

CHAPTER 22

Documentation—Medical Records

Canine Tactical Combat Casualty Care (cTCCC) Card

To document care at the point of injury, a canine Tactical Combat Casualty Care card (cTCCC card) has been approved for use, and is included in this chapter. This form should be used to document trauma or Disease, Non-Battle Injury at the point of injury anywhere an MWD is deployed, by the handler or provider who first provides care. Once care has been transferred to a medical facility, the form should be submitted to veterinary personnel for submission, or scanned and emailed by HCPs to dog.consult@us.af.mil.

The fillable electronic cTCCC care and instructions are available at:

https://jts.health.mil/assets/docs/forms/DD_3073_Canine_Tactical_Combat_Casualty_Care_Card.pdf

https://jts.health.mil/assets/docs/forms/DD_3073_Instructions_Canine_Trauma_Combat_Casualty_Card.pdf

Canine Resuscitation Record Worksheet

To document medical care of MWDs by HCPs, all medical care provided in military medical facilities should be documented on the Canine Resuscitation Record. This new worksheet is included in this chapter. Input all relevant information to the best of your ability, recognizing the form has been revised for canine-specific information, and thus is significantly different from the DD Form 3019 used for human patients. Use a new worksheet each day the dog is an inpatient in the facility. Maintain the worksheets throughout the patient's care. Once care has been transferred to supporting veterinary personnel, either provide the worksheet to them, or scan and email it to dha.mwdtraumaregistry@health.mil

The fillable electronic worksheet and instructions are available at:

https://jts.health.mil/assets/docs/forms/DD_3074_Canine_Treatment_and_Resuscitation_Record.pdf

https://jts.health.mil/assets/docs/forms/DD_3074_Canine_Treatment_and_Resuscitation_Record_Instructions.pdf

Figure 49. Canine Tactical Combat Casualty Care Card (CTCCC), Page 1 of 2

K9 TACTICAL COMBAT CASUALTY CARE (K9TCCC) CARD

EVAC CAT: ☐ Urgent ☐ Priority ☐ Routine

EVAC TYPE: ☐ Fixed ☐ Rotary ☐ Ground ☐ MEDEVAC ☐ CASEVAC

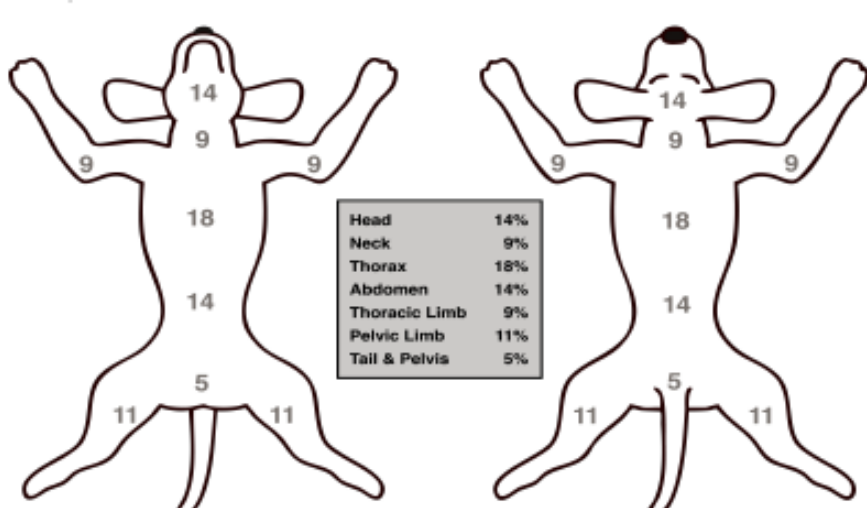
UNIT: _____ K9 NAME: _____ TATTOO: _____

DATE: (DD-MM-YY) _____ TIME: _____ SEX: ☐ M ☐ F

Mechanism of Injury: (Mark X all that apply)

☐ IED ☐ GSW ☐ MINE ☐ BURN ☐ GRENADE ☐ ARTILLERY ☐ FALL ☐ MVC ☐ OTHER: _____

Injury: (Mark all injuries that apply with an X)



