CUI (when filled in)

EVACUATION PATIENT CARE RECORD

Page ____ of ____

Submit by Email

DATA PROTECTED BY PRIVACY ACT OF 1974. Use of this form is directed by by DHA-PM 6025.02 Vol. 1.
Read Privacy Act statement in its entirety before completing this form. See AR 40-66; the proponent agency is the Office of the Surgeon General.

Reset Form

Injury Event Date | Time | Zone ☐ L ☐ Z | Country | Region | State

Mission # | Pt Transfer ☐ YES ☐ NO | Leg # ____ of ____ | 9-Line Date: | 9-Line Time:

Platform | Dispatch Cat: ☐ URG ☐ PRI ☐ ROUT | Assessed Cat: ☐ URG ☐ PRI ☐ ROUT | Delivery Date: | Delivery Time:

Dispatch information (*M.I.S.T., MOI/NOI, Injuries, Disease Diagnosis, Pulse Quality, etc.)*

Pickup Arrival Date: | Arrival Time: | Role/ Facility/POI | Location | Departure Date: | Departure Time:

Dropoff Arrival Date: | Arrival Time: | Role/ Facility/POI | Location | Departure Date: | Departure Time:

INTERVENTIONS

Massive Hemorrhage (TQ/Hemostatic Adjunct)

Time | Location | Type | Time off

Time | Location | Type | Time off

Time | Location | Type | Time off

Time | Location | Type | Time off

Airway

Time | Type | Size | Depth | @

Time | Type | Size | Depth | @

Time | Type | Size | Depth | @

Time | Type | Size | Depth | @

Respiration (Chest seals/NCDC/O2/etc.)

Time | Treatment | Location | Size/Rate | Successful

Time | Treatment | Location | Size/Rate | Successful

Circulation (IV/IO/Cent Lines/A-Lines/etc.)

Time | Side | Size | Type | Location | Successful

Time | Side | Size | Type | Location | Successful

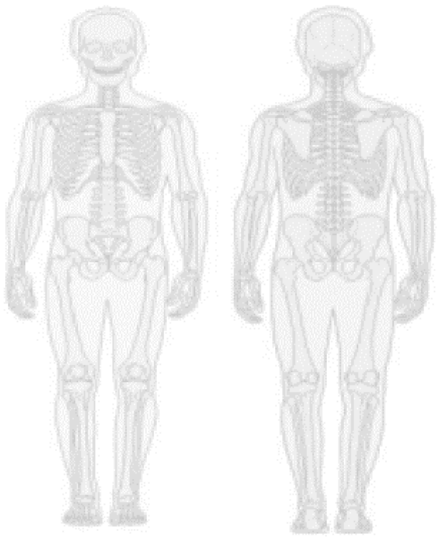
Time | Side | Size | Type | Location | Successful

Time | Side | Size | Type | Location | Successful

INJURY LOCATOR

MOI | ☐ Medical

(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)Suspected ☐ YES ☐ NO



Packaging/Splinting

☐ Pelvic Binder ☐ Traction Splint ☐ Eye Shield
☐ C-Collar ☐ SKED/Stokes ☐ Litter
☐ Backboard ☐ Elevated HOB ☐ Ambulatory
☐ Other *(specify)* ☐ Splinting Type *(specify)* ☐ Dressing *(specify)*

Hypo/Hyperthermia Prevention

Type | Time on | ☐ PTA

Mental Status

A | V | P | U | GCS Eyes (1-4) | Verbal (1-5) | Motor (1-6) | GCS Total (1-15)

PERRLA Right | Pupil Size (mm) | Pupil Appearance | PERRLA Right | Pupil Size (mm) | Pupil Appearance

PERRLA Left | Pupil Size (mm) | Pupil Appearance | PERRLA Left | Pupil Size (mm) | Pupil Appearance

Patient Info Last Name | First Name | MI | Sex ☐ M ☐ F | DOB | Age

BR # | Rank | Unit | Pt Cat

SSN/DoD ID | Est. Height | Est. Weight | Allergy

☐ History/Physical ☐ Treatment
☐ Diagnostic Studies ☐ Flow Chart
☐ Other Examination or Evaluation
☐ Other *(specify)*

CUI (when filled in)

EVACUATION PATIENT CARE RECORD

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Chronological Record of Care

Vitals

Time										
Pulse										
BP										
MAP										
SpO2										
EtCO2										
Resp rate										
Temp										
GCS										
Pain (0-10)										

MEDS

Document any meds administered PTA in Narrative Section.

