) displayed at the bottom of this page.

: 1105 INITIALS: (b)(6)	TIME: _____ INITIALS: _____	TIME: 1915 INITIALS: _____
tion: Abd/ back	Location:	Location: denies
sity (0 - 10 scale):	Intensity (0 - 10 scale):	Intensity (0 - 10 scale):
ription:	Description:	Description:
ased by:	Increased by:	Increased by:
ved by:	Relieved by:	Relieved by:

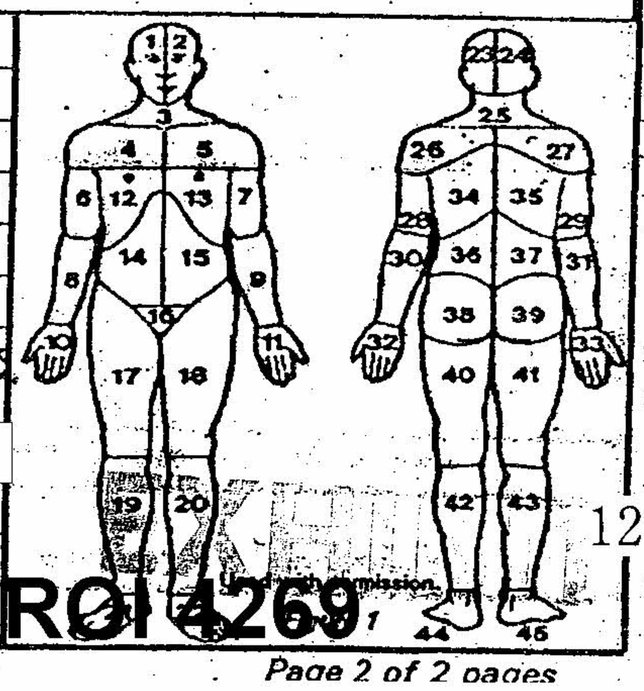
OTHER INTERVENTIONS. Document assessment and care of any drains, wounds, dressings, etc., in the spaces provided below.

: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
vention:	Intervention:	Intervention:
s:	Findings:	Findings:

COMMENTS:

1130 - PT arrived to ward from stepdown unit, PT AAOx3 BP 109/67 P 86 Resp 18 Tap 99.0 Sat 95% pt placed on 2L NC, pt has (R) IJ pt pulses present in all extremities pt has dressing to Abd with staples intact dsg covering G-tube and gall bladder drainage tube, pt given ~~2 tab~~ (b)(6) 4mg morphine IV for pain will reassess for effectiveness 1210 PT ~~alsos~~ ~~alsos~~ asleep in bed will continue to monitor. (b)(6)

1730 - PT OOB to ambulate ~~unlevelled~~ well with steady.



FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

(b)(6)

(b)(6)

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

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

Mo Nov Yr. 05

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8
11/05	(b)(6)	(X)VS: Q 8	D	(b)(6)			
			N				
11/5		(X)Activity: ( )bedrest, HOB > 45, (X) OOB with assist, ( )up ad lib BID	D				
11/5		Ambulate twice daily	N				
		( )~~SCDs to: RLE LLE Bilateral LE~~	D				
			N				
11/5		(X)Foley to gravity D/C Foley	D				
		once Ambulatory	N				
		( )~~Record I/O~~	D				
			N				
11/5		(X)Diet: regular Other NPO	B				
			L				
			D				
11/5		(X)Labs: CBC, Chem 10, ~~Coags~~	05				
		~~Coags~~ QAM & LFT's					
		( )Radiology:					
11/5		Oxygen titrate to maintain SaO2 to > 90%	D				
			N				
11/5		Incentive Spirometer q 1 hr	D				
		while awake/ Deep breath	N				
		& cough q 1 hr while awake					

ALLERGIES: ☐ YES ☐ NO

unknown

PRIMARY DIAGNOSIS: s/p GSW to Abd

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1

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EXHIBIT 9

D124 06 CID789 78479

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1715	1200	1200			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

Gall bladder draina ge

TIME	AMOUNT	TYPE	ACCUM TOTAL
1630	350cc		

GRAND TOTAL OUTPUT

REMARKS

JP drainage = 1630 100cc

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

(b)(6)

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
	120	LARGE SOUP BOWL	240
SMALL FRUIT CUP	160	LARGE WATER GLASS	240
COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

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012 06 [illegible] 79479

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. Nov Yr. 06

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5 6 7 8
11/5	(b)(6)	(X)IVF: D5 NS for 24 hrs @ 75 ml/hr	D	(b) (6)
		( )HLIV when tol PO, then Δ to D5 1/2 NS c 10meq Kcl @ 75	N	
		( )Ancef ____ gm IV Q ____ hrs		
11/5		↑ Promote to 40cc/hr	D	
			N	
11/5		(X)Unasyn 3 gm IV Q 6 hrs	06	
			12	
			18	
			24	
		( )Gentamycin ____ mg IV Q ____ hrs		
11/5		(X)Lovenox 30 mg SC BID	10	
			22	
11/5		Albuterol Nebs 0.5/2.5ml tid	06	
			14	
			22	
11/5		Protonix 40mg IV qd	10	

ALLERGIES: ☐ YES ☐ NO

unknown

PRIMARY DIAGNOSIS: S/P GSW to Abd

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

100-01-2639

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

0124 06 CID789 78479

NIBP	112/64	
A-LINE	/	
MAP	82	
HR	85	
RR	14	
SaO2	100% (b)(6)	
INPUT		
IVF	90	
IVPB	/	
PO/TF	20	
TOTAL		
OUTPUT		
URINE	100	
NGT/OGT	/	
STOOL	/	
G-tube	50	
JP#1		
JP#2		
TOTAL		

[illegible] Pt [illegible] dressing [illegible]. Pt has two JP drains JP#1 from [illegible] JP#2 from [illegible] both [illegible] drainage. Pt has G-tube [illegible] color drainage. Pt has J-tube [illegible] @ 20cc/hr [illegible] @ 40cc/hr will continue to [illegible] (b)(6) [illegible] 40 meq KCl [illegible] (b)(6) Pt to transfer to ICW2 (b)(6)

12 HOUR INPUT:

12 OUTPUT:

(b)(6)

11-

05 NOV 06

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EXHIBIT 9

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. 11 Y

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5
3NOV	(b)(6)	IVF: LR @ 125 ml/hr	07	(b)(6)	(b)(6)	4d 4NOV 06
			19			
3NOV	(b)(6)	Oxygen: Titrate to maintain SaO2> 93%	07		(b)(6)	
		(Decrease FiO2 by 10% q10min to 30% FiO2 minimum)	19		(b)(6)	
		( )Midazolam ( )Propofol drip	07			
		Titrate to SAS 3-4	19			
		( )Fentanyl drip (max 300mcg/hr)	07			
		( )Morphine drip (max 4mg/hr)	19			
		( )Albuterol Nebs 0.5/2.5ml TID	07		(b)(6)	
			15			
			22	(b)(6)		
3NOV	(b)(6)	(X)Pantoprazole 40 mg IV qd	10	(b)(6)		
		( )Ranitidine 50mg IV q8hr				
		( )Carafate 1gm PO/NGT qid				
		( )Colace 100mg PO/NGT bid	08			
			20			
		( )Ancef ____gm IV q8hr	06	(b)(6)		
	(b)(6)	( )Levoflaxacin ____mg IV qd	12	(b)(6)		
3NOV		(X)Ampicillin/Sublactam 3 mg IV q6hr	18	(b)(6)		
			24			
	(b)(6)	( )Heparin 5,000units SQ BID	08	(b)(6)		
3NOV		(X)Enoxaparin 30 mg SQ BID	20	(b)(6)		
		Chlorhexidine Oral Rinse/swabs PO BID	08			
		(swish and spit/suction)	20			
4NOV	(b)(6)	↓LR to 90cc/hr	07	/	/	(b)(6)
			19	/	(b)	

ALLERGIES: ☐ YES ☐ NO

unknown

PRIMARY DIAGNOSIS: cond: stable

s/p Whipple & hepatorhaphy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA PAGE 131

EXHIBIT 9

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

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

Mo. 11 Yr

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETIC

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5
3NOV	(b)(6)	G tube to gravity	07	(b)(6)		
			19	(b)(6)		
3NOV		Promote 10-20cc/hr	07	(b)(6)		
		through J tube as	19	(b)(6)		
		tolerated				
3NOV		LFT's, amylase, lipase	07	/	(b)(6)	
		q am				
3-4NOV		Dress drainage tube	07	/	(b)(6)	
		insertion c gauze, open	19	/	(b)(6)	
		abd wound to air may				
		use Betadine for				
		cleaning				
4NOV		increase promed rate to	07	/	/	(b)(6)
		40mL/hr. monitor for	19	/	(b)(6)	
		signs of intolerance or				
		abdominal distention				

ALLERGIES: ☐ YES ☐ NO

Unknown

PRIMARY DIAGNOSIS:

S/P whipple & hepatorrhaphy

ADDITIONAL PAGES IN US

☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIM

D	8	9	10	11	12	13	14	1
E	16	17	18	19	20	21	22	2
N	24	01	02	03	04	05	06	0

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED.

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. 11 Yr. 06

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3 4 5
3NOV	(b)(6)	Vital Signs q 4 hr	07	(b)(6)
		(X) Cardiac monitor ( ) CVP q ___ hr	19	
3NOV		Activity: (X) HOB 30-45 deg (record degree & circle if contraindicated)	07 deg	
		( ) OOB BID ( ) Other: _____	19 deg	
3NOV		(X) I/O ~~q1hr~~ q3 (X) Foley to gravity	07	
			19	
3NOV		( ) NGT/OGT to: ( ) LCWS or ( ) LIWS	07	
	- - - - - -	(X) JP to: (X) bulb suction or ( ) Record output	19	
	- - - - - -	( ) Vascular checks q ___ hr	07	
	- - - - - -	( ) Neuro checks q ___ hr	19	
	- - - - - -	( ) Spinal precautions with ( ) C-Collar	07	
	- - - - - -	( ) Logroll	19	
	- - - - - -	( ) Soft limb restraints for personal	07	
	- - - - - -	protection	19	
	- - - - - -	( ) Change dressing _____	07	
	- - - - - -	( ) Clean pins BID (1/2 H202 & 1/2 NS)	19	
	- - - - - -	( ) Chest tube to ( ) 20cm suction ( ) H20 seal	07	
	- - - - - -		19	
	- - - - - -	( ) SCD to _____	07	
	- - - - - -		19	
3NOV	(b)(6)	(X) Incentive spirometry q1hr while awake	07	(b)(6)
		(X) Cough & deep breath q1hr while awake	19	
3NOV		Diet: (X) NPO ( ) Clear ( ) Regular	07	
		( ) Advance as tolerated ( ) _____	19	
3NOV		(X) CBC ( ) Chem10 (X) Coags q am	05	
	- - - - - -	( ) ABG qam on all vented patients	05	
	- - - - - -	( ) RAD: CXR qam	05	

ALLERGIES: ☐ YES ☐ NO

Unknown

PRIMARY DIAGNOSIS: cond: Stable

dp whipple @ hepatorrhaphy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDICAL RECORD - PROVIDER ORDERS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Or completed during the shift in which they are written will be signed off adjacent to the order and do not require recopying on other IT

DATE/ TIME	ORDERS (SIGNATURE REQUIRED FOR EACH ORDER/SET OF ORDERS. SIGNATURE MUST BE LEGIBLE; PROVIDER WILL USE SIGNATURE STAMP OR PRINT
	TRAUMA ADMISSION ORDERS (2 OF 2)
	13. IV fluids: X LR@125 ml/hr; ____NS@____ml/hr; ____@____ml/hr
	Medications:
	14. ____Midazolam drip, titrate to SAS 3-4, ____Propofol drip, titrate to SAS 3-4
	____For acute agitation, may give ____midazolam 2-5mg IVP q 5min until sedation achieved
	15. ____Fentanyl drip, titrate for pain (max 300mcg/hr), ____Morphine drip, titrate for pain (max 4mg/hr)
	____For acute pain, may give ____fentanyl 25-100mcg slow IVP q 5min or X morphine sulfate 2-5mg IV
	until pain controlled
	16. ____Norepinephrine drip, titrate to MAP of 60 (max 25mcg/hr)
	____Vasopressin drip 2.4 units/hr (do not titrate)
	____Dopamine drip, titrate to MAP of 60 (max 30mcg/kg/min)
	____Phenylephrine drip, titrate to MAP of 60 (max 300mcg/min)
	17. ____Albuterol Nebs 0.5/2.5ml TID
	18. X Pantoprazole 40 mg IV qd; ____Ranitidine 50mg IV q8hr; ____Carafate 1gm PO/NGT qid
	____Colace 100mg PO/NGT bid; ____Dulcolax 5mg PO/PR qd prn; ____MOM 30ml PO/NGT q8
	19. ____Ancef ____gm IV q8hr; ____Levoflaxacin ____mg IV qd X Ampicillin/Sulbactam 3 mg
	20. ____Heparin 5,000 units SQ bid; X Enoxaparin 30 mg SQ bid
	21. ____Phenergan 25mg IV q6hr prn; ____Zofran 4mg IV q4hr PRN (for nausea and vomiting)
	22. ____Tylenol ____mg/gm PO/OGT/PR q____hrs prn for fever/pain
	23. Electrolyte replacement:
	____For K<4 and Phos >2.5, give 40meq KCL IV in 100ml NS IV over 4hr(250ml NS if no central venous
	____For K<4 and Phos<2.5, give 30mmol Kphos in 100ml NS IV over 4 hrs (250ml NS if no central venou
	____For K>4 and Phos <2.5, give 30mmol NaPhos IV
	____For Mg<2, give 2gm Magnesium Sulfate IV in 100ml NS (250ml NS over 4hr if no central venous acc
	____For Mg<1.5, give 4gm Magnesium Sulfate IV (May add Magnesium to other electrolytes to limit fluid
	24. ____Chlorhexidine Oral Rinse/Swabs PO q6hr (swish and spit/suction)
Chauvin	(b)(6) (b)(6)