Head	14%
Neck	9%
Thorax	18%
Abdomen	14%
Thoracic Limb	9%
Pelvic Limb	11%
Tail & Pelvis	5%

Vital Signs: (fill in the blank)

Time					
Pulse Rate/Location (60-80)					
Respiratory Rate (16-30)					
Temperature (99-102.5°F)					
Capillary Refill (< 2 sec)					
Blood Pressure (120/80)					
Pulse Ox% (> 95%)					
Pain Score (0-10)					

NOTES: _____

FIRST RESPONDER NAME (Last, First): _____ AOC/MOS: _____

DD FORM 3073, APR 2025 (Send card to sha.mwstrum@hhs.gov) Page 1 of 2

PREVIOUS EDITION IS OBSOLETE.

K9 TACTICAL COMBAT CASUALTY CARE (K9TCCC) CARD

Treatments: (Mark X all that apply, and fill in the blank)

Mt: Muzzle - ☐ Handler provided ☐ Hasty ☐ Other: _____

Mt: Dressing - ☐ Hemostatic ☐ Pressure ☐ Other: _____

TQ - ☐ Wide Elastic ☐ Extremity _____ Time _____ ☐ Other: _____

A: ☐ Intact ☐ ET/OTI ☐ TRACH ☐ CRIC ☐ Other: _____

R: ☐ O² ☐ Chest Seal ☐ NDC ☐ Chest Tube ☐ Other: _____

C: Catheter - ☐ IV ☐ IO Location: _____

RESUSCITATION	Name	Volume/Dose	Route	Time
K9 Blood Product				
Crystalloid Fluid 500ml IV bolus, repeat only once				

H: ☐ Hypothermia – Prevention ☐ Hyperthermia – External Cooling

H: ☐ Head Injury ☐ Elevate Head/Neck/Torso ☐ Other: _____

Medications for a 30kg K9 (Mark X if given and write route and time)

DRUG OPTIONS	DRUG NAMES	DOSE (30kg)	ROUTE	TIME
ANALGESIA Mild Pain: ketamine + benzo OR opioid alone; Mod/Severe Pain: ketamine + opioid OR ketamine + benzo + opioid SEDATION ketamine + benzo OR ketamine + opioid	<input type="checkbox"/> Ketamine (analgesia) IV/IO/IM	50mg		
	<input type="checkbox"/> Ketamine (sedation) IV/IO/IM	100mg		
	<input type="checkbox"/> Midazolam IV/IO/IM	10mg		
	<input type="checkbox"/> Hydromorphone IV/IO/IM	3mg		
	<input type="checkbox"/> Fentanyl IV/IO IM	150mcg 300mcg		
	<input type="checkbox"/> Morphine IM	10mg		
	<input type="checkbox"/> Other:			
ANTIBIOTIC	<input type="checkbox"/> Cefazolin/Ceftriaxone IV/IM	750mg		
	<input type="checkbox"/> Cefotaxime IV/IM	750mg		
	<input type="checkbox"/> Ertapenem IV/IM	750mg		
	<input type="checkbox"/> Other:			
OTHER	<input type="checkbox"/> TXA IV/IO	0.5gm		
	<input type="checkbox"/> Naloxone IV/IO IM/IN	2mg 4mg		
	<input type="checkbox"/> Calcium IV/IO	1 gram		
	<input type="checkbox"/> 3 or 5% Hypertonic Saline (HTS) IV/IO	150ml		
	<input type="checkbox"/> Other:			

OTHER: ☐ Splint ☐ Wound Dressing ☐ Other: _____

DD FORM 3073, APR 2025

(Send card to gha.mw@usmcmr.mil)

Page 2 of 2

PREVIOUS EDITION IS OBSOLETE.

General Instructions for the K9TCCC Card (DD Form 3073)

PURPOSE: The K9TCCC Card is to provide standardized and consistent documentation of prehospital care by the Military Departments (MILDEPs) for Department of Defense (DoD) Working Dogs for trauma and disease non-battle injuries (DNBI).

The K9TCCC Card is filled out by the handler or provider who attends to the K9's injuries or DNBI. After medical treatment and resuscitation care is provided, the K9TCCC Card must stay with the K9 when handed off to the next treatment facility to provide information regarding continuity of care.

