



DEPARTMENT OF THE NAVY  
BUREAU OF MEDICINE AND SURGERY  
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Canc frp: Dec 2007

IN REPLY REFER TO  
BUMEDNOTE 6310  
BUMED-M3  
15 Dec 2006

BUMED NOTICE 6310

From: Chief, Bureau of Medicine and Surgery  
To: Ships and Stations Having Medical Department Personnel

Subj: IMPLEMENTATION OF JOINT THEATER TRAUMA RECORDS

Ref: (a) ASD(HA) Memorandum of 19 Dec 2005  
(b) Manual of the Medical Department, Chapter 16

Encl: (1) Sample ASD(HA) Trauma Registry Form/Navy-Marine Corps CTR (Rev. 9b, 14 JUL 2006), Navy-Marine Corps CRT – Theater Medical Registry Form  
(2) Sample ASD(HA) September 2005 Test Form, Physician Trauma Admitting Record (Theater Hospital Care)  
(3) Sample ASD(HA) September 2005 Test Form, Joint Theater Trauma Nursing Record

1. Purpose. To implement the Joint Theater Trauma Records which will provide uniform descriptions of the epidemiology, nature, and severity of injuries; the time and nature of care provided; and patient outcomes as required by reference (a). To make an interim change to reference (b).

2. Background. The Services, Joint Staff, and Office of the Assistant Secretary of Defense for Health Affairs collaborated to develop a series of three trauma record templates to accommodate physician and nurse record keeping at theater Taxonomy-of-Care categories, First Responder, Forward Resuscitative Care (essentially equivalent to Level II) and Theater Care (essentially equivalent to Level III). These standardized templates were provided for DOD-wide use, and as sources of data collection for the Joint Theater Trauma Registry (JTTR). Enclosures (1) through (3) provide samples of these forms.

3. Responsibilities

a. Operational Forces. Clinicians providing care at Navy and Marine Corps Level I, Level II, and Level III medical treatment facilities (MTFs), including Battalion Aid Stations (BASs), Shock Trauma Platoons (STPs), Forward Resuscitative Surgery Systems (FRSSs), Surgical Companies, small deck ships with corpsman level care, Casualty Receiving and Treatment Ships (CRTS), hospital ships (T-AH), and Expeditionary Medical Facilities (EMFs) shall comply with the information provided in this notice.

b. Naval Medical Centers and Naval Hospitals providing definitive care to patients evacuated from combat operations will provide patient data to populate the Navy-Marine Corps Combat Trauma Registry at the Naval Health Research Center.

4. Action. Existing Navy Trauma Records shall be replaced as follows:

a. The ASD(HA) Trauma Registry Form/Naval-Marine Corps CTR (Rev. 9b, 14 JUL 2006), Navy-Marine Corps CRT – Theater Medical Registry Form, enclosure (1), will serve as the Forward Resuscitative Care form within the Navy and will be used by the Navy-Marine Corps Combat Trauma Registry (CTR) to capture clinical encounters within an Area of Operations (AOR), including Battle Injury (BI), Non-Battle Injury (NBI), disease, and psychological clinical events. This form will also be the primary form used in Navy-Marine Corps MTFs. Medical facilities will have the option to complete this form in one of three ways, choosing the method most appropriate for their use. The options are:

(1) Paper and Pen. The clinician in theater fills out the form, placing the original in the patient's medical record and mails the copy to the Navy-Marine Corps Combat Trauma Registry, Naval Health Research Center – Dept 161, P. O. Box 85122, San Diego, CA 92186-5122. Navy-Marine Corps CTR personnel shall abstract and enter the data into the CTR database.

(2) Computer Based. The Navy-Marine Corps CTR has placed a computer in each Marine Expeditionary Force (MEF) level I and level II facilities, MSC and Forward MEF Surgeon's HQ. Providers may complete the form electronically. If this option is chosen, the clinician prints a copy of the completed form for the patient's medical record, the system then electronically forwards the encounter to the MEF Surgeon's HQ server where it is automatically encrypted, digitally signed and e-mailed to NHRC. This option may only be chosen at an MTF with the CTR computer capability.

(3) Web Based. Any MTF computer asset which has connectivity to one of the CTR assets positioned in the AOR (e.g., the MEF Surgeon's server) can connect via a browser to the appropriate Uniform Resource Locator (URL) and complete the online form. The clinician can print the form locally and the system will automatically forward the encounter data both to the MEF Surgeon's server and to NHRC.

b. The ASD(HA) September 2005 Test Form, Physician Trauma Admitting Record (Theater Hospital Care) Form, enclosure (2), will be used by Navy-Marine Corps CTR personnel to capture all clinical encounters within an AOR, including Battle Injury (BI), Non-Battle Injury (NBI), disease, and psychological clinical events. This form will be placed in all Navy-Marine Corps level III MTFs, including T-AH and EMFs. It will be used as the primary admitting data collection form at Navy Level III MTFs. The Navy will use this form in two capacities, i.e., as the clinical encounter instrument for the patient's medical record and as the primary Level III Navy-Marine Corps CTR data collection instrument. Refer to paragraphs 4a(1) and 4a(2) above for choices of form completion options.

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c. The ASD(HA) September 2005 Test Form, Joint Theater Trauma Nursing Record Form, enclosure (3), will be used as the primary record of care administered to the patient throughout the Level III patient stay. Refer to paragraphs 4a(1) and 4a(2) above for form completion options.

d. Filing of Forms. Completed form(s) will be filed in the medical record in chronological order with other treatment forms (e.g., SF 600 forms).

## 5. Forms

a. The ASD(HA) Trauma Registry Form/Navy-Marine Corps CTR (Rev. 9b, 14 JUL 2006), Navy-Marine Corps CRT – Theater Medical Registry Form is available in carbon based paper format from the applicable medical logistics resource in AOR or may be obtained from the Naval Health Research Center – Dept 161, P. O. Box 85122, San Diego, CA 92186-5122 or via e-mail at: [ctr@nhrc.navy.mil](mailto:ctr@nhrc.navy.mil).

b. The ASD(HA) September 2005 Test Form, Physician Trauma Admitting Record (Theater Hospital Care) form is available in carbon based paper format from the applicable medical logistics resource in the AOR or may be obtained from the Naval Health Research Center – Dept 161, P. O. Box 85122, San Diego, CA 92186-5122 or via e-mail at: [ctr@nhrc.navy.mil](mailto:ctr@nhrc.navy.mil).

c. The ASD(HA) September 2005 Test Form, Joint Theater Trauma Nursing Record form is available in carbon based paper format from the applicable medical logistics resource in the AOR or may be obtained from the Naval Health Research Center – Dept 161, P. O. Box 85122, San Diego, CA 92186-5122 or via e-mail at: [ctr@nhrc.navy.mil](mailto:ctr@nhrc.navy.mil).

d. All three forms are also available in the computer based version at MTFs with the CTR computer capability.

