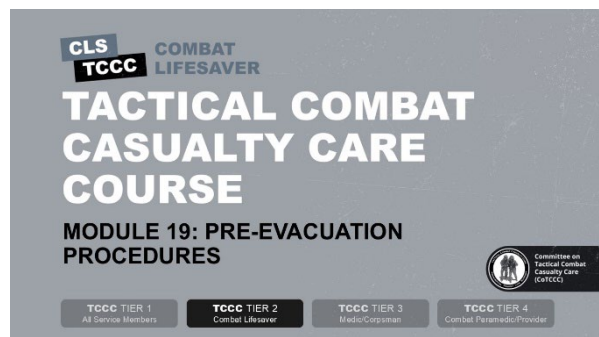


SPEAKER NOTES

MODULE 19 – PRE-EVACUATION PROCEDURES, COMMUNICATION, AND DOCUMENTATION

SLIDE 1 – TITLE SLIDE



SLIDE 2 – CHANGE LOG

The Curriculum Change Log serves as a centralized reference to quickly track recent updates to training materials. It supports trainers by promoting clear communication, accountability, and alignment, helping stakeholders and learners understand what changes were made, why they were implemented, and when they occurred.

PRE-EVACUATION

CHANGE LOG - Curriculum Update History

CHANGE DATE	PRODUCT UPDATE	DESCRIPTION OF CHANGE
30 April 2025	Module 19 - Didactic PPT Slides 6-7	Updated TCCC 1389. Card image to reflect changing "gender" to "sex"

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SLIDE 3 – TCCC ROLES

Tactical Combat Casualty Care is broken up into four roles of care. The most basic is taught to All Service Members (ASM), which is designed to instruct in the absolute basics of hemorrhage control and to recognize more serious injuries.

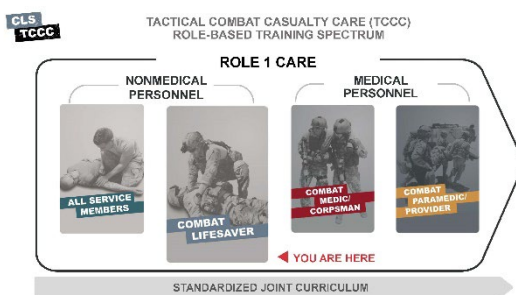
You are in the Combat Lifesaver (CLS) role.

This teaches you more advanced care to treat the most common causes of death on the battlefield, and to recognize, prevent, and communicate with medical personnel the life-threatening complications of these injuries.

The Combat Medic/Corpsman (CMC) role includes much more advanced and invasive care requiring significantly more medical knowledge and skills.

Finally, the last role, Combat Paramedic/Provider (CPP) is for Combat paramedics and advanced providers, to provide the most sophisticated care to keep our wounded warriors alive and get them to definitive care.

Your role as a CLS is to treat the most common causes of death on the battlefield, which are massive hemorrhage and airway/respiratory problems. Also, you are given the skills to prevent complications and treat other associated but not immediately life-threatening injuries.



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SPEAKER NOTES

SLIDE 4 – TLO/ELO

The pre-evacuation procedures module has **four cognitive learning objectives** and **two performance learning objectives**.

The cognitive learning objectives are to identify the importance of and techniques for communicating casualty information, identify the information requirements and format of an evacuation request (9-line), identify the recommended evacuation prioritization for combat casualties, and identify how to document casualty information on the DD Form 1380 TCCC card.

The performance learning objectives are to demonstrate the communication of evacuation request information and modified medical information report and demonstrate the proper documentation of care on a trauma casualty.

The critical aspects are to understand the importance of communication and know the information requirements for evacuation prioritization, evacuation requests, and casualty care documentation. Also, it is necessary to demonstrate the skills needed to successfully document casualty care and communicate an evacuation request.

SLIDE 5 – THREE PHASES OF TCCC

Pre-evacuation procedures bridge both Tactical Field Care (TFC) and Tactical Evacuation Care TACEVAC).