PATIENT IDENTIFICATION *(For typed or written entries note: Name - last, first, middle initial; grade; DOB; hospital or medical facility)*

(b)(6)

Complete the following information on page 1 of provided only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight (lbs): _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page
			134

MEDCOM FORM 688-B (TEST) (MCHO-CL-M) JUN 03 PREVIOUS EDITIONS ARE OBSOLETE

EXHIBIT 9

MEDICAL RECORD - PROVIDER ORDERS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Orders completed during the shift in which they are written will be signed off adjacent to the order and do not require recopying on other ITR forr

DATE/ TIME	ORDERS (SIGNATURE REQUIRED FOR EACH ORDER/SET OF ORDERS. SIGNATURE MUST BE LEGIBLE: PROVIDER WILL USE SIGNATURE STAMP OR PRINT NAME)
	TRAUMA ADMISSION ORDERS (2 OF 2)
—	13. IV fluids: X LR@125 ml/hr; _____NS@____ml/hr; _____@____ml/hr
	Medications:
	14. _____Midazolam drip, titrate to SAS 3-4, _____Propofol drip, titrate to SAS 3-4
	____For acute agitation, may give ____midazolam 2-5mg IVP q 5min until sedation achieved
	15. _____Fentanyl drip, titrate for pain (max 300mcg/hr), _____Morphine drip, titrate for pain (max 4mg/hr)
—	X For acute pain, may give X fentanyl 25-100mcg slow IVP q 5min or X morphine sulfate 2-5mg IVP q6
	until pain controlled
	16. _____Norepinephrine drip, titrate to MAP of 60 (max 25mcg/hr)
	_____Vasopressin drip 2.4 units/hr (do not titrate)
	_____Dopamine drip, titrate to MAP of 60 (max 30mcg/kg/min)
	_____Phenylephrine drip, titrate to MAP of 60 (max 300mcg/min)
	17. _____Albuterol Nebs 0.5/2.5ml TID
—	18. X Pantoprazole 40 mg IV qd; _____Ranitidine 50mg IV q8hr; _____Carafate 1gm PO/NGT qid
	_____Colace 100mg PO/NGT bid; _____Dulcolax 5mg PO/PR qd prn; _____MOM 30ml PO/NGT q8hr prn
4	19. _____Ancef____gm IV q8hr; _____Levoflaxacin____mg IV qd X Ampicillin/Sulbactam 3 mg IVq6
	20. _____Heparin 5,000 units SQ bid; — Enoxaparin 30 mg SQ bid start tomorrow
—	21. X Phenergan 25mg IV q6hr prn; — X Zofran 4mg IV q4hr PRN (for nausea and vomiting)
	22. _____Tylenol ____mg/gm PO/OGT/PR q____hrs prn for fever/pain — X No Tylenol
	23. Electrolyte replacement:
—	____For K<4 and Phos >2.5, give 40meq KCL IV in 100ml NS IV over 4hr(250ml NS if no central venous access
—	____For K<4 and Phos<2.5, give 30mmol Kphos in 100ml NS IV over 4 hrs (250ml NS if no central venous acce
—	____For K>4 and Phos <2.5, give 30mmol NaPhos IV
—	____For Mg<2, give 2gm Magnesium Sulfate IV in 100ml NS (250ml NS over 4hr if no central venous access)
—	____For Mg<1.5, give 4gm Magnesium Sulfate IV (May add Magnesium to other electrolytes to limit fluid volun
	24. ____Chlorhexidine Oral Rinse/Swabs PO q6hr (swish and spit/suction)

Mute 2ND 10

24 Chad V 11/2

(b)(6)

(b)(6)

PATIENT IDENTIFICATION *(For typed or written entries note: Name - last, st, middle initial; grade; DOB; hospital or medical facility)*

(b)(6)

Complete the following information on page 1 of provided orders only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight (lbs): _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.

EDCOM FORM 688-R (TEST) (MCHO)JUN 03 PREVIOUS EDITIONS ARE OBSOLETE MC V2.00

EXHIBIT 9

MEDICAL RECORD - PROVIDER ORDERS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Orders completed during the shift in which they are written will be signed off adjacent to the order and do not require recopying on other ITR for

DATE/ TIME	ORDERS 0124 06 CID 789 78479 (SIGNATURE REQUIRED FOR EACH ORDER/SET OF ORDERS. SIGNATURE MUST BE LEGIBLE; PROVIDER WILL USE SIGNATURE STAMP OR PRINT NAME)
	TRAUMA ADMISSION ORDERS (1 OF 2)
✓	1. Admit/Trasnfer to ICU (1 or 2) or SDU ✓ Physician: (b)(6)
✓	2. Diagnosis: SIP GSW to Abd, Hepatorrhaphy, Whipple, Gastrobe, J-tube, ~~Gastrobe~~ Jejunostomy
✓	3. Condition: ___ Critical ___X Stable Status ___ (ie. US military, host nation, Coalition,
✓	4. Vital Signs:q ___ hrs; ___X Cardiac Monitor; ___X CVP q1hr
✓	5. Activity: ___X Bedrest: HOB to 30-45 deg / ___ OOB BID / ___ Other: ___
✓	6. Allergies: Unknown or NKDA or ___
	7. NURSING
✓	7.1 ___X Accurate I/O ___X Foley to gravity
	7.2 ~~___ NGT/OGT to LCWS/LIS~~; ___X JP to bulb suction; ✓ G-tube to Gravity
	7.3 ___ Vascular checks q1hr ___ Neuro checks q1hr ✓ J-tube to Gravity
✓	7.4 ___ Spinal Precautions with ___ c-collar; ___ logroll
✓	7.5 ___X Soft limb restraints for personal protection
	7.6 Dressings: ___ Change dressing ___; ___ Clean pins BID (use 1/2 peroxide & 1/2 N
	___ Reinforce dressing PRN; ✓ Do Not Change Dressing Unless Surgeon Removes on POD #2
	7.7 ___ Chest Tube to ___ 20cm suction/___ H20 seal
✓	7.8 ___X Sequential Compression Devices (SCD's) to lower extremities
	7.9 ___ Ventilator settings per physician, anesthesia, respiratory therapy
✓	7.10 ___X Oxygen titrate to maintain SaO2 greater than 93% (Decrease FiO2 by 10% q10 min to minimun 30%)
✓	7.11 ___X Incentive spirometry q1hr while awake; ___X Deep breath and cough q1hr while awake
✓	8. Diet: NPO/Clear/Regular/Advance as tolerated/ ✓ ✓ X2 not on
✓	9. Labs: ___X CBC, Chem 10, and coags on arrival and/or ___X qam ___ q8hr ___ q12h (b)(6) 02NOV06@0
✓	___X ABG (iSTAT EG7+ ABG/Hgb/Ca++) on arrival and q am on all ventilated patients
✓	10. Radiology: ___X CXR ___X on arrival, and ___ qam
	11. ___X Call MD if Temp > ___ F, P< ___ or > ___, SaO2 < ___%, MAP< ___; ICP> ___;I/O < ___ml/hr x 2hr
	12. Hold all continuous IV sedation and analgesia at 0600 until SAS is = or > 4. If further sedation/analgesia is indicated , start at 1/2 prior rate and titrate to SAS 3-4.

CONTINUE

PATIENT IDENTIFICATION *(For typed or written entries note: Name - last, first, middle initial; grade; DOB; hospital or medical facility)*

(b)(6)

Complete the following information on page 1 of provided orders only. Note any changes on subsequent pages.

Diagnosis: ___

Height: ___ Weight (lbs): ___ Diet: ___

Allergies: ___

Nursing Unit	Room No.	Bed No.	Page No.

(b)(6)

(b)(6) 11/8/06

	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600
GCS	15	15				15				15		
SAS	4	4				4				4		
TEMP	99.2	99.2				101.5	100.7			100.8		
NIBP	114/62	114/62				122/68				117/70		
A-LINE	X	X				X				X		
MAP	80	80				86				88		
HR	98	98				105				91		
SaO2	91% RA	100% 2L				100% 2L				97% 1L		
RR	20	12				16				⊓		
INPUT												
IVF/LR	125	125	125	125	90	90	30	90	90	90	90	90
IVPB						100						100
PO/(TF)	20	40	40	40	40	20	20	20	20	20	10	20
TOTAL	145	310	475	640	770	980	1030	1140	1250	1360	1460	1670
OUTPUT												
URINE	500	180				320		320		220		270
NGT/OGT												
STOOL												
JP#1		10				10		5		5		10
JP#2		20				10		5		5		5
G-tube		75				50		50		0		25
TOTAL	500	785				1175		1555		1785		2095

COMMENTS

1930 - two abd JP drains ō drain #1 ō serosanguinous drainage + JP #2 ō sanguinous drainage. D/d JP dressings due to sanguinous drainage saturated dressing. Incarcased TF promod to 40cc/hr per MD order. Pt has productive cough. Pt restrained x 3 ext. Pulses normal. Will cont. to monitor. (b)(6)

2310 - administered Albuterol 2.5mg neb to pt. HR 112/108 RR 12/17 B.S. mildly coarse bilaterally ↑ O2 productive cough (b)(6)

2400 - Pt coarse (B) lat. ↑ neb tx. Productive brown tinged cough. Stopped MIVF for 40min. Will reassess + restart. Pt also c/o abd pain. Abd distended. Gave 3mg morphine for pain + ↓ed ~~MIVF~~ TF to 20cc/hr Pt temp ↑ 101.5. Will reassess. (b)(6)

0100 - lungs fields clear on left + slightly coarse on right. Restart IVF @ current rate + temp ↓ 100.7. (b)(6)

0510 2.5mg Alb Neb given to pt. RR 12/16 HR 85/100 B.S. rhonchi (B) ō tx to cleared ↑ tx and good productive cough. (b)(6)

12 HOUR INPUT: 1670

12 HOUR OUTPUT: 2095

-425

24 HOUR INPUT:

24 HOUR OUTPUT:

(b)(6)

					100.0				100.1				Incision Morphine IV IM given Abd dsg open to air drainage tube dressed + gauze OOB to chair tolerated 45 min. — (b)(6)
NIBP	119/61				113/57				118/65				
A-LINE													
MAP	82				78				84				
HR	111				123				100				
RR	15				16								
SaO2	99%				99%				90				
	2L NC				2L NC				4L NC				
INPUT													
IVF LR	125	125	125	125	125	125	125	125	125	125	125	125	
IVPB												100	
~~PO~~/TF Pram	20	20	20	20	20	20	20	20	20	20	20	20	
KCl+Mg	100												
TOTAL												1940	
OUTPUT													
URINE	186		200		140		200	200					
~~NGT/OGT~~													
STOOL													
JP#1	3		5		5		10						
JP#2	10		10		10		10	10					
G Tube	3		~~10~~		~~20~~		~~25~~	5 ~~10~~					
TOTAL	196		421		596		841	1056					

12 HOUR INPUT: 1940

12 OUTPUT: 1056

+884

(b)(6)

28th CSH PHYSICIAN TRAUMA ADMITTING RECORD (THEATER HOSPITAL CARE)

		OBTAINED	PENDING	RESULTS
X RAYS	CT	☐ HEAD ☐ C-SPINE ☐ ABD/PELVIS ☐ CHEST		0124 06 CID789 78479
	CXR	☐ SUPINE ☐ UP RIGHT ☐ _____		
	OTHER	☐ C-SPINE ☐ PELVIS ☐ LLE ☐ RLE ☐ RUE ☐ LUE ☐ _____ ☐ _____		

IMPRESSION:

DIAGNOSIS

1 GSW Abdomen

2

3

4

6

PLAN:

EVACUATED TO/DISPOSITION

☑ Admit to OR, ICU, ICW _____

☐ Evac to: Definitive Care, HN, Coalition

EVAC PRIORITY
☐ Routine
☐ Priority
☐ Urgent

☐ RTD Unit _____

☐ Deceased (see below)

Time of disposition: _____

TRIAD INDICATORS

Damage Control:	☐ yes	☐ no
Hypothermia:	☐ yes	☐ no
Coagulopathy:	☐ yes	☐ no
Shock:	☐ yes	☐ no