At conclusion of care, the K9TCCC Card must be uploaded to the K9's electronic Veterinary Health Record (eVHR). The K9TCCC Card will also be emailed to dha.mwdtraumaregistry@health.mil for inclusion into the DoD Military Working Dog Trauma Registry.

INSTRUCTIONS FOR COMPLETING DD FORM 3073 (FRONT OF CARD):

EVACUATION CATEGORY (Mark as appropriate.)

- **URGENT** – K9 who should be evacuated as soon as possible and within 1 hour to save life, limb, or eyesight and to prevent complications of serious illness and to avoid permanent disability.
- **PRIORITY** – K9 who should be moved within 4 hours, or their condition will deteriorate to such a degree that they will become an urgent precedence or whose requirements for special treatment are not available locally or who will suffer unnecessary pain or disability.
- **ROUTINE** – K9 whose condition requires evacuation but whose condition is not expected to deteriorate significantly and who will require evacuation in the next 24 hours.

EVACUATION TYPE (Mark as appropriate.)

K9 IDENTIFICATION

- **UNIT** – Record the unit the MWD is assigned.
- **K9 NAME** – Self-explanatory.
- **TATTOO** – Self-explanatory.
- **DATE** – DD-MM-YY

- **TIME** – Record all time local 24-hour military format as hh:mm.
- **SEX** – Mark as appropriate.
- **MECHANISM OF INJURY** – Mark as appropriate—use other for Disease Non-Battle Injuries or if unknown-describe.

INJURY (Mark the diagram where the trauma/injury or disease is located—if there is more than one injury, identify each with the mechanism of injury.)

- The percentage numbers are provided as a reference when estimating K9 casualty burn injuries. If burn injuries have been sustained, the estimated percent burned should be annotated in the notes.

VITAL SIGNS (Input vital signs at least hourly.)

Pain Score:

0: Pain free

1 – 2: Mild pain; subtle weight shifting or subtle delay in lying down; enjoys being touched and petted.

3 – 4: Moderate pain; intermittent panting; delayed or slowed movement, subdued, weight shifting, likes to be touched except near or on injury, mild body tension.

5 – 6: Moderate to severe pain; looks uncomfortable when resting, anxious; pulls away when injury touched, moderate body tension.

7 – 8: Severe pain; unsettled, crying, biting or chewing at wound; difficulty maintaining comfortable position; increased respiratory rate, guards painful area, significant body tension when injury touched.

9 – 10: Worst pain possible; panting; constantly groaning or screaming when unattended, may be aggressive to palpation, cries at non-painful palpation, severe body tension.

NOTES (Include any additional information such as location/country, euthanized/KIA, treatment regiments that were used to treat the patient, etc.)

FIRST RESPONDER NAME (Self-explanatory)

AOC/MOS (Self-explanatory)

INSTRUCTIONS FOR COMPLETING DD FORM 3073 (BACK OF CARD):

TREATMENTS (Mark as appropriate and annotate location where appropriate.)

M (Muzzle): Mark as appropriate.

M (Massive Hemorrhage): Mark as appropriate.

A (Airway Control): Mark as appropriate.

R (Respiratory Support): Mark as appropriate.

C (Circulation):

CATHETER (Mark as appropriate.)

FLUIDS (Fill out as appropriate and complete as much as possible.)

H (Hypo/hyperthermia): Self-explanatory.

H (Head Injury): Self-explanatory.

MEDICATIONS (Mark the medication given and write the route and time.)

OTHER (Self-explanatory.)

For additional information regarding the use of the DD Form 3073, please refer to the Defense Health Agency – Procedural Instruction 6040.47-V5.