Immediate life-threatening hemorrhage control followed by the prevention and treatment of other injuries and complications have all been completed before most pre-evacuation procedures are initiated, although some of the communication and documentation may be ongoing during the TFC phase.


SLIDE 6 – COMMUNICATION

Communicate with the casualty **throughout** care.

Being physically wounded may generate significant anxiety and fear above and beyond the psychological trauma of combat.


Talk frankly with the casualty about their injuries. Offer reassurance by describing the treatments being rendered. Emphasize that everything possible is being done on their behalf and that they will be well taken care of. These steps will help to counter their anxiety.

Be honest about the injuries sustained but maintain a positive attitude about rescue and treatment. Talking with the casualty helps assess their mental status, while talking through procedures helps maintain your own confidence and the casualty's confidence in you.



STUDENT LEARNING OBJECTIVES

LEARNING OBJECTIVES



21 Given a **combat or noncombat** scenario, perform **pre-evacuation procedures** during **Tactical Field Care** in accordance with **CoTCCC Guidelines**

- 94 Identify the importance of **aid techniques** for **communicating casualty information** with **evacuation assets** and/or **receiving facilities**
- 95 Identify the **information requirements** and **format** of an **evacuation request**
- 96 Identify the **recommended evacuation prioritization** for **combat casualties**
- 97 Demonstrate the **communication of evacuation request information** and **modified medical information report requirements**

22 Given a **combat or noncombat** scenario, perform **documentation of care** during **Tactical Field Care** in accordance with **CoTCCC Guidelines**

- 98 Identify **how to document casualty information** or the **DD Form 1380 TCCC card** and the **proper placement** of that card on the **casualty**, in accordance with **DHA-PR 6540.0-1 (ASM T10-E37)**
- 99 Demonstrate the **proper documentation of care** on a **trauma casualty in Tactical Field Care**

02

TERMINAL LEARNING OBJECTIVES (TLOs)

06

ENABLING LEARNING OBJECTIVES (ELOs)

● Cognitive ELOs

● Performance ELOs

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The diagram illustrates the Three Phases of TCCC (Tactical Combat Casualty Care) in a horizontal flow. At the top left, there is a logo with 'CLS' in a blue box and 'TCCC' in a white box with a black border. The title 'Three PHASES of TCCC' is centered at the top in a large, bold, black font. Below the title, three numbered circles (1, 2, 3) represent the phases. Phase 1, 'CARE UNDER FIRE', is highlighted with a red background and includes a red box labeled 'RETURN FIRE AND TAKE COVER'. Phase 2, 'TACTICAL FIELD CARE', is highlighted with a yellow background and includes a yellow box labeled 'COVER AND CONCEALMENT'. Phase 3, 'TACTICAL EVACUATION CARE', is highlighted with a blue background and includes a blue box labeled 'EVACUATION'. Below each phase, there are two columns of text. The first column, 'Quick decision-making:', lists four items with red square bullets. The second column, 'Basic management plan:', lists four items with red square bullets. The third column, 'More deliberate assessment and treatment of unrecognized life-threatening injuries', lists two items with red square bullets. At the bottom left, a red box says 'YOU ARE HERE' with a white right-pointing triangle. At the bottom right, a red box says 'NOTE: This is covered in more advanced TCCC training' with a white right-pointing triangle. The bottom right corner has a small red square with the number '5'.

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
Three PHASES of TCCC

- 1 CARE UNDER FIRE**
RETURN FIRE AND TAKE COVER
 - Quick decision-making:
 - Consider scene safety
 - Identify and control life-threatening bleeding
 - Move casualty to safety
 - Basic management plan:
 - Maintain tactical/situational awareness
 - Triage casualties as required
 - MARCH PAWS assessment
- 2 TACTICAL FIELD CARE**
COVER AND CONCEALMENT
 - More deliberate assessment and treatment of unrecognized life-threatening injuries
 - Pre-evacuation procedures
 - Continuation of documentation
- 3 TACTICAL EVACUATION CARE**
EVACUATION