6. Cancellation Contingency. Retain until incorporated into reference (b).



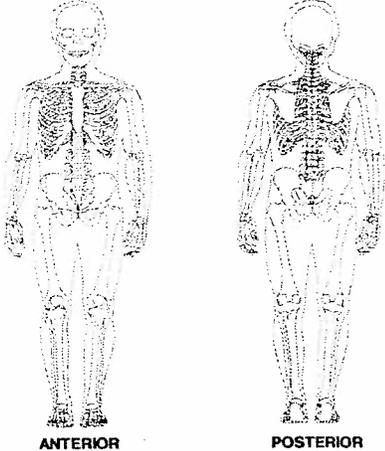
D. C. ARTHUR

Distribution is electronic only via the Navy Medicine Web site at:  
<http://navymedicine.med.navy.mil/default.cfm?seltab=directives>

| <b>Navy-Marine Corps CTR – Theater Medical Registry Form</b>   |  |   |   |   |   |
|--|--|---|---|---|---|
| Name (Last, First MI):   |  | Patient I.D. / SSN:   |   | Rank:   | Unit:   |
| Date of Birth: DDMMYY  |  | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female                                       |   | Blood Type:   | Allergies:  |
| MTF Patient Evacuated From: (If casualty read from point of injury, enter POI)   |  | MTF Designation:  |   | MTF Location:   | Facility Type: <input type="checkbox"/> Base-X<br><input type="checkbox"/> GP <input type="checkbox"/> CBPS <input type="checkbox"/> Hard Bldg  |
| Medical Visit: <input type="checkbox"/> Battle Injury <input type="checkbox"/> Disease <input type="checkbox"/> Non-Battle Injury <input type="checkbox"/> Dental (Routine)  |  |   | Treatment: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-Up  |   |   |
| Date/Time of Injury: DDMMYY.TIME   | Transport Care To Facility:<br><input type="checkbox"/> Casualty Evacuation (CasEvac)<br><input type="checkbox"/> En Route Care (ERC)<br><input type="checkbox"/> Non-Medical<br>Transit Duration Time: _____  |   | Arrival Method:<br><input type="checkbox"/> Walked <input type="checkbox"/> Carried<br><input type="checkbox"/> Med Evac Ground <input type="checkbox"/> Non Med Evac Ground<br><input type="checkbox"/> Med Evac Air <input type="checkbox"/> Non Med Evac Air<br><input type="checkbox"/> Train <input type="checkbox"/> Water Boat<br><input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ |   | Category:<br><input type="checkbox"/> US Marine Corps <input type="checkbox"/> SOF<br><input type="checkbox"/> US Navy <input type="checkbox"/> Civilian<br><input type="checkbox"/> US Army <input type="checkbox"/> Contractor<br><input type="checkbox"/> US Air Force <input type="checkbox"/> Combatant<br><input type="checkbox"/> Host Nation Security <input type="checkbox"/> NGO - _____<br><input type="checkbox"/> TCN: _____ <input type="checkbox"/> Other: _____<br><input type="checkbox"/> Unknown <input type="checkbox"/> None |
| Date/Time of Arrival: DDMMYY.TIME  |  |   |   |   |   |
| Wounded By: <input type="checkbox"/> Enemy <input type="checkbox"/> Friendly   |  | <input type="checkbox"/> Self Accident <input type="checkbox"/> Civilian (Host Country)                     |   | <input type="checkbox"/> Self Non-Accident <input type="checkbox"/> Sports/Recreation   | <input type="checkbox"/> Training <input type="checkbox"/> Other: _____<br><input type="checkbox"/> Unknown <input type="checkbox"/> N/A  |
| Mechanism of Injury:<br><input type="checkbox"/> Aerial Bomb <input type="checkbox"/> Flying Debris <input type="checkbox"/> Machinery/Equipment<br><input type="checkbox"/> Aggravated R.O.M. <input type="checkbox"/> Grenade <input type="checkbox"/> Mortar<br><input type="checkbox"/> Assault/Altercation <input type="checkbox"/> GSW/Bullet <input type="checkbox"/> Motor Vehicle Accident<br><input type="checkbox"/> Bite / Sting <input type="checkbox"/> Helicopter Crash <input type="checkbox"/> Parachute Drop<br><input type="checkbox"/> Blunt Trauma <input type="checkbox"/> Plane Crash <input type="checkbox"/> Pedestrian<br><input type="checkbox"/> Building Collapse <input type="checkbox"/> Hot Object/Liquid <input type="checkbox"/> Rocket<br><input type="checkbox"/> Burn <input type="checkbox"/> IED <input type="checkbox"/> RPG<br><input type="checkbox"/> Crush <input type="checkbox"/> VBIED (Vehicle Borne) <input type="checkbox"/> Unexploded Ordnance<br><input type="checkbox"/> Drowning <input type="checkbox"/> Knife/Edge(Stab) <input type="checkbox"/> Chemical<br><input type="checkbox"/> Electrical/Electrocution <input type="checkbox"/> Landmine <input type="checkbox"/> Biological<br><input type="checkbox"/> Radiation/Nuclear |  |   | Triage Category:<br><input type="checkbox"/> Immediate<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Minimal<br><input type="checkbox"/> Expectant<br><input type="checkbox"/> N/A<br><input type="checkbox"/> Environmental<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Unknown<br><input type="checkbox"/> N/A   | Glasgow Coma Scale (Circle each)<br>Eye Opening: 1-None, 2-To pain, 3-To command, 4-Spontaneous<br>Verbal Response: 1-None, 2-Incomp. sounds, 3-Inapprop. words, 4-Confused, 5-Oriented<br>Motor Response: 1-None, 2-Extend pain, 3-Flex to pain, 4-Withdraws, 5-Localize pain, 6-Obeys<br>Glasgow Score _____ (Enter total number) |   |
| Personal Protective Equipment:   |  | Worn  | Not Worn  | Struck  | Penetrated  |
| Helmet - Circle: USMC / ACH / AVN / CVC / MICH   |  |   |   |   |   |
| Eyewear - Circle: Wiley-X/ESS Land/ESS NVG/SG-1/ SWDG/BLPS/UVEX XC/Other   |  | L <input type="checkbox"/> R <input type="checkbox"/>   | L <input type="checkbox"/> R <input type="checkbox"/>   |   |   |
| Ear Protection - Circle: Combat Ear Plugs/Single/Other Circle: XS / S / M / L / XL   |  | Y <input type="checkbox"/> T <input type="checkbox"/>   | Y <input type="checkbox"/> T <input type="checkbox"/>   | Y <input type="checkbox"/> T <input type="checkbox"/>   | Y <input type="checkbox"/> T <input type="checkbox"/>   |
| Neck Protector - Yoke and Throat   |  |   |   |   |   |
| Flak Vest / IBA - Circle: XS / S / M / L / XL / XXL / XXXL / XXXXL   |  |   |   |   |   |
| Ceramic Plates (Front, Back, Left & Right Side) - Circle: XS / S / M / L / XL  |  | F <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> | F <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/>   | F <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/>   | F <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/>   |
| Axillary / Deltoid / Upper Extremity   |  | L <input type="checkbox"/> R <input type="checkbox"/>   | L <input type="checkbox"/> R <input type="checkbox"/>   | L <input type="checkbox"/> R <input type="checkbox"/>   | L <input type="checkbox"/> R <input type="checkbox"/>   |
| Groin Protector  |  |   |   |   |   |
| Leg / Lower Extremity  |  | L <input type="checkbox"/> R <input type="checkbox"/>   | L <input type="checkbox"/> R <input type="checkbox"/>   | L <input type="checkbox"/> R <input type="checkbox"/>   | L <input type="checkbox"/> R <input type="checkbox"/>   |
| Care Prior to Arrival:   |  |   | Vital Signs   |   |   |
| Tourniquet <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____ Time on: _____ Time off: _____   |  |   | Time  | Temp  | Pulse   |
| Airway <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____  |  |   |   |   |   |
| IV's <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____ Location: _____ Fluid: _____ Amount: _____ ml  |  |   |   |   |   |
| C-Collar <input type="checkbox"/> No <input type="checkbox"/> Yes  |  |   |   |   |   |
| Chest Tube <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Air <input type="checkbox"/> Blood _____ ml   |  |   |   |   |   |
| Needle Decompression <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Air <input type="checkbox"/> Blood _____ ml   |  |   |   |   |   |
| Temp Control Measures <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____   |  |   |   |   |   |
| Intraosseous Access <input type="checkbox"/> No <input type="checkbox"/> Yes Location: _____   |  |   |   |   |   |
| Illustrate wound(s) on figure below (use arrows, circles, text, etc.)  |  |   | Current Treatment & Procedures  |   |   |
| AB Abrasion  | AMP Amputation   | AV Avulsion   | BI Blast Injury   | BL Bleeding   | Burn Burn   |
| C Crepitus   | Deform Deformity   | DG Degloving  | E Ecchymosis  | FB Foreign Body   | Frag Fragment   |
| Fx Fracture  | GSW Gunshot Wound  | H Hematoma  | Lac Laceration  | P Pain  | PW Puncture Wound   |
| SS Seatbelt Sign   | SW Stab Wound  |   |   |   |   |
| Pulses Present:<br>S=Strong<br>W=Weak<br>D=Doppler<br>A=Absent   | Class of Hemorrhage: I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/><br>*Highlight Burn Area - <input type="checkbox"/> 1° <input type="checkbox"/> 2° <input type="checkbox"/> 3°<br>_____% Total Body Surface Area | DTR's:<br>0<br>0.5+ - 1+<br>2+ - 3+<br>4+ - 5+  | Oxygen _____ L/min.   | Fluid Administration:<br>Crystalloid #1: _____ ml<br>Crystalloid #2: _____ ml<br>Colloid #1: _____ ml<br>Colloid #2: _____ ml<br>Other: _____ ml / mg / gm  | Intubated: In _____ Out _____   |
|  |  |   | CRIC _____ No / Yes   | Sedated _____   | Chemically Paralyzed _____  |
|  |  |   | Needle Decompression _____ No / Yes<br><input type="checkbox"/> Left: <input type="checkbox"/> Blood _____ ml <input type="checkbox"/> Right: <input type="checkbox"/> Blood _____ ml   | Chest Tube: _____ No / Yes<br><input type="checkbox"/> Left: <input type="checkbox"/> Blood _____ ml <input type="checkbox"/> Right: <input type="checkbox"/> Blood _____ ml  | Intra-Osseous Access (Location) _____   |
|  |  |   | Foley Catheter _____ No / Yes   | Collar / C-Spine _____ No / Yes   | Tourniquet - - Time On: _____ Time Off: _____   |
|  |  |   | Hemostatic Dressing (e.g. Quik Clot): _____   | Blood Products: _____ Units/Pks   | Auto Transfusion: No / Yes _____ ml   |
|  |  |   |   |   | Factor rFVIIa (NovoSeven) _____ mg  |
|  |  |   |   |   | Walking Blood Bank (FWB) _____ Units  |
|  |  |   |   |   | HBOC _____ ml   |
|  |  |   |   |   | Splints (Location) _____  |