Class of Hemorrhage ☐ I ☐ II ☐ III ☐ IV

Shock ☐ Yes ☐ No

DNBI CATEGORY

☐ Cardiac	☐ GI	☐ Injury, MV
☐ Dermatologic	☐ Heat/Cold	☐ Injury, Wo
☐ Endocrine	☐ Infectious Dz	☐ Injury, Oth
☐ FUO	☐ Injury, Sports	☐ Neurologic

☐ Psychiatric, Stress
☐ Pulmonary
☐ STDs
☐ All Other Medical/Surgical
☐ _____
☐ _____
☐ _____
☐ _____

ATTENDING STAFF

Physician Signature: (b)(6)

Physician Printed or Typed Name: (b)(6)

CAUSE OF DEATH

Anatomic:
☐ Airway ☐ Chest ☐ Extremity U / L
☐ Head ☐ Pelvis ☐ Other, specify
☐ Neck ☐ Abdomen

Physiologic:
☐ MOF ☐ Hemorrhage ☐ Other
☐ CNS ☐ Total Body Disruption
☐ Sepsis ☐ Breathing

PATIENT ID/SSN

Last First MI MTF

(b)(6)

SSN/ID/Trauma No. DOB/AGE DATE: (dd,mm,yy)

ASD(HA) July 2005 8 28th CSH, Baghdad, Iraq

EXHIBIT 9

PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; MANUFACTURER

0124 06 CID789 78479

MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

ICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

JND IRRIGATION ☐ YES ☐ NO, TYPE(S): NS 0.9%

ER ORDERS	TIME	CARRIED OUT BY
>LEY TO GRAVITY		(b)(6)

SICIAN'S SIGNATURE

X-RAY IN OPERATING ROOM
/ES ☐ NO ☑ IF YES, SITE

LABORATORY SPECIMENS

CIMEN (S) ☐ NO ☑	NAME	NAME
ZEN SECTION (FS) ☐ NO ☑	NAME	NAME
TURE (C) ☐ NO ☑	NAME	NAME
E	NAME	NAME
E	NAME	18. DRESSING/IMMOBILIZATION *(Specify)*

TUBES, DRAINS/PACKING YES ☑ NO ☐

/SIZE	1.	2.	3.
	1. Foley 16Fr	2.	3.
	1. bladder	2.	3.

18. XERO Form
ABD'S
4'x4
~~XERO~~ MEDIPORE TAPE

ADDITIONAL INFORMATION

Drg: (b)(6)

Res: (b)(6)

OPERATION(S) PERFORMED
1) ~~Resection~~ in bowel ~~repair~~
2) liver repair
3) right kidney repair
4) Whipple procedure
5) G-TUBE
6) J-TUBE
7) J.P DRAIN x 2

PATIENT TRANSFERRED TO	TIME	METHOD
~~ACCESS~~ ICU	see 7389	bed c propofol and O_2

REGISTERED NURSE SIGNATURE
(b)(6)

0124 06 CID 769 78479

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)													
Sux (mg)		100											
Amidate (mg)		70											
VEC (mg)		5		5				3				2	
Fent mcg				50	50				50			50	
( )													
( )													
VOLAT AGENT 5 % del		2	1.5	1.2	1.2	1.3	1.3	1.3	1.5	1.5	1.5	1.2	1.2
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min		2	2	2	2	2	2	2	2	2	2	2	2

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →

FLUIDS

LINE site	☐ Warmed			PRBC (1)									
	☐ Warmed							FFP (1)	(2)				
Cordis	☒ Warmed	LR		(FL)									
	☐ Warmed							PLATELETS					1

LOSSES

EST BLOOD LOSS		50			400 ml					500 ml			
URINE -					100 ml (3rd)					350 ml			

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 65 KG / LB

HEMATOCRIT: 36

INITIAL DATA:

BP- 122/73

HR- 104

EQUIP CHECK

OK?- Y N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME-

TIME → 1500 . 30 . 1600 . 30 . 1700 . 30

SYMBOLS:

BP by cuff: V ^

Heart rate: ●

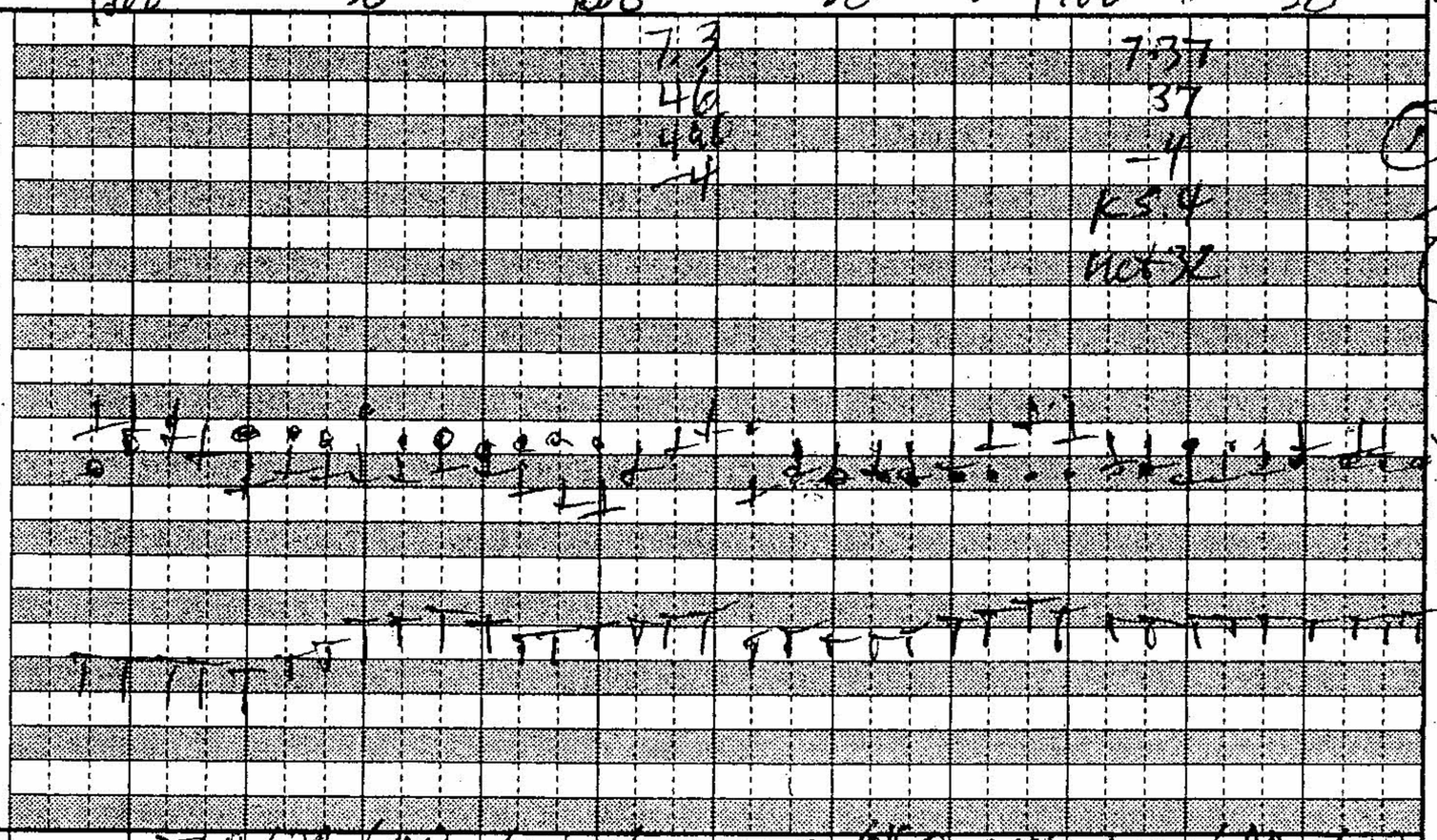
Resp rate

BR (transduced): ═

TOURNIQUET: T—T

ANES- X-X

PROC- ⊙-∅



VENTIL

VT - ml			500	600	600	600	600	600	640	640	600	600	600
f - breaths/min		12	9	9	9	9	11	12	14	14	14	12	12
Peak inf pres / PEEP			23	21	24	29	24	24	24	24	24	24	22
MODE - S(pon), A(ssist), C(on)		S	C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		30	31	35	35	35	35	33	32	30	31	31
BP/oth	FIO2 (Frac or %)		77	76	76	76	77	77	78	77	77	77	78
ART line	SpO2 (%)		100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	ST	ST	ST	ST	ST	ST	ST	SR	SR	SR	SR
Gas analyzer	TEMP-site												
	N-M Block (T/4)		96.6	96.6	9		96.9		97.1	97.2	97.3	97.8	
Warming blkt													
Conv warmer													

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Asepsis (1) (2)

TOTALS — TOTA ~18 — TOTAL 91

FLUIDS - SUMM

CRYSTALLOID- NS/LR - 3

COLLOID- FFP x 4

BLOOD- RBC x 5

REMARKS

Code drugs with nur events with lettters

1500 7.366

-2,

Ca 1.03

Hb: 12.2

(1) NG placed Suction

(2) Tgr-Ca

RECOVERY AT 2

PACU ICU

OTHER TO 99.

CONDITION: extub

RESP- 16 SpO2-

BP- 150/80 HR- 1

ANESTHESIA / PROCI TIMES

	Start	Room
ANES	1425	1435
PROC	Ready	Begin
	1445	1502

PROCEDURES and CPT Codes:

Ex Lap - duodenal repair, liver laceration repair

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

(b)(6)

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA - RSI - DLXT 3 MILLER Gr I 8.0 CC 23

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

(3) BSC + ETCO2 - Eye wrapped.

SURGEONS: (b)(6) (b)(6)

ANESTHETISTS: (b)(6)

PROCEDURE LOCATION: 1 A

DATE: 1 Nov 9

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DA FORM 5538, DEC 1998 — FOR OFFICIAL USE ONLY — LAW ENFORCEMENT SENSITIVE — PROVIDER — USAP

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)						TOTALS
FENTANYL (mcg)						750
Morphine (mg)	4		6			20mg
propofol (mg)			100	50		
( )						
( )						
( )						
VOLAT AGENT SEVO % del	1.5	1.5	1.5	.4 X		
% e.t.						
AIR L/Min						
N2O L/Min						
O2 L/Min	2	2	2	2	2	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTA

TOTAL

FLUIDS - SUMM

CRYSTALLOID- 325

COLLOID-

BLOOD-

FLUIDS

LINE site Colois/18g(L)A/C ☒ Warmed (circled)

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES

EST BLOOD LOSS	<1800>		
URINE -			<900>

REMARKS

Code drugs with num... events with lettters

2045 - Continuous o...

@ 2045 ———

2210 - pt to IC...

Report given - pt ...

Escalator to ICU

STABLE ———

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG LB

HEMATOCRIT:

INITIAL DATA: BP- / HR-

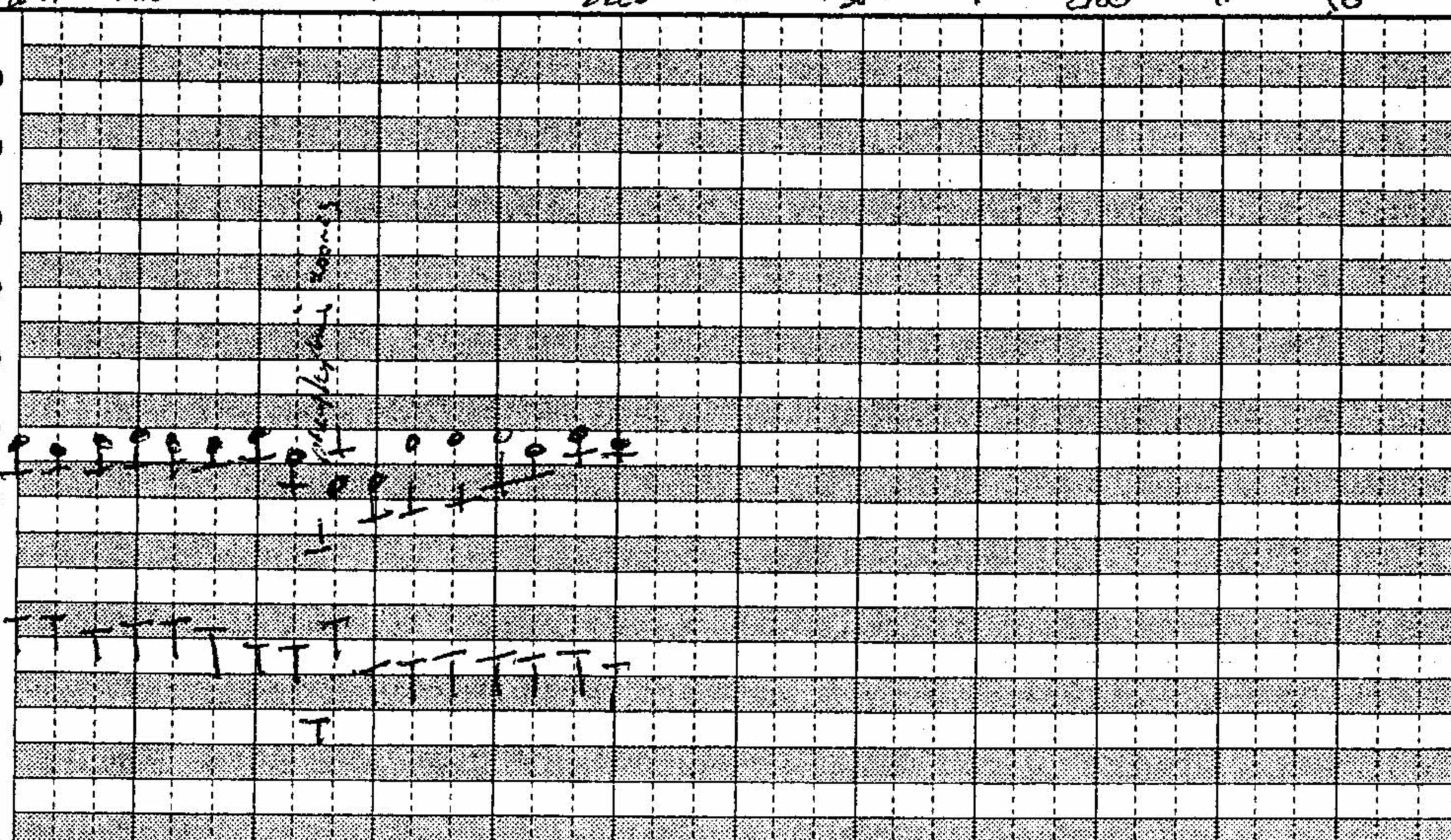
EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME → 2045 2100 • 30 • 2200 • 30 • 2300 • 10

