

1. PATIENT/CANINE INFORMATION

1.1 TRAUMA TEAM DATA <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Service</th> <th style="width:15%;">Time Called</th> <th style="width:15%;">Time Arrived</th> <th style="width:30%;">Name</th> </tr> </thead> <tbody> <tr><td>ED Physician</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Veterinarian</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Trauma Surgeon</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Radiology</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Pharmacy</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Lab/Blood Bank</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Respiratory Therapy</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Anesthesiology</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Consult (Germany)</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>			Service	Time Called	Time Arrived	Name	ED Physician	_____	_____	_____	Veterinarian	_____	_____	_____	Trauma Surgeon	_____	_____	_____	Radiology	_____	_____	_____	Pharmacy	_____	_____	_____	Lab/Blood Bank	_____	_____	_____	Respiratory Therapy	_____	_____	_____	Anesthesiology	_____	_____	_____	Consult (Germany)	_____	_____	_____	1.2 ARRIVAL Date _____ Time of Arrival _____ Time of Injury _____ Date of Injury _____ Transit Time minutes _____		1.3 EVAC FROM <input type="checkbox"/> 1st Responder <input type="checkbox"/> Forward Resuscitative Care <input type="checkbox"/> Theater Hospital Location _____		1.4 MODE OF ARRIVAL <input type="checkbox"/> Walked/Carried <input type="checkbox"/> CCATT <input type="checkbox"/> CASEVAC - Air <input type="checkbox"/> Ship EVAC <input type="checkbox"/> CASEVAC - Ground <input type="checkbox"/> AE <input type="checkbox"/> MEDEVAC - Air <input type="checkbox"/> Other Mission # _____ <input type="checkbox"/> MEDEVAC - Ground Mission # _____	
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1.8 SAFETY <input type="checkbox"/> Muzzle Applied <input type="checkbox"/> Handler Present <input type="checkbox"/> Sedated			1.9 PATIENT CATEGORY <input type="checkbox"/> USA MWD <input type="checkbox"/> USAF MWD <input type="checkbox"/> USN MWD <input type="checkbox"/> USCG MWD <input type="checkbox"/> NATO - Coalition MWD <input type="checkbox"/> USMC MWD <input type="checkbox"/> Non-NATO - Coalition MWD <input type="checkbox"/> Contractor MWD <input type="checkbox"/> Other MWD _____		1.10 PPE <input type="checkbox"/> Body Armor <input type="checkbox"/> Doggles/Eye Protection <input type="checkbox"/> Ear Protection <input type="checkbox"/> Other _____		1.6 INJURY CLASSIFICATION <input type="checkbox"/> Battle <input type="checkbox"/> Non-Battle <input type="checkbox"/> Unknown		1.7 TRIAGE CATEGORY <input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minimal <input type="checkbox"/> Expectant																																							
1.11 INJURY CAUSE <input type="checkbox"/> Building Collapse <input type="checkbox"/> CBRNE Agent _____ <input type="checkbox"/> Bullet/GSW <input type="checkbox"/> Inhalation Injury <input type="checkbox"/> MVC <input type="checkbox"/> Fire/Flame (Burn) <input type="checkbox"/> Mine <input type="checkbox"/> UXO <input type="checkbox"/> IED <input type="checkbox"/> Mortar/Rocket <input type="checkbox"/> Heat/Sun <input type="checkbox"/> Fall <input type="checkbox"/> Artillery Shell <input type="checkbox"/> Medical <input type="checkbox"/> Other _____																																																

2. CARE DONE PRIOR TO ARRIVAL

2.1 PREHOSPITAL TOURNIQUET Front Extremities: Type: _____ <input type="checkbox"/> CAT <input type="checkbox"/> SOFTT <input type="checkbox"/> Other _____ Time On _____ Off _____ <input type="checkbox"/> L How many? <input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 4 Effective? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R How many? <input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 4 Effective? <input type="checkbox"/> Y <input type="checkbox"/> N				2.2 PREHOSPITAL VITALS Sedation Level: <input type="checkbox"/> Alert P _____ <input type="checkbox"/> Sedated RR _____ <input type="checkbox"/> Lethargic BP _____ / _____ <input type="checkbox"/> Unconscious SpO ₂ _____ T _____ F _____ C _____ CRT _____				2.3 HEMORRHAGE CONTROL <input type="checkbox"/> Celox <input type="checkbox"/> Field Dressing <input type="checkbox"/> ChitoFlex <input type="checkbox"/> QuikClot <input type="checkbox"/> Combat Gauze <input type="checkbox"/> None <input type="checkbox"/> Direct Pressure <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				2.4 PREHOSPITAL WARMING <input type="checkbox"/> Blanket <input type="checkbox"/> Body Bag <input type="checkbox"/> HPMK <input type="checkbox"/> Space Blanket <input type="checkbox"/> Other _____			
2.5 PREHOSPITAL MEDS <div style="border: 1px solid black; height: 50px; width: 100%;"></div>				2.6 PREHOSPITAL INTERVENTIONS Intubated <input type="checkbox"/> Y <input type="checkbox"/> N IO Infusions <input type="checkbox"/> Y <input type="checkbox"/> N IV Fluids <input type="checkbox"/> Y <input type="checkbox"/> N Tracheostomy <input type="checkbox"/> Y <input type="checkbox"/> N E-Collar <input type="checkbox"/> Y <input type="checkbox"/> N Pain Scale (0 - 10) _____ Needle Decompression <input type="checkbox"/> Y <input type="checkbox"/> N CPR <input type="checkbox"/> Y <input type="checkbox"/> N CBRNE Decon <input type="checkbox"/> Y <input type="checkbox"/> N											