Figure 50. Canine Treatment and Resuscitation Record Worksheet, Page 1 of 6

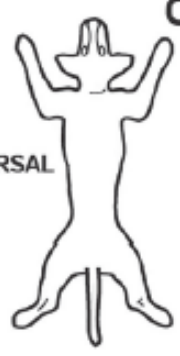
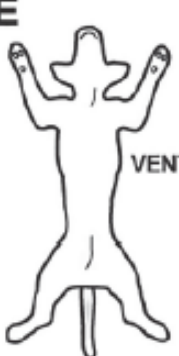
CANINE TREATMENT AND RESUSCITATION RECORD																																																	
Part I, Animal Technician/Nursing Flow Sheet								Date _____																																									
1. PATIENT/CANINE INFORMATION																																																	
1.1 TRAUMA TEAM DATA				1.2 ARRIVAL		1.3 EVAC FROM		1.4 MODE OF ARRIVAL																																									
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 20%;">Service</th> <th style="width: 15%;">Time Called</th> <th style="width: 15%;">Time Arrived</th> <th style="width: 50%;">Name</th> </tr> <tr><td>ED Physician</td><td></td><td></td><td></td></tr> <tr><td>Veterinarian</td><td></td><td></td><td></td></tr> <tr><td>Trauma Surgeon</td><td></td><td></td><td></td></tr> <tr><td>Radiology</td><td></td><td></td><td></td></tr> <tr><td>Pharmacy</td><td></td><td></td><td></td></tr> <tr><td>Lab/Blood Bank</td><td></td><td></td><td></td></tr> <tr><td>Respiratory Therapy</td><td></td><td></td><td></td></tr> <tr><td>Anesthesiology</td><td></td><td></td><td></td></tr> <tr><td>Consult (Germany)</td><td></td><td></td><td></td></tr> </table>				Service	Time Called	Time Arrived	Name	ED Physician				Veterinarian				Trauma Surgeon				Radiology				Pharmacy				Lab/Blood Bank				Respiratory Therapy				Anesthesiology				Consult (Germany)				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"/> Walked/Carried <input type="checkbox"/> CCATT <input type="checkbox"/> CASEVAC - Air <input type="checkbox"/> Ship EVAC <input type="checkbox"/> CASEVAC - Ground <input type="checkbox"/> AE <input type="checkbox"/> MEDEVAC - Air <input type="checkbox"/> Other Mission # _____ <input type="checkbox"/> MEDEVAC - Ground Mission # _____	
Service	Time Called	Time Arrived	Name																																														
ED Physician																																																	
Veterinarian																																																	
Trauma Surgeon																																																	
Radiology																																																	
Pharmacy																																																	
Lab/Blood Bank																																																	
Respiratory Therapy																																																	
Anesthesiology																																																	
Consult (Germany)																																																	
				1.5 INJURY TYPE		1.6 INJURY CLASSIFICATION		1.7 TRIAGE CATEGORY																																									
				<input type="checkbox"/> Blunt <input type="checkbox"/> Burn <input type="checkbox"/> Penetrating <input type="checkbox"/> Medical (Non-trauma)		<input type="checkbox"/> Battle <input type="checkbox"/> Non-Battle <input type="checkbox"/> Unknown		<input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minimal <input type="checkbox"/> Expectant																																									
1.8 SAFETY				1.9 PATIENT CATEGORY		1.10 PPE		1.11 INJURY CAUSE																																									
<input type="checkbox"/> Muzzle Applied <input type="checkbox"/> Handler Present <input type="checkbox"/> Sedated				<input type="checkbox"/> USA MWD <input type="checkbox"/> USAF MWD <input type="checkbox"/> USN MWD <input type="checkbox"/> USCG MWD <input type="checkbox"/> NATO - Coalition MWD <input type="checkbox"/> USMC MWD <input type="checkbox"/> Non-NATO - Coalition MWD <input type="checkbox"/> Contractor MWD <input type="checkbox"/> Other MWD		<input type="checkbox"/> Body Armor <input type="checkbox"/> Doggles/Eye Protection <input type="checkbox"/> Ear Protection <input type="checkbox"/> Other		<input type="checkbox"/> Building Collapse <input type="checkbox"/> IED <input type="checkbox"/> MVC <input type="checkbox"/> Bullet/GSW <input type="checkbox"/> Inhalation Injury <input type="checkbox"/> UXO <input type="checkbox"/> Fire/Flame (Burn) <input type="checkbox"/> Mine <input type="checkbox"/> Heat/Sun <input type="checkbox"/> CBRNE <input type="checkbox"/> Mortar/Rocket <input type="checkbox"/> Medical <input type="checkbox"/> Fall <input type="checkbox"/> Artillery Shell <input type="checkbox"/> Other																																									
2. CARE DONE PRIOR TO ARRIVAL																																																	
2.1 PREHOSPITAL TOURNIQUET				2.2 PREHOSPITAL VITALS		2.3 HEMORRHAGE CONTROL		2.4 PREHOSPITAL WARMING																																									
