

TACTICAL COMBAT CASUALTY CARE AFTER ACTION REPORT (TCCC AAR) - TRAINING


Complete within 72hrs after mission. Students: submit to the Joint Trauma System via email: dha.jbsa.healthcare-ops.list.jts-training@health.mil

Event Date: _____ Time: _____ Local ZULU Country: _____ Theater _____
Injury Battle Injury (BI): WIA KIA DOW Non-Battle Injury (NBI): Alive Dead

Evacuation Category URG PRI ROU
 Litter Type: _____ Time of Pick Up: _____
 Ground Vehicle Type: _____ Time of Pick Up: _____
 Aircraft Type: _____ Time of Pick Up: _____
 Watercraft Type: _____ Time of Pick Up: _____

Casualty Demographics (mini. requirement: last name & last 4 SS#) Last Name: _____ First Name: _____ Rank: _____
 Gender M F SSN/DoD ID: _____ DOB: _____ Unit: _____ BR#: _____ Mission # _____

Non-Medic (NM) First Responder Last Name: _____ First Name: _____ Rank/Title: _____
Point-of-Injury (POI) Provider Info Other POI Provider (OP) Last Name: _____ First Name: _____ Rank/Title: _____
 Medic (M) Last Name: _____ First Name: _____ Rank/Title: _____

<p>M - Mechanism of Injury</p> <input type="checkbox"/> Airborne Operation <input type="checkbox"/> Aircraft Crash <input type="checkbox"/> Blast – Dismounted IED or Mine <input type="checkbox"/> Blast – Mounted IED or Mine <input type="checkbox"/> Blast – RPG or Grenade <input type="checkbox"/> Blast – Indirect Fire (Mortar/Artillery/Missile) <input type="checkbox"/> Blast – Other <input type="checkbox"/> Collapse/Crush/ Compartment from Structure <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Fall, Height: _____ ft <input type="checkbox"/> Fragmentation / Shrapnel <input type="checkbox"/> GSW – Gunshot Wound <input type="checkbox"/> Vehicle Accident/Collision <input type="checkbox"/> Environmental: _____ <input type="checkbox"/> Other: _____	<p>I - Injuries</p> <input type="checkbox"/> (A)mputation <input type="checkbox"/> (B)leeding <input type="checkbox"/> (Bu)rn, TBSA: _____ % <input type="checkbox"/> (C)repitus <input type="checkbox"/> (D)eformity <input type="checkbox"/> (DG)Degloving <input type="checkbox"/> (E)cchymosis <input type="checkbox"/> (FX)Fracture <input type="checkbox"/> (GSW) Gun Shot Wound <input type="checkbox"/> (H)ematoma <input type="checkbox"/> (LAC)eration <input type="checkbox"/> (P)ain <input type="checkbox"/> (PP)Peppering <input type="checkbox"/> (PW)Puncture Wound	<p>Annotate Injuries</p> 
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<p>S - Signs Initial Check Time _____</p> <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U GCS: _____ /15 (E _____ /4 V _____ /5, M _____ /6) RR: _____ HR: _____ BP: _____ pOx (%): _____ Pain level (_/10): _____ EtCO2 (mmHG): _____ Eye Opening - 4: spontaneous, 3: to speech, 2: to pain, 1: no response Motor Response - 6: follows commands, 5: localizes pain, 4: withdraws from pain, 3: decorticate flexion, 2: decerebrate extension, 1: no response Verbal Response - 5: alert and oriented, 4: disoriented conversation, 3: speaking but nonsensical, 2: moans, unintelligible sounds, 1: no response	<p>Last Check Time _____</p> <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U GCS: _____ /15 (E _____ /4 V _____ /5, M _____ /6) RR: _____ HR: _____ BP: _____ pOx (%): _____ Pain level (_/10): _____ EtCO2 (mmHG): _____
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T - Treatments

<p>Massive Hemorrhage Control (TQ/Hemostatic Adjunct)</p> Time <input type="checkbox"/> Location <input type="checkbox"/> Type <input type="checkbox"/> Time off <input type="checkbox"/> Time <input type="checkbox"/> Location <input type="checkbox"/> Type <input type="checkbox"/> Time off <input type="checkbox"/> Time <input type="checkbox"/> Location <input type="checkbox"/> Type <input type="checkbox"/> Time off <input type="checkbox"/> Time <input type="checkbox"/> Location <input type="checkbox"/> Type <input type="checkbox"/> Time off <input type="checkbox"/>	<p>Airway</p> Time <input type="checkbox"/> Type <input type="checkbox"/> Size <input type="checkbox"/> Depth <input type="checkbox"/> @ <input type="checkbox"/> Time <input type="checkbox"/> Type <input type="checkbox"/> Size <input type="checkbox"/> Depth <input type="checkbox"/> @ <input type="checkbox"/> Time <input type="checkbox"/> Type <input type="checkbox"/> Size <input type="checkbox"/> Depth <input type="checkbox"/> @ <input type="checkbox"/> Time <input type="checkbox"/> Type <input type="checkbox"/> Size <input type="checkbox"/> Depth <input type="checkbox"/> @ <input type="checkbox"/>
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Respiration/Breathing Spontaneous Labored Assisted Assisted with BVM Time _____

NM M OP Chest Seal Type: _____

NM M OP Needle Decompression Location 2ICS/MCL 5ICS/AAL # of attempts _____ Cath/Needle size _____

NM M OP Chest Tube Finger Thoracostomy Output Air Blood (ml) _____

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Circulation - Resuscitation	Time
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Saline Lock	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> IO-Intraosseous Device, Type _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> TXA-Tranexamic Acid Dose _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Blood products Type _____ Volume _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> IV Fluids Type _____ Volume _____	_____
Interventions - Other	Time
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Pelvic Binder Type _____ Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Outcome: _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Hypothermia Prev. Type _____ Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Outcome: _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Eye Shield <input type="checkbox"/> Left <input type="checkbox"/> Right Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Outcome: _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Splint Type _____ Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Outcome: _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> C-Collar <input type="checkbox"/> Spine Board Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Outcome: _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Tourniquet Conversion Location _____ Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Outcome: _____	_____
Medications - Pain, Infection, Other	Time
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Combat Wound Medication Pack	_____ Outcome: _____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Analgesic Name: _____ Dose: _____ Route: _____ Outcome: _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Analgesic Name: _____ Dose: _____ Route: _____ Outcome: _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Analgesic Name: _____ Dose: _____ Route: _____ Outcome: _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Analgesic Name: _____ Dose: _____ Route: _____ Outcome: _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Antibiotic Name: _____ Dose: _____ Route: _____ Outcome: _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Antibiotic Name: _____ Dose: _____ Route: _____ Outcome: _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Other Med Name: _____ Dose: _____ Route: _____ Outcome: _____	_____
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Other Med Name: _____ Dose: _____ Route: _____ Outcome: _____	_____
Comments-Additional Treatment	
Sustains (Treatment, Equipment, Evacuation, Operations):	
Improves (Treatment, Equipment, Evacuation, Operations):	

Last Name: _____ SSN/DoD ID: _____