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø

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



VENTIL

VT - ml	640	620	620	600	340
f - breaths/min	10	10	8	6	6-10
Peak inf pres / PEEP	23/4	21/4	22/4	23/4	
MODE - S(pon), A(ssist), C(on)	VC	VC	VC	VC	SV

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	34	33	37	40	49
BP/oth	X FIO2 (Frac or %)	.77	78	.78	.70	.79
X ART line	X SpO2 (%)	100	100	100	100	99
Steth- PC/ES	X ECG	ST	ST	ST	ST	ST
X Gas analyzer	X TEMP-site (EK)	99.0	99.1	99.1	99.2	
X HME	N-M Block (T/4)					
Warming blkt						
Conv warmer	X UBBH	———→ 2210				

Mark with letters & symbols, explain under REMARKS EVENTS Position → OR/ICU ... Arm restraints ... pads

RECOVERY AT: PACU ICU ____ OTHER ____

CONDITION: RESP- SpO2- BP- HR-

ANESTHESIA / PROC TIMES

	Start	Room
ANES		
	Ready	Begin
PROC		

PROCEDURES and CPT Codes: EX LAP (Small Bowel resection / Whipple / Duodenal repair / Liver / (R) Kidney repair)

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — SEE PG. 1

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

(b)(6)

SURGEONS: (b)(6)

ANESTHETISTS: (b)(6)

PROCEDURE LOCATION: IA H...

DATE: 1 Nov 06

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9

13. PROSTHESIS, MPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

0124 06 CID 789 78479

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NACL 0.9% qs

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE N/A

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

	1.	2.	3.
TYPE/SIZE	* NO additional Tubes or Drains		
SITE	this procedure.		

4x4s
ABD
Medipore tape

19. ADDITIONAL INFORMATION

Surgeon: (b)(6)

Anesth: (b)(6)

20. OPERATION(S PERFORMED (1) RE-EX LAP
(2) Removal of Retained LAP Sponge

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU I	See PA 7389	Bed c SR↑ x 2

22. REGISTERED NURSE SIGNATURE (b)(6)

REVERSE OF DA FORM 5179-1, OCT 87

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LAW ENFORCEMENT SENSITIVE

143 PA V1

EXHIBIT 9

(b)(6)	11/3/2006 10:34:27 AM	tolerated. Recommend promote, as this has MCT oil and therefor will not require pancreatic involvement for digestion. Additionally promote is high protein, lower fat and carbohydrate formula. Feeding at 20mL per hour will supply 30g protein and 480kcals per day. Goal rate to achieve estimated needs is 82mL per hour which will provide 1968kcals and 123 grams of protein, protein will exceed patients needs so may need to switch formulas as patient progresses. M: Tolerance of feeding and achieving optimal nutrition will be the primary monitor for this patient. E: Will continue to follow via am rounds.	28TH CSH SOUTH BAGHDAD

STATUS	LOCATION	DATE	FACILITY	AUTHOR
INPATIENT	ICU-icu1	11/1/2006	28TH CSH SOUTH - BAGHDAD	(b)(6)
INPATIENT	ICU-SDU	11/3/2006	28TH CSH SOUTH - BAGHDAD	

0124 06 CID 789 78479

View or Add Attached Files - 0 Current

Patient Transport History

EXHIBIT 9

0124 06 CID 789 78479

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) (yyyymmdd): 19980308

SHIFT ASSESSMENT

	ROS	TIME 1600 INITIALS (b)(6)	TIME	INITIALS
N E U R O	Pupils	eyes covered SI		
	Sensorium/LOC	A+O×3		
	Motor/Sensory	moves all extremities		
	Sedation	none		
	Pain Control	denies pain at this time		
R E S P	Airway	open, patent		
	Respirations	normal, reg, unlabored		
	Breath Sounds	clear t/o		
	Oxygenation/Ventilation	2LNC Sats 100%		
	Ventilator Settings	N/A		
	Secretions	moist cough		
C V	Heart Rate/Rhythm	NSR, no ectopy		
	Pulses/Capillary Refill	diminished dist, <3sec		
	Edema	none		
	Hemo Monitoring	Ø		
G I	Abdomen	bulky dressing to abd unable to assess		
	Bowel Sounds			
	NGT/OGT	Ø		
	Incisions/Stomas	midline abd c bulky dressing		
	Drains	JP×2 abd, J tube & TF, G tube to gravity		
G U	Voiding/Foley	foley to gravity		
	Color/Clarity	WNL		
S K I N	Color/Temperature	WFR, warm, dry		
	Integrity	duoderm to small wound on back		
A C C E S S	#1: Type/Location/Size/	RIJ triple lumen		
	Dressing/IV Fluid/Rate	opsite, LR@125ml/hr		
	#2: Type/Location/Size/			
	Dressing/IV Fluid/Rate			
	#3: Type/Location/Size/			
	Dressing/IV Fluid/Rate			

PREPARED BY (*Signature & Title*): (b)(6)

DEPARTMENT/SERVICE/CLINIC: ICU, 86th CSH, Baghdad, Iraq

DATE (YYYYMMDD): 3NOV06

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

Name: (b)(6)

Rank: Age:

Unit:

Gender:

Status: US: AD/CIV Coalition Iraq: CIV / ING / POLICE / SI

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION ☐ OTHER (*Specify*)

☐ DIAGNOSTIC STUDIES

DA FORM 4700, FEB 2003 EDITION OF MAY 78 IS OBSOLETE

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 145 9

0124 06 CID789 78479

PATIENT ID

DATE

TOTAL INTAKE

(b)(6)

(b)(6)

(b)(6)

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. 11 Y

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRAT

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2 3
2NOV	(b)(6)	IVF: LR @ 125 ml/hr	07	(b)(6)
			19	(b)(6)
2NOV	(b)(6)	Oxygen: Titrate to maintain SaO2> 93%	07	(b)(6)
		(Decrease FiO2 by 10% q10min to 30% FiO2 minimum)	19	(b)(6)
		( )Midazolam ( )Propofol drip	07	
		Titrate to SAS 3-4	19	
		( )Fentanyl drip (max 300mcg/hr)	07	
		( )Morphine drip (max 4mg/hr)	19	
		( )Albuterol Nebs 0.5/2.5ml TID	07	
			15	
			23	
2NOV	(b)(6)	(X)Pantoprazole 40 mg IV qd	10	(b)(6)
		( )Ranitidine 50mg IV q8hr		
		( )Carafate 1gm PO/NGT qid		
		( )Colace 100mg PO/NGT bid	08	
			20	
		( )Ancef ____gm IV q8hr	06	(b)(6)
		( )Levoflaxacin ____mg IV qd	12	(b)(6)
2NOV	(b)(6)	(X)Ampicillin/Sublactam 3 mg IV q6hr	18	(b)(6)
			24	
		~~( )Heparin 5,000units SQ BID~~	08	(b)(6)
2NOV	(b)(6)	(X)Enoxaparin ____mg SQ BID start tomorrow 5/11/3	20	(b)(6)
		Chlorhexidine Oral Rinse/swabs PO BID	08	
		(swish and spit/suction)	20	
		NO	07	(b)(6)
2NOV	(b)(6)	TYLENOL	19	(b)(6)

ALLERGIES: ☐ YES ☐ NO

Unknown

PRIMARY DIAGNOSIS: Cond-Stable

s/p whipple, hepatorhaphy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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USAP, PAGE 9

28TH COMBAT SUPPORT HOSPITAL 04 Nov 2006@0608 Pa

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

PATIENT LAB INQUIRY

For: 03 Nov 06 - 04 Nov 06

Report requested by: (b)(6) 0124 06 CID789 78479

UNKNOWN,UNKNOWN (b)(6) M/93 Reg #: 81

Ph: Military Unit: UNKN

---

04 Nov 06 @ 0545 (Coll) SEI

ASAP PROTEIN TOTAL	4.1	L	(6.3-8.2)	g/dL
ALBUMIN	2.1	L	(3.5-5.5)	g/dL
ALK PHOS	43		(38-126)	U/L
AST	227	H	(15-46)	U/L
ALT	287	H	(11-66)	U/L
GGT	21		(12-58)	
TBILI	3.2	H*	(.2-1.3)	mg/dL

Result Comment: INFORMED CPT TO OF RESULTS AT 0448

AMYLASE	297	H	(30-110)	U/L
K	3.8			mmol/L
CL-	99		(98-107)	mmol/L
MG	TNP			
CO2	26		(22-30)	mmol/L
GLUCOSE	109		(75-110)	mg/dl
BUN	12		(9-20)	mg/dL
CREAT	1.2		(0.8-1.5)	mg/dL
CA	TNP		(8.4-10.2)	mg/dL
PHOSPHORUS	TNP			mg/dL
NA+	134	L	(135-145)	mmol/L
LIPASE	TNP		(23-300)	U/L

04 Nov 06 @ 0545 (Coll) PLA

ASAP PT	7.0	L	(9-12)	sec
APTT	TNP		(25-33)	sec
INR	<.8		(1 B unit)	B unit

Interpretations:
B unit

04 Nov 06 @ 0545 (Coll) BL

ASAP WBC	8.4		(4.5-10.5)	x10 3/uL
RBC CNT	2.91	L	(4.0-6.0)	x10 6/uL
HGB	8.1	L	(11-18)	g/dL
HCT	25.7	L	(35-60)	%
MCV	88.2		(80.0-99.9)	fl
MCH	28.0		(27.0-32.0)	pg
MCHC	31.7	L	(33.0-37.0)	g/dL
PLATELETS	180		(150-450)	x 10 3/uL
LYMPHS/100 WBC	9.7			
LYMPH#	0.8	L	(1.2-3.4)	x10 3/uL

==========

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

==========

0124 06 CID789 78479

CLINICAL RECORD

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

Mo. 11 Yr. 06

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23
3 Nov 06	(b)(6)	trickle feed Promote	07	(b)(6)
		at 10-20mL as	19	
		tolerated		

ALLERGIES: ☐ YES ☐ NO
Unknown

PRIMARY DIAGNOSIS:
s/p whipple, hepatorrhaphy

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

PATIENT IDENTIFICATION:
(b)(6)

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

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Mo. 11 Yr

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2 3
2NOV	(b)(6)	G tube & J tube to gravity	07 19	(b)(6) (b)(6)
3NOV	(b)(6)	LFT's Amylase and Lipase q am	05	(b)(6)

ALLERGIES: ☐ YES ☐ NO — Unknown

PRIMARY DIAGNOSIS: s/p whipple, hepatorhaphy

ADDITIONAL PAGES IN US: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: (b)(6)

ACTION TIMES

USE PENCIL. CIRCLE ACTION TI

D	8	9	10	11	12	13	14	1
E	16	17	18	19	20	21	22	
N	24	01	02	03	04	05	06	

150

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CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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Mo. 11 Yr. 06

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 23 NOV 06 CID 78979 78479
2NOV	(b)(6)	Vital Signs q 1 hr	07	(b)(6)
		(X) Cardiac monitor ( ) CVP q ___ hr	19	
		Activity: (X) HOB 30-45 deg Bed Rest (record degree & circle if contraindicated)	07 deg	
		( ) OOB BID ( ) Other: _____	19 deg	
2NOV	(b)(6)	(X) I/O q1hr (X) Foley to gravity	07	
			19	
		( ) NGT/OGT to: ( ) LCWS or ( ) LIWS	07	
2Nov		(X) JP to: (X) bulb suction or ( ) _____	19	
		( ) Vascular checks q ___ hr	07	
		( ) Neuro checks q ___ hr	19	
		( ) Spinal precautions with ( ) C-Collar	07	
		( ) Logroll	19	
2NOV	(b)(6)	(X) Soft limb restraints for personal protection	07 / 19	(b)(6) / (b)(6)
2NOV	(b)(6)	( ) Change dressing Dont Dressing until 11/4	07	(b)(6)
		( ) Clean pins BID(1/2 H202 & 1/2 NS)	19	(b)(6)
		( ) Chest tube to ( ) 20cm suction ( ) H20 seal	07	
			19	
		( ) SCD to _____	07	
			19	
2NOV	(b)(6)	(X) Incentive spirometry q1hr while awake	07	(b)(6)
		(X) Cough & deep breath q1hr while awake	19	
2NOV		Diet: (X) NPO ( ) Clear ( ) Regular	07	
		( ) Advance as tolerated ( ) _____	19	
2NOV		(X) CBC (X) Chem10 (X) Coags qam	05	
		( ) ABG qam on all vented patients	05	/ /
		( ) RAD: CXR qam	05	/ /

