

# DD 1380 TCCC CASUALTY CARD

## A CASUALTY DETAILS

Fill in casualty's personal info and unit details along with the date (DD-MM-YY) and the time of injury. Use a 24-hour clock indicating local (L) or zulu (Z) time (e.g., "1300Z").

**Battle Roster #** consists of the initials of casualty's first and last name, followed by the last four digits of casualty's Social Security number (found on dog tag). (e.g., John Doe. John Doe 123-12-1234 = #JD1234).

### Urgent (evac <1 hr)

Evac within one hour to prevent loss of life, limb, or eyesight.

### Priority (<4 hrs)

Evac within 4 hours to prevent condition from worsening and becoming urgent.

### Routine (<24 hrs)

For all other situations, but still accomplished within 24 hrs.

## B DETAILS OF INJURY

**Mechanism of injury:** Mark an "X" on the mechanism of injury (or cause of injury e.g., artillery, blunt, burn, fall, grenade, gunshot wound (GSW), improvised explosive device (IED), landmine, motor vehicle crash/collision (MVC), rocket-propelled grenade (RPG), other (specify)).

### Injury:

Mark all that apply. Mark injury sites on the body picture using an "X". For burn injuries, circle the burn percentage(s) on the figure. If multiple mechanisms of injury and multiple injuries, draw a line between the mechanism of injury and the anatomical site of the injury.

If a tourniquet is applied to an arm or leg, write type of tourniquet used and the time of tourniquet application in the box that corresponds to the tourniquet location.

## C SIGNS & SYMPTOMS

Make a record of vital signs (*pulse rate and location, blood pressure, respiratory rate, oxygen saturation*) indicating time of reading above.

Record level of consciousness (**AVPU**: Alert, responds to Verbal stimulus, responds to Pain stimulus, Unresponsive), and level of pain (*on numeric rating scale of 0 to 10, with 0 being no pain and 10 being the worst pain*) with time.

| TACTICAL COMBAT CASUALTY CARE (TCCC) CARD   |   |  |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
|---|---|--|---|----------|------|--|--|--|--|------------------------------------|--|--|--|--|-----------------------|---|---|---|---|-------------------------|--|--|--|--|--------------------------|--|--|--|--|-------------|--|--|--|--|--------------------------|--|--|--|
| <b>BATTLE ROSTER #:</b> _____<br><b>EVAC:</b> <input type="checkbox"/> Urgent <input type="checkbox"/> Priority <input type="checkbox"/> Routine  |   |  |   | <b>A</b> |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>NAME</b> (Last, First): _____  |   | <b>LAST 4:</b> _____                           |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>SEX:</b> <input type="checkbox"/> M <input type="checkbox"/> F   |   | <b>DATE</b> (DD-MMM-YY): _____                 |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>SERVICE:</b> _____   |   | <b>UNIT:</b> _____                             |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>ALLERGIES:</b> _____   |   |  |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>Mechanism of Injury:</b> (X all that apply)  |   |  |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <input type="checkbox"/> Artillery <input type="checkbox"/> Blunt <input type="checkbox"/> Burn <input type="checkbox"/> Fall <input type="checkbox"/> Grenade <input type="checkbox"/> GSW <input type="checkbox"/> IED<br><input type="checkbox"/> Landmine <input type="checkbox"/> MVC <input type="checkbox"/> RPG <input type="checkbox"/> Other: _____   |   |  |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>Injury:</b> (Mark injuries with an X)  |   |  |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>TQ: R Arm</b><br>TYPE: _____<br>TIME: _____  |   | <b>TQ: L Arm</b><br>TYPE: _____<br>TIME: _____ |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>TQ: R Leg</b><br>TYPE: _____<br>TIME: _____  |   | <b>TQ: L Leg</b><br>TYPE: _____<br>TIME: _____ |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>Signs &amp; Symptoms:</b> (Fill in the blank)  |   |  |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <table border="1"> <thead> <tr> <th>Time</th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td><b>Pulse (Rate &amp; Location)</b></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Blood Pressure</b></td> <td>/</td> <td>/</td> <td>/</td> <td>/</td> </tr> <tr> <td><b>Respiratory Rate</b></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Pulse Ox % O2 Sat</b></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>AVPU</b></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Pain Scale (0-10)</b></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> |   |  |   |          | Time |  |  |  |  | <b>Pulse (Rate &amp; Location)</b> |  |  |  |  | <b>Blood Pressure</b> | / | / | / | / | <b>Respiratory Rate</b> |  |  |  |  | <b>Pulse Ox % O2 Sat</b> |  |  |  |  | <b>AVPU</b> |  |  |  |  | <b>Pain Scale (0-10)</b> |  |  |  |
| Time  |   |  |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>Pulse (Rate &amp; Location)</b>  |   |  |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>Blood Pressure</b>   | / | /  | / | /        |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>Respiratory Rate</b>   |   |  |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>Pulse Ox % O2 Sat</b>  |   |  |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>AVPU</b>   |   |  |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |
| <b>Pain Scale (0-10)</b>  |   |  |   |          |      |  |  |  |  |                                    |  |  |  |  |                       |   |   |   |   |                         |  |  |  |  |                          |  |  |  |  |             |  |  |  |  |                          |  |  |  |

