

BATTLE AND NON-BATTLE INJURY DOCUMENTATION: THE RESUSCITATION RECORD

Original Release/Approval	1 Jun 2008	Note: This CPG requires an annual review.	
<input checked="" type="checkbox"/> Reviewed	Dec 2013	<input checked="" type="checkbox"/> Approved for PACOM	Dec 2014
<input checked="" type="checkbox"/> Supersedes:	Battle Non Battle Injury Documentation Resuscitation Record 20 Sep 12		

- 1. Goal.** Obtain complete trauma documentation, including evacuation documentation, on all trauma patients from Role II and Role III within the PACOM 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 Role II Access trauma database) that offer new approaches and maximize computer technologies and the deployment of trauma coordinators to Role III 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 PACOM 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 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

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- 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, 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/GSW/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. Near-Drowning
- n. Sports
- o. UXO
- p. Other
- q. All trauma admissions to any/all Role III 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 II or Role III 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, 3.2, and 3.3.

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- 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 section 3 had the trauma Resuscitation Record completed.
 - 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) Department of Defense Trauma Registry (DoDTR)
- 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 PACOM JTTS Director,
JTS Director and PACOM SG

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

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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		1.4 MODE OF ARRIVAL	1.6 INJURY CLASSIFICATION	1.9 PATIENT CATEGORY	1.10 INJURY CAUSE																																			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 15%;">Service</th> <th style="width: 15%;">Time Called</th> <th style="width: 15%;">Time Arrived</th> <th style="width: 55%;">Name</th> </tr> <tr> <td>ED Physician</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Trauma Surgeon</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>Lab/Blood Bank</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>Consult (i.e., Ortho)</td> <td></td> <td></td> <td></td> </tr> </table>	Service	Time Called	Time Arrived	Name	ED Physician				Trauma Surgeon				Respiratory Therapy				Anesthesiology				Lab/Blood Bank				Radiology				Pharmacy				Consult (i.e., Ortho)				<input type="checkbox"/> Walked/Carried <input type="checkbox"/> CASEVAC - Air <input type="checkbox"/> CASEVAC - Ground <input type="checkbox"/> MEDEVAC - Air Mission # _____ <input type="checkbox"/> MEDEVAC - Ground Mission # _____ <input type="checkbox"/> CCATT <input type="checkbox"/> Ship EVAC <input type="checkbox"/> AE <input type="checkbox"/> Other _____	<input type="checkbox"/> Battle <input type="checkbox"/> Non-Battle <input type="checkbox"/> Unknown	<input type="checkbox"/> USA <input type="checkbox"/> USAF <input type="checkbox"/> USMC <input type="checkbox"/> USN <input type="checkbox"/> USCG <input type="checkbox"/> USPHS <input type="checkbox"/> Civilian - Local <input type="checkbox"/> Civilian - Other <input type="checkbox"/> Contractor <input type="checkbox"/> EPW <input type="checkbox"/> NATO - Coalition <input type="checkbox"/> Non-NATO - Coalition <input type="checkbox"/> Other _____	<input type="checkbox"/> Building Collapse <input type="checkbox"/> Bullet/GSW/Firearm <input type="checkbox"/> Burn <input type="checkbox"/> EFP <input type="checkbox"/> Fall <input type="checkbox"/> Fire/Flame <input type="checkbox"/> IED <input type="checkbox"/> Inhalation Injury <input type="checkbox"/> Mine <input type="checkbox"/> Mortar/Rocket/Artillery Shell <input type="checkbox"/> Multi-Frag <input type="checkbox"/> MVC <input type="checkbox"/> Sports <input type="checkbox"/> UXO <input type="checkbox"/> Other _____