| <b>Name (Last, First MI):</b>  |   | <b>Patient I.D. / SSN:</b>   |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
|--|---|--|----------------|----------------|----------------|-----------------------------------|-----------|-----------|-----------|---------------------------------|-----------|-----------|-----------|-----------------------------------|-----------|-----------|-----------|----------------------------------|-----------|-----------|-----------|-------------------------------------|-----------|-----------|-----------|---|--|
| <b>Prior Medical History:</b>  |   | <b>Medications Administered:</b>   |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <input type="checkbox"/> None <input type="checkbox"/> Unknown<br><input type="checkbox"/> Cardiac <input type="checkbox"/> HTN<br><input type="checkbox"/> Respiratory <input type="checkbox"/> DM<br><input type="checkbox"/> Seizure <input type="checkbox"/> Ulcer (G.I.)<br><input type="checkbox"/> Other: _____ | <table style="width:100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Medication:</th> <th style="text-align: left; border-bottom: 1px solid black;">Dose #1 / Time</th> <th style="text-align: left; border-bottom: 1px solid black;">Dose #2 / Time</th> <th style="text-align: left; border-bottom: 1px solid black;">Dose #3 / Time</th> </tr> <tr> <td><input type="checkbox"/> Morphine</td> <td>____/____</td> <td>____/____</td> <td>____/____</td> </tr> <tr> <td><input type="checkbox"/> Versed</td> <td>____/____</td> <td>____/____</td> <td>____/____</td> </tr> <tr> <td><input type="checkbox"/> Fentanyl</td> <td>____/____</td> <td>____/____</td> <td>____/____</td> </tr> <tr> <td><input type="checkbox"/> Demerol</td> <td>____/____</td> <td>____/____</td> <td>____/____</td> </tr> <tr> <td><input type="checkbox"/> Ancef/Gent</td> <td>____/____</td> <td>____/____</td> <td>____/____</td> </tr> </table> | Medication:  | Dose #1 / Time | Dose #2 / Time | Dose #3 / Time | <input type="checkbox"/> Morphine | ____/____ | ____/____ | ____/____ | <input type="checkbox"/> Versed | ____/____ | ____/____ | ____/____ | <input type="checkbox"/> Fentanyl | ____/____ | ____/____ | ____/____ | <input type="checkbox"/> Demerol | ____/____ | ____/____ | ____/____ | <input type="checkbox"/> Ancef/Gent | ____/____ | ____/____ | ____/____ | #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3 <input type="checkbox"/> Antibiotic (Name): _____<br>Dose/Time ____/____ - ____/____ - ____/____<br>#1 <input type="checkbox"/> #2 <input type="checkbox"/> #3 <input type="checkbox"/> Other (Name): _____<br>Dose/Time ____/____ - ____/____ - ____/____<br>#1 <input type="checkbox"/> #2 <input type="checkbox"/> #3 <input type="checkbox"/> Other (Name): _____<br>Dose/Time ____/____ - ____/____ - ____/____ |  |
| Medication:  | Dose #1 / Time  | Dose #2 / Time   | Dose #3 / Time |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <input type="checkbox"/> Morphine  | ____/____   | ____/____  | ____/____      |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <input type="checkbox"/> Versed  | ____/____   | ____/____  | ____/____      |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <input type="checkbox"/> Fentanyl  | ____/____   | ____/____  | ____/____      |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <input type="checkbox"/> Demerol   | ____/____   | ____/____  | ____/____      |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <input type="checkbox"/> Ancef/Gent  | ____/____   | ____/____  | ____/____      |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <b>Subjective (Chief Complaint) / History:</b>   |   |  |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <b>Objective / Exam:</b>   |   |  |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| Laboratory Results:  |   | X-Ray Results:   |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <b>Assessment / Diagnosis:</b> Primary -   |   | Secondary -  | Tertiary -     |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| OR Start Time:   | OR Stop Time:   | Vent Time On:  | Vent Time Off: |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <b>Plan / Procedure(s) / Treatment / Operative Notes / Nursing Notes / etc:</b>  |   |  |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <b>DNBI Category:</b> <input type="checkbox"/> N/A<br><input type="checkbox"/> Combat/Oper. Stress Rxn<br><input type="checkbox"/> Dermatologic<br><input type="checkbox"/> GI, Infectious   |   | <input type="checkbox"/> Gynecologic<br><input type="checkbox"/> Heat/Cold Injuries<br><input type="checkbox"/> Injury, Recreational/Sports<br><input type="checkbox"/> Injury, MVA  |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <input type="checkbox"/> Injury, Work/Training<br><input type="checkbox"/> Injury, Other<br><input type="checkbox"/> Ophthalmologic<br><input type="checkbox"/> Psych., Mental Disorders   |   | <input type="checkbox"/> Respiratory<br><input type="checkbox"/> STDs<br><input type="checkbox"/> Fever, Unexplained<br><input type="checkbox"/> All Other Med/Surg  |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <input type="checkbox"/> Dental<br><input type="checkbox"/> Misc./Admin./Follow-up<br><input type="checkbox"/> Definable<br><input type="checkbox"/> Neurological <input type="checkbox"/> Ear   |   | <b>Disposition</b><br><b>Date/Time:</b>  |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <input type="checkbox"/> RTD<br><input type="checkbox"/> Light Duty x ____ day(s)<br><input type="checkbox"/> SIQ x ____ day(s)  |   | <input type="checkbox"/> Up Chit (Aviation)<br><input type="checkbox"/> Down Chit (Aviation)<br><input type="checkbox"/> Evac to _____<br><input type="checkbox"/> Admit to ____ x ____ day(s)<br><input type="checkbox"/> Other: _____                        |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <input type="checkbox"/> Deceased - - - <input type="checkbox"/> DOW <input type="checkbox"/> KIA (see below)  |   | <b>Evacuation Priority:</b><br><input type="checkbox"/> N/A <input type="checkbox"/> Urgent (Medical)<br><input type="checkbox"/> Routine <input type="checkbox"/> Urgent (Surgical)<br><input type="checkbox"/> Priority <input type="checkbox"/> Convenience |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <b>Date/Time of Death:</b> _____ <input type="checkbox"/> N/A  |   |  |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <b>ANATOMIC:</b><br><input type="checkbox"/> Airway <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Extremity (Upper/Lower) <input type="checkbox"/> Other, specify: (_____)      |   |  |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <b>PHYSIOLOGIC:</b><br><input type="checkbox"/> Breathing <input type="checkbox"/> CNS <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Total Body Disruption <input type="checkbox"/> Sepsis <input type="checkbox"/> Multi-organ Failure <input type="checkbox"/> Other, specify: (_____)                |   |  |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |
| <b>Provider Name (Printed or Typed):</b>   |   | <b>Provider Signature:</b>   |                |                |                |                                   |           |           |           |                                 |           |           |           |                                   |           |           |           |                                  |           |           |           |                                     |           |           |           |   |  |

