DATE | NOTES

12/25/03 MEDICAL PROGRESS NOTE (cont)

1600 IMP: ① SIRS / EARLY SEPSIS

② R/O Intestinal Obstruction

③ R/O Pneumonia

PLAN: ① SIRS / EARLY SEPSIS - Pt with ↑ in WBC count over 24 HR period with ⊕ Tmax F 101.4. Initial cultures negative. Sources to include Pulmonary (? Early infiltrate RLL on chest x-ray) / ABDominal (free fluid in pelvis / soft tissue mass / early torsion?). will continue Zosyn. will contact on call surgeon for further evaluation. consider transfer to DACH ⊕ immediately if any signs of decompensation (↑ HR, persistent ↑ temp, hemodynamic instability).

② R/O Intestinal obstruction - ⊕ CT scan finding concerning for obstruction from soft tissue mass / intestinal torsion?. will consult surgeon for eval.

③ R/O Pneumonia - questionable early infiltrate over RLL. will await CT report film in AM for further eval. Pt currently on Zosyn which adequate covers CAP.

(b)(3):10 USC §130b,(b)(6)

STANDARD FORM 509 (REV. 5-96) BACK

GTMO JMG 363

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
12-24-05	Afternoon Medical Officer Watch Note.
18:01	Upon the nursing staff's recommendation, I am ordering a Psych consultation by Mental Health. The detainee has mood swings and at times is attention seeking. At one time he states he is well + appears to be well. A few minutes later he is observed to be acting differently. Patient is stable.
	The patient's vital signs - 101.4 F.
	Labs: 24 DEC 2005
	Mg - 2.2
	Phos - 4.4
	Glucose - 88
	BUN 3(L)
	141 / 105 / 3.8 / 24 / 88
	albumin - 3.6; AST - 23; ALT - 32; T Bili - 1.0
	24 DEC 05 at 0800
	2.9 / 13.8 / 40 / 164K - Neutro 57 / lymph 39 / 3 Mono -
	Exam: Shivering male detainee - Weight - 122.2#
	HEENT - moist mucous membranes
	Lungs - coarse breath sounds
	Heart - Pulse ox % 100 pulse 75/min 122/80 18/min
	Skin - warm

continued →

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

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

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

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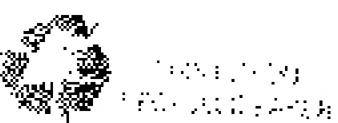
PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 7-91)



DATE	NOTES
12-24-05 18:29	continued: - Skin - no skin break down.
	Assessment - Fever in Malnourished Hunger Striker
	I am concerned that upon clinical exam he may
	be septic due to infection or [(b)(3):10 USC §130b,(b)(6)]
	pneumonia. I have called [(b)(3):10 USC §130b,(b)(6)]
	to have CT Scan of his Chest / abdomen read.
	The CT was put in the routine pile to read +
	I have asked to have the study read tonight.
	Plan ⇒ Blood cultures x 2
	CX Ray PA & Lat
	CBC - stat ⇒
	U/A & culture.
	After this, I'll cover with 1 gram Rocephin
	IV Piggyback q 6 hours x 2 doses.
	I am using the Rocephin to cover initially
	against a septicemia or pneumonia. As
	the test results come back, I'll adjust the
	antibx coverage accordingly. — GTMO [(b)(3):10 USC §130b,(b)(6)]
12-24-05 20:12	Medical Officer Duty Note. 51/min 98% PulseOx 105/53
	Review of PA + Lateral Chest X Ray showed
	a possible infiltrate in Left upper / Lingula area +
	Right lower Lobe. CBC:
	↑9.5 > 14.8 / 44 < 139
	Diff ⇒ Neut 91% Lymph 5%.
	Assessment: Pneumonia w/ possible septicemia. Please note
	jump in WBC from am and shift in the Differential to 91%.
	1 gram Rocephin in. DHT in place for Motrin. Start
	Zosyn 3.375 gram q 6° IVPB at midnight. continued ⇒

STANDARD FORM 509 (REV 7-91) BACK

GTMO JMG 365

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
12/23/15	MEDICAL PROGRESS NOTE
1215	S: Pt seen + examined. Complaints of abd pain and bilat kidney pain x 2-3 weeks
	O: Temp 97.7 HR 64 RR 16 114/76 100% RA
	GEN: AOx3
	HEENT: Ø lymph, Ø [illegible], Ø JVD
	HEART: RRR, Ø m/r/s
	LUNGS: CTAx2
	ABD: ? tenderness over Rt L upper quad, BS ⊕
	THORAX: +/- flank tenderness
	EXT: pulses palp bilat 2+
	LABS: U/A ⊖, H pylori serum ⊕, PHOS 2.0, CK 162, 143/102/4 < 110, 3.4/26.3/0.6
	3.6 > 14.5/46.8 < 202, N 11.1, L 74.4, M 8.4, AST 26, ~~ALT 20~~, Ca 9.4, MB 4.3
	Imp: (1) Weight loss of undetermined origin
	~~(2) Hypophosphatemia~~
	(3) Dyspepsia
	(4) Hx of Nephrolithiasis
	PLAN: (1) Weight loss of undetermined origin - Etiologies to include hunger strike,
	~~(2) Hypophosphatemia~~ PUD, GERD, gastritis, less likely (given age) malignancy
	(3) Pt is currently on IV Protonix will want CT scan of ABD/CHEST/PELVIS
	for further eval. H pylori stool antigen pending. At this time given
	inconsistent hx of abd pain/current refusal of meals, hunger striking is
	high on list. If CT scan shows Ø evidence of obstruction/malignancy/
	other etiology of weight loss, will proceed with endoscopy on Dec 30