Front Extremities: Type: <input type="checkbox"/> CAT <input type="checkbox"/> SOFTT <input type="checkbox"/> Other _____ Time On _____ Off _____ L How many? <input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 4 Effective? <input type="checkbox"/> Y <input type="checkbox"/> N R How many? <input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 4 Effective? <input type="checkbox"/> Y <input type="checkbox"/> N				Rear Extremities: Type: <input type="checkbox"/> CAT <input type="checkbox"/> SOFTT <input type="checkbox"/> Other _____ Time On _____ Off _____ L How many? <input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 4 Effective? <input type="checkbox"/> Y <input type="checkbox"/> N R How many? <input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 4 Effective? <input type="checkbox"/> Y <input type="checkbox"/> N		Sedation Level: <input type="checkbox"/> Alert <input type="checkbox"/> P <input type="checkbox"/> Sedated <input type="checkbox"/> RR <input type="checkbox"/> Lethargic <input type="checkbox"/> BP <input type="checkbox"/> / <input type="checkbox"/> Unconscious <input type="checkbox"/> SpO ₂ _____ T _____ F _____ C _____ CRT _____		<input type="checkbox"/> Celox <input type="checkbox"/> Field Dressing <input type="checkbox"/> ChitoFlex <input type="checkbox"/> QuikClot <input type="checkbox"/> Combat Gauze <input type="checkbox"/> None <input type="checkbox"/> Direct Pressure <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____		<input type="checkbox"/> Blanket <input type="checkbox"/> Body Bag <input type="checkbox"/> HPMK <input type="checkbox"/> Space Blanket <input type="checkbox"/> Other _____																																							
				2.5 PREHOSPITAL MEDS		2.6 PREHOSPITAL INTERVENTIONS																																											
						Intubated <input type="checkbox"/> Y <input type="checkbox"/> N IO Infusions <input type="checkbox"/> Y <input type="checkbox"/> N IV Fluids <input type="checkbox"/> Y <input type="checkbox"/> N Tracheostomy <input type="checkbox"/> Y <input type="checkbox"/> N E--collar <input type="checkbox"/> Y <input type="checkbox"/> N Pain Scale (0 - 4) _____ Needle <input type="checkbox"/> Y <input type="checkbox"/> N CPR <input type="checkbox"/> Y <input type="checkbox"/> N _____ Decompression <input type="checkbox"/> Y <input type="checkbox"/> N																																											
3. PRIMARY ASSESSMENT																																																	
3.1 VITALS		3.2 NEURO/MENTAL STATUS			3.3 HYPO / HYPERTHERMIA CONTROL MEASURES																																												
P _____ RR _____ BP _____ / _____ SpO ₂ _____ Pain Scale (0 - 4) _____		<input type="checkbox"/> Hyperactive <input type="checkbox"/> Disoriented <input type="checkbox"/> MGCS <input type="checkbox"/> Alert <input type="checkbox"/> Stupor <input type="checkbox"/> L of C <input type="checkbox"/> Sedated <input type="checkbox"/> Comatose <input type="checkbox"/> Motor <input type="checkbox"/> Depressed <input type="checkbox"/> Brainstem TOTAL _____			Arrival Temp _____ <input type="checkbox"/> F <input type="checkbox"/> C Temperature Control Procedure: Time _____ Date _____ <input type="checkbox"/> Bair Hugger <input type="checkbox"/> Warming Blanket <input type="checkbox"/> Rectal <input type="checkbox"/> Warmed Fluids <input type="checkbox"/> Cooling Blanket <input type="checkbox"/> Water <input type="checkbox"/> IV Fluids <input type="checkbox"/> Other _____																																												
3.4 AIRWAY			3.5 BREATHING																																														
<input type="checkbox"/> Patent <input type="checkbox"/> BVM (Ambu) <input type="checkbox"/> Panting <input type="checkbox"/> Intubated <input type="checkbox"/> Stridor <input type="checkbox"/> Other _____ <input type="checkbox"/> Obstructed <input type="checkbox"/> OPA			<input type="checkbox"/> Unlabored <input type="checkbox"/> Labored <input type="checkbox"/> Panting <input type="checkbox"/> Abdominal Component <input type="checkbox"/> Absent Breath Sounds: Clear <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Equal <input type="checkbox"/> L > R <input type="checkbox"/> R > L Rales <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Wheeze <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Absent <input type="checkbox"/> L <input type="checkbox"/> R Chest Symmetry: <input type="checkbox"/> Equal <input type="checkbox"/> L > R <input type="checkbox"/> R > L Trachea: <input type="checkbox"/> Midline <input type="checkbox"/> Deviated Flail: <input type="checkbox"/> L <input type="checkbox"/> R																																														
PATIENT IDENTIFICATION																																																	
Name _____ Tattoo # _____ Microchip # _____ DOB _____ Age _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F Breed _____ MWD Type _____ Handler Name _____ Deployed/Assigned Unit _____ Vet/Tech/HCP Name _____ Vet/Tech/HCP Signature _____ Facility Name _____ Facility Location _____ Submit by Email dha.mwdtraumaregistry@health.mil																																																	