S A M P L E

| PHYSICIAN TRAUMA ADMITTING RECORD (THEATER HOSPITAL CARE) (Level 3)   |  |  |  |
|---|--|--|--|
| (All shaded areas mandatory for Joint Theater Trauma Registry data collection)  |  |  |  |
| DATE: _____   |  | <b>VITAL SIGNS</b>   |  |
| TIME OF INJURY: _____   |  | T _____ P _____ R _____ BP _____ / _____ O2 Sat _____  |  |
| TIME OF ARRIVAL: _____  |  |  |  |
| LOCATION OF PRE-HOSP. CARE: _____   |  |  |  |
| <b>HISTORY &amp; PHYSICAL</b>   |  | <b>MECHANISM OF INJURY</b>   |  |
| INJURY DESCRIPTION<br>(AB)rasion<br>(AMP)utation<br>(AV)ulsion<br>(BL)eeding<br>(B)um %TBSA _____<br>(C)repitus<br>(D)eformity<br>(DG)degloving<br>(E)chymosis<br>(FX)Fracture<br>(F)oreign Body<br>(GSW)Gun Shot Wound<br>(H)ematoma<br>(LAC)eration<br>(PW)Puncture Wound<br>(SS)Seatbelt Sign  |  | Pulses Present:<br>S= Strong<br>W= Weak<br>D= Doppler<br>A= Absent   |  |
|  <p>ANTERIOR                      POSTERIOR</p>  |  | <input type="checkbox"/> Assault/Fight <input type="checkbox"/> Helo Crash<br><input type="checkbox"/> Biological <input type="checkbox"/> Hot Obj/Liquid<br><input type="checkbox"/> Blast/Explosion <input type="checkbox"/> IED<br><input type="checkbox"/> Blunt Trauma <input type="checkbox"/> Knife/Edge<br><input type="checkbox"/> Bomb <input type="checkbox"/> Landmine<br><input type="checkbox"/> Building Collapse <input type="checkbox"/> Machinery<br><input type="checkbox"/> Burn <input type="checkbox"/> Mortar<br><input type="checkbox"/> Chemical <input type="checkbox"/> Multi-frag<br><input type="checkbox"/> Crush <input type="checkbox"/> MVC<br><input type="checkbox"/> Drowning <input type="checkbox"/> Plane Crash<br><input type="checkbox"/> Fall <input type="checkbox"/> Red/Nuclear<br><input type="checkbox"/> Flying Debris <input type="checkbox"/> Single Frag<br><input type="checkbox"/> Grenade <input type="checkbox"/> UXO<br><input type="checkbox"/> GSW/Bullet <input type="checkbox"/> Other |  |
| <b>HISTORY AND PRESENTING ILLNESS:</b> _____  |  | <b>CARE DONE PRIOR TO ARRIVAL</b>  |  |
|   |  | Pre-hospital Airway: <input type="checkbox"/> no <input type="checkbox"/> yes<br>Pre-hosp. Tourniquet : <input type="checkbox"/> no <input type="checkbox"/> yes   Type: _____   TIME On: _____   Off: _____<br>Pre-hosp. Chest Tube: <input type="checkbox"/> no <input type="checkbox"/> yes   R   L (circle as applicable)<br>Temp Control Measure: <input type="checkbox"/> no <input type="checkbox"/> yes   type: <input type="checkbox"/> dry bag <input type="checkbox"/> ice<br>Intraosseous Access: <input type="checkbox"/> y <input type="checkbox"/> n  |  |
| <b>HISTORY &amp; PHYSICAL</b>   |  | <b>INITIAL PROCEDURES / DIAGNOSTICS</b>  |  |
| Head & Neck:                              Tymp Membranes<br>Clear   R <input type="checkbox"/> L <input type="checkbox"/><br>Blood   R <input type="checkbox"/> L <input type="checkbox"/>  |  | <input type="checkbox"/> C--collar <input type="checkbox"/> Intubate <input type="checkbox"/> Canthotomy (circle L/R)<br><input type="checkbox"/> Airway (oral/ nasal) <input type="checkbox"/> CRIC <input type="checkbox"/> Cantholysis (circle L/R)<br><input type="checkbox"/> Chest tube <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Output <input type="checkbox"/> Blood: mls _____   Air _____<br><input type="checkbox"/> Needle decompression <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Output: <input type="checkbox"/> Blood: mls _____   Air _____<br><input type="checkbox"/> Pericardiocentesis <input type="checkbox"/> Thoracotomy  |  |
| Chest:  |  | Rectal Exam <input type="checkbox"/> FAST<br>Tone _____ <input type="checkbox"/> DPL<br>Gross Blood +/- <input type="checkbox"/> NG/OG<br>Prostate _____ <input type="checkbox"/> Pelvic Binder<br>GYN _____ <input type="checkbox"/> Foley  |  |
| Abdomen:  |  | <input type="checkbox"/> Closed Reduction <input type="checkbox"/> EXT Fixation<br><input type="checkbox"/> Splint <input type="checkbox"/> Wound Washout<br><input type="checkbox"/> Tourniquet    Type CAT / SOFT / Oth    Time On: _____    Time Off: _____   |  |
| Pelvis: <input type="checkbox"/> Stable <input type="checkbox"/> Unstable   |  | <input type="checkbox"/> Closed reduction <input type="checkbox"/> EXT Fixation<br><input type="checkbox"/> Splint <input type="checkbox"/> Wound washout<br><input type="checkbox"/> Tourniquet    Type CAT / SOFT / Oth    Time on: _____    Time off: _____   |  |
| Upper Extremities:  |  | <input type="checkbox"/> Sedated<br><input type="checkbox"/> Chemically Paralyzed<br><input type="checkbox"/> Seizure Protocol<br><input type="checkbox"/> Mannitol<br><input type="checkbox"/> Intraosseus<br><input type="checkbox"/> Central Line<br><input type="checkbox"/> A-Line  |  |
| Lower extremities:  |  | <b>HYPO / HYPERTHERMIA CONTROL MEASURES</b>  |  |
| Neuro: GCS: _____<br>E ___/4    M ___/6    V ___/5<br>Motor Deficit:                      None<br>R UE/LE<br>L UE/LE<br>C-Spine Tender<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>Skin: Burn: 1st   2nd   3rd   %TBSA   |  | Beginning Temp _____                      Time/date _____<br>Ending Temp _____                      Time/date _____<br>Temperature Control Procedure<br><input type="checkbox"/> Bair Huggler <input type="checkbox"/> Fwd Resus Fluid Warmer<br><input type="checkbox"/> Chill Buster <input type="checkbox"/> Body Bag<br><input type="checkbox"/> Cooling Blanket <input type="checkbox"/> Other _____  |  |
| <b>CBC</b>  |  | <b>CHEMISTRY 7</b>   |  |
| L<br>A<br>B<br>O<br>R<br>A<br>T<br>O<br>R<br>Y<br>PT/ INR/ PTT  |  | LFT<br>Amylase: _____<br>Alk Phos: _____<br>LDH: _____<br>Bili: _____<br>SGOT: _____<br>SGPT: _____<br>Other: _____  |  |
| <b>URINALYSIS</b>   |  | <b>ALLERGIES</b>   |  |
| SpGr: _____<br>pH: _____<br>Chem: _____<br>Micro: _____<br>RBC: _____<br>WBC: _____<br>Bact: _____<br>HCG: _____  |  | <input type="checkbox"/> NKDA<br><input type="checkbox"/> ASA<br><input type="checkbox"/> PCN<br><input type="checkbox"/> Sulfa<br><input type="checkbox"/> Morphine<br><input type="checkbox"/> Codeine<br><input type="checkbox"/> Latex<br><input type="checkbox"/> Other _____   |  |
| <b>ABG</b>  |  | <b>MEDICATIONS</b>   |  |
| FIO2: _____                      VENT: _____<br>pH: _____                      YES NO<br>pCO2: _____                      ETT Size: _____<br>pO2: _____<br>HCO3: _____<br>Sat: _____<br>BE: _____   |  | <input type="checkbox"/> DT<br><input type="checkbox"/> Abx _____<br><input type="checkbox"/> Versed<br><input type="checkbox"/> Morphine<br><input type="checkbox"/> Fentanyl<br><input type="checkbox"/> Other: _____  |  |
| <b>IV FLUIDS/BLOOD PRODUCTS</b>   |  | <b>PMH</b>   |  |
| <input type="checkbox"/> Crystalloids _____ cc's    NS   LR<br><input type="checkbox"/> Colloids _____ cc's<br><input type="checkbox"/> PRBC's _____ units<br><input type="checkbox"/> FFP _____ units<br><input type="checkbox"/> Whole Bld _____ units<br><input type="checkbox"/> Cryo _____ units<br><input type="checkbox"/> PLT's _____ packs |  | <input type="checkbox"/> Unknown <input type="checkbox"/> ITN<br><input type="checkbox"/> None <input type="checkbox"/> DM<br><input type="checkbox"/> Cardiac <input type="checkbox"/> Ulcer<br><input type="checkbox"/> Respiratory <input type="checkbox"/> Other<br><input type="checkbox"/> Seizure   |  |
| Patient NAME/ID: _____  |  | DATE: (dd,mm,yy)   |  |
| Last: _____ First _____ MI _____  |  | MTF transferred from: _____  |  |
| SSN/ID _____ DOB/AGE _____  |  | MTF: _____   |  |

S A M P L E

Enclosure (2)