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (b)(3):10 USC §130b,(b)(6) | SPONSOR'S ID NUMBER (SSN or Other)

LAST | FIRST | MIDDLE

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

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

PROGRESS NOTES
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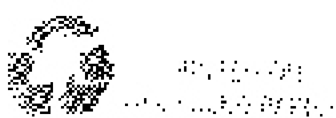

DATE	NOTES
12/23/05	MEDICAL PROGRESS NOTE (cont)
	2) Hypophosphatemia - Continue IV PHOS x 24hrs/48hrs. Daily Mg, PHOS, K
	3) Dyspepsia - low likely GERD. on Protonix 40mg IV BID. Consider Endoscopy for further workup (scheduled for FRIDAY DEC 30
	4). Nephrolithiasis - U/A w/o signs of infection/RBC's Pt with inconsistent physical exam. Do not suspect Nephrolithiasis at this time.
	5) Continue to monitor carefully. Consider NG tube tomorrow if CT scan normal.
	(b)(3):10 USC §130b,(b)(6)
2-24-05 12:07	Hospital Day #2 Unexplained weight loss Dyspepsia
	Record reviewed. Case discussed w/ (b)(3):10 USC §130b,(b)(6) who is working up this patient. In 1800 cc (AS 1/2 NS w/ 20KCl) out - not measuring.
	Patient states he has some slight pain in abdomen & substernum. No Nausea. He is otherwise resting
	Exam: Patient is alert + Oriented x 4 spheres
	afebrile 97.8°F, pulse 58/min, Resp 12/min, BP 120/80, O2 sat 100%
	Chest clear
	Abdomen soft
	XRay - Plain films - Chest ∅ lesions. No air under diaphragm
	KUB - no air fluid levels; increased stool in colon.
	CT scan of chest + abdomen - pending
	a/p ① Hunger Striker suspected w/ 50# weight loss.
	⇒ Get CT Scan Results today
	⇒ Dietician consult
	⇒ Check Lab Results today
	② Chest pain - EKG - no significant change from AUG 25 2005 EKG. Atypical pain associated w/ (?) medication
	?? hunger striking. Stable condition at 12:10 - GTMO (b)(3):10 USC §130b,(b)(6)

STANDARD FORM 509 (REV. 7-91) BACK

GTMO JMG 367

MEDICAL RECORD | PROGRESS NOTES

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
23Dec05	Medical Nutrition Therapy - Assessment
@1325	I: Admitted to det hosp secondary to ↓wt. 9/o constipation
	24 yo det Diet: Liquid
	Ht: 67" Entry Wt: 172# Current wt (12/22): 122#
	IBW: 148# %IBW: 82% %UBW: 71% BMI: 19.1
	Adj wt / FW: 129# / 59 kg
	Est needs: 2065-2360 kcal / 35-40 kcal/kg FW
	59-89 g prot (1-1.5 g/kg FW)
	1770 ml H_2O (30 ml/kg FW)
	Current po intake unknown at this time. To ensure est
	needs met, would need to provide ↑kcal/prot supplementation
	(ie Ensure Plus). Enteral support indicated if po intake <75%
	est needs. Will continue to monitor; to obtain weights
	@ 2 days.
	P/R: ① Provide Ensure Plus c̄ all meals; encourage
	po intake (b)(3):10 USC §130b (b)(

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST / FIRST / MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

#693

PROGRESS NOTES
Medical Record

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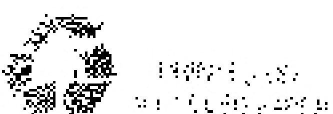


DATE	NOTES

(b)(3):10 USC §130b,(b)(6)

NSN 7540-00-634-4176

MEDICAL RECORD | AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

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

JTF –JMG, Medical Department, Guantanamo Bay, Cuba

23 DEC 05

1000

PROGRESS NOTE – PHYSICAL THERAPY INTIAL ASSESSMENT

Subjective: Patient was referred from M.D. from Detention Hospital Clinic for B LE pain. Patient was recently admitted to the Detention Hospital ward due to significant lost of weight. Patient states that he was given a knee brace a while back but "someone" took it away from me. Able to communicate with PT staff through an interpreter.