DD Form 1380

TCCC CARD

# DD 1380 TCCC CASUALTY CARD

## D BATTLE ROSTER #

**Battle Roster #** consists of the initials of casualty's first and last name, followed by last four numbers of casualty's Social Security number (found on dog tag) (e.g., John Doe. John Doe 123-12-1234 = #JD1234).

## E TREATMENTS

### C (Circulation – Massive Hemorrhage):

Mark an "X" for all Circulation hemorrhage control interventions.

**A (Airway):** Mark an "X" for all Airway interventions and write type of device(s) used.

**B (Breathing):** Mark an "X" for all Breathing interventions and write type of device(s) used.

### C (Fluid and Blood Products):

Circulation resuscitation interventions. Write name, volume, route, and time of any fluids given.

## F MEDICATIONS

Document any medications given. Write **name**, **dose**, **route**, and **time** of any analgesics, antibiotics, or other medications given.

Mark an "X" for any eye-shield limb splinting, or hypothermia treatments.

Hypothermia type would be either **active** or **passive**.

## G NOTES

Use this space to record any other pertinent information and/or clarifications.

If more space is needed for documentation, attach another DD Form 1380 to the original. Label the second DD Form 1380 #2. It will show the soldier's name and unit.

## H RESPONDER DETAILS

Fill in responder's personal details including last four numbers of their Social Security number.

| BATTLE ROSTER #: _____  |      |        |       |               | D         |
|---|------|--------|-------|---------------|-----------|
| EVAC: <input type="checkbox"/> Urgent <input type="checkbox"/> Priority <input type="checkbox"/> Routine  |      |        |       |               |           |
| <b>Treatments:</b> (X all that apply, and fill in the blank)  |      |        |       | Type          | E         |
| C: TQ- <input type="checkbox"/> Extremity <input type="checkbox"/> Junctional <input type="checkbox"/> Truncal  |      |        |       |               |           |
| Dressing- <input type="checkbox"/> Hemostatic <input type="checkbox"/> Pressure <input type="checkbox"/> Other  |      |        |       |               |           |
| A: <input type="checkbox"/> Intact <input type="checkbox"/> NPA <input type="checkbox"/> CRIC <input type="checkbox"/> ET-Tube <input type="checkbox"/> SGA                   |      |        |       |               |           |
| B: <input type="checkbox"/> O2 <input type="checkbox"/> Needle-D <input type="checkbox"/> Chest-Tube <input type="checkbox"/> Chest-Seal                                      |      |        |       |               |           |
| C:  | Name | Volume | Route | Time          |           |
| Fluid   |      |        |       |               |           |
|   |      |        |       |               |           |
| Blood Product   |      |        |       |               |           |
|   |      |        |       |               |           |
| <b>MEDS:</b>  |      |        |       |               | F         |
| Analgesic<br>(e.g., Ketamine, Fentanyl, Morphine)   | Name | Dose   | Route | Time          |           |
|   |      |        |       |               |           |
|   |      |        |       |               |           |
| Antibiotic<br>(e.g., Moxifloxacin, Ertapenem)   | Name | Dose   | Route | Time          |           |
|   |      |        |       |               |           |
| Other<br>(e.g., TXA)  | Name | Dose   | Route | Time          |           |
|   |      |        |       |               |           |
| OTHER: <input type="checkbox"/> Combat-Pill-Pack <input type="checkbox"/> Eye-Shield ( <input type="checkbox"/> R <input type="checkbox"/> L) <input type="checkbox"/> Splint |      |        |       |               |           |
| <input type="checkbox"/> Hypothermia-Prevention Type: _____   |      |        |       |               |           |
| <b>NOTES:</b>   |      |        |       |               | G         |
| FIRST RESPONDER   |      |        |       |               | H         |
| NAME (Last, First): _____   |      |        |       | LAST 4: _____ |           |
| DD Form 1380 (Back)   |      |        |       |               | TCCC CARD |