BATTLE AND NON-BATTLE INJURY DOCUMENTATION: THE RESUSCITATION RECORD

Original Release/Approval		1 Jun 2008	Note: This CPG requires an annual review.	
Reviewed:	Sep 2012	Approved:	18 Sep 2012	
Supersedes:	Use of Trauma Flow Sheets 1 Dec 2008			
☐ Minor Changes (***or)***		☐ **Changes are substantial and require a thorough reading of this CPG (or)**		
☒ Significant Changes		PI monitoring plan added; New tri-service approved Resuscitation Record replaces prior Trauma Flow Sheet, Role 2 and Role 3.		

1. **Goal**. Obtain complete trauma documentation, including evacuation documentation, on all trauma patients from Role 2 and Role 3 within the CENTCOM AOR.

2. **Background**. The role of trauma documentation within the Joint Theater Trauma System for trauma performance improvement has continuously increased since the Joint Theater Trauma Registry (JTTR) was initiated in 2004. This progression is not unlike the first civilian trauma registries and standardized trauma flow sheets that were developed in the late 1980s. JTTR data acquisition and processing has improved greatly, partly because of the continuing advances (i.e., development of a standardized Resuscitation Record, formerly trauma flow sheet, initiation of Oracle-based registry database, and Level II Access trauma database) that offer new approaches and maximize computer technologies and the deployment of trauma coordinators to Role 3 sites. Data collection that allows theater-wide comparison is important for the continuous learning process and to improve outcomes, standard of care development, analysis of differences in the mechanisms of injury, rescue systems, and approved treatment guidelines.

   Although Resuscitation Record documentation can incorporate information from numerous sources (nursing flow sheets, monitors, MEDEVAC run-sheets, I-stat print outs, etc.); if the history taking, physical examination, or decision making is not documented by the trauma team leader, it did not occur. Therefore, good documentation on the Resuscitation Record is most important for care of the individual patient and the system-wide delivery of trauma/critical care to all injured patients within the CENTCOM AOR. It is easy to forget or only capture limited data on the Resuscitation Record when trauma patients spend very little time in the ED prior to heading to the OR. However, it is imperative to document the thought process and to take the time to complete the Resuscitation Record when time permits, even if completed the next day.

   Although trauma documentation requirements are well known, it is noted that this is an area in need of improvement. Although not exhaustive, the following are documentation performance improvement areas that repeatedly surface which need careful attention:

   a. Complete set of initial vital signs, including temperature and respiration rate

   b. GCS total score and individual Motor, Verbal and Eye opening scores

   c. Total IV volume (blood, colloid and crystalloid) infused in the ED, even if fluid administration continues after transport

   d. Disposition: Place and time

e. Arrival time

f. Mechanism of Injury

g. Labs transferred to trauma flow sheet (especially HCT, INR, and BE)

h. Lethal Triad Indicators (Hypothermia, Acidosis, Coagulopathy)

3. Indications for Initiation and Completion of Resuscitation Record. A Resuscitation Record should be initiated on ***ALL*** patients (battle/non-battle injury coalition forces, ANA, ANP, LN, contractors, etc.) triaged as Immediate. In addition, Resuscitation Record should be completed on all patients seen within the first 72 hours following injury, including but not limited to the following injury causes:

a. Building Collapse

b. Bullet/GSM/Firearm

c. Burn

d. EFP

e. Fall

f. Fire/Flame

g. IED

h. Inhalation Injury

i. Mine

j. Mortar/Rocket/Artillery Shell

k. Multi-Frag

l. MVC

m. Sports

n. UXO

o. Other

p. All trauma admissions to any/all Role 3 facilities in the continuum

It is the intent of this guideline that the broadest definition of trauma be used. This should include the majority of patients with single or multi-system injury seen in the emergency department or admitted directly to the ICU and is to be used as the primary method of initial documentation.

4. Performance Improvement (PI) Monitoring.

a. Intent (Expected Outcomes).

1) All patients in a US lead Role 2 or Role 3 facility have a Trauma Resuscitation Record complete and in the patient's record.

2) Trauma Resuscitation Record Part I Nursing Flow Sheet has complete and accurate documentation from the primary survey in sections 3.1, 3.1, and 3.3.

3) Trauma Resuscitation Record has complete and accurate documentation in the patient identification section, i.e. patient name, patient ID/SSN, facility, nurse and provider.

4) Trauma Resuscitation Record Part II Physician H & P has complete and accurate documentation in sections 1.3, 1.5 and 6.3.

b. Performance/Adherence Measures.

1) All trauma patients triaged as immediate or with injuries sustained from one of the causes listed in 2i had the Trauma Resuscitation Record completed and their record.

2) The Trauma Resuscitation Record was completed by the provider and the nurse on every patient expected to be admitted to a Role 3 or actually admitted to a Role 3 facility.

c. Data Source.

1) Patient Record

2) Joint Theater Trauma Registry (JTTR)

d. System Reporting & Frequency.

