PURPOSE: The Resuscitation Record is for documenting a trauma patient's injuries and related medical treatment and resuscitation care provided at DoD medical treatment facilities (MTFs). It is to be used at all DoD MTFs which have a surgical capability or emergency department (ED). A trauma patient is defined as a person who has an injury with the potential of requiring a surgical intervention. The form is comprised of two parts. Part I, Nursing Flow Sheet is completed by the nurse fulfilling the role as a scriber or the nurse providing bed side care. Part II, Physician H&P (History and Physical) is completed by the trauma physician providing care for the patient. The Resuscitation Record becomes part of the patient's permanent DoD medical record.

PART I: NURSING FLOW SHEET

GENERAL INSTRUCTIONS

- To be completed by the nurse fulfilling the role as a scriber or the nurse providing bed side care.
- Time Zones: Record all time local 24 hour military format, hh:mm
- A+ (plus sign) means positive test result; a - (minus sign) means negative test result.

PATIENT IDENTIFICATION (at bottom of each page). As stated.

FACILITY NAME. Record your MTF unit identifier

FACILITY LOCATION. Record FOB, COB, or geographic site

BRN. Battle Roster Number

MOS. Military Occupational Specialty

AFSC. Air Force Specialty Code

NEC. Navy Enlisted Classification

1.0 PATIENT INFORMATION

1.1 TRAUMA TEAM DATA. As stated. Record all time local 24 hour military format, hh:mm

1.2 ARRIVAL. As stated.

1.3 EVAC FROM. Check all that apply. Location is the facility name.

1.4 MODE OF ARRIVAL. Check one. MEDEVAC Air includes DUSTOFF. If Other, describe the method by which the patient arrived, such as PJ or MERT, but not DUSTOFF.

1.5 INJURY TYPE. Check all that apply.

1.6 INJURY CLASSIFICATION. Check one.

1.7 TRIAGE CATEGORY. Check one.

Immediate - Patients who require rapid, immediate intervention in order to preserve life and/or limb AND are likely to survive because of the intervention--damage control surgery (ex: respiratory obstruction, unstable casualty with chest or abdominal injuries, uncontrolled hemorrhage, hypovolemic shock, emergency amputation)

Delayed - Patients who require surgery or other specific therapeutic intervention, but who will not be severely compromised if the intervention is delayed to a later time (ex: closed fx without neurovascular compromise, moderate burns of < 50% TBSA, large muscle wounds, intra-abdominal and/or thoracic wounds)

Minimal - Non-Urgent: Minor Injuries; patient can safely care for themselves or be helped by non-medical personnel. (ex: Minor lacerations, abrasions, fractures of small bones, and minor burns). Can safely wait 12-24 hours or longer for care.

Expectant - Patients whose injuries are so severe that even with the benefit of optimal medical resources, their survival would be unlikely (ex: massive open head injury with brain matter present, high spinal cord injuries, mutilating explosive wounds involving multiple anatomical sites and organs, second/third degree burns in excess of 60% TBSA, profound shock with multiple injuries and agonal respirations)

1.8 VALUABLES FOUND. Check one. Time correlates to checked item.

1.9 PATIENT CATEGORY. Check one. If Other, describe the patient's classification as it relates to military, government or civilian organizations.

USA. United States Army

USAF. United States Air Force

USMC. United States Marine Corp

USN. United States Navy

USCG. United States Coast Guard

USPHS. United States Public Health Services

Civilian – Local. Includes Host Nation.

Civilian – Other. Includes Host Nation Police

EPW. Enemy Prisoner of War

NATO-Coalition. Joining military forces

Non-NATO Coalition. Opposing military forces

Other. Describe not otherwise specified category.

1.10 INJURY CAUSE. Check all that apply. If Other, describe cause of the injury.

EFP. Explosively Formed Projectile/Penetrator

IED. Improvised Explosive Device

Mortar/Rocket/Artillery Shell. Includes Indirect and Direct Fire

MVC. Motor Vehicle Crash

UXO. Unexploded Ordnance

2.0 CARE DONE PRIOR TO ARRIVAL

2.1 PREHOSPITAL TOURNIQUET. Check all that apply.

SOFTT. Special Operations Forces Tactical Tourniquet

CAT. Combat Application Tourniquet

If Other. Describe the type of tourniquet.