YOU ARE HERE


NOTE: This is covered in more advanced TCCC training

5




PRE-EVACUATION COMMUNICATION





Communicate with the casualty if possible

- Encourage
- Reassure
- Explain each step of the way



Communicate immediately with tactical leader for

- Status
- Evac requirements
- Casualty treatment

COMMUNICATE WITH EVACUATION AND MEDICAL ASSETS

■ Communicate with evacuation system to coordinate TACEVAC/MEDEVAC using MEDEVAC request

■ Keep the casualty's DD Form 1380 up-to-date

"PATIENT" CASUALTY CASUALTY CAMP/POC/CARD

BRIEF INFORMATION ONLY

NAME: _____ GRADE: _____ (Organ) _____ Priority: _____ Phone # _____

DOB: _____ M: _____ DATE OF INJURY: _____ TIME: _____

SOURCE: _____ PRE: _____ B. J. JAMESON _____

SPEAKER NOTES

Communicate **with tactical leadership ASAP** and throughout casualty treatment. Tactical leadership needs to understand the impact to the mission.

For example, tactical leadership may need to know:

- How many casualties were inflicted?
- Who is down as a casualty?
- Can the casualty still fight?
- Has the enemy threat been eliminated?
- Are weapons systems down or fields of fire not covered because the unit has taken casualties?
- Is it necessary to have others fill in the casualties' fighting positions or to move the casualties?

Communicate with the **evacuation coordination cell** to arrange for TACEVAC. Communicate with medical providers about details of the casualty's injuries. This includes **9-line** communication and ongoing **MIST** reports.

Medical leadership may need to know:

- What injuries were sustained
- The mental and physical status of each casualty
- Treatments rendered and treatments needed
- Does the medic need to triage multiple casualties?
- Should the medic move to a casualty, or should the casualty be moved to the medic?
- Are there enough Class VIII medical supplies?
- Does the unit need to break out litters or extraction equipment?

SLIDE 7 – COMMUNICATE RELEVANT CASUALTY DATA

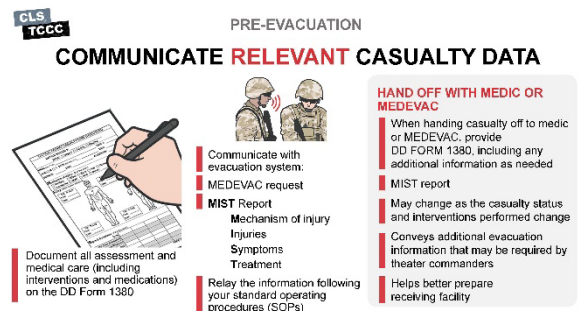
Medical documentation may be difficult to accomplish in tactical prehospital settings, but it is important to the casualty's **subsequent care** that every effort be made to document the care provided by first responders and medics throughout the trauma care continuum, from point of wounding/injury to definitive care at the hospital.

Communication is also important, as the injured casualty may impact the success of the mission or change the tactical landscape.

A **DD Form 1380 TCCC Card** is provided in each Joint First Aid Kit (JFAK). Based on the principles of TCCC, the card provides an easy way to document initial lifesaving care provided at the point of wounding. The card also serves as a prompt to remind first responders of the assessment and treatment steps of the MARCH sequence.

The DD 1380 is relatively self-explanatory, but there might be some acronyms or sections that are intuitive to someone who hasn't filled one out before. So, we'll watch this video on the subject to familiarize ourselves with the form, and then we'll practice filling one out with each casualty as we go through the rest of the skills training. This information about the casualty informs the medical evacuation request and can be collected simultaneously with the other required information.

MIST reporting was instituted as a standard part of the MEDEVAC request during *Operation Enduring Freedom* in Afghanistan. **MIST** stands for **M**echanism of injury, **I**njuries, **S**igns and **S**ymptoms and **T**reatment. Though **not** a formal part of the NATO and U.S. standard MEDEVAC request, MIST reporting has become a norm in combat theaters. The MIST transmits medical information to the receiving



SPEAKER NOTES

treatment facility and to the evacuation platform. A MIST report conveys additional evacuation information that may be required by theater commanders. MIST information helps the receiving Military Training Facility better prepare for specific inbound casualties. Transitioning casualty care to another medical team is best accomplished with an oral discussion of the casualty's status, along with the written documentation on the DD Form 1380. But in cases where an oral hand-off isn't a viable option, the written information may be the only way receiving medical personnel will know what you have done to help the casualty and what the next steps should be to provide the best care going forward.