Figure 50. Canine Treatment and Resuscitation Record Worksheet, Page 2 of 6

[illegible]

Canine Treatment and Resuscitation Record Worksheet, Page 3 of 6

CANINE TREATMENT AND RESUSCITATION RECORD																																																																																												
Part I, Animal Technician/Nursing Flow Sheet										Date _____																																																																																		
4. SECONDARY SURVEY (CONT.)																																																																																												
4.9 VENT SETTINGS				4.10 INTRAVENOUS/INTRAOSSEOUS ACCESS AND FLUIDS/BLOOD PRODUCTS																																																																																								
Time: _____				<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Start Time</th> <th>Rate</th> <th>Type</th> <th>Gauge</th> <th>Site</th> <th>IVF Type</th> <th>Amount Up</th> <th>Amount In</th> <th>Stop Time</th> <th>Initials</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> IV <input type="checkbox"/> IO</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> IV <input type="checkbox"/> IO</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> IV <input type="checkbox"/> IO</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> IV <input type="checkbox"/> IO</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td> </tr> <tr> <td>_____</td> <td>_____</td> <td><input type="checkbox"/> IV <input type="checkbox"/> IO</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td> </tr> </tbody> </table>								Start Time	Rate	Type	Gauge	Site	IVF Type	Amount Up	Amount In	Stop Time	Initials	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																					
Start Time	Rate	Type	Gauge	Site	IVF Type	Amount Up	Amount In	Stop Time	Initials																																																																																			
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																			
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																			
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																			
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																			
_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> IO	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																			
Mode: _____																																																																																												
FIO2: _____																																																																																												
Rate: _____																																																																																												
PEEP: _____																																																																																												
TV: _____																																																																																												
Notes: _____																																																																																												
4.11 MEDICATIONS						4.12 LABS																																																																																						
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Start Time</th> <th>Drug</th> <th>Dose</th> <th>Site</th> <th>Route</th> <th>Stop Time</th> <th>Initials</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> </tbody> </table>						Start Time	Drug	Dose	Site	Route	Stop Time	Initials	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Time</th> <th>Test</th> <th>Time</th> <th>Test</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>CBC</td> <td>_____</td> <td>INR</td> </tr> <tr> <td>_____</td> <td>Chem7</td> <td>_____</td> <td>Lactate</td> </tr> <tr> <td>_____</td> <td>Chem12</td> <td>_____</td> <td>U/A</td> </tr> <tr> <td>_____</td> <td>H&H</td> <td>_____</td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td>_____</td> <td>ABG/Serial _____</td> <td>_____</td> <td></td> </tr> <tr> <td>_____</td> <td>VBG</td> <td>_____</td> <td></td> </tr> <tr> <td>_____</td> <td>PT/PTT</td> <td>_____</td> <td></td> </tr> </tbody> </table>						Time	Test	Time	Test	_____	CBC	_____	INR	_____	Chem7	_____	Lactate	_____	Chem12	_____	U/A	_____	H&H	_____	<input type="checkbox"/> Other, specify: _____	_____	ABG/Serial _____	_____		_____	VBG	_____		_____	PT/PTT	_____	
Start Time	Drug	Dose	Site	Route	Stop Time	Initials																																																																																						
_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																						
_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																						
_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																						
_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																						
_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																						
_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																						
Time	Test	Time	Test																																																																																									
_____	CBC	_____	INR																																																																																									
_____	Chem7	_____	Lactate																																																																																									
_____	Chem12	_____	U/A																																																																																									
_____	H&H	_____	<input type="checkbox"/> Other, specify: _____																																																																																									
_____	ABG/Serial _____	_____																																																																																										
_____	VBG	_____																																																																																										
_____	PT/PTT	_____																																																																																										
4.13 CT		4.14 X-RAY		4.15 Pending Studies				4.16 Results																																																																																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Type</th> <th>Time</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Spine</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Chest</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Abd/Pelvis</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Pan