Effective. An effective tourniquet controls active hemorrhage. May be combined with a dressing.

2.2 PREHOSPITAL VITALS. As stated.

2.3 PREHOSPITAL HEMORRHAGE CONTROL MEASURES – Check all that apply.

Celox. Granules, applicator or gauze. Stops bleeding by bonding with red blood cells and gelling with fluids to produce a sticky pseudo clot. This clot sticks to moist tissue to plug the bleeding site. Celox is made with chitosan, a natural polysaccharide.

ChitoFlex. A stuffable wound dressing conducive to narrow wound tracks.

Combat Gauze. Combat Gauze™ is a 3-inch x 4-yard roll of sterile gauze. The gauze is impregnated with kaolin, a material that causes the blood to clot.

Direct Pressure. Pressure applied directly to a wound, usually with sterile, low-adherent gauze between the wound and source of bleeding.

Field Dressing. A casualty's dressing applied to a wound to control hemorrhaging.

HemCon. Bandage or patch that becomes sticky when in contact with blood, seals the wound and controls the bleeding. HemCon products are made from chitosan, a naturally occurring, bio-compatible polysaccharide.

QuikClot. Emergency dressing, combat gauze, interventional bandage, QuikClot ACS+™, QuikClot 1st Response™. When QuikClot® comes into contact with blood in and around a wound, it takes in the smaller water molecules from the blood. The larger platelet and clotting factor molecules remain in the wound in a concentrated form. This promotes rapid natural clotting and prevents severe blood loss.

None. Check if no hemorrhage control measures.

Unknown. Check if hemorrhage control measures are unknown.

Other. Describe the not otherwise specified hemorrhage control measure.

2.4 PREHOSPITAL WARMING. Check all that apply.

HPMK. Hypothermia Prevention and Management Kit. Check only if all three components were used: Hat/Hood, Activated Liner, and Outer Shell.

If Other. Describe the not otherwise specified warming device.

2.5 PREHOSPITAL MEDS. Enter medication, dose and route.

2.6 PREHOSPITAL INTERVENTIONS. As stated.

3.0 PRIMARY SURVEY

3.1 VITALS. As stated. For Pain Scale, enter level that patient indicates their pain to be. Zero indicates the least pain; 10 is the most severe pain.

3.2 AIRWAY. As stated. If Other, describe the not otherwise specified type of airway.

3.3 HYPO/HYPERTHERMIA CONTROL MEASURES. As stated. Other includes Body Bag.

3.4 CPR IN ED. As stated.

3.5 BREATHING. As stated.

3.6 CIRCULATION. As stated.

3.7 DEFICIT/NEURO. As stated.

Pediatric Broselow Tape Color: Pediatric is a patient less than 15 years old at the time of injury. A patient 15 years old or older is considered an adult.

Color	Patient Weight
Grey/Pink	3 - 7 Kg
Red/Purple/Yellow	8-14 Kg
White	15 - 18 Kg
Blue	19- 23 Kg
Orange	24 - 29 Kg
Green	30 - 35 Kg

4.0 SECONDARY SURVEY

4.1 HEAD/NECK ENT. As stated.

4.2 HEART / THORACIC.

Rhythm. As stated. If Other, describe not otherwise specified rhythm.

Pulses. Enter S, W, D, A as appropriate. Doppler includes non-palpable, but detected with Doppler. Absent means no pulse, non-palpable and not detected with Doppler.

4.3 ABDOMINAL/GU. As stated. Unable to Assess includes TAC (Temporary Abdominal Closure).

Last meal @. Enter date and time.

4.4 EXTREMITIES. Check all that apply. For Pulses Present (positive) enter S, W, D, or A. Doppler includes non-palpable, but detected with Doppler. Absent means no pulse, non-palpable and not detected with Doppler.

