APPENDIX E: SUPPLEMENTAL CBRN DOCUMENTATION FORM

JTS CBRN 3 Supplemental Clinical Documentation Form

EXPOSURE INCIDENT

Time exposure occurred ____ Duration of exposure ____ ◯ Check if unknown

Radiation type/agent type (if known): ____

PPE worn? ◯ YES ◯ NO

Type of PPE if worn ____

Did the patient vomit after the exposure? ◯ YES ◯ NO

If yes, how long after the exposure did the patient vomit? _____ minutes

ARRIVAL TEMPERATURES

Note 1-hour temperatures for first 4 hours: _____ _____ _____ _____

Note 2-hour temperatures for next 16 hours: _____ _____ _____ _____

_____ _____ _____ _____

Comments

TREATMENT TEAM INFORMATON

Facility/Location ____ Unit ____

Team type ____ Split team? ◯ YES ◯ NO

RN/Medic name ____ Signature Field ____ Date ____

Provider name ____ Signature Field ____ Date ____

PATIENT INFORMATION

Patient last name ____ First name ____ MI ____ DOB ____ Age ____

Sex ◯ M ◯ F MOS/AFSC/NEC ____ Patient deployed unit ____

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