

PROGRESS NOTES

DATE

NOTES

12/20/05

Md Note

Detention brought to clinic for slp passing out
 Detention claims not to be hunger strikes, but
 acting like hunger strikes. Having CP and abd pain in
 clinic. CP all over and continuous and worse w/
 palpation. Feels very uncomfortable. Detention will
 not allow labs and IV fluids initially. Smiling when
 I assure him of hunger strikes. Will not admit to
 hunger strikes to Integreter or myself.

VS P 99 ^{135/105} RR 28 ^{99% O2} } AFTER 2L Fuids
 T 98.0 } P 55 BP 105/67
 RR 14

CV: RR 21/15/12 Pain to palpation of left side of chest
 lung: CTA
 abd: no epigastric pain on palpation, ⊕BS
 ext: ⊕w/e

A/P:

① Hunger strikes - clearly record hunger strikes. Although doesn't
 admit to it. Will give IV fluids, glass, return to table.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
DEPT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	REGISTER NO	WARD NO.

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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-09)
Prescribed by GSA/COMR HPMPR (41 CFR) 101-11.203(b)(1)(i)

DATE

NOTES

Will begin working for further weight loss and other changes
Need to obtain weight.

② Used pin - numerous skeletal not repairs per birds

③ expectative pin - 2nd to M/S

④ 4 pins - due to M/S - give 1 sup DSO.

(b)(3):10 USC §130b,(b)(6)

RECORD

PROGRESS NOTES

NOTES

2/17/05

NURSING NOTE: CURRENT MED PROBLEMS
SUPPRESSED (Drug) T TB3 T1D
ACIPHEX 20mg DAILY
ARTIFICIAL TEARS BID

(b)(3):10 USC §130b,(b)(6)

MO NOK

17/DEC/05 @ 0750

Remained here for follow up. First not describing any
testicular pain at skin time. So no issue w/ this. Skin

Wgt=126

lost week of ea pain. Feels muffled and hot at dinner

T=98.7

lost week. Would like migration today.

P=63

Wants to off. 30mg pred. Feels continued. No steroids

BP=122/85

5 days. Pain epigastric more w/ eating. Tolerating food

R=16

No rashes / vomiting. All eval w/ base. Weight stable

~~since~~ since Sept 2005 (13/1/05). No induration w/ base
Epigastric pain x 1 month.

gen: NAD

test: WNL

iv: PARR at SIS2

Aug: CTA

also tender to palpation epigastrically

etc. of life

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY		RECORDS MAINTAINED AT	
PATIENT'S IDENTIFICATION: (For typed or machine entries: Last 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 609 (REV. 3-89)
Prescribed by GSA/USAR PPMO (41 CFR) 101-11.203(L)(10)

DATE

NOTES

A/P:

① Wt loss - stable. Usually eating, but less likely for
prolonged N/S episodes - most recently in December

② ① car accident. Will tonight delay. He scheduled to
return to clinic in 2-3 weeks

③ Epigastric pain - ↑ acetaminophen 20mg po bid. Will start on
omeprazole 40mg qd for stool softening. Follow up in 3 weeks

④ ✓ H. pylori

⑤ Tibial pain no longer - No issue

⑥ Knee pain - ✓ PT list

(b)(3):10 USC §130b,(b)(6)

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
31 Oct 05	Det came to 90 medivac and asked what the
31 Oct 05	Zantac in MD waiting room to stop Zantac and start Aspirin 80 qd
1 Nov 05	PA Note - will stop Zantac and start Aspirin 80mg daily
5 Dec 05	Det seen today @ sick call. Det states Pain in eyes. Det stated that pain started when the weather got cold. We suggest eye drops.
5 Dec 05	Mentor/prime ophthalmics
07 Dec 05	HM NOTE: Det stopped corpsman during med pass for ear pain when HM looked into det ear + heavy wax, + redness. HM barely usable. HM recommends det. come to clinic for ear irrigation PA Note - will bring into clinic for ear irrigation

(b)(3):10 USC

(b)(3):10 USC §130b,(b)(6)

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

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DATE	SYMPTOMS DIAGNOSIS TREATMENT TREATING ORGANIZATION (Sign each entry)		
10/26/05	<p>Det. is not receiving Act. tears. Him contacted pharmacist. Pharmacist states there is no Rx.</p>	<p>(b)(3):10 USC §130b,(b)(6)</p>	<p>(b)(3) :10 USC</p>
10/26/05	<p>of not in ear exam eval. e/o pain, pressure and muffled hearing intermittently. ⊖ HC ⊖ vertigo Sx^s ⊖ tinnitus. ⊖ precipitating or palliative factors. ⊖ other ENT/ear/neck Sx^s</p>		
	<p>Judgment NAD VSS HEENT - oral cephalic, PRN, Sx^s small amt. the of eardrum, TM^s retracted, ↓ mobility, ⊖ emphysema ⊖ air/fluid levels ⊖ nasal discharge/lesions ⊖ oral lesions</p>		
	<p>neck - supple & lymphadenopathy A/RTD P/ Sudafed 10mg i tabs PO TID x 30 days Tylenol 325 1-2 tabs PO q4h PRN</p>		
	<p>Ear pain Flu pen in 2-3wks</p>		

(b)(3):10 USC §130b,(b)(6)

VOLUNTARY AND VOLUNTARY TOTAL FASTING AND RE-FEEDING

SOP: 001

Refusal to Accept Food or Water/Fluids As Medical Treatment

Detainee Number 1093 Age _____ Date 29 OCT 05

The above detainee has refused to accept food or water/fluids as medically indicated by the Camp Delta Medical Officer of the Day.