Service	Time Called	Time Arrived	Name																																					
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Radiology																																								
Pharmacy																																								
Consult (i.e., Ortho)																																								
1.2 ARRIVAL	1.3 EVAC FROM	1.5 INJURY TYPE		1.7 TRIAGE CATEGORY																																				
Date _____ Time of Arrival _____ Time of Injury _____ Date of Injury _____ Transit Time minutes _____	<input type="checkbox"/> 1st Responder <input type="checkbox"/> Forward Resuscitative Care <input type="checkbox"/> Theater Hospital Location _____	<input type="checkbox"/> Blunt <input type="checkbox"/> Burn <input type="checkbox"/> Penetrating		<input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minimal <input type="checkbox"/> Expectant																																				
2. CARE DONE PRIOR TO ARRIVAL																																								
2.1 PREHOSPITAL TOURNIQUET		2.2 PREHOSPITAL VITALS	2.3 PREHOSPITAL HEMORRHAGE CONTROL MEASURES	2.4 PREHOSPITAL WARMING	2.6 PREHOSPITAL INTERVENTIONS																																			
Upper Extremities: Type: <input type="checkbox"/> CAT <input type="checkbox"/> SOFTT <input type="checkbox"/> Other _____ Time On _____ Off _____ R How many? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 Effective? <input type="checkbox"/> Y <input type="checkbox"/> N L How many? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 Effective? <input type="checkbox"/> Y <input type="checkbox"/> N	Lower Extremities: Type: <input type="checkbox"/> CAT <input type="checkbox"/> SOFTT <input type="checkbox"/> Other _____ Time On _____ Off _____ R How many? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 Effective? <input type="checkbox"/> Y <input type="checkbox"/> N L How many? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 Effective? <input type="checkbox"/> Y <input type="checkbox"/> N	GCS Eye ___/4 Verbal ___/5 Motor ___/6 Total ___/15 T _____ P _____ RR _____ BP ___/___ O2Sat _____	<input type="checkbox"/> Celox <input type="checkbox"/> ChitoFlex <input type="checkbox"/> Combat Gauze <input type="checkbox"/> Direct Pressure <input type="checkbox"/> Field Dressing <input type="checkbox"/> HemCon <input type="checkbox"/> QuikClot <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Blanket <input type="checkbox"/> Body Bag <input type="checkbox"/> HPMK <input type="checkbox"/> Space Blanket <input type="checkbox"/> Other _____	Prehospital Airway <input type="checkbox"/> Y <input type="checkbox"/> N Intubated _____ <input type="checkbox"/> Y <input type="checkbox"/> N Cric _____ <input type="checkbox"/> Y <input type="checkbox"/> N Trach _____ <input type="checkbox"/> Y <input type="checkbox"/> N Needle Decompression <input type="checkbox"/> Y <input type="checkbox"/> N C-spine Immobilized <input type="checkbox"/> Y <input type="checkbox"/> N Pelvic Binder <input type="checkbox"/> Y <input type="checkbox"/> N IO Infusions <input type="checkbox"/> Y <input type="checkbox"/> N Eye Shield OS <input type="checkbox"/> Y <input type="checkbox"/> N OD <input type="checkbox"/> Y <input type="checkbox"/> N CPR prior to arrival <input type="checkbox"/> Y <input type="checkbox"/> N																																			
3. PRIMARY SURVEY																																								
3.1 VITALS	3.3 HYPO / HYPERTHERMIA CONTROL MEASURES	3.5 BREATHING	3.6 CIRCULATION																																					