3. PRIMARY ASSESSMENT

3.1 VITALS P _____ RR _____ BP _____ / _____ SpO ₂ _____ Pain Scale (0 - 10) _____		3.2 NEURO/MENTAL STATUS <input type="checkbox"/> Hyperactive <input type="checkbox"/> Disoriented <input type="checkbox"/> Alert <input type="checkbox"/> Stupor <input type="checkbox"/> Sedated <input type="checkbox"/> Comatose <input type="checkbox"/> Depressed MGCS L of C _____ Motor _____ Brainstem _____ TOTAL _____		3.3 HYPO / HYPERTHERMIA CONTROL MEASURES Arrival Temp _____ <input type="checkbox"/> F <input type="checkbox"/> C Temperature Control Procedure: <input type="checkbox"/> Bair Hugger <input type="checkbox"/> Warming Blanket <input type="checkbox"/> Warmed Fluids <input type="checkbox"/> Cooling Blanket <input type="checkbox"/> Water <input type="checkbox"/> IV Fluids <input type="checkbox"/> Other _____ Time _____ Date _____ Route: <input type="checkbox"/> Aural <input type="checkbox"/> Rectal					
3.4 AIRWAY <input type="checkbox"/> Patent <input type="checkbox"/> BVM (Ambu) <input type="checkbox"/> Panting <input type="checkbox"/> Intubated <input type="checkbox"/> Stridor <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Obstructed <input type="checkbox"/> OPA		3.5 BREATHING <input type="checkbox"/> Unlabored <input type="checkbox"/> Labored <input type="checkbox"/> Panting <input type="checkbox"/> Abdominal Component <input type="checkbox"/> Absent		Breath Sounds: Clear <input type="checkbox"/> L <input type="checkbox"/> R Rales <input type="checkbox"/> L <input type="checkbox"/> R Wheeze <input type="checkbox"/> L <input type="checkbox"/> R Absent <input type="checkbox"/> L <input type="checkbox"/> R		Chest Symmetry: <input type="checkbox"/> Equal <input type="checkbox"/> L > R <input type="checkbox"/> R > L Flail: <input type="checkbox"/> L <input type="checkbox"/> R		Trachea: <input type="checkbox"/> Midline <input type="checkbox"/> Deviated	

PATIENT ID	Name _____ DOB _____ Age _____ Weight _____ Gender <input type="checkbox"/> N <input type="checkbox"/> F <input type="checkbox"/> M	Breed _____ MWD Type _____
Tattoo # _____	Microchip # _____ SSN _____	Handler Name _____ Deployed/Assigned Unit _____
Vet/Tech/HCP Name _____	Facility Name _____	Facility Location _____

4. SECONDARY SURVEY, continued

4.9 VENT SETTINGS

Time _____
 Mode: _____
 FiO2: _____
 Rate: _____
 PEEP: _____
 TV: _____
 Notes: _____

4.10 INTRAVENOUS/INTRAOSSEOUS ACCESS AND FLUIDS/BLOOD PRODUCTS

Start Time	Rate	Type	Gauge	Site	IVF Type	Amount Up	Amount In	Stop Time	Initials
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	_____
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	_____
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	_____
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	_____
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	_____

4.11 MEDICATIONS

Start Time	Drug	Dose	Site	Route	Stop Time	Initials
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

4.12 LABS

Time	Test	Time	Test
_____	CBC	_____	INR
_____	Chem7	_____	Lactate
_____	Chem12	_____	U/A
_____	H&H	<input type="checkbox"/>	Other, specify: _____
_____	ABG/Serial	_____	_____
_____	VBG	_____	_____
_____	PT/PTT	_____	_____

4.13 CT

Type	Time
<input type="checkbox"/> Head	_____
<input type="checkbox"/> Spine	_____
<input type="checkbox"/> Chest	_____
<input type="checkbox"/> Abd/Pelvis	_____
<input type="checkbox"/> Pan Scan	_____