SLIDE 8 – REQUESTING EVACUATION OF CASUALTIES

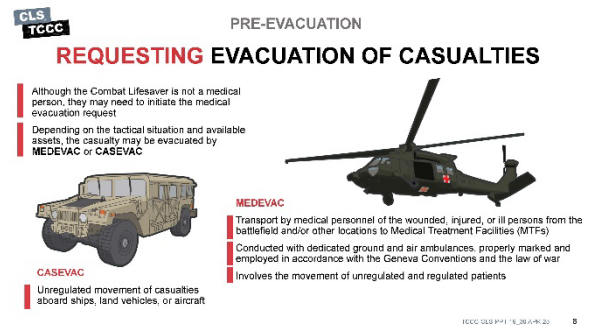
Every service member should **be able to initiate** a medical evacuation request.

Depending on the situation, the evacuation options may involve dedicated evacuation resources with medical capabilities, MEDEVAC, or could involve other transportation assets not dedicated to patient movement but called on as vehicles of opportunity to support **Casualty Evacuation (CASEVAC)**.

In CASEVAC, the casualties are moved without regulating their movement, and in MEDEVAC the patients are often regulated.

MEDEVAC assets are usually marked with a **red cross** and **cannot** be used for nonmedical missions.

Communicate with the evacuation system, **the Patient Evacuation Coordination Cell**, to arrange for TACEVAC. Communicate with medical providers on the evacuation asset if possible and relay mechanism of injury, injuries sustained, signs/symptoms, and treatments rendered. Provide additional information as appropriate.



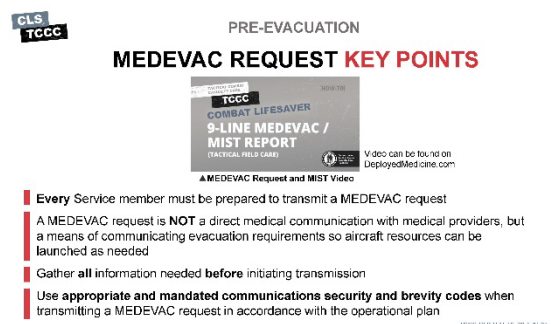
SLIDE 9 – MEDEVAC REQUEST KEY POINTS

Play video.

Before initiating an evacuation, collect all of the information you will need, and when calling in, be sure to follow all appropriate communication protocols and guidance.

Remember that when you request a medical evacuation, you aren't directly coordinating with medical providers but are explaining your evacuation requirements with someone who coordinates air asset movements.

Although they still require some general information about the status of the casualty, much of the information that they need to coordinate evacuation is not clinical and relates to logistical and operational issues.



SPEAKER NOTES

SLIDE 10 – 9-LINE: MEDEVAC REQUEST LINES 1–5

The standard MEDEVAC request has **9 lines**. However, lines 1–5 are required before a MEDEVAC can be launched.

Using a **phonetic alphabet** and following your unit's normal communications procedures, call in your grid location, your radio frequency and call sign, the number of casualties that you have by precedence, any equipment that needs to be brought by the evacuation team, how many of the casualties will be on litters, and how many will be ambulatory.

Determining the precedence of the casualties is arguably the hardest part of this process, as it is often difficult to estimate how well a casualty might do after you have provided appropriate initial TCCC support.

