MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

Reset Form

REPORT TITLE

Tactical Evacuation After Action Report & Patient Care Record, *Page 1*

JTS APPROVED *(Date)* *(12 Jul 2018) -V4.1*

Event: Date ____ Time ____ Time Zone ◯L ◯Z | MM (____) ____ | Pt # ____ of ____ | Tail to Tail ◯Y ◯N | Leg # ____ of ____

9-Line: Time ____ Platform ____ Dispatch Cat ____ Assessed Cat ____

Trauma MIST Report: *M=Mechanism of Injury, I=Injury, S=Signs & Symptoms, T=Treatments* / **Disease Diagnosis:** ____

M ____ I ____ S ____ T ____

Comments ____

Pickup: Time ____ Role ____ Other ____ Region ____ Other ____ Location ____

Dropoff: Time ____ Role ____ Other ____ Region ____ Other ____ Location ____

Capability ☐ EMT-B ☐ EMT-I ☐ EMT-P ☐ EMT-FPC ☐ RN ☐ CRNA ☐ PA ☐ MD/DO Other ____

Circulation-Hemorrhage Control

☐ Direct Pressure
☐ Hemostatic Dressing
☐ Kerlix Dressing
☐ Pressure Dressing
Other ____

Tourniquet
Prior TQ: Reassess/tighten
◯ Y ◯ N ◯ N/A

Time On ____ ☐ CAT ☐ SOFTT ☐ Other ____ ☐ RUE ☐ LUE ☐ RLE ☐ LLE # ____
Time On ____ ☐ CAT ☐ SOFTT ☐ Other ____ ☐ RUE ☐ LUE ☐ RLE ☐ LLE # ____
Time On ____ ☐ CAT ☐ SOFTT ☐ Other ____ ☐ RUE ☐ LUE ☐ RLE ☐ LLE # ____
Time On ____ ☐ CAT ☐ SOFTT ☐ Other ____ ☐ RUE ☐ LUE ☐ RLE ☐ LLE # ____
Time On ____ ☐ AAJT ☐ CRoC ☐ JETT ☐ SAM ☐ Other Junctional ____ #____
TQ Comments ____

Airway

☐ Self ☐ NPA ☐ OPA ☐ Cric ☐ Trach ☐ ETT ☐ SGA Type ____

Tube Size ____ Pos ____ @ ____ Confirmed ☐BS ☐ Vis ☐ $ETCO_2$

O_2 Source ☐ NC ☐ NRB ☐ BVM ☐ Vent LPM ____

Intubated ☐ Prior to transport ☐ By transport crew **Suction** ☐ ETT ☐ Yaunker

Breathing

Needle Decompression

Time ____ ☐ R ☐ L ☐ Mid-ax ☐ Mid-clav
Time ____ ☐ R ☐ L ☐ Mid-ax ☐ Mid-clav
Time ____ ☐ R ☐ L ☐ Mid-ax ☐ Mid-clav
Time ____ ☐ R ☐ L ☐ Mid-ax ☐ Mid-clav

Chest Tube Time ____ ☐ R ☐ L

Chest Equal Rise and Fall
◯ Y ◯ N ◯ N/A

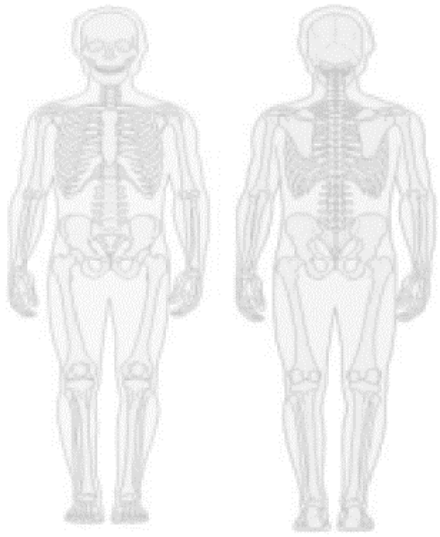
Respiratory Effort
☐ Unlabored ☐ Labored
☐ Agonal ☐ Assisted

Vent Settings

	Time	Mode	Rate	TV	FiO_2	PEEP	PIP	$ETCO_2$
Initial								
Change								
Change								
Change								

Annotate Injuries

(AMP)utation
(BL)eeding
(B)urn % TBSA ____
(C)repitus
(D)eformity
(DG)Degloving
(E)cchymosis
(FX)Fracture
(GSW)Gunshot Wound
(H)ematoma
(IMP)Impaled Object
(LAC)eration
(P)ain
(PP)Peppering
(PW)Puncture Wound
(SQA)Subcutaneous Air
(TBI)Suspect
Other ____



Circulation - Assessment

Rhythm / Ectopy
☐ NSR ☐ SVT
☐ ST ☐ VT
☐ SB ☐ VF
☐ PEA
☐ Paced
☐ Asystole
☐ A-FIB
☐ A-FLUT