ALLERGIES: ☐ YES ☐ NO

Unknown

PRIMARY DIAGNOSIS: Cond: Stable s/p Whipple, hepatorhaphy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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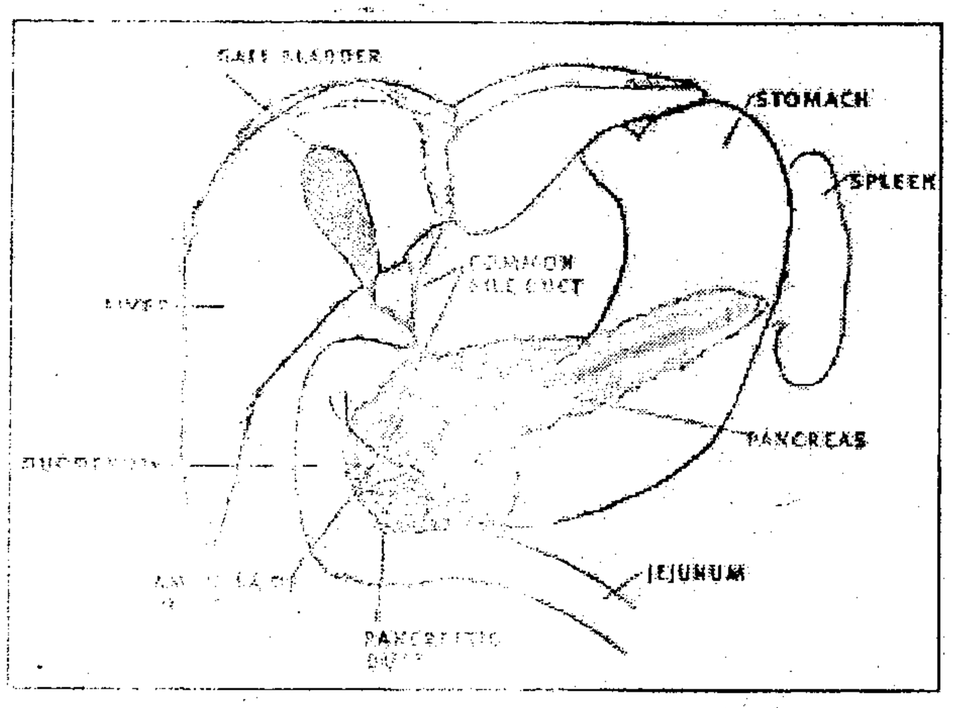
ABOUT THE PANCREAS

Structure

The pancreas is a gland of about six inches by two inches located in the back of your abdomen behind the stomach. The pancreas is divided in four parts: the head, the neck, the body, and the tail. The head lies surrounded by the first part of the small intestine called the duodenum. The body lies behind the stomach. The tail is on the left side next to your spleen. (see figure 1)



The pancreatic duct, which carries digestive enzymes, runs along the entire length of the pancreas. The enzymes empty into the duodenum through an opening called the Ampulla of Vater. The major bile ducts come out of the liver and join to form the common bile duct. The end of the common bile duct meets with the pancreatic duct at the Ampulla of Vater and empties bile into the duodenum. If a tumor develops in the head of the pancreas it can block the common bile duct and you will become jaundiced. Your skin and the white of your eyes might become yellow, your urine will become dark and your stool might become light in color.

Function

The pancreas secretes hormones and enzymes. Insulin and Glucagon are the pancreatic hormones, which regulate blood sugar level. Pancreatic enzymes help digesting food, especially fat. Removing part of your pancreas usually does not affect your blood sugar levels. It sometimes happens that the remaining pancreas does not make sufficient enzymes. In that case enzyme replacement can be taken as pills with every meal.

Gallbladder

THE OPERATION

Patients will stay an average of 8-10 days in hospital after pancreaticoduodenectomy. In order to remove a tumor in the head of the pancreas it is necessary to remove the head of the pancreas, the duodenum, the gallbladder and the end of the common bile duct. Sometimes, a part of the stomach is also removed. The end of your bile duct and the remaining pancreas are then connected to the small bowel to ensure flow of bile and enzymes into your intestines (see figure 3). The procedure takes between 4-7 hours.

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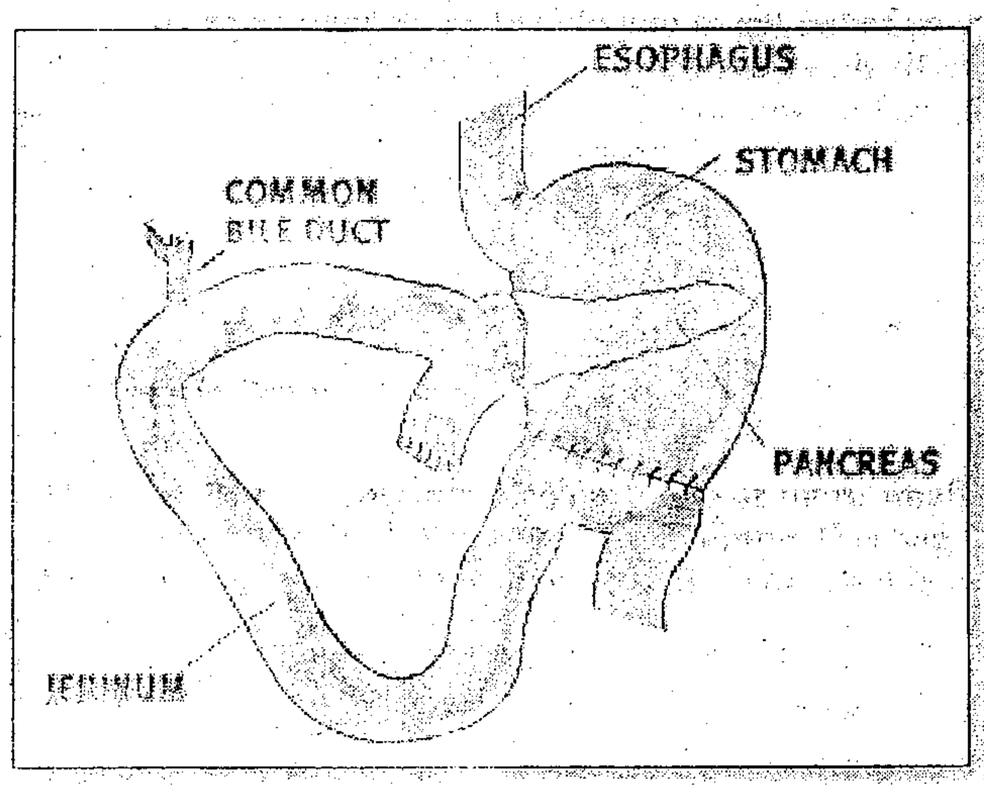

FIGURE 3

WHAT TO EXPECT AFTER SURGERY

Pain Control

On the first day after surgery, there is a moderate amount of discomfort at the site of the operation. Pain medication will be given either in the form of an epidural anesthesia which continuously infuses medication into your spine, or by a device called a Patient Controlled Analgesia (PCA) device until you are able to take pain medication by mouth. Your surgeon and anesthesiologist will determine which of these methods will be used. Your nurse will provide you with instructions on how to use the PCA pump, and will evaluate how effective it is in providing you with relief. Every effort will be made to minimize the discomfort and keep it bearable. Your physicians and nurses will be monitoring your level of pain control frequently.

Go to top

Eating

You will not have anything to eat or drink for the first several days after surgery. An intravenous infusion will provide you with the necessary fluids for healing. In some cases you will have a nasogastric tube (NG) in your nose which will remove the stomach contents until your stomach and intestines recover. A feeding tube also called a jejunostomy tube may be inserted to help with supplemental feeding after the surgery. Your surgeon will evaluate you each morning while in hospital, and let you know when you will be able to eat.

Go to top

Urinating/Bowel Movements

- Cloudy fluid coming from the wound
- Bright red blood or foul smelling discharge coming from the wound
- An increase in drainage from the wound

Go to top

DIET

As soon as your bowels have recovered from surgery and start working again you will be allowed to drink clear liquids. Your diet will then be gradually advanced to a regular diet. You might not be able to eat large portions of food right after surgery. We suggest you have 4-6 small meals a day. You can then increase the portions as your recovery progresses. Some patients might have difficulty digesting fat after this operation and may experience diarrhea. If this is the case your doctor can prescribe supplemental enzymes that will help digest the fat.

Go to top

DISCHARGE FROM THE HOSPITAL

You are ready for discharge once you tolerate a regular diet and have no signs of complications. Your doctor will give you discharge instructions and prescriptions for medications you might need.

Go to top

EXERCISE

Regular exercise is recommended and will help you regain strength. Initially you should have daily walks. Check with your doctor before you engage in more strenuous exercise. Walking upstairs is allowed right after discharge. You should avoid lifting items heavier than ten pounds for six weeks.

Go to top

FREQUENTLY ASKED QUESTIONS

Q: When can I drive again?
A: Usually three weeks after the operation. You can't drive as long as you are taking pain medications that could make you drowsy.

Q: When is my appetite going to be normal again?
A: It is normal to have a lack of appetite after the operation. Try to eat small amounts of your favorite foods frequently throughout the day. It will take some time to regain lost weight. The main goal is to have a balanced diet with adequate calories to prevent further weight loss and promote healing process. If you find it difficult to eat for lack of appetite you may try a supplement such as Ensure.

Q: How long am I going to be fatigued?
A: Extreme fatigue after this kind of surgery is normal and lasts for 6-8 weeks. You will gradually improve gradually over time. Try to get up get dressed and walk every day. You may rest during the day but stay out of bed as much as possible.

Go to top

CALL YOUR DOCTOR IF YOU HAVE

- Chills or fever of 101(F) 38(C) or higher
- Redness or drainage from your incision
- Nausea and/or vomiting
- Diarrhea
- Constipation for more than 3 days

Go to top

Return to Dr. Steer's Page

Our experience has been that patients who are diabetic at the time of surgery or who have an abnormal blood sugar level that is controlled on a diet prior to surgery have a high chance for the severity of the diabetes becoming worse after the surgery. On the other hand patients who have completely normal blood sugar prior to surgery with no history of diabetes and who have chronic pancreatitis have a low probability of developing diabetes after the Whipple operation.

What can I eat after the surgery?

There is no restriction of your diet after the operation. Some patients may not tolerate very sweet foods and may need to avoid this.

Will my life be altered very much after the Whipple operation? Will I be able to do all the things that I can do now

There is acceptable alteration of lifestyle after the Whipple operation. Most patients are able to go back to their normal functional levels.

Researchers at John Hopkins University mailed surveys to Whipple operation survivors who had been operated on at Hopkins between 1981 and 1997. The questionnaire was broken down into sections that looked at physical abilities, psychological issues and social issues; an additional section evaluated functional capabilities and disabilities. Scores were reported as a percentile, with 100 percent being the highest possible score. The same questionnaire was then sent to a group of healthy individuals and a group of patients who had laparoscopic gallbladder removal.

Responses from this study at Johns Hopkins were tallied from 188 Whipple survivors, 37 laparoscopic gallbladder surgery patients and 31 healthy individuals. Whipple survivors on average rated their physical quality of life a 79, compared with an 83 among laparoscopic surgery patients and an 86 among healthy people. For psychological issues, Whipple survivors rated their quality of life to be a 79, compared with an 82 for laparoscopic surgery patients and an 83 among healthy people. Looking at social issues, Whipple survivors ranked their quality of life at an 81, compared with an 84 among laparoscopic surgery patients and an 83 among healthy individuals. There were no statistical difference among the groups.

What are the complications that are likely to happen immediately after surgery for the Whipple operation?

The Whipple operation is a complex operation with a high chance of developing complications if the surgeon performing the surgical procedure has limited experience in this operation. In the hands of surgeons who are experienced with this surgical operation the complication rate is surprisingly low.

The problems and complications that may be seen after this operation include:

- Pancreatic fistula: After the tumor is removed from the pancreas the cut end of the pancreas is sutured back into to the intestine so that pancreatic juices can go back into the intestine. The pancreas is a very soft organ and in some patients this suture line may not heal very well. If this happens then patients develop leakage of pancreatic juice. Usually the surgeon leaves behind a drainage catheter in the abdomen during the surgery. Any leakage of pancreatic juice after the surgery is usually removed from the body by this drainage catheter. In almost all patients who develop leakage of pancreatic juice after the surgery, the leakage heals on its own. It is uncommon for patients to be re-operated for this complication. At USC

this complication has occurred in about 4% of all the surgeries that we have performed.