The above constitutes the minimum criteria for PI monitoring of this CPG. System reporting will be performed biannually; additional PI monitoring and system reporting may be performed as needed.

The system review and data analysis will be performed by the Joint Theater Trauma System (JTTS) Director, JTTS Program Manager, and the Joint Trauma System (JTS) Performance Improvement Branch.

5. Responsibilities.

a. It is the trauma team leader's responsibility to ensure the Resuscitation Record Part II, Physician H&P is complete at Role 2 and Role 3.

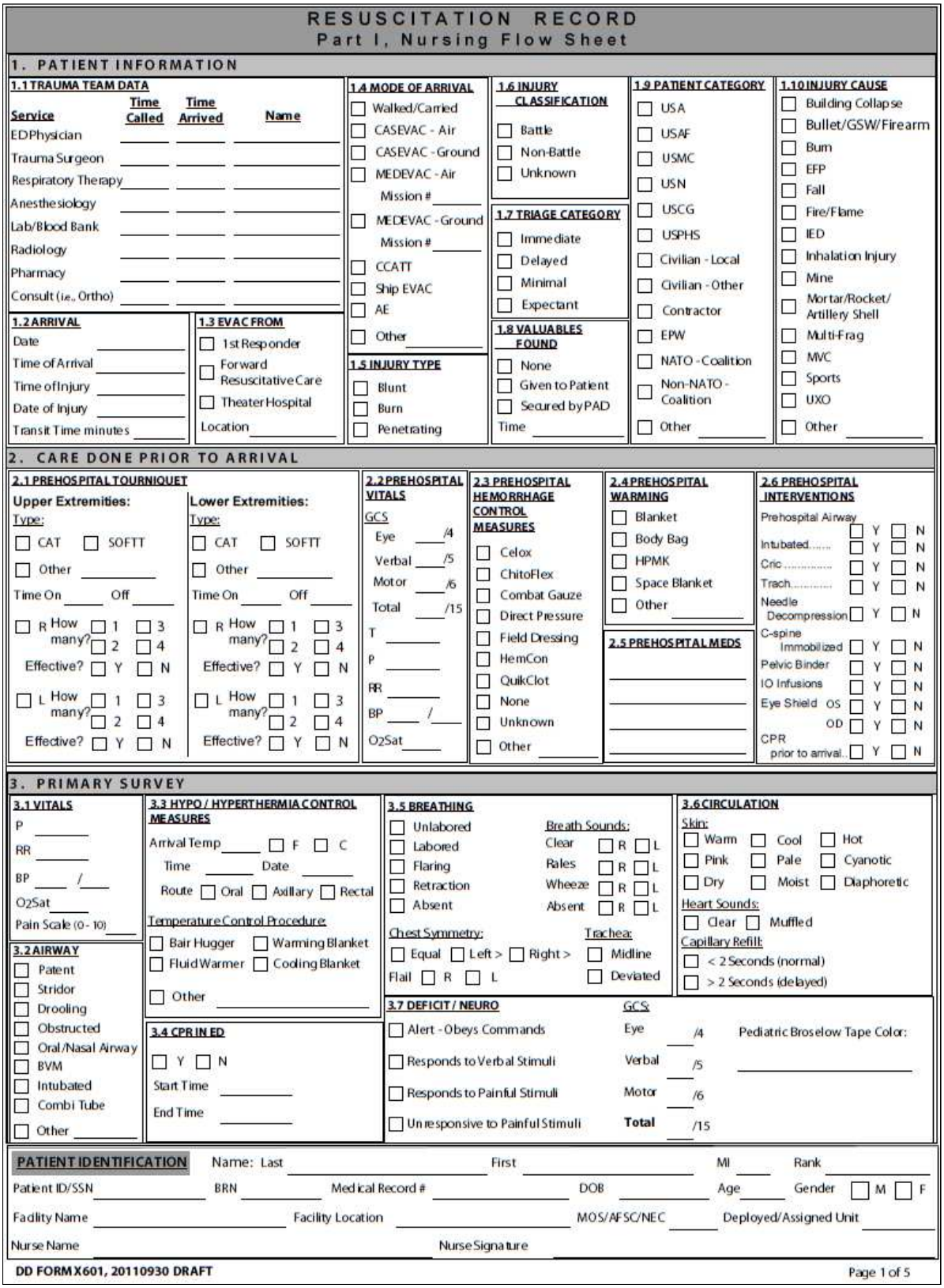
b. It is the responsibility of the nurse assigned to the trauma bay/patient to ensure the Resuscitation Record Part I, Nursing Flow Sheet is completed at Role 3.

c. A member of the trauma team that is receiving report (CCATT, medevac, ground ambulance) should request a copy of the transport run-sheet and ensure it is included in the patient's record. All times on the Resuscitation Record should be local 24-hour military format (hhmm).

Approved by CENTCOM JTTS Director, JTS Director and CENTCOM SG

Opinions, interpretations, conclusions, and recommendations are those of the authors and are not necessarily endorsed by the Services or DoD.