Scan</td><td>_____</td></tr> </tbody> </table>		Type	Time	<input type="checkbox"/> Head	_____	<input type="checkbox"/> Spine	_____	<input type="checkbox"/> Chest	_____	<input type="checkbox"/> Abd/Pelvis	_____	<input type="checkbox"/> Pan Scan	_____	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Type</th> <th>Time</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Spine</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Chest</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Abd/Pelvis</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Pan Scan</td><td>_____</td></tr> </tbody> </table>		Type	Time	<input type="checkbox"/> Head	_____	<input type="checkbox"/> Spine	_____	<input type="checkbox"/> Chest	_____	<input type="checkbox"/> Abd/Pelvis	_____	<input type="checkbox"/> Pan Scan	_____	<input type="checkbox"/> Extremity <input type="checkbox"/> LF <input type="checkbox"/> RF <input type="checkbox"/> LR <input type="checkbox"/> RR Time _____																																																																
Type	Time																																																																																											
<input type="checkbox"/> Head	_____																																																																																											
<input type="checkbox"/> Spine	_____																																																																																											
<input type="checkbox"/> Chest	_____																																																																																											
<input type="checkbox"/> Abd/Pelvis	_____																																																																																											
<input type="checkbox"/> Pan Scan	_____																																																																																											
Type	Time																																																																																											
<input type="checkbox"/> Head	_____																																																																																											
<input type="checkbox"/> Spine	_____																																																																																											
<input type="checkbox"/> Chest	_____																																																																																											
<input type="checkbox"/> Abd/Pelvis	_____																																																																																											
<input type="checkbox"/> Pan Scan	_____																																																																																											
4.17 VITAL SIGNS						4.18 DISPOSITION																																																																																						
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Time</th> <th>BP</th> <th>P</th> <th>RR</th> <th>Temp</th> <th>SpO₂</th> <th>Other (ICP)</th> <th>Initials</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td><td><div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div></td></tr> </tbody> </table>						Time	BP	P	RR	Temp	SpO ₂	Other (ICP)	Initials	_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>	Date: _____ Time: _____ Handler Present: <input type="checkbox"/> Y <input type="checkbox"/> N RTD <input type="checkbox"/> Full <input type="checkbox"/> Light Work <input type="checkbox"/> No Work for _____ Days Admit <input type="checkbox"/> OR <input type="checkbox"/> ICU <input type="checkbox"/> ICW <input type="checkbox"/> Vet Clinic Evac to <input type="checkbox"/> VTF Role 2 <input type="checkbox"/> VTF Role 3 <input type="checkbox"/> VMCE Facility Name: _____ Evac Priority <input type="checkbox"/> Routine <input type="checkbox"/> Priority <input type="checkbox"/> Urgent Evac Mode <input type="checkbox"/> Ambulatory <input type="checkbox"/> Gurney/Litter <input type="checkbox"/> Crate/Kennel Evac Transport Vehicle MEDEVAC: <input type="checkbox"/> Rotary Wing <input type="checkbox"/> Fixed Wing <input type="checkbox"/> OCATT Ground: <input type="checkbox"/> Ambulance <input type="checkbox"/> Non-Medical						
Time	BP	P	RR	Temp	SpO ₂	Other (ICP)	Initials																																																																																					
_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																					
_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																					
_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																					
_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																					
_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																					
_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																					
_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																					
_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																					
_____	_____	_____	_____	_____	_____	_____	<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																					
4.19 NOTES																																																																																												
PATIENT IDENTIFICATION																																																																																												
Name _____		Tattoo # _____		Microchip # _____		DOB _____																																																																																						
Age _____		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Breed _____		MWD Type _____		Handler Name _____																																																																																				
Deployed/Assigned Unit _____		Vet/Tech/HCP Name _____		Vet/Tech/HCP Signature <div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">DATA NAME</div>																																																																																								
Facility Name _____		Facility Location _____		<div style="background-color: #cccccc; width: 50px; height: 15px; text-align: center;">Submit by Email</div>		dha.mwdtraumaregistry@health.mil																																																																																						