P _____ RR _____ BP ___/___ O2Sat _____ Pain Scale (0 - 10) _____	Arrival Temp _____ <input type="checkbox"/> F <input type="checkbox"/> C Time _____ Date _____ Route <input type="checkbox"/> Oral <input type="checkbox"/> Adillary <input type="checkbox"/> Rectal Temperature Control Procedure: <input type="checkbox"/> Bair Hugger <input type="checkbox"/> Warming Blanket <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Coding Blanket <input type="checkbox"/> Other _____	<input type="checkbox"/> Unlabored <input type="checkbox"/> Labored <input type="checkbox"/> Flaring <input type="checkbox"/> Retraction <input type="checkbox"/> Absent Chest Symmetry: <input type="checkbox"/> Equal <input type="checkbox"/> Left > <input type="checkbox"/> Right > Flail <input type="checkbox"/> R <input type="checkbox"/> L	Breath Sounds: Clear <input type="checkbox"/> R <input type="checkbox"/> L Rales <input type="checkbox"/> R <input type="checkbox"/> L Wheeze <input type="checkbox"/> R <input type="checkbox"/> L Absent <input type="checkbox"/> R <input type="checkbox"/> L Trachea: <input type="checkbox"/> Midline <input type="checkbox"/> Deviated	Skin: <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Hot <input type="checkbox"/> Pink <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Diaphoretic Heart Sounds: <input type="checkbox"/> Clear <input type="checkbox"/> Muffled Capillary Refill: <input type="checkbox"/> < 2 Seconds (normal) <input type="checkbox"/> > 2 Seconds (delayed)																																				
3.2 AIRWAY	3.4 CPR IN ED	3.7 DEFICIT / NEURO																																						
<input type="checkbox"/> Patent <input type="checkbox"/> Stridor <input type="checkbox"/> Drooling <input type="checkbox"/> Obstructed <input type="checkbox"/> Oral/Nasal Airway <input type="checkbox"/> BVM <input type="checkbox"/> Intubated <input type="checkbox"/> Combi Tube <input type="checkbox"/> Other _____	<input type="checkbox"/> Y <input type="checkbox"/> N Start Time _____ End Time _____	<input type="checkbox"/> Alert - Obeyes Commands <input type="checkbox"/> Responds to Verbal Stimuli <input type="checkbox"/> Responds to Painful Stimuli <input type="checkbox"/> Unresponsive to Painful Stimuli	GCS: Eye ___/4 Pediatric Broselow Tape Color: _____ Verbal ___/5 Motor ___/6 Total ___/15																																					
PATIENT IDENTIFICATION																																								
Name: Last _____ First _____ MI _____ Rank _____		Patient ID/SSN _____ BRN _____ Medical Record # _____ DOB _____ Age _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F																																						
Facility Name _____ Facility Location _____		MOS/AFSC/NEC _____ Deployed/Assigned Unit _____																																						
Nurse Name _____		Nurse Signature _____																																						
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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 Drainage: <input type="checkbox"/> Nasal (Color) _____ <input type="checkbox"/> Ear (Color) _____ Dental Injury <input type="checkbox"/> Y <input type="checkbox"/> N CSF (Halo Test) <input type="checkbox"/> + / <input type="checkbox"/> - C-spine Tender <input type="checkbox"/> Y <input type="checkbox"/> N JVD <input type="checkbox"/> Y <input type="checkbox"/> N Reactive Pupils Right: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Brisk <input type="checkbox"/> Sluggish <input type="checkbox"/> NR Left: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Brisk <input type="checkbox"/> Sluggish <input type="checkbox"/> NR	4.2 HEART / THORACIC Rhythm <input type="checkbox"/> NSR <input type="checkbox"/> Tachy/Brady <input type="checkbox"/> V-fib / V-tach <input type="checkbox"/> PEA <input