APPENDIX A Resuscitation Record—Part I Nursing Flow Sheet, page 1 of 5



RESUSCITATION RECORD
Part I, Nursing Flow Sheet

1. PATIENT INFORMATION

1.1 TRAUMA TEAM DATA

Service	Time Called	Time Arrived	Name
ED Physician			
Trauma Surgeon			
Respiratory Therapy			
Anesthesiology			
Lab/Blood Bank			
Radiology			
Pharmacy			
Consult (i.e., Ortho)			

1.2 ARRIVAL
Date
Time of Arrival
Time of Injury
Date of Injury
Transit Time minutes

1.3 EVAC FROM
☐ 1st Responder
☐ Forward Resuscitative Care
☐ Theater Hospital
Location

1.4 MODE OF ARRIVAL
☐ Walked/Carried
☐ CASEVAC - Air
☐ CASEVAC - Ground
☐ MEDEVAC - Air
Mission #
☐ MEDEVAC - Ground
Mission #
☐ CCATT
☐ Ship EVAC
☐ AE
☐ Other

1.5 INJURY TYPE
☐ Blunt
☐ Burn
☐ Penetrating

1.6 INJURY CLASSIFICATION
☐ Battle
☐ Non-Battle
☐ Unknown

1.7 TRIAGE CATEGORY
☐ Immediate
☐ Delayed
☐ Minimal
☐ Expectant

1.8 VALUABLES FOUND
☐ None
☐ Given to Patient
☐ Secured by PAD
Time

1.9 PATIENT CATEGORY
☐ USA
☐ USAF
☐ USMC
☐ USN
☐ USCG
☐ USPHS
☐ Civilian - Local
☐ Civilian - Other
☐ Contractor
☐ EPW
☐ NATO - Coalition
☐ Non-NATO - Coalition
☐ Other

1.10 INJURY CAUSE
☐ Building Collapse
☐ Bullet/GSW/Firearm
☐ Burn
☐ EFP
☐ Fall
☐ Fire/Flame
☐ IED
☐ Inhalation Injury
☐ Mine
☐ Mortar/Rocket/Artillery Shell
☐ Multi-Frag
☐ MVC
☐ Sports
☐ UXO
☐ Other

2. CARE DONE PRIOR TO ARRIVAL

2.1 PREHOSPITAL TOURNIQUET

Upper Extremities:
Type:
☐ CAT ☐ SOFTT
☐ Other
Time On Off
☐ R How many? ☐ 1 ☐ 2 ☐ 3 ☐ 4
Effective? ☐ Y ☐ N
☐ L How many? ☐ 1 ☐ 2 ☐ 3 ☐ 4
Effective? ☐ Y ☐ N

Lower Extremities:
Type:
☐ CAT ☐ SOFTT
☐ Other
Time On Off
☐ R How many? ☐ 1 ☐ 2 ☐ 3 ☐ 4
Effective? ☐ Y ☐ N
☐ L How many? ☐ 1 ☐ 2 ☐ 3 ☐ 4
Effective? ☐ Y ☐ N

2.2 PREHOSPITAL VITALS
GCS
Eye /4
Verbal /5
Motor /6
Total /15
T
P
RR
BP /
O2Sat

2.3 PREHOSPITAL HEMORRHAGE CONTROL MEASURES
☐ Celox
☐ ChitoFlex
☐ Combat Gauze
☐ Direct Pressure
☐ Field Dressing
☐ HemCon
☐ QuikClot
☐ None
☐ Unknown
☐ Other

2.4 PREHOSPITAL WARMING
☐ Blanket
☐ Body Bag
☐ HPMK
☐ Space Blanket
☐ Other

2.5 PREHOSPITAL MEDS

2.6 PREHOSPITAL INTERVENTIONS
Prehospital Airway ☐ Y ☐ N
Intubated ☐ Y ☐ N
Cric ☐ Y ☐ N
Trach ☐ Y ☐ N
Needle Decompression ☐ Y ☐ N
C-spine Immobilized ☐ Y ☐ N
Pelvic Binder ☐ Y ☐ N
IO Infusions ☐ Y ☐ N
Eye Shield OS ☐ Y ☐ N
OD ☐ Y ☐ N
CPR prior to arrival ☐ Y ☐ N

3. PRIMARY SURVEY

3.1 VITALS
P
RR
BP /
O2Sat
Pain Scale (0 - 10)

3.2 AIRWAY
☐ Patent
☐ Stridor
☐ Drooling
☐ Obstructed
☐ Oral/Nasal Airway
☐ BVM
☐ Intubated
☐ Combi Tube
☐ Other

3.3 HYPO / HYPERTHERMIA CONTROL MEASURES
Arrival Temp ☐ F ☐ C
Time Date
Route ☐ Oral ☐ Axillary ☐ Rectal
Temperature Control Procedure:
☐ Bair Hugger ☐ Warming Blanket
☐ Fluid Warmer ☐ Cooling Blanket
☐ Other