- **Gastroparesis (paralysis of the stomach):** The first five to six days after the surgery, you will be provided with intravenous fluids until your bowel function returns. After your bowel function have return your surgeon will begin you on a diet of clear liquids and your diet will progress to a regular diet as you tolerate it.

  In up to 25% of patients, the stomach may remain paralyzed after the surgery and it may take up to 4 to 6 weeks for the stomach to adapt to the changes after the surgery to function normally. During this period you may not a tolerate a diet very well. If you fall in this category then you will be provided with nutrition through a small feeding tube that your surgeon has placed into the intestine at the time of surgery. In almost all patients the stomach function returns to normal after this 4 to 6 week period after the surgery

What are the long-term complications of the Whipple operation?

Some of the long-term consequences of the Whipple operation include the following:

- **Mal-absorption:** The pancreas produces enzymes required for digestion of food. In some patients removal of part of the pancreas during the Whipple operation can lead to a diminished production of these enzymes. Patients complain of bulky diarrhea type of stool that is very oily. Long-term treatment with oral pancreatic enzyme supplementation usually provides relief from this problem.
- **Alteration in diet:** After the Whipple operation we generally recommend that the patient ingest smaller meals and snack between meals to allow better absorption of the food and to minimize symptoms of feeling of being bloated or getting too full.
- **Loss of weight:** It is common for patients to lose up to 5 to 10% of their body weight compared to their weight prior to their illness. The weight loss usually stabilizes very rapidly and most patients after a small amount of initial weight loss are able to maintain their weight and do well.

What questions should I ask my surgeon about a Whipple operation?

The Whipple operation is a very complex operation and staging of the patient and outcome of surgery is very much dependent on the experience of the surgeon in treating the pancreatic cancer. Outcome research studies in Maryland, New York and elsewhere has suggested that best outcomes from the Whipple operation is dependant on the experience of the surgeon with the operation.An open and frank discussion with your physician may help you make appropriate choices regarding your therapy. The following are some of the questions that

- How many pancreatic cancers are operated at your hospital on a yearly basis?
- How many Whipple operations have you done?
- How many Whipple operations do you do a year?
- What are the complications in your hands of a Whipple operations?
- What is the death rate of the Whipple operation at your institution and in your hands?
- How many pancreatic cancer patients do you treat per year?
- What is the average length of hospital stay of the patients that you have treated in the past?

Contact information: [illegible] for Pancreatic and Biliary Diseases
1510 San [illegible] Street, Los [illegible], CA
Phone: [illegible] pdeas@surgery.usc.edu

Programs: pancreatic cancer, pancreatitis, laparoscopic surgery, endocrine surgery, ddddddddd biliary surgery

Center for Pancreatic and Biliary Diseases

University of Southern California, Department of Surgery

WHIPPLE OPERATION

Pancreas cancer home/ whipple operation/ distal pancreatectomy/ central pancreatectomy/ laparoscopic pancreatic surgery/ surgical techniques for pancreas preservation

The Whipple operation was first described in the 1930's by Allan Whipple. In the 1960's and 1970's the mortality rate for the Whipple operation was very high. Up to 25% of patients died from the surgery. This experience of the 1970's is still remembered by some physicians who are reluctant to recommend the Whipple operation.

Today the Whipple operation has become an extremely safe operation in the USA. At tertiary care centers where a large numbers of these procedures are performed by a selected few surgeons, the mortality rate from the operation is less than 4%. Studies have shown that for good outcomes from the Whipple surgery, the experience of the center and the surgeon is important. At USC, Dilip Parekh M.D. has performed more than 100 consecutive Whipple type of procedures over the past 9 years with good outcomes.

What is a Whipple operation?

In the Whipple operation the head of the pancreas, a portion of the bile duct, the gallbladder and the duodenum is removed. Occasionally a portion of the stomach may also be removed. After removal of these structures the remaining pancreas, bile duct and the intestine is sutured back into the intestine to direct the gastrointestinal secretions back into the gut.

Laparoscopic Whipple operation

At USC, Dr Parekh is developing techniques for a laparoscopic Whipple operation. At present this procedure may be offered at USC to selected patients with chronic pancreatitis, cystic tumors and islet cell tumors of the pancreas and patients who have ampullary cancer. We do not offer the laparoscopic Whipple operation for pancreatic adenocarcinoma. The Whipple operation is performed laparoscopically utilizing a laparoscopic hand-access device.

When is a Whipple operation required

A Whipple operation is performed for

- cancer of the head of the pancreas
- cancer of the duodenum
- cholangiocarcinoma (cancer of the the bottom end of the bile)
- cancer of the ampula – an area where the bile and pancreatic duct enter into the duodenum.
- whipple operation may also sometimes be performed for patients with benign (non-cancerous) disorders such as chronic pancreatitis and benign tumors of the

HOME
CENT
•Panc
•Panc
•Billia
•Lapa
•Endc
AREA
•Whip
•Treat
•Lapa
•Lapa
•Lapa
•Treat
•Surg
Panc
•Radi
•Bloo
•Pain
•Inter
APPO
FACU
CONT
PATIE
INTEF
DOWI
WEBL

head of the pancreas.

What is the results of the Whipple surgery?

Over the last 15 years major pancreatic centers in the United States have developed excellent results for the Whipple surgery. In almost all the major centers the death rate from this surgery is now less than 5%.

Recent studies from Johns Hopkins and Memorial Sloan Kettering have shown that outcome from surgery for a Whipple operation is dependent on the experience of the hospital and the surgeon performing the surgical operation. In those that hospitals that perform high volume of these procedures the death rate from the Whipple operation is now less than 5%. In hospitals that infrequently perform the Whipple operation a much higher complication rate and the death rate from the surgery often greater than 15 to 20% has been reported in surgical literature.

The American Cancer Society recommends that the Whipple operation should be performed in a center that is experienced and does high volume of these complex surgical procedures to ensure the best outcome.

What is the experience of the Whipple operation at USC?

At USC Dilip Parekh, MD has performed more than a hundred consecutive Whipple operations without any deaths from the surgical procedure.

Will the Whipple operation improve my survival?

The overall survival after the whipple operation for pancreatic adenocarcinoma is about 20% at five years after surgery. Patients without spread of cancer into their lymph nodes may have up to a 40% survival. The actuarial survival is less than 5% at five years for patients patients with pancreatic adenocarcinoma who are treated with chemotherapy alone.

The operation is usually curative in patients with benign or low grade cancers of the pancreas.

Will I require any further treatment for my cancer after the Whipple operation?

We recommend that all patients with pancreatic cancer should have chemotherapy and radiation therapy after the operation. Recent studies from Johns Hopkins University have shown that the survival rate can be increased by as much as 10% by adding chemotherapy and radiation therapy to the surgery for patients with pancreatic adenocarcinoma.

We do not recommend any further treatment for patients who have benign tumors of the pancreas and in patients with neuroendocrine tumors of the pancreas.

Will I become diabetic after a Whipple operation?

During the Whipple operation part of the pancreas, the head of the pancreas, is removed. Pancreatic tissue produces insulin that is required for blood sugar control. When pancreatic tissue is removed the body releases less insulin and the risk of developing diabetes is present.

Tufts-New England Medical Center

Department of SURGERY

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PEDIATRIC SURGERY
VASCULAR SURGERY

Whipple Procedure
Pancreatic Cancer and Pancreatitis

INTRODUCTION

Surgical removal of tumors of the pancreas is the only way to cure patients with pancreatic cancer. Removal of part of the pancreas may also be the best form of treatment for some patients with pancreatic inflamation (pancreatitis). The Whipple procedure, also called pancreaticoduodenectomy, is a technically intricate procedure that involves removing the head and neck of the pancreas. It should be performed by specialists in this area. Some patients with malignant tumors benefit from additional (adjuvant) chemotherapy and radiation treatments.

The Whipple procedure or pancreaticoduodenectomy is an operation to remove a part of the pancreas know as the head (**figure 1**). The head of the pancreas may need to be removed for a variety of reasons.

A. A tumor of the pancreas
B. A tumor of the bile duct
C. Inflammation of the pancreas or chronic pancreatitis.

For patients whose tumor or inflammation does not involve the head of the pancreas, other operations such as removal of the body and tail of the pancreas ("a distal pancreatectomy") may be more appropriate.

This page provides information and answers to commonly asked questions about the Whipple procedure. Keep in mind that diagnosis and treatment may differ from patient to patient. Your doctor will discuss your specific diagnosis and treatment in detail.

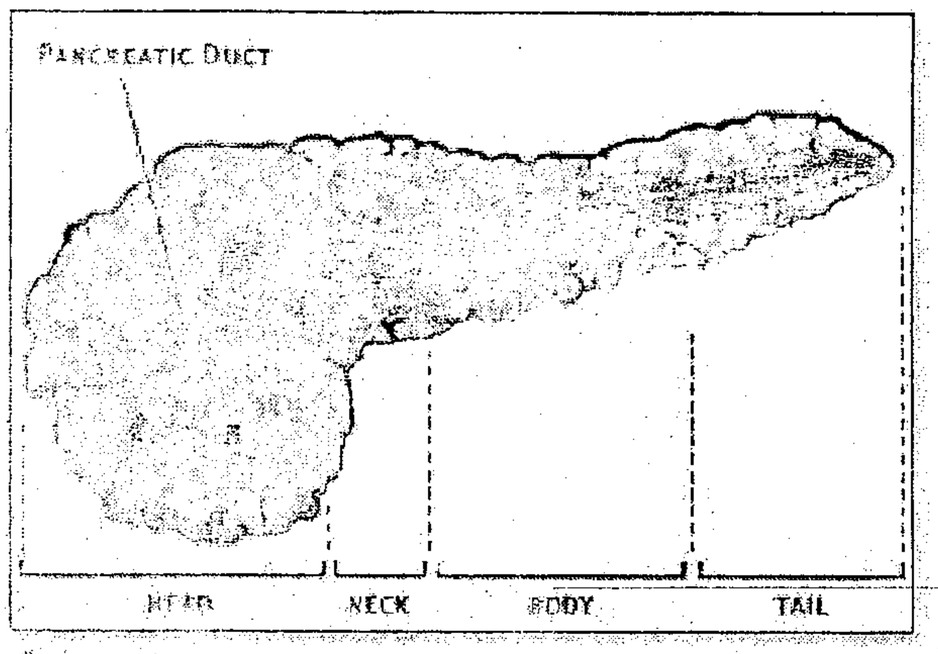
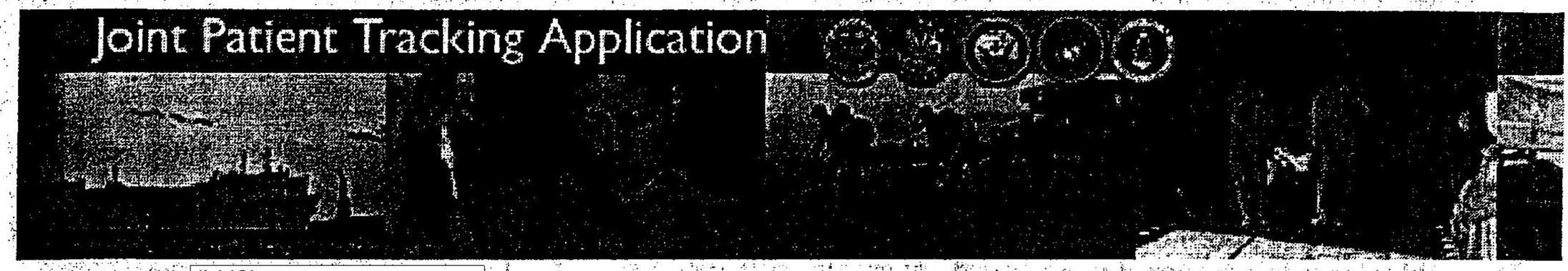


FIGURE 1

- About The Pancreas
- The Operation
- What To Expect After Surgery
- Pain Control
- Eating
- Urinating/Bowel Movements
- Activity
- Pancreatic Drain
- Discharge
- Other Important Information
- Other Long-Term Pancreatic Surgery



Welcome (b)(6) **28TH CSH SOUTH - BAGHDAD**

Patient Reg./Update | Patient Search | Patient Info. | Reports | Patients By :

Patient Treatment Management

SSN (b)(6) ? NAME ?