type="checkbox"/> Asystole <input type="checkbox"/> 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 <input type="checkbox"/> Open Wound <input type="checkbox"/> Flat <input type="checkbox"/> Obese <input type="checkbox"/> Distended <input type="checkbox"/> Tender <input type="checkbox"/> Non-Tender <input type="checkbox"/> Rebound Tenderness <input type="checkbox"/> Guarding <input type="checkbox"/> Rigid <input type="checkbox"/> Unable to Assess Pelvic Binder <input type="checkbox"/> Y <input type="checkbox"/> N Blood at Meatus/Vagina <input type="checkbox"/> Y <input type="checkbox"/> N FAST <input type="checkbox"/> + describe _____ <input type="checkbox"/> - <input type="checkbox"/> Equivocal Last Meal @ _____	4.4 EXTREMITIES Deformities Pulses Present Motor Sensory <input type="checkbox"/> RUE _____ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> LUE _____ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> RLE _____ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> LLE _____ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N Pulses Present: indicate S=Strong W=Weak D=Doppler A=Absent 4.5 ALLERGIES <input type="checkbox"/> Unknown <input type="checkbox"/> NKDA Other _____ 4.6 CURRENT MEDICATIONS <input type="checkbox"/> Unknown <input type="checkbox"/> Last Tetanus Date _____ <input type="checkbox"/> None <input type="checkbox"/> Current Meds: (List med, dose, & route) _____ _____ _____		
4.7 PROCEDURES					
Procedure	Time	Size/Type	Site	Performed By	Results
O ₂ Therapy _____ Lpm	On _____ Off _____	<input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Oral Airway <input type="checkbox"/> NRB Mask <input type="checkbox"/> Nasal Airway _____ % <input type="checkbox"/> BVM			
ET Intubation (Put additional changes in Remarks)	Time _____	Teeth _____ cm	<input type="checkbox"/> Oral <input type="checkbox"/> Nasal		<input type="checkbox"/> ETCO ₂ Change <input type="checkbox"/> BBS Post Intubation
C-Collar Placed	Time _____	C-Collar Removed	Time _____		
Chest Tube #1	Time _____		<input type="checkbox"/> L <input type="checkbox"/> R		<input type="checkbox"/> Air Blood (cc) _____
Chest Tube #2	Time _____		<input type="checkbox"/> L <input type="checkbox"/> R		<input type="checkbox"/> Air Blood (cc) _____
Needle Decompression	Time _____		<input type="checkbox"/> L <input type="checkbox"/> R		<input type="checkbox"/> Air Blood (cc) _____
Thoracotomy	Time _____		<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Clamshell		
Toumiquet	Time _____	Types _____	Sites _____		
Eye Shield	Time _____		<input type="checkbox"/> OS <input type="checkbox"/> OD <input type="checkbox"/> Both		
A-line	Time _____		<input type="checkbox"/> L <input type="checkbox"/> R		
Gastric Tube	Time _____		<input type="checkbox"/> Oral <input type="checkbox"/> Nasal		Verified <input type="checkbox"/> Y <input type="checkbox"/> N Suction <input type="checkbox"/> Y <input type="checkbox"/> N
Urinary	Time _____	Amount _____ Color _____ Foley Size _____	<input type="checkbox"/> Meatus <input type="checkbox"/> Suprapubic		Heme Dip <input type="checkbox"/> - / <input type="checkbox"/> + Results _____ cc
Other Procedure	Time _____	Describe _____			
Other Procedure	Time _____	Describe _____			
Hemorrhage Control Measures					
<input type="checkbox"/> Celox	<input type="checkbox"/> Combat Gauze	<input type="checkbox"/> Field Dressing	<input type="checkbox"/> QuikClot	<input type="checkbox"/> Unknown	
<input type="checkbox"/> ChitoFlex	<input type="checkbox"/> Direct Pressure	<input type="checkbox"/> HemCon	<input type="checkbox"/> None	<input type="checkbox"/> Other _____	
PATIENT IDENTIFICATION Name: Last _____ First _____ MI _____ Patient ID/SSN _____					
BRN _____ Facility Location _____		Nurse Name _____		Nurse Signature _____	