3.4 CPR IN ED
☐ Y ☐ N
Start Time
End Time

3.5 BREATHING
☐ Unlabored
☐ Labored
☐ Flaring
☐ Retraction
☐ Absent
Breath Sounds:
Clear ☐ R ☐ L
Rales ☐ R ☐ L
Wheeze ☐ R ☐ L
Absent ☐ R ☐ L
Chest Symmetry:
☐ Equal ☐ Left > ☐ Right >
Flail ☐ R ☐ L
Trachea:
☐ Midline
☐ Deviated

3.6 CIRCULATION
Skin:
☐ Warm ☐ Cool ☐ Hot
☐ Pink ☐ Pale ☐ Cyanotic
☐ Dry ☐ Moist ☐ Diaphoretic
Heart Sounds:
☐ Clear ☐ Muffled
Capillary Refill:
☐ < 2 Seconds (normal)
☐ > 2 Seconds (delayed)

3.7 DEFICIT / NEURO
☐ Alert - Obeys Commands
☐ Responds to Verbal Stimuli
☐ Responds to Painful Stimuli
☐ Unresponsive to Painful Stimuli

GCS:
Eye /4
Verbal /5
Motor /6
Total /15

Pediatric Broselow Tape Color:

PATIENT IDENTIFICATION
Name: Last First MI Rank
Patient ID/SSN BRN Medical Record # DOB Age Gender ☐ M ☐ F
Facility Name Facility Location MOS/AFSC/NEC Deployed/Assigned Unit
Nurse Name Nurse Signature

DD FORM X601, 20110930 DRAFT Page 1 of 5

Resuscitation Record—Part I Nursing Flow Sheet, page 2 of 5

RESUSCITATION RECORD
Part I, Nursing Flow Sheet

4. SECONDARY SURVEY

4.1 HEAD / NECK ENT

Drainage:
- ☐ Nasal (Color) _____
- ☐ Ear (Color) _____

Dental Injury ☐ Y ☐ N

CSF (Halo Test) ☐ + / ☐ -

C-spine Tender ☐ Y ☐ N

JVD ☐ Y ☐ N

Reactive Pupils

Right:	Left:
☐ Y ☐ N	☐ Y ☐ N
☐ Brisk	☐ Brisk
☐ Sluggish	☐ Sluggish
☐ NR	☐ NR

4.2 HEART / THORACIC

Rhythm
- ☐ NSR
- ☐ Tachy/Brady
- ☐ V-fib / V-tach
- ☐ PEA
- ☐ Asystole
- ☐ Other _____

Pulses
S = Strong W = Weak
D = Doppler A = Absent

Carotid	___ R	___ L
Femoral	___ R	___ L
Brachial	___ R	___ L
Radial	___ R	___ L
Pedal	___ R	___ L

4.3 ABDOMINAL/GU
- ☐ Open Wound
- ☐ Flat
- ☐ Obese
- ☐ Distended
- ☐ Tender
- ☐ Non-Tender
- ☐ Rebound Tenderness
- ☐ Guarding
- ☐ Rigid
- ☐ Unable to Assess

Pelvic Binder ☐ Y ☐ N

Blood at Meatus/Vagina ☐ Y ☐ N

FAST
- ☐ + describe _____
- ☐ -
- ☐ Equivocal

Last Meal @ _____

4.4 EXTREMITIES

Deformities	Pulses Present	Motor	Sensory
☐ RUE	_____	☐ Y ☐ N	☐ Y ☐ N
☐ LUE	_____	☐ Y ☐ N	☐ Y ☐ N
☐ RLE	_____	☐ Y ☐ N	☐ Y ☐ N
☐ LLE	_____	☐ Y ☐ N	☐ Y ☐ N