S A M P L E

| PHYSICIAN TRAUMA ADMITTING RECORD (THEATER HOSPITAL CARE) (Level 3)            |  |  |   |
|--|--|--|---|
|  | OBTAINED                                     | PENDING  | RESULTS   |
| <b>X</b><br><b>R</b><br><b>A</b><br><b>Y</b><br><b>S</b>                       | <input type="checkbox"/> HEAD                |  |   |
|  | <b>C</b> <input type="checkbox"/> C-SPINE    |  |   |
|  | <b>T</b> <input type="checkbox"/> ABD/PELVIS |  |   |
|  | <input type="checkbox"/> CHEST               |  |   |
|  | <b>C</b> <input type="checkbox"/> SUPINE     |  |   |
|  | <b>X</b> <input type="checkbox"/> UP RIGHT   |  |   |
|  | <b>R</b> <input type="checkbox"/>            |  |   |
|  | <b>O</b> <input type="checkbox"/> C-SPINE    |  |   |
|  | <b>T</b> <input type="checkbox"/> PELVIS     |  |   |
|  | <b>H</b> <input type="checkbox"/> LLE        |  |   |
|  | <b>E</b> <input type="checkbox"/> RLE        |  |   |
|  | <b>R</b> <input type="checkbox"/> RUE        |  |   |
| <input type="checkbox"/> LUE   |  |  |   |
| <input type="checkbox"/>   |  |  |   |
| <input type="checkbox"/>   |  |  |   |
| <b>IMPRESSION:</b>   |  |  |   |
|  |  |  |   |
| <b>DIAGNOSIS</b>   |  |  |   |
| 1  |  |  |   |
| 2  |  |  |   |
| 3  |  |  |   |
| 4  |  |  |   |
| 5  |  |  |   |
| <b>PLAN:</b>   |  |  |   |
|  |  |  |   |
| <b>EVACUATED TO/DISPOSITION</b>  |  | <b>TRIAD INDICATORS</b>  |   |
| Admit to OR, ICU, ICW _____  |  | Damage Control: <input type="checkbox"/> yes <input type="checkbox"/> no   |   |
| <input type="checkbox"/> Evac to: Def Care, HN, Coalition, Facility Name _____ |  | Hypothermia: <input type="checkbox"/> yes <input type="checkbox"/> no  |   |
| <input type="checkbox"/> RTD Unit _____  |  | Coagulopathy: <input type="checkbox"/> yes <input type="checkbox"/> no   |   |
| <input type="checkbox"/> Deceased (see below)                                  |  | Shock: <input type="checkbox"/> yes <input type="checkbox"/> no  |   |
| Time of disposition: _____   |  | Class of Hemorrhage<br>I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> |   |
| <b>EVAC PRIORITY</b>   |  |  |   |
| <input type="checkbox"/> Routine   |  |  |   |
| <input type="checkbox"/> Priority  |  |  |   |
| <input type="checkbox"/> Urgent  |  |  |   |
| <b>DNBI CATEGORY</b>   |  |  |   |
| <input type="checkbox"/> Cardiac   | <input type="checkbox"/> GI                  | <input type="checkbox"/> Injury, MVC   | <input type="checkbox"/> Psychiatric, Stress        |
| <input type="checkbox"/> Dermatologic  | <input type="checkbox"/> Heat/Cold           | <input type="checkbox"/> Injury, Work/Training   | <input type="checkbox"/> Pulmonary                  |
| <input type="checkbox"/> Endocrine   | <input type="checkbox"/> Infectious Dz       | <input type="checkbox"/> Injury, Other   | <input type="checkbox"/> STDs                       |
| <input type="checkbox"/> FUO   | <input type="checkbox"/> Injury, Sports      | <input type="checkbox"/> Neurologic  | <input type="checkbox"/> All Other Medical/Surgical |
| <b>ATTENDING STAFF</b>   |  | <b>CAUSE OF DEATH</b>  |   |
| Physician Signature: _____   |  | <b>Anatomic:</b>   |   |
| Physician Printed or Typed Name: _____   |  | <input type="checkbox"/> Airway <input type="checkbox"/> Chest <input type="checkbox"/> Extremity U / L                                |   |
|  |  | <input type="checkbox"/> Head <input type="checkbox"/> Pelvis <input type="checkbox"/> Other, specify                                  |   |
|  |  | <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen   |   |
|  |  | <b>Physiologic:</b>  |   |
|  |  | <input type="checkbox"/> MOF <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Other  |   |
|  |  | <input type="checkbox"/> CNS <input type="checkbox"/> Total Body Disruption  |   |
|  |  | <input type="checkbox"/> Sepsis <input type="checkbox"/> Breathing   |   |
| <b>PATIENT ID/SSN</b>  |  |  |   |
| Last   | First  | MI   | MTF   |
| SSN/D  |  | DOB/AGE  |   |