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9-LINE: MEDEVAC REQUEST LINES 1-5

NOTE: Lines 1-5 are the lines **NEEDED** to launch an asset

- 1 Location of the pickup site: (8-digit grid coordinate)
- 2 YOUR radio frequency, call signal, and suffix
- 3 Numbers of patients by precedence:
 - A. Urgent: < 2 hours to save life, limb, or eyesight
 - B. Urgent Surgical: < 2 hours to nearest surgical unit
 - C. Priority: < 4 hours or could deteriorate to urgent
 - D. Routine: < 24 hours
 - E. Convenience: Not medical necessity
- 4 Special equipment required:
 - A. None
 - B. Hoist
 - C. Extraction equipment
 - D. Ventilator
- 5 Numbers of patients by type: (Encrypt using brevity codes)
Ex: L+8 - number of litter casualties
Ex: A+8 - number of ambulatory casualties

NOTE: If two or more categories are reported in the same request, insert the word "break" between each category

Most common request: hoist, Stokes litter, and forest penetrator

QUANTITY OF CASUALTIES degree burns >70% BSA

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SLIDE 11 – 9-LINE: MEDEVAC REQUEST LINES 6–9

The **last four lines** of the request include:

1. Security situation at the pick-up site
2. How you plan on marking the landing zone
3. The casualty's nationality and status
4. Chemical, Biological, Radiological, Nuclear, and Explosive (CBRNE) threats that might be present

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9-LINE: MEDEVAC REQUEST LINES 6-9

- 6 Security of the pickup site:
 - N = No enemy troops in the area; routine
 - P = Possible enemy troops in the area
 - E = Enemy troops in the area; approach with caution
 - X = Enemy troops in area; armed escort required
- 7 Method of marking pickup site:
 - A = Panels
 - B = Pyrotechnic signal
 - C = Smoke signal
 - D = None
 - E = Other
- 8 Patient Nationality and status: (Encrypt using brevity codes)
 - A = US Military
 - B = US Civilian
 - C = Non-US Military
 - D = Non-US Civilian
 - E = Enemy Prisoner (EPW)
- 9 CBRN Contamination: (Encrypt using brevity codes)
 - C = Chemical
 - B = Biological
 - R = Radiological
 - N = Nuclear

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SLIDE 12 – SKILL STATION

At this time, we will break into skill stations to practice the following skills:

- 9-Line: MEDEVAC Request and MIST Report

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SKILL STATION

Communication and Documentation (Skill)

9-Line: MEDEVAC Request & MIST Report

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SLIDE 13 – CASUALTY CATEGORIES

CLS TCCC PRE-EVACUATION

CASUALTY CATEGORIES

Ground medical personnel will determine EVAC categories of casualties

	URGENT	URGENT SURGICAL	PRIORITY	ROUTINE	CONVENIENCE
	<2 hours to save life, limb, or eyesight	<2 hours to nearest surgical unit	<4 hours or could deteriorate to urgent	<24 hours	Not a medical necessity
Examples	Tourniquets Corrected hemorrhage Traumatic Brain Injuries (TBIs)	Needle Decompression of the Chest (NDCs) Cricothyroidotomy Major internal bleeding Massive head trauma	Compensated shock Broken arm with loss of distal pulse 2 nd -degree burns to a large portion of the abdomen or extremities	Abrasions Cardiac arrest Small fractures Frostbite 2 nd /3 rd -degree burns >70% of body surface area (BSA)	Used for administrative purposes for casualty movement

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SPEAKER NOTES


SLIDE 14 – OVER-CATEGORIZATION

It is important to **accurately categorize casualties** for MEDEVAC to ensure that the limited evacuation resources are used as efficiently as possible.

Over-categorization is a tendency to categorize a wound or injury as being more severe than it actually is. This has been and is currently a **problem** on the battlefield.

Proper categorization helps triage casualties in the order of greatest need and avoid sending evacuation assets to a casualty who has less severe injuries while a more seriously injured casualty has a delayed evacuation.

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PRE-EVACUATION

OVER-CATEGORIZATION

OVER-CATEGORIZATION: the tendency to classify a wound or injury as being more severe than it actually is

Historically **AND** currently a problem

Proper casualty categorization is needed to ensure that those casualties in greatest need are evacuated first and receive the necessary care required to help ensure their **survival**

Casualties will be picked up **as soon as possible**, consistent with available resources and pending missions

- A. Urgent – < 2 hours to save life, limb, or eyesight
- B. Urgent Surgical – < 2 hours to nearest surgical unit
- C. Priority – < 4 hours or could deteriorate to urgent
- D. Routine – < 24 hours
- E. Convenience – Not medical necessity

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SLIDE 15 – COMMUNICATE AND DOCUMENT

In summary, during the TFC phase, we must continue to communicate with the casualty and with tactical leadership, and to initiate evacuation.