Objective:

Observation: Patient was seen bedside and he was in a 2-point restraint. No gross deformities noted and patient was positioned in supine position.

AROM: Bilateral UE/LE grossly WFL

SPECIAL TESTS: Negative Bilateral Lachman's, Varus/Valgus stress or McMurray's tests for his knee. Negative talar tilt tests for his ankles.

PALPATION: (+) global pain along R > L medial/lateral aspects of knee and R > L lateral/medial aspects of mallaoli. Negative patella crepitis noted.

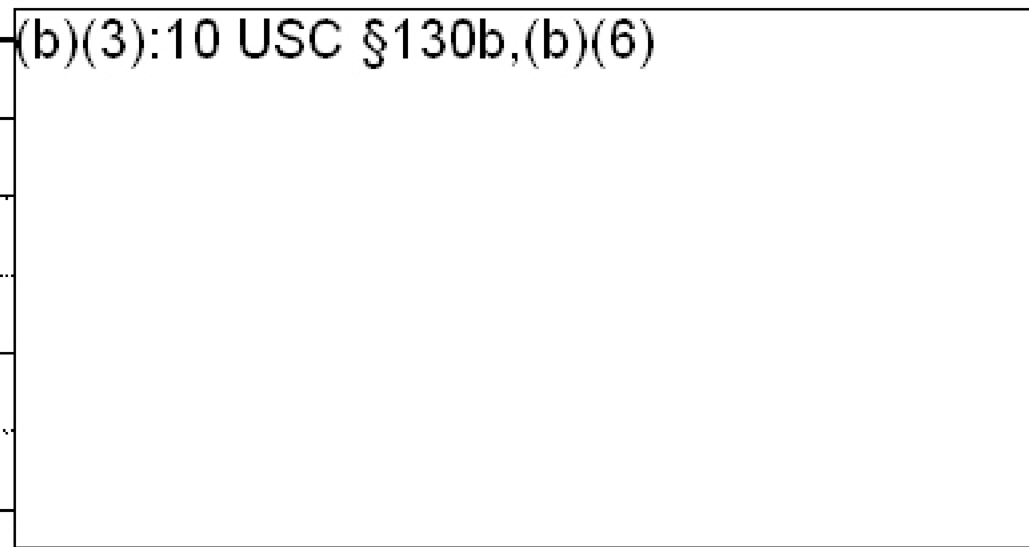
Assessment:

Global R > L knee and ankle pain. No evidence of any ligamentous, meniscal or muscle disruption at this time. Patient would not benefit with either a knee or ankle brace however, would benefit B LE exercises. PT GOALS: a) patient able to demonstrate to PT staff his new exercise program independently in 5-7 days

Plan: 1) Instruct mat/bed exercises for his B knee/ankles by PT staff. Will also do strengthening exercises for gait and standing activities.

2) PT staff will see patient QD while on the hospital ward to ensure compliance with his B LE exercises.

3) F/U with PT as indicated or needed.



DETAINEE'S IDENTIFICATION NUMBER:

693

513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | CONSULTATION SHEET

REQUEST

TO: Physical Therapy

(b)(3):10 USC §130b,(b)(6)

DATE OF REQUEST: 12/23/05

REASON FOR REQUEST (Complaints and findings)

Detainee w/ recent 50 lb wt loss. Detainee w/ complaints of bilateral knee pain. Please evaluate for ~~[illegible]~~ need for knee brace.

PROVISIONAL DIAGNOSIS

Wt. loss

DOC (b)(3):10 USC §130b,(b)(6)

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

See other SF600

(b)(3):10 USC §130b,(b)(6)

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other)

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

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CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
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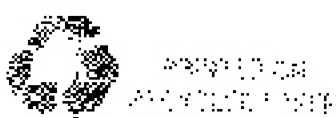

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MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

MO Note

Detainee admitted for evaluation of weight loss. Detainee continues to claim not hunger striker and continues to claim [illegible] cause of pain. Doesn't really want to get better. Refused meds and food last night. BMI low and will get tube fed if continues and [illegible]. Requesting knee braces for knees bilaterally. Doesn't want endoscopy at this time.

VS 97.7 64 16 114/76 100% RA

Gen: NAD
Heart: WNL
CV: RRR S1S2
Lung: CTA

Abd: significant tenderness diffusely, [illegible] with RUQ and epigastric. BS present and guarding. ext: ø c/c/e.

143 | 102 | 4 / 110
3.4 | 26 | 0.9

amylase <30, lipase 70, phos 2.0
Ca 16.2, AST 26, ALT 20, TB 1.1
PTT 29.6, PT 12.2, INR 1.02, ESR 2

H. pylori ⊕ - Ab. 3.6 ╳ 14.5 / 202 / 41.8

A/P:

Wt loss - differential includes hunger strike and GI causes (ulcer, [illegible] bowel, SBO) are a differential and must be [illegible]. Other things on differential: Thyroid disease, infections (HIV, TB)

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

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

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

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
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