S A M P L E

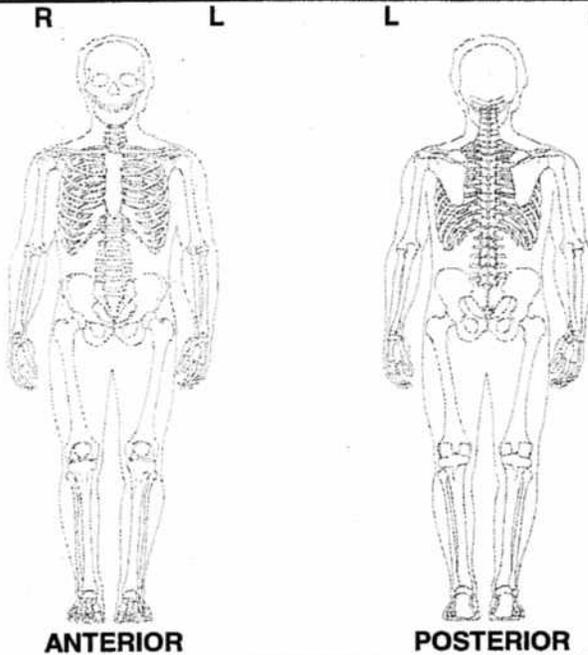
| JOINT THEATER TRAUMA NURSING RECORD   |   |   |  |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
|---|---|---|--|--|--------------|-------------|------------|--|-----|-------|-------|-------|--|-----|-------|-------|-------|--|-----|-------|-------|-------|--|-----|-------|-------|-------|--|--|
| (All shaded areas mandatory for Joint Theater Trauma Registry data collection)  |   |   |  |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| <b>ARRIVAL STATUS</b>   | <b>TRIAGE CATEGORY</b>  | <b>WOUNDED BY</b>   | <b>MODE OF ARRIVAL</b>   | <b>PATIENT CATEGORY</b>  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| Date: _____<br>Time of injury: _____<br>Time of arrival: _____<br>Transit time: _____<br>C-spine immob: Y/N    Functional IV: Y/N<br>Intubated: Y/N    Cric: Y/ N    Needle Decompr: Y/N<br>T: _____ BP: _____ / _____ HR: _____ RR: _____ O <sub>2</sub> Sat: _____<br>PAIN: _____ 0 1 2 3 4 5 6 7 8 9 10  | <input type="checkbox"/> Immediate<br><input type="checkbox"/> Delayed<br><input type="checkbox"/> Minimal<br><input type="checkbox"/> Expectant  | <input type="checkbox"/> Unknown<br><input type="checkbox"/> Enemy<br><input type="checkbox"/> Friendly<br><input type="checkbox"/> Civ (Host Nation)<br><input type="checkbox"/> Training<br><input type="checkbox"/> Self Accident<br><input type="checkbox"/> Self Inflicted<br><input type="checkbox"/> Sports Recreation<br><input type="checkbox"/> Other:  | <input type="checkbox"/> Walked<br><input type="checkbox"/> Carried<br><input type="checkbox"/> USMC CASEVAC<br><input type="checkbox"/> Non-med Ground<br><input type="checkbox"/> Ground Ambulance<br><input type="checkbox"/> Non-med Air<br><input type="checkbox"/> Air Ambulance<br><input type="checkbox"/> Ship EVAC<br><input type="checkbox"/> Other:  | <b>Nation:</b><br><input type="checkbox"/> US<br><input type="checkbox"/> Host nation<br><input type="checkbox"/> Coalition: _____<br><input type="checkbox"/> Enemy: _____<br><b>Service:</b><br><input type="checkbox"/> USA<br><input type="checkbox"/> USN<br><input type="checkbox"/> USMC<br><input type="checkbox"/> USAF<br><input type="checkbox"/> SOF<br><input type="checkbox"/> Civilian<br><input type="checkbox"/> Combatants<br><input type="checkbox"/> Contractor<br><input type="checkbox"/> Media<br><input type="checkbox"/> ING<br><input type="checkbox"/> IP<br><input type="checkbox"/> Non-gov't Org<br><input type="checkbox"/> Other:<br><input type="checkbox"/> ID WRIST BAND ON |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| <b>TOURNIQUET</b>   | <b>CPR IN PROGRESS</b>  | <b>GENDER</b>   | <b>PRE-HOSP. WARMING</b>   |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Time on: _____ off: _____<br>Type: CAT/ SOFTT/ Other: _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Time started: _____<br>Time ended: _____  | <input type="checkbox"/> Male<br><input type="checkbox"/> Female  | <input type="checkbox"/> Blanket<br><input type="checkbox"/> Space blanket<br><input type="checkbox"/> Body bag<br><input type="checkbox"/> Other:   |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| <b>PRE HOSP. MEDS @ _____ (time)</b>  |   | <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other:   | <b>HOSP. WARMING</b>   |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| <input type="checkbox"/> Morphine _____<br><input type="checkbox"/> Fentanyl _____  | <input type="checkbox"/> RSI Meds<br><input type="checkbox"/> Seizure Med   | <input type="checkbox"/> Mannitol   | <input type="checkbox"/> Radiant Warmer<br><input type="checkbox"/> IV bag Warmer<br><input type="checkbox"/> Bair Hugger<br><input type="checkbox"/> Pre-arrival<br><input type="checkbox"/> Other:   |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| <b>CHIEF COMPLAINT</b>  | <b>EVAC FROM</b> (Check/circle all that apply)  |   |  |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
|   | <input type="checkbox"/> Field<br><input type="checkbox"/> Coalition<br>USA/ USN/ USAF/ USMC<br>Init Resp/Fwd Resus Care/Theater Hosp   |   |  |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| PRIMARY SURVEY  |   |   |  |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| <b>AIRWAY</b>   | <b>BREATHING</b>  | <b>Breath Sounds</b>  | <b>CIRCULATION</b>   | <b>DEFICIT/NEURO</b>   |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| <input type="checkbox"/> Patent<br><input type="checkbox"/> Stridor<br><input type="checkbox"/> Drooling<br><input type="checkbox"/> Obstructed<br><input type="checkbox"/> Oral/Nasal Airway<br><input type="checkbox"/> BVM<br><input type="checkbox"/> Combi Tube<br><input type="checkbox"/> Intubated<br><input type="checkbox"/> Other:                     | <input type="checkbox"/> Unlabored<br><input type="checkbox"/> Labored<br><input type="checkbox"/> Absent<br><input type="checkbox"/> Retraction<br><input type="checkbox"/> Flaring<br>Trachea: <input type="checkbox"/> Midline <input type="checkbox"/> Deviated<br>Chest Symmetry: (circle one)<br>Left > Equal < Right   | Right    Left<br><input type="checkbox"/> Clear <input type="checkbox"/><br><input type="checkbox"/> Rales <input type="checkbox"/><br><input type="checkbox"/> Wheeze <input type="checkbox"/><br><input type="checkbox"/> Absent <input type="checkbox"/>   | <b>Skin:</b><br><input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Hot<br><input type="checkbox"/> Pink <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic<br><input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Diaph<br><b>Heart Sounds:</b><br><input type="checkbox"/> Clear <input type="checkbox"/> Muffled<br>Capillary Refill:<br><input type="checkbox"/> <2 seconds (normal)<br><input type="checkbox"/> >2 seconds (delayed)   | <input type="checkbox"/> Alert<br><input type="checkbox"/> Responds to Verbal<br><input type="checkbox"/> Responds to Pain<br><input type="checkbox"/> Unresponsive<br>GCS: _____<br>Eyes ___/4 Verbal ___/5<br>Motor ___/6 Total ___/15<br>Sphincter Tone:<br><input type="checkbox"/> WNL <input type="checkbox"/> Weak <input type="checkbox"/> None  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| SECONDARY SURVEY  |   |   |  |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| <b>HEAD/NECK EENT</b>   | <b>HEART/THORACIC</b>   | <b>ABDOMINAL/GU</b>   | <b>EXTREMITIES</b>   |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| Drainage:<br>Nose (color): _____<br>CSF: + / -<br>Eyes: Equal    R / L<br>Fixed    R / L<br>Reactive R / L<br>Dilated    R / L<br>Other: _____<br>C-Spine Tender:<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>Dental Injury:<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>Tympanic Membrane:<br>Clear    R L<br>Blood    R L | <b>Rhythm:</b><br><input type="checkbox"/> NSR (tachy/brady)<br><input type="checkbox"/> V-fib/tach<br><input type="checkbox"/> PEA<br><input type="checkbox"/> Asystole<br><input type="checkbox"/> Other<br><b>Pulses:</b><br>S = Strong    D = Doppler<br>W = Weak    A = Absent<br>Carotid _____ R _____ L<br>Femoral _____ R _____ L<br>Brachial _____ R _____ L<br>Radial _____ R _____ L<br>Pedal _____ R _____ L<br>JVD Distension: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Flail _____ R _____ L | <input type="checkbox"/> Flat<br><input type="checkbox"/> Distended<br><input type="checkbox"/> Obese<br><input type="checkbox"/> Non-tender<br><input type="checkbox"/> Tender<br><input type="checkbox"/> Rigid<br><input type="checkbox"/> Guarding<br><input type="checkbox"/> Rebound<br>Tenderness<br><input type="checkbox"/> Unable to Assess<br><input type="checkbox"/> Open Wound<br><b>FAST DONE:</b> POS / NEG / NA<br>Last Meal @ _____ | <b>Pelvis Stable:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Binder:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Hemorrhage:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Blood at Meatus/Vagina:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Fracture/Dislocation:</b><br><input type="checkbox"/> RUE <input type="checkbox"/> RLE<br><input type="checkbox"/> LUE <input type="checkbox"/> LLE<br><table style="width:100%; font-size: small;"><tr><td></td><td style="text-align: center;"><b>Motor</b></td><td style="text-align: center;"><b>Sens</b></td><td style="text-align: center;"><b>ROM</b></td><td></td></tr><tr><td>RUE</td><td style="text-align: center;">+ / -</td><td style="text-align: center;">+ / -</td><td style="text-align: center;">+ / -</td><td></td></tr><tr><td>LUE</td><td style="text-align: center;">+ / -</td><td style="text-align: center;">+ / -</td><td style="text-align: center;">+ / -</td><td></td></tr><tr><td>RLE</td><td style="text-align: center;">+ / -</td><td style="text-align: center;">+ / -</td><td style="text-align: center;">+ / -</td><td></td></tr><tr><td>LLE</td><td style="text-align: center;">+ / -</td><td style="text-align: center;">+ / -</td><td style="text-align: center;">+ / -</td><td></td></tr></table> <b>LOG ROLL TIME:</b> _____<br><b>Back exam:</b><br><input type="checkbox"/> WNL<br><input type="checkbox"/> ABNL (describe) |  | <b>Motor</b> | <b>Sens</b> | <b>ROM</b> |  | RUE | + / - | + / - | + / - |  | LUE | + / - | + / - | + / - |  | RLE | + / - | + / - | + / - |  | LLE | + / - | + / - | + / - |  |  |
|   | <b>Motor</b>  | <b>Sens</b>   | <b>ROM</b>   |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| RUE   | + / -   | + / -   | + / -  |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| LUE   | + / -   | + / -   | + / -  |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| RLE   | + / -   | + / -   | + / -  |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| LLE   | + / -   | + / -   | + / -  |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| <b>PATIENT IDENTIFICATION</b>   | <b>ALLERGIES</b>  | <b>PAST MED HX</b>  | <b>CURRENT MEDICATIONS</b>   |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |
| Name/Rank:<br>SSN/Patient Id #:<br>DOB: (ddmmyy)    Age: _____<br>Deployed Unit:<br>MTF Transferred from:    MTF: _____   | <input type="checkbox"/> Unknown<br><input type="checkbox"/> NKDA<br><input type="checkbox"/> PCN<br><input type="checkbox"/> Sulfa<br><input type="checkbox"/> Morphine<br><input type="checkbox"/> Codeine<br><input type="checkbox"/> ASA<br><input type="checkbox"/> Other:   | <input type="checkbox"/> Unknown<br><input type="checkbox"/> None<br><input type="checkbox"/> Respiratory hx<br><input type="checkbox"/> Seizure hx<br><input type="checkbox"/> Cardiac hx<br><input type="checkbox"/> HTN<br><input type="checkbox"/> DM<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Other:   | <input type="checkbox"/> Unknown<br><input type="checkbox"/> None<br><input type="checkbox"/> List Current Meds:<br>_____<br>_____<br>_____  |  |              |             |            |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |     |       |       |       |  |  |