It has been explained to the detainee the grave risks involved with not following the medical advice directing him to eat life-sustaining food and to drink water/fluids. As a direct result of his refusal to eat and/or drink, he understands that they may experience: hunger, nausea, tiredness, feeling ill, headaches, swelling of their extremities, muscle wasting, abdominal pain, chest pain, irregular heart rhythms, altered level of consciousness, organ failure and coma. He understands that his refusal to eat life-sustaining food or drink water/fluids and to follow the medical advice may cause irreparable harm to himself or lead to his death.

He understands that this is not a complete list of the risks involved with the refusal to follow medical advice and that he may experience other severe complications.

He understands the alternatives available to him including oral food and fluid, oral rehydration solutions (Gatorade), oral nutritional supplements (Ensure), intravenous hydration, and intravenous nutrition (total parenteral nutrition and peripheral parenteral nutrition).

He fully understands the prognosis if he does not accept food as directed above.

Translator Signature	(b)(3):10 USC §130b,(b)(6)	_____
Witness Signature		_____
Medical Provider		_____

Enclosure (1)

Voluntary Total Fasting Medical Evaluation Sheet

Detainee Number 1693

Date of Evaluation 29 Oct 05

Date of Onset _____

Hunger striker: Food Fluids Both

HPI:

Depression? Y
H/O Suicidal ideation? Y
Mood problems? Y
Anxiety problems? Y

N
N
N
N

MEDS: -

ALLERGIES: NKDA or _____

PMH:

Reason for Strike? no reason given

Physical Assessment: Refused Exam

Inprocessing BMI: _____

Current Weight: _____ Current BMI: _____

Heart Rate _____ BP _____ RR _____ T _____ LOC: Yes No

Other Pertinent Physical Exam Findings:

Assessment: Hunger striker

Plan:

1. Explained risks of inadequate intake of food and/or water to detainee. Risks include, but are not limited to: headache, fatigue, malaise, nausea, abdominal discomfort, muscle wasting, heart problems/cardiac dysrhythmias, and death.
2. Detainee given informational handout and expressed understanding after all his questions were answered.
3. Continue follow-up as per Voluntary Total Fasting and Re-feeding SOP.
4. Other:

Translator: (b)(3):10 USC §130b,(b)(6)

Provider: _____

Enclosure (3)

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

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

10 OCT 65 (1) Det 2/0 knee pain x 2 months States that pain is
 worse with walking Also says that he has trouble
 walking sometimes (2) WOUND NAD AHOX3 Neg edema
 Neg erythema, Neg eschmoycii FROM (3) Chronic knee
 (P) Motrin PRN for pain

(b)(3):10 USC §130b,(b)(6)

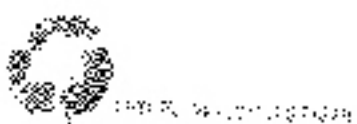
HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/IO NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; IO No or SSN; Sex; Date of Birth; Rank/Grade.)		REGISTER NO.	WARD NO.

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 800 (REV. 6-97)
Prescribed by GSA/ICMR
PRMR (41 CFR) 201-9-202-7

GTMO JMG 64



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Voluntary and Voluntary Total Fasting Medical Flow Sheet

Detainee Number

Date	Daily Standing Heart Rate	Daily Mental Status Assessment	Drinking?	Eating?	Time of last urination?	Document per CP (B.L.D)	Daily Weight	Weekly BMI	Comments
2/11		Detention cell							
9/12	R	A4OX3	R	R	R				DET LAYING IN BED DID NOT WAKE.
9/13	⁰⁵⁰⁰ 88	A4OX3	Y	NO	unknown	?			DET D/ced HS. DRANK IT ENSURES AND REQUESTS SOFT DIET.
9/13	86	A4OX3	Y	Y little	today				wants soft food, DET. STARVING AND SMILING. WANTS ENSURE
D/c Hungerstrike per Dims									

(b)(2)

Enclosure

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

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

2 Sept 05
 0600
 9-21-05
 98.0
 R 18
 B/P 122/64
 PO2 100
 P/S 4/10
 WT: 171lbs

Current notes: Ensure TID (cup loss)
 of diet in per oral 1/2 hunger strike. Currently
 no dyspepsia and constipation. eating soft
 diet. @ n/v/d @ other co/resp/ur/renal
 of wound? H&B vs
 cv - RHR nml 6.42
 Resp - cta all lung fields
 Abd - H&K, soft, @TTP @guarding
 A/ @dyspepsia @constipation
 Zantac 150mg TID po tabs indef
 Prozac 10mg TID tabs x 3 days
 Simethicone 80mg TID tabs TID x 7 weeks
 Continue soft diet
 Quinine TID x 2 weeks

(b)(3):10 USC §130b,(b)(6)

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

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-87)
Prescribed by GSA/ICMR
FPMR (41 CFR) 201-9.202-1