Time										
Medication										
Dose										
Route										
Time										
Medication										
Dose										
Route										
Time										
Medication										
Dose										
Route										

Blood/Fluid

Time										
Product										
Volume										
Rh/ABO										
Route										
Unit#/DIN										
Warmer Type										
Calcium given										

VENT

Time										
Mode										
Rate										
I:E										
Volume										
FIO2										
PEEP										
PIP										
PPLAT										

Outputs

Time										
Source										
Output volume										
Time										
Source										
Output volume										

Total Input Volume ☐ **Total Output Volume** ☐

Patient Info Last Name ☐ First Name ☐ MI ☐ Sex ☐ M ☐ F DOB ☐ Age ☐

BR # ☐ Rank ☐ Unit ☐ Pt Cat ☐

SSN/DoD ID ☐ Est. Height ☐ Est. Weight ☐ Allergy ☐

☐ History/Physical ☐ Treatment
☐ Diagnostic Studies ☐ Flow Chart
☐ Other Examination or Evaluation
☐ Other *(specify)* ☐

CUI (when filled in)

EVACUATION PATIENT CARE RECORD

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Chronological Record of Care

Notes *(labs/ABG, blood DIN stickers, etc.)*

Narrative Summary of Care

Comments/Notes

☐ CPR Performed ☐ ROSC	Blood Available ☐ YES ☐ NO	Blood Transfusion Indication ☐ Amputation ☐ HR>100 ☐ SBP<100 ☐ Other	ABG Received *(Vent Pt's)* ☐ YES ☐ NO	JTS Burn Flow Sheet Initiated? ☐ YES ☐ NO

En Route Care Provider	Medical Director Review - must be signed by MD/DO/PA/NP
Last Name / First Name	Last Name / First Name
Rank / Professional Licensure	Rank / Licensure
Signature / Date	Signature / Date

En Route Care Provider	Medic or Senior Official - Form Submitter *(last signature)*
Last Name / First Name	Last Name / First Name
Rank / Professional Licensure	Rank / Professional Licensure
Signature / Date	Signature / Date

Send form to dha.jbsa.healthcare-ops.list.jts-patientevacuation@health.mil

Patient Info Last Name ☐ First Name ☐ MI ☐ Sex ☐ M ☐ F DOB ☐ Age ☐

BR # ☐ Rank ☐ Unit ☐ Pt Cat ☐

SSN/DoD ID ☐ Est. Height ☐ Est. Weight ☐ Allergy ☐

☐ History/Physical ☐ Treatment
☐ Diagnostic Studies ☐ Flow Chart
☐ Other Examination or Evaluation
☐ Other *(specify)* ☐

EVACUATION PATIENT CARE RECORD

PRIVACY ACT STATEMENT

APPLICABLE SYSTEM OF RECORDS NOTICE (SORN): The Evacuation Patient Care Record Form will collect personally identifiable information (PII) to be stored in a system of records and retrieved by a personal identifier. Therefore, a SORN is required. According to the Department of Defense issuance associated included with this form, "DoDI 6040.45, `DoD Health Record Lifecycle Management,'" PII collected will be stored in patients' medical records. The appropriate SORN is EDHA 07, Military Health Information System (June 15, 2020, 85 FR 36190)

The Evacuation Patient Care Record Form will collect the patient's biographical information, medical history, and document the trauma treatment and resuscitation care provided to them, along with a chronological and narrative summary of their care.

Purpose: To document a patient's biographical information, medical history, and document the trauma treatment and resuscitation care provided to them, along with a chronological and narrative summary of their care.

Authority: 10 U.S.C. Chapter 55, Medical and Dental Care; Public Law 104-191, Health Insurance Portability and Accountability Act of 1996

Privacy Act Statement: The Evacuation Patient Care Record Form will collect PII that is stored in the patient's medical record, a system of records, and retrieved by a personal identifier. Therefore, the Privacy Act applies, and a Privacy Act Statement is required. The attached Privacy Act Statement should be provided to patients prior to their completing or being asked for any of the information requested in the Evacuation Patient Care Record Form. It is recognized, however, that the nature of this form means it will be used in medical emergency and tactical environments. In such cases, the Privacy Act Statement should be provided to patients as soon as is practically possible

Patient Info Last Name | First Name | MI | Sex ☐ M ☐ F | DOB | Age

BR # | Rank | Unit | Pt Cat

SSN/DoD ID | Est. Height | Est. Weight | Allergy

☐ History/Physical ☐ Treatment
☐ Diagnostic Studies ☐ Flow Chart
☐ Other Examination or Evaluation
☐ Other *(specify)*