S A M P L E

JOINT THEATER TRAUMA NURSING RECORD

SECONDARY SURVEY

- (AB)rasion
- (AMP)utation
- (AV)ulsion
- (BL)eeding
- (B)urn
- (C)repitus
- (D)eformity
- (DG)Degloving
- (E)chymosis
- (FX)Fracture
- (F)oreign Body
- (GSW)Gun Shot Wound
- (H)ematoma
- (LAC)eration
- (PW)Puncture Wound
- (P)ain
- (SS)Seatbelt Sign
- (SW)Stab Wound



MECHANISM OF INJURY

- Assault/Fight
- Biological
- Blast/Explosion
- Blunt Trauma
- Bomb
- Bldg Colapse
- Burn
- Chemical
- Crush
- Drowning
- Fall
- Flying Debris
- Grenade
- GSW/Bullet
- Helo Crash
- Other:
- Hot Obj/Liquid
- IED
- Knife/Edge
- Landmine
- Machinery
- Mortar
- Multi-frag
- MVC
- Plane Crash
- Rad/Nuclear
- Single Frag
- UXO

Burn:  
 1st  2nd  3rd  
 %TBSA = \_\_\_ Cause \_\_\_\_\_

PRE-HOSPITAL HEMOSTATIC DEVICES:

- Unknown
- Quick Clot
- None
- Fibrin Bandage (Type: \_\_\_\_\_ example: Chitosan)
- Direct Pressure
- Field Dressing
- Other: \_\_\_\_\_

PROTECTIVE GEAR

|   | <input type="checkbox"/> Unknown | Worn  | Not Worn  | Struck  | Penetrated  |
|---|----------------------------------|---|---|---|---|
| Helmet (Kevlar / ACH / MICH / CVC / AVN / USMC)         | <input type="checkbox"/>         | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                              |
| Flak Vest/IBA (circle XSM/S/ML/XL/XXL/XXXL/XXXXL)       | <input type="checkbox"/>         | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                              |
| Ceramic Plate (circle XSM / S / M / L / XL)             | <input type="checkbox"/>         | F <input type="checkbox"/> B <input type="checkbox"/> | F <input type="checkbox"/> B <input type="checkbox"/> | F <input type="checkbox"/> B <input type="checkbox"/> | F <input type="checkbox"/> B <input type="checkbox"/> |
| Eyewear (SPECS/SG-1/BLPS/UVEX XC/ESS land/ESS NVG/SWDG) | <input type="checkbox"/>         | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                              |
| Deltoid/Axilla Ext (left/ right)                        | <input type="checkbox"/>         | L <input type="checkbox"/> R <input type="checkbox"/> | L <input type="checkbox"/> R <input type="checkbox"/> | L <input type="checkbox"/> R <input type="checkbox"/> | L <input type="checkbox"/> R <input type="checkbox"/> |
| Neck Protector (collar/ throat)                         | <input type="checkbox"/>         | C <input type="checkbox"/> T <input type="checkbox"/> | C <input type="checkbox"/> T <input type="checkbox"/> | C <input type="checkbox"/> T <input type="checkbox"/> | C <input type="checkbox"/> T <input type="checkbox"/> |
| Groin/leg ext   | <input type="checkbox"/>         | G <input type="checkbox"/> L <input type="checkbox"/> | G <input type="checkbox"/> L <input type="checkbox"/> | G <input type="checkbox"/> L <input type="checkbox"/> | G <input type="checkbox"/> L <input type="checkbox"/> |

| TIME | PROCEDURE                                | SIZE/TYPE                | SITE   | BY | RESULTS   | X-RAY  |         | CT                                     |      |
|------|--|--------------------------|--|----|---|--------|---------|--|------|
|      |  |                          |  |    |   | TIME   | TYPE    | TIME                                   | TYPE |
|      | ET Intubation<br>(Adnl changes in Notes) | Teeth _____              | <input type="checkbox"/> oral<br><input type="checkbox"/> nasal    |    | <input type="checkbox"/> ETCO <sub>2</sub> Change<br><input type="checkbox"/> BBS Post Int. |        |         |  |      |
|      | Gastric Tube                             |                          | <input type="checkbox"/> oral<br><input type="checkbox"/> nasal    |    | <input type="checkbox"/> Verified _____<br>Suction Y N                                      |        |         |  |      |
|      | Urinary                                  | Amt _____<br>Color _____ | <input type="checkbox"/> meatus<br><input type="checkbox"/> supra. |    | Heme Dip +/-<br>Results _____ cc  |        |         |  |      |
|      | Chest tube #1                            |                          | L R  |    | Air Blood   |        |         |  |      |
|      | Chest tube #2                            |                          | L R  |    | Air Blood   |        |         |  |      |
|      | A-line                                   |                          | L R  |    |   | O2 on: | O2 off: | Nasal cannula <input type="checkbox"/> |      |
|      | Thoracotomy                              |                          | L R  |    |   |        |         | NRB Mask <input type="checkbox"/>      |      |
|      | Tourniquet                               | Type: _____              | Site: _____  |    |   |        |         | BVM <input type="checkbox"/>           |      |

| LABS (others in Notes) |           |      |               | Intravenous Access |   |       |          |      |        |        |
|------------------------|-----------|------|---------------|--------------------|---|-------|----------|------|--------|--------|
| Time                   | Test      | Time | Test          | Time               | # | Gauge | IVF Type | Site | Amt Up | Amt In |
|                        | CBC       |      | T & S         |                    |   |       |          |      |        |        |
|                        | ABG       |      | T & C x _____ |                    |   |       |          |      |        |        |
|                        | Chemistry |      | UA            |                    |   |       |          |      |        |        |
|                        | PT/PTT    |      | HCG           |                    |   |       |          |      |        |        |
|                        | TEG       |      | Other         |                    |   |       |          |      |        |        |
|                        |           |      |               |                    |   |       |          |      | Total: |        |

PATIENT IDENTIFICATION

Name: (Last/First/Rank)      DOB: (ddmmyy)      Age  
 Patient ID./SSN:      Deployed Unit

S A M P L E