Pulses Present: indicate S=Strong W=Weak D=Doppler A=Absent

4.5 ALLERGIES

☐ Unknown ☐ NKDA Other _____

4.6 CURRENT MEDICATIONS
- ☐ Unknown ☐ Last Tetanus Date _____
- ☐ None
- ☐ Current Meds: (List med, dose, & route)

_____
_____
_____
_____

4.7 PROCEDURES

Procedure	Time	Size/Type	Site	Performed By	Results
O_2 Therapy ___ Lpm	On _____ Off _____	☐ Nasal Cannula ☐ Oral Airway ☐ NRB Mask ☐ Nasal Airway ___% ☐ BVM		_____	
ET Intubation (Put additional changes in Remarks)	Time _____	Teeth _____ cm	☐ Oral ☐ Nasal	_____	☐ $ETCO_2$ Change ☐ BBS Post Intubation
C-Collar Placed Time _____	C-Collar Removed Time _____				
Chest Tube #1	Time _____	_____	☐ L ☐ R	_____	☐ Air ☐ Blood (cc) _____
Chest Tube #2	Time _____	_____	☐ L ☐ R	_____	☐ Air ☐ Blood (cc) _____
Needle Decompression	Time _____	_____	☐ L ☐ R	_____	☐ Air ☐ Blood (cc) _____
Thoracotomy	Time _____		☐ L ☐ R ☐ Clamshell	_____	
Tourniquet	Time _____	Types _____	Sites _____	_____	
Eye Shield	Time _____		☐ OS ☐ OD ☐ Both	_____	
A-line	Time _____	_____	☐ L ☐ R	_____	
Gastric Tube	Time _____	_____	☐ Oral ☐ Nasal	_____	Verified ☐ Y ☐ N Suction ☐ Y ☐ N
Urinary	Time _____	Amount _____ Color _____ Foley Size _____	☐ Meatus ☐ Suprapubic	_____	Heme Dip ☐ - / ☐ + Results _____ cc
Other Procedure	Time _____	Describe _____			
Other Procedure	Time _____	Describe _____			

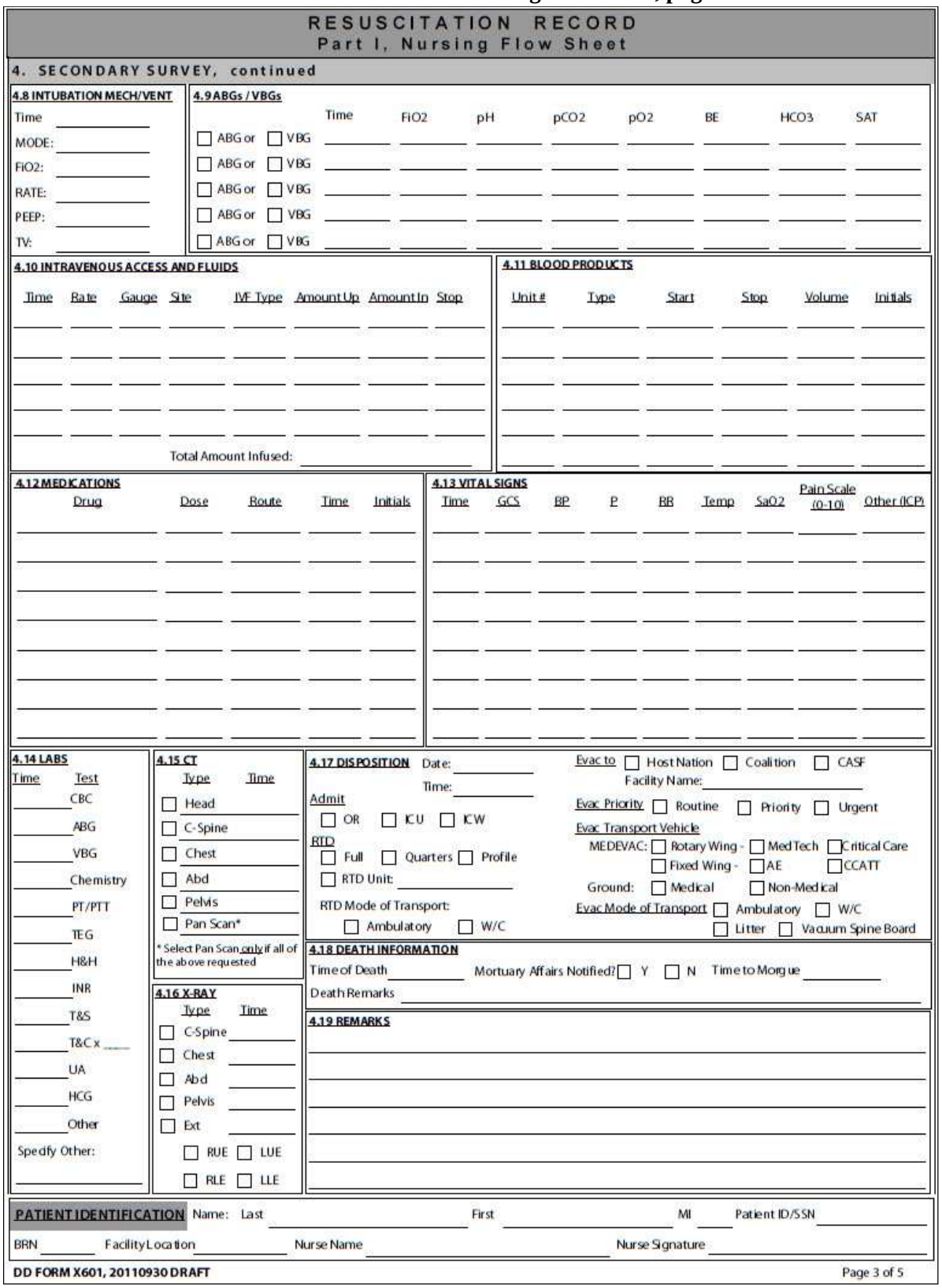
Hemorrhage Control Measures
- ☐ Celox
- ☐ Combat Gauze
- ☐ Field Dressing
- ☐ QuikClot
- ☐ Unknown
- ☐ ChitoFlex
- ☐ Direct Pressure
- ☐ HemCon
- ☐ None
- ☐ Other _____