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RESUSCITATION RECORD Part I, Nursing Flow Sheet											
4. SECONDARY SURVEY, continued											
4.8 INTUBATION MECH/VENT		4.9 ABGs / VBGs									
Time _____		Time _____ FIO2 _____ pH _____ pCO2 _____ pO2 _____ BE _____ HCO3 _____ SAT _____									
MODE: _____		<input type="checkbox"/> ABG or <input type="checkbox"/> VBG _____									
FIO2: _____		<input type="checkbox"/> ABG or <input type="checkbox"/> VBG _____									
RATE: _____		<input type="checkbox"/> ABG or <input type="checkbox"/> VBG _____									
PEEP: _____		<input type="checkbox"/> ABG or <input type="checkbox"/> VBG _____									
TV: _____		<input type="checkbox"/> ABG or <input type="checkbox"/> VBG _____									
4.10 INTRAVENOUS ACCESS AND FLUIDS					4.11 BLOOD PRODUCTS						
Time Rate Gauge Site IV Type Amount Up Amount In Stop					Unit# Type Start Stop Volume Initials						
Total Amount Infused: _____											
4.12 MEDICATIONS					4.13 VITAL SIGNS						
Drug Dose Route Time Initials					Time GCS BP P BB Temp SaO2 Pain Scale (0-10) Other (ICP)						
4.14 LABS					4.15 CT		4.17 DISPOSITION			Evac to	
Time Test					Type Time		Date: _____ Time: _____			<input type="checkbox"/> Host Nation <input type="checkbox"/> Coalition <input type="checkbox"/> CASF Facility Name: _____	
CBC					<input type="checkbox"/> Head		Admit			<input type="checkbox"/> Routine <input type="checkbox"/> Priority <input type="checkbox"/> Urgent Evac Transport Vehicle	
ABG					<input type="checkbox"/> C-Spine		<input type="checkbox"/> OR <input type="checkbox"/> ICU <input type="checkbox"/> I/W			MEDEVAC: <input type="checkbox"/> Rotary Wing - <input type="checkbox"/> Med Tech <input type="checkbox"/> Critical Care <input type="checkbox"/> Fixed Wing - <input type="checkbox"/> AE <input type="checkbox"/> CCATT	
VBG					<input type="checkbox"/> Chest		RTD			Ground: <input type="checkbox"/> Medical <input type="checkbox"/> Non-Medical Evac Mode of Transport	
Chemistry					<input type="checkbox"/> Abd		<input type="checkbox"/> Full <input type="checkbox"/> Quarters <input type="checkbox"/> Profile			<input type="checkbox"/> Ambulatory <input type="checkbox"/> W/C <input type="checkbox"/> RTD Unit: _____	
PT/PTT					<input type="checkbox"/> Pelvis		RTD Mode of Transport:			<input type="checkbox"/> Ambulatory <input type="checkbox"/> W/C <input type="checkbox"/> Litter <input type="checkbox"/> Vacuum Spine Board	
TEG					<input type="checkbox"/> Pan Scan*		* Select Pan Scan only if all of the above requested			Evac Mode of Transport <input type="checkbox"/> Ambulatory <input type="checkbox"/> W/C	
H&H					4.16 X-RAY		4.18 DEATH INFORMATION			4.19 REMARKS	
INR					Type Time		Time of Death _____ Mortuary Affairs Notified? <input type="checkbox"/> Y <input type="checkbox"/> N Time to Morgue _____				
T&S					<input type="checkbox"/> C-Spine		Death Remarks _____				
T&C x					<input type="checkbox"/> Chest						
UA					<input type="checkbox"/> Abd						
HCG					<input type="checkbox"/> Pelvis						
Other					<input type="checkbox"/> Ext						
Specify Other: _____					<input type="checkbox"/> RUE <input type="checkbox"/> LUE						
					<input type="checkbox"/> RLE <input type="checkbox"/> LLE						
PATIENT IDENTIFICATION											
Name: Last _____ First _____ MI _____ Patient ID/SSN _____											
BRN _____ Facility Location _____ Nurse Name _____ Nurse Signature _____											