SSN	NAME	SEX	RANK	BRANCH
100012639	UNKNOWN 2639	M	SI	UNKNOWN
DIAGNOSIS:	OPN WND ANTERIOR ABDOMEN			
ATTACHMENTS:0 files			AF3899: Create	
View SF 502 Narrative Summary (PDF)				

STATUS	LOCATION	DATE	FACILITY
INPATIENT	ICU-Icu1	11/1/2006 6:51:56 PM	28TH CSH SOUTH - BAGHDAD

FACILITY	AUTHOR	DATE	NOTES
28TH CSH SOUTH - BAGHDAD	(b)(6)	11/1/2006 10:42:55 PM	Patient brought to ER with GSW to right upper quadrant. Patient was relatively stable but was brought emergently to the operating room for exploration. Patient had a chevron incision with midline extension. The liver was mobilized. The anterior branch of the right portal vein was laying in the fracture of the right anterior lobe of the liver just lateral to cantleys line. There was a rent in a branch of the right hepatic vein at the base of the liver fracture that was sutured with 4-0 prolene. There were several small hole from avulsed branches of the portal vein that were sutured with 5-0 or 6-0 prolene. Devitalized liver was remove using finger fracture and clips. Once the liver injury was controlled attention was turned to the small bowel. An injured area of ileum was removed with GIAs. Attention was turned to the duodenum which had a significant area of injury to 2/3 of the lateral wall of the second portion and to an area adjacent to the pancreas proximal to the ampulla. An injury to the inferior pole of the kidney was indentified and the inferior pole was sutured with pledgets of 4-0 prolene to control bleeding. The fracture did not extend into the collecting system. There was an injury to the CBD as it entered the duodenum in the pancreas and so a

PATIENT ID (b)(6)

DATE 02NOV06

TOTAL INTAKE

TOTAL

PATIENT (b)(6)

DATE 01 NOV 06

TOTAL INTAKE

TOTAL OU

SYMBOLS

B/P CUFF PRESSURE

ARTERIAL LINE PRESSURE

MEAN ARTERIAL PRESSURE

PULSE

RESPIRATION

TEMPERATURE

O2 Delivery

CVP

CPP

Glucose

INTAKE

OUTPUT

L 24 06 0107 89 78479

28th CSH INTENSIVE CARE NURSING FLOW SHEET

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	For Invasive lines / Tubes Insert Location & Date Inserted	0400	0800	1200	1600	2000	2400
NEURO	LOC/SAS						1 4
	PUPILS Right/Left						3+ 3+
	VENTRIC HEIGHT						X
	GCS(Eye/Motor/Verbal)						14
	PAIN CONTROL						fentanyl
	SEE NURSES NOTES						✓
CARDIOVASCULAR	RHYTHM						ST
	CAP REFILL						<3 sec
	PULSES						+3
	EDEMA						Ø
	SKIN COLOR						NPR
	IV'S						18a ⓐ RC
							ⓐ Rem cordis
	A-LINE						
	SEE NURSES NOTES						ⓐ rad A-line ✓
	TIME	0400	0800	1200	1600	2000	2400
PULMONARY	RESP PATTERN						Reg
	BREATH SOUNDS						CTA
	COUGH						Ø
	AIRWAY						S
	CHEST TUBE						X
	SEE NURSES NOTES						✓
GI/GU	ABDOMEN						S
	BOWEL SOUNDS						A
	NG/OG/FEEDING TUBE						X
	STOOL						Ø
	FOLEY / VOID						F
	COLOR						A
	CHARACTER						C
	SEE NURSES NOTES						X
	TIME	0400	0800	1200	1600	2000	2400
	abdominal ultrasound						CDI
	JP #1						S
	JP #2						S
	J-tube						Ø
	G-tube						brown
	SEE NURSES NOTES						✓
VENTILATOR	Mode						
	F_iO_2						
	TV						
	Rate						
	MV						
	PEEP / PS						
	Suction						

LEGENDS

LOC: A- ALERT L- LETHARGIC S- SEDATED C-COMA

SAS: 7-Dangerous Agitatio 6- Very Agitated 5- Agitated 4- Calm/Cooperative

Pupils: 1mm 2mm 3mm 4mm 5mm 6mm

Pupil Response: ++(brisk), +(slow) or –(no response)

ICP Norm: 0-10mm Hg

Heart Rhythm: Normal sinus rhythm: NSR; Tach arrhythmia: T Sinus Tach: ST; Brady arrhythmia: B Sinus Brady: SB

Pulses: 3+ 2+ 1+ 0:

Edema: 3+, 2+, 1+, none Generalized: G

Skin Color: Pink: P or Norm for race: NFR, Pale: PA, Dusk Cyanotic:CY Jaundice: J

Access: Central lines: Subclavian: LSCV, RSCV, IJ, EJ; Peripheral: PIV; Femoral: Fem; Cordis: C; Triple lumen: TLC

A-I

A-Line Hourly Assessment: Intact: I Pulses Present: P Color: P: Pink NI

Resp Pattern: Reg, Irreg

Breath sounds: Rhonchi: Rh Clear: CL Crackles: CR Wheezing: WH

Airways: Nasopharyngeal: NPA Oral pharyngeal: OPA Endotrach tube: ETT Trach: T Self: S

Chest tube: Water seal: WS Suction: SU

Chest tube: S: wall Suction WS: Water Seal

Abdomen: Firm: F Soft: SF Tender: T Distended: D Obese: OB

Bowel Sounds: Present: P Absent: A Hypoactive: H Hyperac

Stool: Formed: F Loose: L Ostomy: OS

NG/OG Tube: Suction: SU Clamped: C Gravity: G Feeding: F

Urine Color: Amber: A Yellow: Y Sediment: S Hematuria: H

Vent Suc

Y: Yellow

Character: Clear: C Cloudy: CL

C: Crean

BL: Bloo

Integumentar: Put Dressings/wound locations in box and then unde

CDI: Clean dry intact Changed: Δ'd SAT: Saturate

May also document drains in these slots: JP, Wound Vac

To document drains every 4 hrs describe drainage:

SS: Sero sanguineous CL: Clear P: Purulent

If you run out of space use notes section

Mouth Care	2400						
Turn							
Foley Care	2230						
Trach Care							
Drsing Chg							
Bath	2230						

Notes: 2230 received pt from OR. VSS ☒ ST 150s-160s, (b)(6) aware + Low grade temp 100s. Pert
IVP for pain control. Oral airway in place due to pt lethargic + extubated @ bedside. 4L NC in pl
= O2 sat > 100%. Will titrate down. J-tube ☒ Ø drainage, G-tube ☒ brown drainage. JP #1 + JP
☒ sanguinous drainage. Ⓐ radial A-line not correlate ☒ NIBP. Restraints in place. (b)(6)
0040 Pt HR remain 150s-160s. Notified (b)(6) of VS + Labs. 500 NS bolus + Ketamine given + ord
0200 Pt more alert, oral airway discontinued. Interpreter explained pt status + restraint use. Pt so
Gave 100 mcg Fentanyl. Will cont. to assess pain level + vitals. (b)(6)

	Signature	Initials
Night Nurse		
Day Nurse		
Night Nurse	(b)(6)	

PT ID: ~~NAZMAN, SEIFALLAH~~ (b)(6) (b)(6)

Date: 01

Version 2 31Mar05

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0124 06 CID 789 70479

28th CSH INTENSIVE CARE NURSING FLOW SHEET

Page 762

NEURO	For invasive lines / Tubes/ Insert Location & Date Inserted	0400	0800	1200	1600	2000	2400
	LOC/SAS	A 4	A 4		A 4	A 4	
	PUPILS Right/Left	3+ 3+	3+ 3+		3+ 3+	3+ 3+	
	VENTRIC HEIGHT	X					
	GCS(Eye/Motor/Verbal)	15	15		15	15	
	PAIN CONTROL	Fentanyl	Fent.		Fent	Fent	
	SEE NURSES NOTES	X					
CARDIOVASCULAR	RHYTHM	ST	ST		ST	ST	
	CAP REFILL	<3	<3sec		<3sec	<3	
	PULSES	+2	+1+2		+1+2	+2x4	
	EDEMA	Ø	Ø		Ø	Ø	
	SKIN COLOR	NFR	NFR		NFR	NFR	
	IV'S	18g@AC	18g@AC		18g@AC	18g@AC	
		@Transcath	@Femcath		@TLC	@TLC	
	A-LINE	@rad	@rad		@rad Alm	@rad	
	SEE NURSES NOTES	X					
PULMONARY	TIME	0400	0800	1200	1600	2000	2400
	RESP PATTERN	Reg.	Reg		reg	reg	
	BREATH SOUNDS	CTA	CTA		CTA	CTA	
	COUGH	Ø	Ø		Ø	Ø	
	AIRWAY	S	S		S	S	
	CHEST TUBE	X	X				
	SEE NURSES NOTES	V					
GASTRO INTESTINAL	ABDOMEN	SF	SF		SF	SF	
	BOWEL SOUNDS	A	A		A	A	
	NG/OG/FEEDING TUBE	X	—				
	STOOL	X	—				
GENITO URINARY	FOLEY / VOID	F	F		F	F	
	COLOR	A	A		A	A	
	CHARACTER	C	C		C	C	
	SEE NURSES NOTES	X					
	TIME	0400	0800	1200	1600	2000	2400
INTEGUMENTARY	abdominal wound	CDI	CDI		CDI	CDI	
	JP #1	S	S		S	SS	
	JP #2	SS	S		S	SS	
	J-tube	Ø	Ø		e		
	G-tube	brown	Brown		Brown	brown	
	SEE NURSES NOTES	X					

LEGENDS

LOC: A-ALERT L- LETHARGIC S- SEDATED C-COMA

SAS: 7-Dangerous Agitatic 6- Very Agitated 5- Agitated 4- Calm/Cooperative

Pupils: 1mm 2mm 3mm 4mm 5mm 6mm

Pupil Response ++(brisk), +(slow) or -(no response)

ICP Norm: 0-10mm Hg Pulses: 3

Heart Normal sinus rhythm: NSR 2

Rhythm Tach arrhythmia: T Sinus Tach: ST 1

Brady arrhythmia: B Sinus Brady: SB

Edema 3+, 2+, 1+, none Generalized: G

Skin Color: Pink: P or Norm for race: NFR, Pale: PA, Du

Cyanotic:CY Jaundice: J

Access Central lines: Subclavian: LSCV, RSCV, IJ, EJ

Peripheral: PIV Femoral: Fem

Cordis: C Triple lumen: TLC

A-Line Hourly Assessment: Intact I Pulses Present P Color P: Pink

Resp Pattern: Reg, Irreg

Breath sounds: Rhonchi: Rh Clear: CL Crackles: CR Wheezing: WH

Airways: Nasopharyngeal: NI Oral pharyngeal: OI Endotrach tube: ET Trach: T Self: S

Chest tube: Water seal: WS Suction: SU

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Bowel Sounds: Present: P Absent: A Hypoactive: H Hyp

Stool: Formed: F Loose: L Ostomy: OS

NG/OG Tube: Suction: SU Clamped: C Gravity: G Feeding

Urine Color Amber: A Sediment: S Ven

Yellow: Y Hematuria: H Y: Y

Character Clear: C C: C

Cloudy: CL BL:

Integumentar Put Dressings/wound locations in box and then

CDI: Clean dry intact Changed: Δ'd SAT: Sa

May also document drains in these slots: JP, Wound Vac

To document drains every 4 hrs describe drainage:

SS: Sero sanguineous CL: Clear P: Purulent

If you run out of space use notes section

Mode							
F_iO_2							
TV							
Rate							
MV							
PEEP/PS							
Suction							

Mouth Care	0200	0315	2200				
Turn							
Foley Care	2200						
Trach Care							
Drsing Chg							
Bath	2200						

Notes: 0315 Pt c/o abd pain. Gave 50mg fentanyl
0415 Pt c/o pain in abd. Gave fentanyl 100mg. HR remains 160s. MAP >50 d/o. MAP 70s. Informed (b)(6) fentanyl + ketamine gtt ordered.
0420 - noted dec bowel sounds LLQ. CXR completed Hab. Will cont to monitor.
0600 - noted bile in JP#2 (b)(6) notified. (b)(6)
0730 Pt. calm alert follows command. For OR today. Dsg to Abd CDI no active bleeding
1230 Pt. back to CR for spouse removal.