Pulses
A, D, +1, +2, +3
RAD ____
BRAC ____
CAR ____
FEM ____
PED ____
TEMP ____

Circulation - Resuscitation

Transfusion Indication
☐ Amputation
☐ HR > 120
☐ SBP < 90

Blood Infusion

Time	Component	ABO/RH	Unit Number	Exp. Date	Blood Age

IV Lines

Peripheral
Hand ☐ R ☐ L ga ____
Arm ☐ R ☐ L ga ____
EJ ☐ R ☐ L ga ____

IO Type / Site
☐ Fast-1 ☐ EZ IO Other ____
Humerus ☐ R ☐ L
Tibia ☐ R ☐ L
☐ Sternum

Central Line Location
☐ Triple lumen ____
☐ Cordis ____

Arterial Line
Wrist ☐ R ☐ L
Groin ☐ R ☐ L

PREPARED BY *(Name, Rank & Title)* ____

DEPARTMENT/SERVICE/CLINIC *(Treating Unit)* ____

DATE ____

PATIENT'S IDENTIFICATION (*Name: last, first, middle; grade; date; hospital or medical facility)*

Last Name ____ First Name ____ MI ____

BR# ____ Rank ____ Unit ____ Pt Cat ____

SSN ____ DOB ____ Gender ◯ M ◯ F Allergy ____ Other ____

☐ HISTORY/PHYSICAL ☒ TREATMENT
☐ DIAGNOSTIC STUDIES ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER, Specify

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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REPORT TITLE

Tactical Evacuation After Action Report & Patient Care Record, *Page 2*

JTS APPROVED *(Date)*
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Vital Signs

	Time	HR	BP	RR	SpO_2	$ETCO_2$	Temp	F	C	AVPU	GCS: Eyes 1-4	Verbal 1-5	Motor 1-6	Total	Pain 0-10
First			/					◯	◯						
			/					◯	◯						
			/					◯	◯						
Last			/					◯	◯						

PERRLA ☐ R Size (mm) ____ ☐ L Size (mm) ____

Field Ultrasound Results ____ Other Diagnostics ____

Additional Interventions

Foley Time ____ Comment ____ **Gastric Tube** Time ____ ☐ Oral ☐ Nasal Comment ____

Protection ____ ☐ Eye Shield ☐ Protective Eyewear ☐ Right ☐ Left Comment ____

Immobilization ____ ☐ C-Collar ☐ C-Spine ☐ Spine Board ☐ Pelvic Splint ☐ Pelvic Binder, Type ____

____ ☐ Splint, Type/Location ____

Warming ____ ☐ Hypothermia Prevention, Product ____

____ ☐ Hypothermia Prevention, Product ____

Other Interventions ____ ____

____ ____

Medications and Fluids

Route = IM, IN, IO, IV, PO, PR, SL, SQ

Time	Drug / Fluid	Dose	Route

Medications and Fluids

Route = IM, IN, IO, IV, PO, PR, SL, SQ

Time	Drug / Fluid	Dose	Route

Documents Received ☐ TCCC Card ☐ Patient Chart ☐ None Other ____

Narrative Summary of Care

Enroute Care Provider

Last Name	First Name	Rank	Capability	Signature

Email PCR to: DHA.JBSA.J-3.List.JTS-Prehospital@mail.mil **MM (** ____ **)** ____

PREPARED BY
(Signature & Title)

DEPARTMENT/SERVICE/CLINIC *(Treating Unit)*

DATE

PATIENT'S IDENTIFICATION (*Name: last, first, middle; grade; date; hospital or medical facility)*

Last Name ____ First Name ____ MI ____

BR# ____ Rank ____ Unit ____ Pt Cat ____

SSN ____ DOB ____ Gender ◯ M ◯ F Allergy ____ Other ____

☐ HISTORY/PHYSICAL ☒ TREATMENT
☐ DIAGNOSTIC STUDIES ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER, Specify

TACTICAL EVACUATION-AFTER ACTION REPORT & PATIENT CARE RECORD

IAW AR 40-68 (RAR) 22 May 2009 Paragraph 3–7. This page is a quality assurance document. Do not file in medical records.

Casualty's Protective Equipment *(Check all worn)*

☐ Helmet, Ballistic	☐ Plate Front	☐ Neck Protector *(Back)*	☐ Groin Shield	☐ Blast Gauge
☐ Tactical Vest *(IOTV)*	☐ Plate Back	☐ Throat Protector *(Front)*	☐ Pelvic Undergarment Tier 1	☐ Blast Sensor Helmet
☐ Eye Protection	☐ Plate Right Side	☐ Deltoid Right	☐ Pelvic Undergarment Tier 2	☐ Blast Sensor Other
☐ Ear Protection	☐ Plate Left Side	☐ Deltoid Left		

AAR Discussion

Event Date _____ ☐ Tactical situation complicated care *(Explain in discussion)*

Sustains	Improves

PATIENT'S IDENTIFICATION (*Name: last, first, middle; grade; date; hospital or medical facility)*

Last Name _____ First Name _____ MI ____

BR# _____ Rank _____ Unit _____

SSN _____ DOB _____ Gender ◯ M ◯ F Pt Cat _____

Date _____ Allergy _____ Other _____