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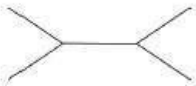
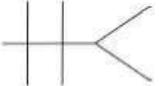
Resuscitation Record—Part II Physician H &P, page 4 of 5

RESUSCITATION RECORD Part II, Physician H&P																							
1. HISTORY & PHYSICAL - INJURY DESCRIPTION																							
1.1 ARRIVAL Date _____ Time of Arrival _____	1.2 TRIAGE CATEGORY <input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minimal <input type="checkbox"/> Expectant	1.4 INJURY DESCRIPTION (A)B()rasion (A)M()putation (A)V()ulsion (B)L()eeding (B)urn %TBSA _____ (C)repitus (D)efornity (D)G()degloving (E)cchymosis (F)X()Fracture (F)oreign Body (G)S()W()Gun Shot Wound (H)ematoma (L)A()C()eration (P)W()Puncture Wound (S)S()Seatbelt Sign (S)W()Stab Wound (P)ain (P)P()Peppering	Pulses Present S= Strong W= Weak D= Doppler A= Absent																				
																							
1.3 CHIEF COMPLAINT, HISTORY AND PRESENTING ILLNESS _____ _____ _____ _____ _____ _____																							
1.5 HISTORY AND PHYSICAL Head & Neck: _____ Chest: _____ Abdomen/Back and Spine: _____ Pelvis: <input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Binder Upper Extremities: _____ Lower Extremities: _____ Interventions Prior to Arrival: _____		1.6 PRE / INITIAL PROCEDURES / DIAGNOSTICS Pre / Initial <input type="checkbox"/> Cric <input type="checkbox"/> C-Collar/ Time Removed _____ <input type="checkbox"/> ICP Monitor <input type="checkbox"/> Cantholysis & Canthotomy <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Ventric <input type="checkbox"/> Tympanic Membranes Rupture <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Eye Shield <input type="checkbox"/> R <input type="checkbox"/> L Needle Decompression <input type="checkbox"/> R <input type="checkbox"/> L Pericardial describe: Output <input type="checkbox"/> Air <input type="checkbox"/> Blood (cc) _____ FAST <input type="checkbox"/> - / <input type="checkbox"/> + _____ <input type="checkbox"/> Pericardiocentesis																					
Prostate _____ Gyn _____ <input type="checkbox"/> Closed Reduction <input type="checkbox"/> EXT Fixation <input type="checkbox"/> Tourniquet <input type="checkbox"/> R # _____ <input type="checkbox"/> Wound Washout <input type="checkbox"/> Splint <input type="checkbox"/> L # _____ <input type="checkbox"/> Closed Reduction <input type="checkbox"/> EXT Fixation <input type="checkbox"/> Tourniquet <input type="checkbox"/> R # _____ <input type="checkbox"/> Wound Washout <input type="checkbox"/> Splint <input type="checkbox"/> L # _____		DPL <input type="checkbox"/> Gross Blood: <input type="checkbox"/> - / <input type="checkbox"/> + describe _____ Log Roll Time _____ Back Exam <input type="checkbox"/> WNL <input type="checkbox"/> ABNL describe _____ Rectal Exam <input type="checkbox"/> WNL <input type="checkbox"/> Weak/Absent Tone Gross Blood: <input type="checkbox"/> - / <input type="checkbox"/> + <input type="checkbox"/> Sedated <input type="checkbox"/> 3% Saline <input type="checkbox"/> Cntrl Line Loc: _____ Site: _____ <input type="checkbox"/> Chemical Paralyze <input type="checkbox"/> Mannitol <input type="checkbox"/> IO Loc: _____ Site: _____ <input type="checkbox"/> Seizure Protocol <input type="checkbox"/> A-Line Loc: _____ Site: _____																					
1.7 PUPILS / VISION Brisk <input type="checkbox"/> R <input type="checkbox"/> L Hand Motion <input type="checkbox"/> R <input type="checkbox"/> L Sluggish <input type="checkbox"/> R <input type="checkbox"/> L Light Perception <input type="checkbox"/> R <input type="checkbox"/> L NR <input type="checkbox"/> R <input type="checkbox"/> L No Light Perception <input type="checkbox"/> R <input type="checkbox"/> L Size Right mm _____ Left mm _____		1.8 BURN <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd %TBSA _____ >20% Use the Burn Flow Sheet Cause _____																					