(b)(6)

(b)(6)

(b)(6)

(b)(6)

(b)(6)

	Signature	Initials
Night Nurse	(b)(6)	
Day Nurse		
Night Nurse		

PT ID: (b)(6)

Da

Ø2NO1

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Version 2 21 Mar 05 FOR OFFICIAL USE ONLY

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

PATIENT LAB INQUIRY

For: 03 Nov 06 - 03 Nov 06

Report requested by: (b)(6)

0124 06 CID789 78479

UNKNOWN,UNKNOWN (b)(6) M/93 Reg #: (b)(6)

Ph: Military Unit: UNKNO

03 Nov 06 @ 0558 (Coll)				SER
PROTEIN TOTAL	4.1	L	(6.3-8.2)	g/dL
ALBUMIN	2.1	L	(3.5-5.5)	g/dL
ALK PHOS	47		(38-126)	U/L
AST	455	H	(15-46)	U/L
ALT	450	H	(11-66)	U/L
GGT	22		(12-58)	
TBILI	5.0	H*	(.2-1.3)	mg/dL
Result Comment: CALLED CPT MCAUTRY@0530				
AMYLASE	717	H*	(30-110)	U/L
K	4.4			mmol/L
CL-	101		(98-107)	mmol/L
MG	TNP			
CO2	26		(22-30)	mmol/L
GLUCOSE	122	H	(75-110)	mg/dl
BUN	15		(9-20)	mg/dL
CREAT	0.9		(0.8-1.5)	mg/dL
CA	7.9	L	(8.4-10.2)	mg/dL
PHOSPHORUS	TNP			mg/dL
NA+	129	L	(135-145)	mmol/L
03 Nov 06 @ 0558 (Coll)				PLAS
PT	14.3	H	(9-12)	sec
APTT	TNP		(25-33)	sec
INR	1.43		(1 B unit)	B unit

Interpretations:
B unit

03 Nov 06 @ 0558 (Coll)				BLC
WBC	10.8	H	(4.5-10.5)	x10 3/uL
RBC CNT	3.59	L	(4.0-6.0)	x10 6/uL
HGB	10.4	L	(11-18)	g/dL
HCT	32	L	(35-60)	%
MCV	89.2		(80.0-99.9)	fl
MCH	28.9		(27.0-32.0)	pg
MCHC	32.4	L	(33.0-37.0)	g/dL
PLATELETS	240		(150-450)	x 10 3/uL
LYMPHS/100 WBC	7.3			
LYMPH#	0.8	L	(1.2-3.4)	x10 3/uL

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

EXHIBIT 167 9

28TH COMBAT SUPPORT HOSPITAL 02 Nov 2006@0126 Pa

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

PATIENT LAB INQUIRY

For: 01 Nov 06 - 02 Nov 06

Report requested by: (b)(6)

0124 06 CID789 78479

UNKNOWN,UNKNOWN (b)(6) M/93 Reg #: (b)(6)

Ph: Military Unit: UNKNO

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02 Nov 06 @ 0012 (Coll) SER

ASAP PROTEIN TOTAL	3.7	L	(6.3-8.2)	g/dL
ALBUMIN	2.1	L	(3.5-5.5)	g/dL
ALK PHOS	41		(38-126)	U/L
AST	293	H	(15-46)	U/L
ALT	212	H	(11-66)	U/L
GGT	29		(12-58)	
TBILI	4.0	H*	(.2-1.3)	mg/dL

Result Comment: INFORMED LT. THORNTON OF CRITICALS AT 2326

AMYLASE	205	H	(30-110)	U/L
K	5.1			mmol/L
CL-	102		(98-107)	mmol/L
MG	TNP			
CO2	23		(22-30)	mmol/L
GLUCOSE	147	H	(75-110)	mg/dl
BUN	11		(9-20)	mg/dL
CREAT	1.3		(0.8-1.5)	mg/dL
CA	TNP		(8.4-10.2)	mg/dL
PHOSPHORUS	TNP			mg/dL
NA+	135		(135-145)	mmol/L

02 Nov 06 @ 0012 (Coll) PLAS

PT	17.4	H	(9-12)	sec
APTT	TNP		(25-33)	sec
INR	1.7		(1 B unit)	B unit

Interpretations:
B unit

02 Nov 06 @ 0012 (Coll) BLO

WBC	4.9		(4.5-10.5)	x10 3/uL
RBC CNT	4.13		(4.0-6.0)	x10 6/uL
HGB	11.7		(11-18)	g/dL
HCT	36.8		(35-60)	%
MCV	89.0		(80.0-99.9)	fl
MCH	28.4		(27.0-32.0)	pg
MCHC	31.9	L	(33.0-37.0)	g/dL
PLATELETS	248		(150-450)	x 10 3/uL
LYMPHS/100 WBC	20.0			
LYMPH#	1.0	L	(1.2-3.4)	x10 3/uL

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

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

PATIENT LAB INQUIRY

For: 01 Nov 06 - 02 Nov 06

Report requested by: (b)(6)

0124 06 CID 789 78479

UNKNOWN,UNKNOWN (b)(6) M/93 Reg #: (b)(6)

Ph: Military Unit: UNKNOV

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02 Nov 06 @ 0615 (Coll) SERU

PROTEIN TOTAL	3.8	L	(6.3-8.2)	g/dL
ALBUMIN	2.4	L	(3.5-5.5)	g/dL
ALK PHOS	36	L	(38-126)	U/L
AST	388	H	(15-46)	U/L
ALT	330	H	(11-66)	U/L
GGT	28		(12-58)	
TBILI	5.0	H*	(.2-1.3)	mg/dL

Result Comment: NOTIFIED WHITE IN ICU1 AT 0524.

AMYLASE	491	H	(30-110)	U/L
STAT K	4.9			mmol/L
CL-	105		(98-107)	mmol/L
MG	TNP			
CO2	22		(22-30)	mmol/L
GLUCOSE	122	H	(75-110)	mg/dl
BUN	14		(9-20)	mg/dL
CREAT	1.0		(0.8-1.5)	mg/dL
CA	TNP		(8.4-10.2)	mg/dL
PHOSPHORUS	TNP			mg/dL
NA+	138		(135-145)	mmol/L

02 Nov 06 @ 0615 (Coll) PLASM

STAT PT	17.6	H	(9-12)	sec
APTT	TNP		(25-33)	sec
INR	1.76		(1 B unit)	B unit

Interpretations:
B unit

02 Nov 06 @ 0615 (Coll) BLOC

STAT WBC	5.9		(4.5-10.5)	x10 3/uL
RBC CNT	4.24		(4.0-6.0)	x10 6/uL
HGB	12.0		(11-18)	g/dL
HCT	36.6		(35-60)	%
MCV	86.3		(80.0-99.9)	fl
MCH	28.2		(27.0-32.0)	pg
MCHC	32.7	L	(33.0-37.0)	g/dL
PLATELETS	215		(150-450)	x 10 3/uL
LYMPHS/100 WBC	16.4			
LYMPH#	1.0	L	(1.2-3.4)	x10 3/uL

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General

Mo 11 Yr 06

VERIFY BY INITIALING

(b)(6)

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	RECURRING ACTIONS FREQUENCY, TIME	HR	DATE COMPLETED
01NOV	Vital Signs q [ ] hr	(b)(6)	
	Cardiac monitor CVP q 1 hr		
01NOV	Activity: HOB 30-45 deg BR (record degree & circle if contraindicated)		
	HOB BIP ( ) Other:		
01NOV	W/O q [ ] hr Policy to gravity		
	( )NG/ ( ) G ( )LCWS or ( )LWS		
01NOV	( ) to ( ) suction or ( )		
	Wet-to-dry dressing q [ ] hr		
	Wet-to-moist q [ ] hr		
	Sputum specimens with ( ) C & culture		
01NOV	( ) sputum		
	Strict I&O		
	Restrictions: ( ) H2O ( ) Na		
	Chest tube to [ ] 20cm suction ( ) H2O		
01NOV	Diet:		
	Ambulate [ ] times daily with assistance		
01NOV	Encourage use of incentive spirometer q [ ] hr while awake		
	Cough & deep breathe q [ ] hr while awake		
01NOV	Ice chips ( ) Regular		
	Nothing by mouth (NPO)		
01NOV	Other: Cough & deep breathe q 1 hr while awake		

ALLERGIES

PATIENT IDENTIFICATION

(b)(6)

ADDITIONAL PAGES SERIAL NO.

PAGE NO.

ACTION TIMES

CIRCLE ACTION TIMES

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

(b)(6)

DA FORM 3762

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012A 06 CID 789 78479

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 11 Yr. C

Verify by Initialing		SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Ir
Order Date	Clerk/ Nurse					
02NOV	(b)(6)	NS 500mL IV over 30 min	02NOV		0040	(b)(6)
02NOV		Ketamine 50mg x 1	02NOV		0045	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED											
		( )For acute agitation, may give	Date/ Time											
		Midazolam 2-5mg IVP q5min until sedation achieved	Amt											
			Initial											
01NOV	(b)(6)	(✓)For acute pain may give until pain controlled	Date/ Time	02NOV 0045	02NOV 0200	02NOV 0220	02NOV 0315	02NOV 0410						
01NOV		(✓)Fentanyl 25-100mcg slow IVP q5min	Amt	50mg	50mg	100mg	50mg	100mg						
01NOV		(✓)Morphine sulfate 2-5mg IVP q6min	Initial	(b)(6)										
01NOV		( )For K< 4 and Phos > 2.5 give 40meqKCl IV in NS over 4hr												
01NOV		(✓)For K< 4 and Phos < 2.5 give 30mmol Kphos IV in NS over 4hr												
01NOV		(✓)For K> 4 and Phos < 2.5 give 30mmol NaPhos IV												
01NOV		(✓)For Mg< 2 give 2gm Magnesium Sulfate IV in NS												
01NOV		(✓)For Mg< 1.5 give 4gm Magnesium Sulfate IV in NS												
01NOV		Phenergan 25mg IV Q6hr prn nausea + vomiting												
01NOV		Zofran 4mg IV Q4hr prn nausea + vomiting												

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

Mo. 11 Yr.

VERIFIED BY INTEGRATED ... | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS FREQUENCY TIME	HR	DATE COMPLETED 1	2
01 Nov	(b)(6)	Do not change dressings until surgeon removes on POD #2	07		(b)(6)
			19	(b)(6)	
01 Nov		Elevate to prevent swelling	07		(b)(6)
			19	(b)(6)	
01 Nov		Elevate to prevent swelling	07		(b)(6)
			19	(b)(6)	

(b)(6)

(b)(6)

(b)(6)

(b)(6)

DA FORM 3645 (OCT 78) PREVIOUS EDITION IS OBSOLETE

A

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11 Yr 06	
Order Date	Clerk / Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
01 NOV	(b)(6)	Admit to ICU (b)(6)	01 NOV		2230	(b)(6)
01 NOV		✓ CBG (✓ Chem 10 ✓ Coags on arrival	01 NOV	on arrival	2230	
01 NOV		✓ ABG (STAT EG7+ w/ABG, Hgb, Ca) on arrival for all vented patients	01 NOV	on arrival	2230	
01 NOV		✓ CXR on arrival	01 NOV	on arrival	2230	
01 NOV		abg chem 10, coag q8h x 2	02 NOV	0600	0400	
			02 NOV	1200		
01 NOV		continue stable	01 NOV		2230	(b)(6)
01 NOV		cpt 5 pneumbac, + hpaac c labs	01 NOV		2230	

Order Expir. Date	Clerk / Nurse	PRN ACTION FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
		Call MD if UOP < [illegible]	
		SaO2 <	

0124 06 CID 739 72479

CLINICAL RECORD — THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. 11 Yr.

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATIC

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2
01 NOV	(b)(6)	IVF: LR @ 150 ml/hr	07	✓	(b)(6)
			19	(b)(6)	
01 NOV	(b)(6)	Oxygen: Titrate to maintain SaO2> 93%	07	✓	(b)(6)
		(Decrease FiO2 by 10% q10min to 30% FiO2 minimum)	19	(b)(6)	
		( )Midazolam ( )Propofol drip	07		
		Titrate to SAS 3-4	19		
02 NOV	(b)(6)	(✓)Fentanyl drip (max 300mcg/hr) 25-200mcg/hr titrate to pain	07	✓	(b)(6)
		( )Morphine drip (max 4mg/hr)	19	(b)(6)	
		( )Albuterol Nebs 0.5/2.5ml TID	07		
			15		
			23		
01 NOV	(b)(6)	(✓)Pantoprazole 40 mg IV qd (Protonix)	10	✓	(b)(6)
		( )Ranitidine 50mg IV q8hr			
		( )Carafate 1gm PO/NGT qid			
		( )Colace 100mg PO/NGT bid	08		
			20		
		( )Ancef ___ gm IV q8hr	04	✓	(b)(6)
		( )Levoflaxacin ___ mg IV qd	12	✓	•
01 NOV	(b)(6)	(✓)Ampicillin/Sublactam 3 mg IV q6hr (Unasyn)	18	✓	•
			24	(b)(6)	
		( )Heparin 5,000units SQ BID	08	✓	
01 NOV	(b)(6)	(✓)Enoxaparin 30 mg SQ BID	20	(b)(6)	
		Chlorhexidine Oral Rinse/swabs PO BID	08		
		(swish and spit/suction)	20		
02 NOV	(b)(6)	Ketamine drip 1mg/Kg/hr	07	/	(b)(6)
			19	(b)(6)	

ALLERGIES: ☐ YES ☐ NO

UNK

PRIMARY DIAGNOSIS:

S/p GSW to abd, hepatorrhapy, whipple, G-tube J-tube, renorrhapy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 4678-1 FEB 7[illegible] EDITION OF [illegible] 7 WILL BE USED UNTIL EXHAUSTED

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PAGE 1 (

0124 06 CID789 78479

CLINICAL RECORD

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

Mo. 11 Yr. 06

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED

ALLERGIES: ☐ YES ☐ NO

WNK

PRIMARY DIAGNOSIS:
S/p GSW to abd, hepatorrhapy, whipple G-tube, J-tube, renorrhapy

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

PATIENT IDENTIFICATION:

(b)(6)

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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AGENT'S INVESTIGATIVE REPORT *CID Regulation 195-1*	ROI NUMBER 0124-06-CID789-78479 PAGE 1 OF 1

On 31 May 07, SA [b(6), b(7)(C)] Forensic Science Officer, 22nd Military Police Battalion (CID), Camp Victory, IZ, APO AE 09342, conducted a review of the medical records pertaining to Mr. HUMUD. Based on the review and the opinion of Dr (MAJ) [b(6), b(7)(C)] it was determined the cause of death was complications due to a gunshot wound to the abdomen and the manner of death was homicide.///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA [b(2), b(6), b(7)(C)]	22nd Military Police Battalion (CID) APO AE 09342	
SIGNATURE [b(6), b(7)(C)]	DATE 31 May 07	EXHIBIT 10