4.5 ALLERGIES. Check one. NKDA is No Known Drug Allergies. If Other, describe not otherwise specified allergy.

4.6 CURRENT MEDICATIONS. As stated. Current Meds: List medication, dose and route.

4.7 PROCEDURES. As stated. Hemorrhage Control Measures. Refer to Prehospital Hemorrhage Control Measures.

4.8 INTUBATION MECH/VENT. As stated.

4.9 ABGs/VBGs. As stated.

4.10 INTRAVENOUS ACCESS AND FLUIDS. As stated.

4.11 BLOOD PRODUCTS. As stated. Initials: Legible initials of person who performed task.

4.12 MEDICATIONS. As stated. Initials: Legible initials of person who performed task.

4.13 VITAL SIGNS. As stated.

4.14 LABS. Enter time as stated.

4.15 CT. As stated.

4.16 X-RAY. As stated.

4.17 DISPOSITION. As stated.

4.18 DEATH INFORMATION. If death, as stated. Leave blank if patient is alive.

4.19 REMARKS. Enter additional information relevant to the patient’s nursing care.

PART II: PHYSICIAN H&P

GENERAL INSTRUCTIONS:

- To be completed by the trauma physician providing care for the patient.
- Time Zones: Record all time local 24 hour military format, hh:mm
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PATIENT IDENTIFICATION (at bottom of each page). As stated.

FACILITY NAME. Record your MTF unit identifier

FACILITY LOCATION. Record FOB, COB, or geographic site

BRN. Battle Roster Number

1.0 HISTORY & PHYSICAL – INJURY DESCRIPTION

1.1 ARRIVAL. As stated.

1.2 TRIAGE CATEGORY. Check one. Refer to 1.7 for definitions from Part I Nursing Flow Sheet.

1.3 CHIEF COMPLAINT, HISTORY AND PRESENTING ILLNESS. As stated.

1.4 INJURY DESCRIPTION. As stated. Doppler includes non-palpable, but detected with Doppler. Absent means no pulse, non-palpable and not detected with Doppler.

1.5 HISTORY AND PHYSICAL. As stated. Interventions Prior to Arrival is any intervention performed in a prehospital or transferring facility.

1.6 PRE/INITIAL PROCEDURES/DIAGNOSTICS. As stated. Pre means prior to arrival. Cntrl Line is Central Line.

1.7 PUPILS/VISION. As stated.

1.8 BURN. As stated. Describe the cause of burn.

1.9 EXTREMITIES. As stated.

2.0 X-RAYS AND CT

2.1 CT OBTAINED. As stated.

2.2 X-RAYS OBTAINED. As stated.

2.3 PENDING STUDIES. As stated.

2.4 RESULTS. Include TEG/Rotem results.

2.5 C-SPINE RESULTS. As stated.

3.0 LABORATORY RESULTS

3.1 CBC. As stated. See example for format.

WBC 4.5 - 10.5
Hgb 11.0 - 18.0
Hct 35 - 60
Plt 150 - 450

3.2 CHEMISTRY 7. As stated. See example for format.

Na^{+} 135 - 145	Cl^{+} 98 - 107	BUN 7 - 18
		Glucose 75 - 110
K^{+} 3.5 - 4.3	CO_2 22 - 30	Cr 0.8 - 1.5

3.3 PT/INT/PTT. As stated.

3.4 LFT. As stated. Other, describe not otherwise specified findings.

3.5 URINALYSIS. As stated.

4.0 IMPRESSION

Enter impressions and findings.

5.0 DIAGNOSES

Enter diagnoses and findings, up to six. If more than six, record the most life-threatening findings.

6.0 PLAN

6.1 PLAN. Enter the treatment plan.

6.2 TRIAD INDICATORS UPON ARRIVAL IN ED. As stated. For FWB Requested, indicate whether Fresh Whole Blood was requested.

6.3 DISPOSITION. As stated.

7.0 DNBI/NBI CATEGORY

Check all Disease Non Battle Injuries/Non Battle Injuries that apply. Describe any injury not otherwise specified.

8.0 CAUSE OF DEATH.

If death, complete sections. Leave blank if patient is alive.

8.1 ANATOMIC. As stated. If Other, describe not otherwise specified anatomy.

8.2 PHYSIOLOGIC. As stated. If Other, Specify, describe not otherwise specified physiology.