1.9 EXTREMITIES <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Motor</th> <th>Sens</th> <th>ROM</th> </tr> </thead> <tbody> <tr> <td>RUE</td> <td>+ / - / -</td> <td>+ / - / -</td> <td>+ / - / -</td> </tr> <tr> <td>LUE</td> <td>+ / - / -</td> <td>+ / - / -</td> <td>+ / - / -</td> </tr> <tr> <td>RLE</td> <td>+ / - / -</td> <td>+ / - / -</td> <td>+ / - / -</td> </tr> <tr> <td>LLE</td> <td>+ / - / -</td> <td>+ / - / -</td> <td>+ / - / -</td> </tr> </tbody> </table>					Motor	Sens	ROM	RUE	+ / - / -	+ / - / -	+ / - / -	LUE	+ / - / -	+ / - / -	+ / - / -	RLE	+ / - / -	+ / - / -	+ / - / -	LLE	+ / - / -	+ / - / -	+ / - / -
	Motor	Sens	ROM																				
RUE	+ / - / -	+ / - / -	+ / - / -																				
LUE	+ / - / -	+ / - / -	+ / - / -																				
RLE	+ / - / -	+ / - / -	+ / - / -																				
LLE	+ / - / -	+ / - / -	+ / - / -																				
PATIENT IDENTIFICATION Name: Last _____ First _____ MI _____ Rank _____ Patient ID/SSN _____ BRN _____ Medical Record # _____ DOB: _____ Age _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Facility Name _____ Facility Location _____ Physician Signature _____																							
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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
<input type="checkbox"/> Head <input type="checkbox"/> C-Spine <input type="checkbox"/> Chest <input type="checkbox"/> Abd/Pelvis <input type="checkbox"/> Pan Scan* <small>* Select Pan Scan only if all of the above requested</small>	<input type="checkbox"/> C-Spine <input type="checkbox"/> Extremity <input type="checkbox"/> Spine <input type="checkbox"/> RUE <input type="checkbox"/> Chest/Upright <input type="checkbox"/> LUE <input type="checkbox"/> Pelvis <input type="checkbox"/> RLE <input type="checkbox"/> <input type="checkbox"/> LLE Other _____ Other _____			<input type="checkbox"/> CT Scan Normal <input type="checkbox"/> CT Scan Abnormal C-Spine cleared based on: <input type="checkbox"/> Normal Exam, reliable Pt <input type="checkbox"/> Normal CT scan, normal exam C-Spine <u>not</u> cleared based on: <input type="checkbox"/> Neuro c/o, abnormal exam <input type="checkbox"/> Abnormal imaging <input type="checkbox"/> Unreliable Pt
3. LABORATORY RESULTS				
3.1 CBC		3.2 CHEMISTRY 7		3.4 LET
				Amylase _____ Bill _____ Alk Phos _____ SGOT _____ LDH _____ SGPT _____ Other _____
3.3 PT / INR / PTT _____ / _____ / _____		3.5 URINALYSIS		
		SpGr _____ Chem _____ Micro _____ HCG _____ pH _____ Bact _____ 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		INR > 1.4 <input type="checkbox"/> Yes <input type="checkbox"/> No		Base Deficit > 5 <input type="checkbox"/> Yes <input type="checkbox"/> No
		FWB Requested <input type="checkbox"/> Yes <input type="checkbox"/> No		Damage Control <input type="checkbox"/> Yes <input type="checkbox"/> No
6.3 DISPOSITION				
<input type="checkbox"/> OR <input type="checkbox"/> ICU <input type="checkbox"/> ICW <input type="checkbox"/> Transfer		Date: _____ Time: _____		
7. DNBI / NBI CATEGORY				
<input type="checkbox"/> Injury, Sports <input type="checkbox"/> Injury, Work/Training <input type="checkbox"/> Surgical				
<input type="checkbox"/> Injury, MVC <input type="checkbox"/> Injury, Other				
8. CAUSE OF DEATH				
8.1 ANATOMIC			8.2 PHYSIOLOGIC	
<input type="checkbox"/> Airway <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen <input type="checkbox"/> Extremity <input type="checkbox"/> U / <input type="checkbox"/> L <input type="checkbox"/> Head <input type="checkbox"/> Chest <input type="checkbox"/> Pelvis <input type="checkbox"/> Other, Specify _____			<input type="checkbox"/> MOF <input type="checkbox"/> Sepsis <input type="checkbox"/> Total Body Disruption <input type="checkbox"/> CNS <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Breathing <input type="checkbox"/> Other, Specify _____	
PATIENT IDENTIFICATION				
Name: Last _____ First _____ MI _____ Patient ID/SSN _____				
BRN _____ Facility Location _____ Physician Name _____ Physician Signature _____				
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Joint Theater Trauma System Clinical Practice Guideline

