


TACTICAL COMBAT CASUALTY CARE AFTER ACTION REPORT (TCCC AAR)

Complete within 72hrs after mission and submit to the Joint Trauma System via email: DHA.JBSA.j-3.List.JTS-Prehospital@mail.mil

Event Date: _____ Time: _____ <input type="checkbox"/> Local <input type="checkbox"/> ZULU		Country: _____ Theater: _____	
Injury <input type="checkbox"/> Battle Injury (BI): <input type="checkbox"/> WIA <input type="checkbox"/> KIA <input type="checkbox"/> DOW		<input type="checkbox"/> Non-Battle Injury (NBI): <input type="checkbox"/> Alive <input type="checkbox"/> Dead	
Evacuation Category <input type="checkbox"/> URG <input type="checkbox"/> PRI <input type="checkbox"/> ROU			
<input type="checkbox"/> Litter	Type: _____	Time of Pick Up: _____	
<input type="checkbox"/> Ground Vehicle	Type: _____	Time of Pick Up: _____	
<input type="checkbox"/> Aircraft	Type: _____	Time of Pick Up: _____	
<input type="checkbox"/> Watercraft	Type: _____	Time of Pick Up: _____	
Casualty Demographics (mini. requirement: last name & last 4 SS#)			
Last Name: _____		First Name: _____ Rank: _____	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN/DoD ID: _____	DOB: _____	Unit: _____ BR#: _____ Mission # _____
Point-of-Injury (POI) Provider Info			
Non-Medic (NM) First Responder Last Name: _____		First Name: _____ Rank/Title: _____	
Other POI Provider (OP) Last Name: _____		First Name: _____ Rank/Title: _____	
Medic (M) Last Name: _____		First Name: _____ Rank/Title: _____	
M - Mechanism of Injury		I - Injuries	
<input type="checkbox"/> Airborne Operation <input type="checkbox"/> Aircraft Crash <input type="checkbox"/> Blast – Dismounted IED or Mine <input type="checkbox"/> Blast – Mounted IED or Mine <input type="checkbox"/> Blast – RPG or Grenade <input type="checkbox"/> Blast – Indirect Fire (Mortar/Artillery/Missile) <input type="checkbox"/> Blast – Other <input type="checkbox"/> Collapse/Crush/ Compartment from Structure <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Fall, Height: _____ ft <input type="checkbox"/> Fragmentation / Shrapnel <input type="checkbox"/> GSW – Gunshot Wound <input type="checkbox"/> Vehicle Accident/Collision <input type="checkbox"/> Environmental: _____ <input type="checkbox"/> Other: _____		<input type="checkbox"/> (A)mputation <input type="checkbox"/> (B)leeding <input type="checkbox"/> (Bu)rn, TBSA: _____ % <input type="checkbox"/> (C)repitus <input type="checkbox"/> (D)eformity <input type="checkbox"/> (DG)Degloving <input type="checkbox"/> (E)cchymosis <input type="checkbox"/> (FX)Fracture <input type="checkbox"/> (GSW) Gun Shot Wound <input type="checkbox"/> (H)ematoma <input type="checkbox"/> (LAC)eration <input type="checkbox"/> (P)ain <input type="checkbox"/> (PP)Peppering <input type="checkbox"/> (PW)Puncture Wound	
		Annotate Injuries	
			
S - Signs			
Initial Check Time _____		Last Check Time _____	
<input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U GCS: _____ /15 (E _____ /4 V _____ /5, M _____ /6) RR: _____ HR: _____ BP: _____ pOx (%): _____ Pain level (/_/10): _____ EtCO2 (mmHG): _____		<input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U GCS: _____ /15 (E _____ /4 V _____ /5, M _____ /6) RR: _____ HR: _____ BP: _____ pOx (%): _____ Pain level (/_/10): _____ EtCO2 (mmHG): _____	
Eye Opening - 4: spontaneous, 3: to speech, 2: to pain, 1: no response Motor Response - 6: follows commands, 5: localizes pain, 4: withdraws from pain, 3: decorticate flexion, 2: decerebrate extension, 1: no response Verbal Response - 5: alert and oriented, 4: disoriented conversation, 3: speaking but nonsensical, 2: moans, unintelligible sounds, 1: no response			
T - Treatments			
Massive Hemorrhage Control (TQ/Hemostatic Adjunct)		Airway	
Time _____ Location _____ Type _____ Time off _____	Time _____ Location _____ Type _____ Time off _____	Time _____ Type _____ Size _____ Depth _____ @ _____	Time _____ Type _____ Size _____ Depth _____ @ _____
Time _____ Location _____ Type _____ Time off _____	Time _____ Location _____ Type _____ Time off _____	Time _____ Type _____ Size _____ Depth _____ @ _____	Time _____ Type _____ Size _____ Depth _____ @ _____
Time _____ Location _____ Type _____ Time off _____	Time _____ Location _____ Type _____ Time off _____	Time _____ Type _____ Size _____ Depth _____ @ _____	Time _____ Type _____ Size _____ Depth _____ @ _____
Time _____ Location _____ Type _____ Time off _____	Time _____ Location _____ Type _____ Time off _____	Time _____ Type _____ Size _____ Depth _____ @ _____	Time _____ Type _____ Size _____ Depth _____ @ _____
Respiration/Breathing <input type="checkbox"/> Spontaneous <input type="checkbox"/> Labored <input type="checkbox"/> Assisted <input type="checkbox"/> Assisted with BVM		Time _____	
<input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Chest Seal Type: _____ <input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Needle Decompression Location <input type="checkbox"/> 2ICS/MCL <input type="checkbox"/> 5ICS/AAL # of attempts _____ Cath/Needle size _____ <input type="checkbox"/> NM <input type="checkbox"/> M <input type="checkbox"/> OP <input type="checkbox"/> Chest Tube <input type="checkbox"/> Finger Thoracostomy <input type="checkbox"/> Output <input type="checkbox"/> Air Blood (ml) _____			

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Circulation - Resuscitation

Time

<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Saline Lock	_____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> IO-Intraosseous Device, Type _____	_____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> TXA-Tranexamic Acid Dose _____	_____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Blood products Type _____	Volume _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> IV Fluids Type _____	Volume _____

Interventions - Other

Time

<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Pelvic Binder Type _____	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Hypothermia Prev. Type _____	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Eye Shield <input type="checkbox"/> Left <input type="checkbox"/> Right	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Splint Type _____	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> C-Collar <input type="checkbox"/> Spine Board	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Tourniquet Conversion Location _____	Successful? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Outcome: _____

Medications - Pain, Infection, Other

Time

<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Combat Wound Medication Pack	_____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Analgesic Name: _____	Dose: _____ Route: _____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Analgesic Name: _____	Dose: _____ Route: _____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Analgesic Name: _____	Dose: _____ Route: _____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Analgesic Name: _____	Dose: _____ Route: _____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Antibiotic Name: _____	Dose: _____ Route: _____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Antibiotic Name: _____	Dose: _____ Route: _____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Other Med Name: _____	Dose: _____ Route: _____	Outcome: _____
<input type="checkbox"/> NM	<input type="checkbox"/> M	<input type="checkbox"/> OP	<input type="checkbox"/> Other Med Name: _____	Dose: _____ Route: _____	Outcome: _____

Comments-Additional Treatment

Sustains (Treatment, Equipment, Evacuation, Operations):

Improves (Treatment, Equipment, Evacuation, Operations):

Last Name: _____ SSN/DoD ID: _____