PATIENT IDENTIFICATION Name: Last _____ First _____ MI ___ Patient ID/SSN _____

BRN _____ Facility Location _____ Nurse Name _____ Nurse Signature _____

DD FORM X601, 20110930 DRAFT Page 2 of 5

Resuscitation Record—Part I Nursing Flow Sheet, page 3 of 5



RESUSCITATION RECORD
Part I, Nursing Flow Sheet

4. SECONDARY SURVEY, continued

4.8 INTUBATION MECH/VENT

Time _____
MODE: _____
FiO2: _____
RATE: _____
PEEP: _____
TV: _____

4.9 ABGs / VBGs

	Time	FiO2	pH	pCO2	pO2	BE	HCO3	SAT
☐ ABG or ☐ VBG								
☐ ABG or ☐ VBG								
☐ ABG or ☐ VBG								
☐ ABG or ☐ VBG								
☐ ABG or ☐ VBG								

4.10 INTRAVENOUS ACCESS AND FLUIDS

Time	Rate	Gauge	Site	IVF Type	Amount Up	Amount In	Stop

Total Amount Infused: _____

4.11 BLOOD PRODUCTS

Unit #	Type	Start	Stop	Volume	Initials

4.12 MEDICATIONS

Drug	Dose	Route	Time	Initials

4.13 VITAL SIGNS

Time	GCS	BP	P	RR	Temp	SaO2	Pain Scale (0-10)	Other (ICP)

4.14 LABS

Time / Test

_____ CBC
_____ ABG
_____ VBG
_____ Chemistry
_____ PT/PTT
_____ TEG
_____ H&H
_____ INR
_____ T&S
_____ T&C x ____
_____ UA
_____ HCG
_____ Other

Specify Other: _____

4.15 CT

Type	Time
☐ Head	
☐ C-Spine	
☐ Chest	
☐ Abd	
☐ Pelvis	
☐ Pan Scan*	

* Select Pan Scan only if all of the above requested

4.16 X-RAY

Type	Time
☐ C-Spine	
☐ Chest	
☐ Abd	
☐ Pelvis	
☐ Ext	
☐ RUE ☐ LUE	
☐ RLE ☐ LLE	

4.17 DISPOSITION Date: _____ Time: _____

Admit ☐ OR ☐ ICU ☐ ICW

RTD ☐ Full ☐ Quarters ☐ Profile
☐ RTD Unit: _____

RTD Mode of Transport: ☐ Ambulatory ☐ W/C

Evac to ☐ Host Nation ☐ Coalition ☐ CASF
Facility Name: _____

Evac Priority ☐ Routine ☐ Priority ☐ Urgent

Evac Transport Vehicle
MEDEVAC: ☐ Rotary Wing - ☐ MedTech ☐ Critical Care
☐ Fixed Wing - ☐ AE ☐ CCATT
Ground: ☐ Medical ☐ Non-Medical

Evac Mode of Transport ☐ Ambulatory ☐ W/C ☐ Litter ☐ Vacuum Spine Board

4.18 DEATH INFORMATION

Time of Death _____ Mortuary Affairs Notified? ☐ Y ☐ N Time to Morgue _____

Death Remarks _____

4.19 REMARKS

PATIENT IDENTIFICATION Name: Last _____ First _____ MI ____ Patient ID/SSN _____

BRN _____ Facility Location _____ Nurse Name _____ Nurse Signature _____

DD FORM X601, 20110930 DRAFT Page 3 of 5

Resuscitation Record—Part II Physician H &P, page 4 of 5

RESUSCITATION RECORD
Part II, Physician H&P

1. HISTORY & PHYSICAL - INJURY DESCRIPTION

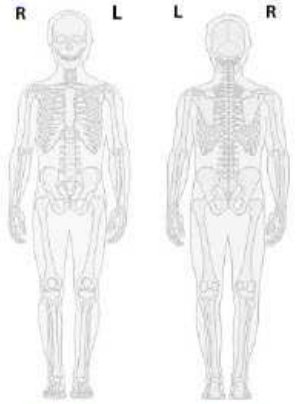
1.1 ARRIVAL
Date _____
Time of Arrival _____

1.2 TRIAGE CATEGORY
☐ Immediate
☐ Delayed
☐ Minimal
☐ Expectant

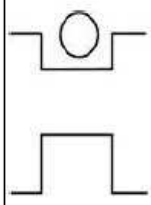
1.3 CHIEF COMPLAINT, HISTORY AND PRESENTING ILLNESS

1.4 INJURY DESCRIPTION

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



Pulses Present
S= Strong
W= Weak
D= Doppler
A=Absent



1.5 HISTORY AND PHYSICAL

Head & Neck:

Chest:

Abdomen/Back and Spine:

Pelvis: ☐ Stable ☐ Unstable ☐ Binder

Upper Extremities:

Lower Extremities:

Interventions Prior to Arrival:

1.6 PRE / INITIAL PROCEDURES / DIAGNOSTICS

Pre / Initial
☐ ☐ Cric
☐ ☐ ICP Monitor
☐ ☐ Ventric

Pre / Initial
☐ ☐ C-Collar/ Time Removed _____
☐ ☐ Cantholysis & Canthotomy ☐ R ☐ L
☐ ☐ Tympanic Membranes Rupture ☐ R ☐ L
Blood ☐ R ☐ L
☐ ☐ Eye Shield ☐ R ☐ L

Needle Decompression ☐ R ☐ L Pericardial FAST ☐ - / ☐ + describe: _____
Output ☐ Air Blood (cc) _____
☐ Pericardiocentesis

DPL ☐ Gross Blood: ☐ - / ☐ + describe _____
Log Roll Time _____
Back Exam ☐ WNL ☐ ABNL describe _____
Rectal Exam ☐ WNL ☐ Weak/Absent Tone Gross Blood: ☐ - / ☐ +

Prostate _____
Gyn _____

☐ Closed Reduction ☐ EXT Fixation ☐ Tourniquet ☐ R # _____ ☐ L # _____
☐ Wound Washout ☐ Splint

☐ Closed Reduction ☐ EXT Fixation ☐ Tourniquet ☐ R # _____ ☐ L # _____
☐ Wound Washout ☐ Splint

☐ Sedated ☐ 3% Saline ☐ Cntrl Line Loc _____ Site _____
☐ Chemical Paralyze ☐ Mannitol ☐ IO Loc _____ Site _____
☐ Seizure Protocol ☐ A-Line Loc _____ Site _____

1.7 PUPILS / VISION

Brisk	☐ R ☐ L	Hand Motion	☐ R ☐ L
Sluggish	☐ R ☐ L	Light Perception	☐ R ☐ L
NR	☐ R ☐ L	No Light Perception	☐ R ☐ L

Size Right mm _____ Left mm _____

1.8 BURN
☐ 1st ☐ 2nd ☐ 3rd
%TBSA _____
>20% Use the Burn Flow Sheet
Cause _____

1.9 EXTREMITIES

	Motor	Sens	ROM
RUE	+ ___ / - ___	+ ___ / - ___	+ ___ / - ___
LUE	+ ___ / - ___	+ ___ / - ___	+ ___ / - ___
RLE	+ ___ / - ___	+ ___ / - ___	+ ___ / - ___
LLE	+ ___ / - ___	+ ___ / - ___	+ ___ / - ___

PATIENT IDENTIFICATION Name: Last _____ First _____ MI _____ Rank _____
Patient ID/SSN _____ BRN _____ Medical Record # _____ DOB _____ Age _____ Gender ☐ M ☐ F
Facility Name _____ Facility Location _____ Physician Signature _____

DD FORM X601, 20110930 DRAFT Page 4 of 5

Resuscitation Record—Part II Physician H &P, page 4 of 5

RESUSCITATION RECORD
Part II, Physician H&P

2. X-RAYS and CT

2.1 CT OBTAINED	2.2 X-RAYS OBTAINED	2.3 PENDING STUDIES	2.4 RESULTS (include TEG/Rotem results)	2.5 C-SPINE RESULTS
☐ Head ☐ C-Spine ☐ Chest ☐ Abd/Pelvis ☐ Pan Scan* * Select Pan Scan only if all of the above requested	☐ C-Spine ☐ Extremity ☐ Spine ☐ RUE ☐ Chest/Upright ☐ LUE ☐ Pelvis ☐ RLE ☐ LLE Other _____ Other _____			☐ CT Scan Normal ☐ CT Scan Abnormal C-Spine cleared based on: ☐ Normal Exam, reliable Pt ☐ Normal CT scan, normal exam C-Spine not cleared based on: ☐ Neuro c/o, abnormal exam ☐ Abnormal imaging ☐ Unreliable Pt

3. LABORATORY RESULTS

3.1 CBC

3.2 CHEMISTRY 7

3.3 PT / INR / PTT _____ / _____ / _____

3.4 LFT				3.5 URINALYSIS			
Amylase		Bili		SpGr		Chem	
Alk Phos		SGOT		Micro		HCG	
LDH		SGPT		pH		Bact	
Other				WBC		RBC	

4. IMPRESSION

5. DIAGNOSES

1	4
2	5
3	6

6. PLAN

6.1 PLAN

6.2 TRIAD INDICATORS UPON ARRIVAL IN ED
Temp < 96F/36C ☐ Yes ☐ No INR > 1.4 ☐ Yes ☐ No Base Deficit > 5 ☐ Yes ☐ No
FWB Requested ☐ Yes ☐ No
Damage Control ☐ Yes ☐ No

6.3 DISPOSITION ☐ OR ☐ ICU ☐ ICW ☐ Transfer Date: _____ Time: _____

7. DNBI / NBI CATEGORY

☐ Injury, Sports ☐ Injury, Work/Training ☐ Surgical ☐ _____
☐ Injury, MVC ☐ Injury, Other ☐ _____