Every member of the unit must be prepared to perform any of these communication requirements.

It is **important** that all TCCC actions and information are documented for each casualty so that the next provider in the continuum of casualty care knows what interventions have been performed, including tourniquet times, medications administered, etc.


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COMMUNICATE:

- WITH THE CASUALTY**
Encourage, reassure, and explain care
- WITH TACTICAL LEADERSHIP**
Provide leadership with the casualty status and location
- WITH MEDICAL PERSONNEL**
Discuss the casualty's injuries and symptoms, as well as any medical aid provided with the responding medics

PRE-EVACUATION

DOCUMENT:




DD FORM 1380
COMBAT CASUALTY CARE CARD

▲ DD FORM 1380 How-To Video
Video can be found on DeployedMedicine.com

MIST Report is generated from Casualty's DD Form 1380

- CASUALTY ASSESSMENT FINDINGS**
- MEDICAL AID RENDERED**
- CHANGES IN CASUALTY STATUS**



Attach DD Form 1380 to the casualty in a prominent location (wrist, belt loop of pants, etc.)

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SLIDE 16 – SKILL STATION

During the skill station for this module, you will all be given a scenario that requires you to fill out a DD Form 1380, documenting the casualty's injuries and treatment.

Afterwards, using this information and additional information from the scenario, you will need to prepare a MIST report and then call in a 9-line MEDEVAC request.

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SKILL STATION

Communication and Documentation (skill)

9-Line & Mist Report


DHA

#TCCC-CLS-PPT-19 30 DEC 19 15

SLIDE 17 – SUMMARY

In this module we highlighted the importance of and techniques for communicating casualty information. We demonstrated how to communicate evacuation request information and a modified medical information report along with how to properly document care on a trauma casualty. We discussed the information requirements and format of an evacuation request (9-line), the recommended evacuation prioritization for combat casualties, and


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PRE-EVACUATION

SUMMARY

- We discussed **9-Line** and **MIST** Report
- We discussed **requesting** an **evacuation** of casualty
- We identified **over-categorization**
- We identified **key information** to relay to tactical leadership



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SPEAKER NOTES

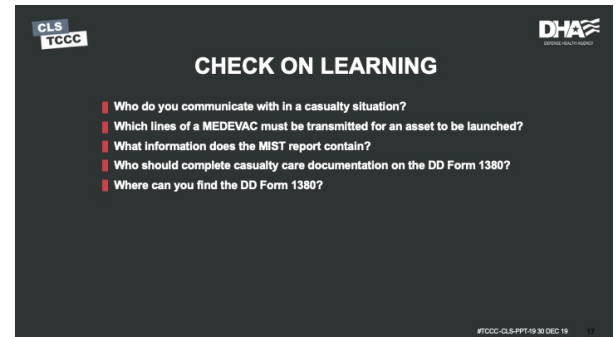
documentation of casualty information on the DD Form 1380 TCCC card.

SLIDE 18 – CHECK ON LEARNING

Ask questions of the learners referring to key concepts from the module.

Now for a check on learning.

1. With whom do you communicate in a casualty situation?
 - The casualty
 - The tactical leader
 - Medical personnel upon arrival
2. Which lines of a MEDEVAC must be transmitted for an asset to be launched?
 - Lines 1–5 and/or 6 are enough information to initiate a MEDEVAC depending upon pre-planning and coordination between tactical and evacuation units.
3. What information does the MIST report contain?
 - Mechanism of injury
 - Injuries
 - Symptoms
 - Treatment
4. Who should complete casualty care documentation on the DD Form 1380?
 - The card should be filled out by whomever provides care to the casualty.
5. Where can you find the DD Form 1380?
 - In the casualty's JFAK



SLIDE 19 – QUESTIONS

