

EXHIBIT “A”

Aeromedical Evacuation Patient Record

1. NAME (Last, First, Middle, Initial) FORD, Frank G.		2. SSN 548-98-3791		3. STATUS A10		4. SERVICE USA		5. GRADE E-5	
6. AGE 48		7. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE		8. WEIGHT 185		9. BLOOD TYPE B+		10. CLASSIFICATION (1A TO 5F)- (B)	
11. ACCEPTING MD (S. M. ...)		12. CITE/AUT		13. APPT/SURG DATE		14a. ORIGINATING FACILITY AMA		15a. DESTINATION FACILITY TRMC	
14b. ORIGINATING FACILITY PHONE NUMBER		15b. DESTINATION FACILITY PHONE NUMBER		16. # OF ATTENDANTS 16a. MED 16b. NON-ME		17. DIAGNOSIS No Psychosis NOS.		19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)	
18. BATTLE CASUALTY		DISEASE		NON BATTLE INJURY		20. PHYSICIANS ORDERS		21. PRE-FLIGHT VITALS	
20a. DATE 6/18/03		20b. TIME 1545		20c. ALLERGIES NKA		20d. DIET <input checked="" type="checkbox"/> REG <input type="checkbox"/> IREG		20e. IV / BLOOD none	
20d. DIET		3GM NA		CARDIAC		DIABETIC		CALC	
RENAL		Gm Prot		Gm Na		MagK		mg PO4	
TUBE		TYPE		cc/hr, 1/2, 3/4, FULL STRENGTH		21a. DATE / TIME		21b. TEMP:	
PEDIATRIC: AGE		OTHER (Specify)		TPN: Change to D10 at		cc/hr for max of		days	
TUBE FEEDING:		at		strength at		cc/hr		21d. RESP:	
20f. SPECIAL EQUIPMENT		FOLEY CATH		ORTHO BRACES		CHEST/HEIMLICH		RESTRAINTS	
SUCTION		TRACTION		STRYKER		MONITOR		OTHER (USE 23)	
OXYGEN: PERCENT or		LITERS		ROUTE:		22. BRIEF NARRATIVE		23. ASSESSMENT / PROGRESS	
VENT SETTINGS:		20g. ALTITUDE RESTRICTION: Yes (No)		feet		DATE / TIME		NOTES	
20h. RECORDS TO ACCOMPANY PATIENT		<input checked="" type="checkbox"/> OUTPATIENT RECORDS		<input type="checkbox"/> XRAYS		<input type="checkbox"/> OTHER:		19 Jun 03 ORSI → OK BK (includes inpatient evaluation such as MRI, CT scan)	
<input type="checkbox"/> INPATIENT RECORDS		<input type="checkbox"/> OB		<input type="checkbox"/> DENTAL		<input type="checkbox"/> FINANCIAL		1455Z It happened on 1755Z little 2 att. @ site of go. ...	
20i. MEDICATIONS / TREATMENTS		Valium 5 mg IM q 4-6 hours per agitator not to exceed 10 mg in 12 hours		6/19/03 - 2400 Switch pt to Amulyastery etc V10 per Cpt Madera CRT/Kowas AA		ATT FORD		SCOTT	
24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN <i>Cpt Madera M.D.</i>		25. STAMP AND SIGNATURE OF FLIGHT SURGEON		19 Jun 03 379th FAEB/MASF Camp Wicks 2200/1200Z planned letter 137/81 601/18 get for to ...		19 Jun 03 19 Jun 03 At A category to AA ...		06021/03022 pt released to AF ...	

MEDICAL RECORD SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-68; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
MENTAL HEALTH INTAKE INTERVIEW

OTS6 APPROVED (Date)

DATE: 23 June 03 IDENTIFICATION:

REFERRAL SOURCE: SELF COMMAND CONSULT OTHER

Patient/Family/Both ready to learn today: Y N NA
Patient/Family/Both educated on: (circle all that apply)

- 1. New Medications: MA per AW LRMC MEMO 40-76: Care notes given.
- 2. Ongoing Medications.
- 3. Diagnoses.
- 4. Coping Strategies.
- 5. Other:

Patient/Family/Both verbalize understanding of education provided: Y N NA
Side effects from medications? Y N NA

HPI: 48 y.o. white, divorced, S. NG. E-S was sent to LRMC from Iraq because his unit questioned his claimed (possible delusions of grandiosity) about his background. His problem started when he wanted to place charges against other GIs of torturing Iraqi detainees. He was able to provide proof of some of his claims. (Example, he showed student ID of Medical Student at West Sonoma etc.)

FAM/SOC HX: No past psych.
EDU / WORK / LEGAL HX: No

MIL HX: TIS 31 yrs TIC PCS ETS UCMJ Art 15 HX

MED HX: No

MED ALLERGIES: No

SUBSTANCE USE: No

FAM HX of SUBSTANCE ABUSE / PSYCHIATRIC ILLNESS: No

USCG. 1973-77
Navy 77-82
Army Reserve 82
out for 1 year.
NG 90-present
California Prison Guard
1986-present
Oceania Medical S
2002-present
He takes classes to attend the school

PREPARED BY (Signature & Title) [Signature]

DEPARTMENT/SERVICE/CLINIC
LRMC Outpatient Psychiatry Clinic (IC)

PATIENT'S IDENTIFICATION (For typed or written entries give: first, middle, grade, date; hospital or medical facility)
NAME: 23 June 03
SSN:
DOB:

- HISTORY/PHYSICAL
- OTHER EXAMINATION OR EVALUATION
- DIAGNOSTIC STUDIES
- TREATMENT
- FLOW CHART
- OTHER (Specify)

Mental Health Evaluation on: FORD, FRANK GREGORY 2 July 2003

1800

Continued:

The circumstances in Iraq, or to authenticate the history he gives concerning his background, psychiatric or medical history, or family mental health background. Thus this brief evaluation is based purely on interview and review of very sparse previous documentation, other than the similar findings made earlier today by MAJ Luckie at the Community Behavioral Health Services, and his psychological testing.

There is no overt evidence of any psychiatric disorder at this time, based on the limitations articulated above.

Diagnosis:

Axis I: No dx

Axis II: Deferred

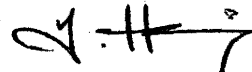
Axis III: No dx

Axis IV: Combat stressors and stressors associated with conflict in patient's Counterintelligence unit regarding interrogation methods

Axis V: Appears 90-100

Recommendations:

1. Depending on the administrative and ultimate legal outcome of this individual's situation further mental health evaluation may or may not be required. There is nothing on my initial screening evaluation indicating any overt pathology or personality problems.
2. Patient, as per recommendation made earlier today at CBHS, has consulted with the BAMC IG regarding his allegations described above.
3. Patient appears mentally stable to be able to handle any administrative actions at this time, such as leave, pass, and commercial travel.
4. Recommend to soldier that he give consent for this and previous mental health evaluations to be shared with IG and appropriate Command channels.
5. Release patient from Behavioral Medicine Clinic.



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