8. CAUSE OF DEATH

8.1 ANATOMIC
☐ Airway ☐ Neck ☐ Abdomen ☐ Extremity ☐ U / ☐ L
☐ Head ☐ Chest ☐ Pelvis ☐ Other, Specify _____

8.2 PHYSIOLOGIC
☐ MOF ☐ Sepsis ☐ Total Body Disruption
☐ CNS ☐ Hemorrhage ☐ Breathing
☐ Other, Specify _____

PATIENT IDENTIFICATION Name: Last _____ First _____ MI ____ Patient ID/SSN _____
BRN _____ Facility Location _____ Physician Name _____ Physician Signature _____

DD FORM X601, 20110930 DRAFT Page 5 of 5

APPENDIX B General Instructions for Resuscitation Record, Page 1 of 5

General Instructions for Resuscitation Record

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 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.

DD FORM X601, 20110930 Draft Page 1 of 5

General Instructions for Resuscitation Record, Page 2 of 5

General Instructions for Resuscitation Record

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 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.

DD FORM X601, 20110930 Draft Page 2 of 5

General Instructions for Resuscitation Record, Page 3 of 5

General Instructions for Resuscitation Record

None. Check if no hemorrhage control measures.

Unknown. Check if hemorrhage control measures are unknown.

If 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 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 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.

DD FORM X601, 20110930 Draft Page 3 of 5

General Instructions for Resuscitation Record, Page 4 of 5

General Instructions for Resuscitation Record

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
- 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

1 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 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.

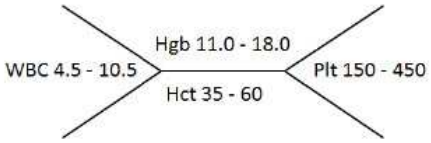
DD FORM X601, 20110930 Draft Page 4 of 5

General Instructions for Resuscitation Record, Page 5 of 5

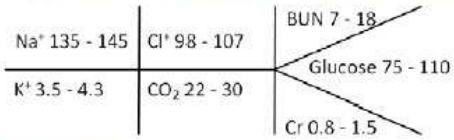
General Instructions for Resuscitation Record

3 LABORATORY RESULTS

3.1 CBC. As stated. See example for format.



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



3.3 PT/INT/PTT. As stated.

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

3.5 URINALYSIS. As stated.

4 IMPRESSION

Enter impressions and findings.

5 DIAGNOSES

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

6 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 DNBI/NBI CATEGORY

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

8 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.

DD FORM X601, 20110930 Draft — Page 5 of 5

APPENDIX C
ADDITIONAL INFORMATION REGARDING OFF-LABEL USES IN CPGs

1. **Purpose**. The purpose of this Appendix is to ensure an understanding of DoD policy and practice regarding inclusion in CPGs of "off-label" uses of U.S. Food and Drug Administration (FDA)–approved products. This applies to off-label uses with patients who are armed forces members.

2. **Background**. Unapproved (i.e., "off-label") uses of FDA-approved products are extremely common in American medicine and are usually not subject to any special regulations. However, under Federal law, in some circumstances, unapproved uses of approved drugs are subject to FDA regulations governing "investigational new drugs." These circumstances include such uses as part of clinical trials, and in the military context, command required, unapproved uses. Some command requested unapproved uses may also be subject to special regulations.

3. **Additional Information Regarding Off-Label Uses in CPGs**. The inclusion in CPGs of off-label uses is not a clinical trial, nor is it a command request or requirement. Further, it does not imply that the Military Health System requires that use by DoD health care practitioners or considers it to be the "standard of care." Rather, the inclusion in CPGs of off-label uses is to inform the clinical judgment of the responsible health care practitioner by providing information regarding potential risks and benefits of treatment alternatives. The decision is for the clinical judgment of the responsible health care practitioner within the practitioner-patient relationship.

4. **Additional Procedures**.

   a. Balanced Discussion. Consistent with this purpose, CPG discussions of off-label uses specifically state that they are uses not approved by the FDA. Further, such discussions are balanced in the presentation of appropriate clinical study data, including any such data that suggest caution in the use of the product and specifically including any FDA-issued warnings.

   b. Quality Assurance Monitoring. With respect to such off-label uses, DoD procedure is to maintain a regular system of quality assurance monitoring of outcomes and known potential adverse events. For this reason, the importance of accurate clinical records is underscored.

   c. Information to Patients. Good clinical practice includes the provision of appropriate information to patients. Each CPG discussing an unusual off-label use will address the issue of information to patients. When practicable, consideration will be given to including in an appendix an appropriate information sheet for distribution to patients, whether before or after use of the product. Information to patients should address in plain language: a) that the use is not approved by the FDA; b) the reasons why a DoD health care practitioner would decide to use the product for this purpose; and c) the potential risks associated with such use.