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 scribe 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 scribe 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.

Joint Theater Trauma System Clinical Practice Guideline

General Instructions for Resuscitation Record, Page 2 of 5

General Instructions for Resuscitation Record	
1.9	<p>PATIENT CATEGORY. Check one. If Other, describe the patient's classification as it relates to military, government or civilian organizations.</p> <p>USA. United States Army</p> <p>USAF. United States Air Force</p> <p>USMC. United States Marine Corp</p> <p>USN. United States Navy</p> <p>USCG. United States Coast Guard</p> <p>USPHS. United States Public Health Services</p> <p>Civilian – Local. Includes Host Nation.</p> <p>Civilian – Other. Includes Host Nation Police</p> <p>EPW. Enemy Prisoner of War</p> <p>NATO-Coalition. Joining military forces</p> <p>Non-NATO Coalition. Opposing military forces</p> <p>Other. Describe not otherwise specified category.</p>
1.10	<p>INJURY CAUSE. Check all that apply. If Other, describe cause of the injury.</p> <p>EFP. Explosively Formed Projectile/Penetrator</p> <p>IED. Improvised Explosive Device</p> <p>Mortar/Rocket/Artillery Shell. Includes Indirect and Direct Fire</p> <p>MVC. Motor Vehicle Crash</p> <p>UXO. Unexploded Ordnance</p>
2	<p>CARE DONE PRIOR TO ARRIVAL</p>
2.1	<p>PREHOSPITAL TOURNIQUET. Check all that apply.</p> <p>SOFTT. Special Operations Forces Tactical Tourniquet</p> <p>CAT. Combat Application Tourniquet</p> <p>If Other. Describe the type of tourniquet.</p> <p>Effective. An effective tourniquet controls active hemorrhage. May be combined with a dressing.</p>
2.2	<p>PREHOSPITAL VITALS. As stated.</p>
2.3	<p>PREHOSPITAL HEMORRHAGE CONTROL MEASURES – Check all that apply.</p> <p>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.</p> <p>ChitoFlex. A stuffable wound dressing conducive to narrow wound tracks.</p> <p>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.</p> <p>Direct Pressure. Pressure applied directly to a wound, usually with sterile, low-adherent gauze between the wound and source of bleeding.</p> <p>Field Dressing. A casualty's dressing applied to a wound to control hemorrhaging.</p> <p>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.</p> <p>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.</p>
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General Instructions for Resuscitation Record, Page 3 of 5

General Instructions for Resuscitation Record															
<p>None. Check if no hemorrhage control measures.</p> <p>Unknown. Check if hemorrhage control measures are unknown.</p> <p>If Other, describe the not otherwise specified hemorrhage control measure.</p>															
2.4	<p>PREHOSPITAL WARMING. Check all that apply.</p> <p>HPMK. Hypothermia Prevention and Management Kit. Check only if all three components were used: Hat/Hood, Activated Liner, and Outer Shell.</p> <p>If Other. Describe the not otherwise specified warming device.</p>														
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.															
<table border="1"><thead><tr><th>Color</th><th>Patient Weight</th></tr></thead><tbody><tr><td>Grey/Pink</td><td>3 - 7 Kg</td></tr><tr><td>Red/Purple/Yellow</td><td>8-14 Kg</td></tr><tr><td>White</td><td>15 - 18 Kg</td></tr><tr><td>Blue</td><td>19- 23 Kg</td></tr><tr><td>Orange</td><td>24 - 29 Kg</td></tr><tr><td>Green</td><td>30 - 35 Kg</td></tr></tbody></table>		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
Color	Patient Weight														
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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.														
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Joint Theater Trauma System Clinical Practice Guideline

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:	
<ul style="list-style-type: none">• 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.
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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.	
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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.