4.14 X-RAY

Type	Time	
<input type="checkbox"/> Head	_____	<input type="checkbox"/> Extremity
<input type="checkbox"/> Spine	_____	<input type="checkbox"/> LF
<input type="checkbox"/> Chest	_____	<input type="checkbox"/> RF
<input type="checkbox"/> Abd	_____	<input type="checkbox"/> LR
<input type="checkbox"/> Pelvis	_____	<input type="checkbox"/> RR
		Time _____

4.15 Pending Studies

4.16 Results

4.17 VITAL SIGNS

Time	BP	P	RR	Temp	SpO2	Other (ICP)	Initials
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

4.18 DISPOSITION

Date: _____ Time: _____ Handler Present: Y N

RTD Full Light Work No Work for _____ Days

Admit OR ICU ICW Vet Clinic

Evac to VTF Role 2 VTF Role 3
 VMCE Facility Name: _____

Evac Priority Routine Priority Urgent

Evac Mode Ambulatory Gurney/Litter Crate/Kennel

Evac Transport Vehicle
 MEDEVAC: Rotary Wing Fixed Wing CCATT
 Ground: Ambulance Non-Medical

4.19 NOTES

PATIENT ID Name _____ DOB _____ Age _____ Weight _____ Gender N F M Breed _____ MWD Type _____

Tattoo # _____ Microchip # _____ SSN _____ Handler Name _____ Deployed/Assigned Unit _____

Vet/Tech/HCP Name _____ Facility Name _____ Facility Location _____

CANINE TREATMENT AND RESUSCITATION RECORD

Part II, Veterinarian/Physician

Date _____

1.7 PUPILS / VISION

Brisk L R Sluggish L R NR L R Hand Motion L R
 Light Perception L R No Light Perception L R
 Anisocoria L > R R > L

1.8 BURN

Super Deep PT %TBSA _____ Cause _____
 Super PT Full _____

1.9 EXTREMITIES

	Motor	Sensory	ROM
LF	+ _____ / - _____	+ _____ / - _____	+ _____ / - _____
RF	+ _____ / - _____	+ _____ / - _____	+ _____ / - _____
LR	+ _____ / - _____	+ _____ / - _____	+ _____ / - _____
RR	+ _____ / - _____	+ _____ / - _____	+ _____ / - _____

2. LABORATORY RESULTS

2.1 CBC

_____ WBC	_____ Na	_____ Gluc	_____ TProtein
_____ RBC	_____ K	_____ BUN	_____ ALT
_____ HGB	_____ Cl	_____ Crea	_____ AST
_____ HCT	_____ Ca	_____ Albumin	_____ ALP
_____ PLT	_____ CO2	_____ TBili	_____ Lactate

2.2 CHEMISTRY 7/12

2.3 COAG

_____ PT
 _____ PTT
 _____ INR

2.5 VBG/ABG

VBG	ABG
_____ pH	_____
_____ PaO2	_____
_____ PaCO2	_____
_____ HCO3	_____
_____ SaO2	_____

2.6 URINALYSIS

_____ SpGr
 _____ pH
 _____ LEU
 _____ PRO
 _____ GLU
 _____ KET
 _____ UBG
 _____ BIL
 _____ HGB

2.7 OTHER LABS

3. X-RAYS and CT

3.1 CT OBTAINED

Head
 Spine
 Chest
 Abd/Pelvis
 Pan Scan*
 * Select Pan Scan only if all of the above requested

3.2 X-RAYS OBTAINED

Head Extremity
 Spine LF
 Chest RF
 Abd LR
 Pelvis RR
 Other _____
 Other _____
 Other _____

3.4 PENDING STUDIES

3.5 RESULTS (include TEG/Rotem results)

3.3 Foreign Body

Projectile Shrapnel Debris
 Incendiary Device Bones
 Other: _____

4. IMPRESSION/ASSESSMENT

4.1 Severity

Critical
 Severe
 Moderate
 Mild

4.2 Impression/Assessment Comments

5. DIAGNOSES

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

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6. PLAN

6.1 PLAN

7. DNBI / NBI CATEGORY

Injury, MVC Surgical Other _____
 Injury, Work/Training Disease Describe _____

8. CAUSE OF DEATH

8.1 ANATOMIC

Airway Neck Abdomen
 Head Chest Pelvis
 Extremity LF RF LR RR Other, Specify

8.2 PHYSIOLOGIC

MOF Sepsis CNS Hemorrhage Breathing
 Heart Failure Total Body Disruption Other, Specify

8.3 DEATH INFORMATION

Date of Death _____ Time of Death _____ Mortuary Affairs Notified? N/A Y N

Euthanized Y N Method _____

Gross Necropsy by DVM Y N Necropsy Date _____ Necropsy Time _____

Time between death and necropsy _____ Gross Pathology Report: Y N Unknown

Samples Shipped to JPC Y N N/A Unknown

Death Remarks

Sign and submit when form is completed Vet/Tech/HCP Signature Submit to: dog.consult@us.af.mil

PATIENT ID Name _____ DOB _____ Age _____ Weight _____ Gender N F M Breed _____ MWD Type _____
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