CANINE TREATMENT AND RESUSCITATION RECORD Part II, Veterinarian/Physician				Date _____															
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 (AB)rasion (AMP)utation (AV)ulsion (BL)eeding (B)urn %TBSA _____ (C)repitus (D)eformity (DG)degloving (E)chymosis (FX)Fracture (F)oreign Body (GSW)Gun Shot Wound (H)ematoma (I)llness (not trauma) (LAC)eration (PW)Puncture Wound (SW)Stab Wound (P)ain (PP)Peppering	<div style="text-align: center; font-weight: bold; font-size: 1.2em;">CANINE</div> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> L R  DORSAL </div> <div style="text-align: center;"> R L  VENTRAL </div> </div>																
1.3 CHIEF COMPLAINT, HISTORY AND PRESENTING ILLNESS <div style="border: 1px solid black; height: 100px; margin-top: 5px;"></div>			Pulses Present S= Strong W= Weak D= Doppler A=Absent _____																
1.5 HISTORY AND PHYSICAL Head & Neck: <div style="border: 1px solid black; height: 100px; margin-top: 5px;"></div>		1.6 PRE / INITIAL PROCEDURES / DIAGNOSTICS <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><u>Pre/Initial</u></td> <td style="width: 33%;"><u>Pre/Initial</u></td> <td style="width: 34%;"></td> </tr> <tr> <td><input type="checkbox"/> Trach</td> <td><input type="checkbox"/> Cantholysis & Canthotomy</td> <td><input type="checkbox"/> L <input type="checkbox"/> R</td> </tr> <tr> <td><input type="checkbox"/> ICP Monitor</td> <td><input type="checkbox"/> Tympanic Membranes</td> <td>Rupture <input type="checkbox"/> L <input type="checkbox"/> R</td> </tr> <tr> <td><input type="checkbox"/> Eye Injury</td> <td><input type="checkbox"/> L <input type="checkbox"/> R</td> <td>Blood <input type="checkbox"/> L <input type="checkbox"/> R</td> </tr> <tr> <td><input type="checkbox"/> Fluorescein</td> <td><input type="checkbox"/> - / <input type="checkbox"/> +</td> <td></td> </tr> </table>			<u>Pre/Initial</u>	<u>Pre/Initial</u>		<input type="checkbox"/> Trach	<input type="checkbox"/> Cantholysis & Canthotomy	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> ICP Monitor	<input type="checkbox"/> Tympanic Membranes	Rupture <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> L <input type="checkbox"/> R	Blood <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Fluorescein	<input type="checkbox"/> - / <input type="checkbox"/> +	
<u>Pre/Initial</u>	<u>Pre/Initial</u>																		
<input type="checkbox"/> Trach	<input type="checkbox"/> Cantholysis & Canthotomy	<input type="checkbox"/> L <input type="checkbox"/> R																	
<input type="checkbox"/> ICP Monitor	<input type="checkbox"/> Tympanic Membranes	Rupture <input type="checkbox"/> L <input type="checkbox"/> R																	
<input type="checkbox"/> Eye Injury	<input type="checkbox"/> L <input type="checkbox"/> R	Blood <input type="checkbox"/> L <input type="checkbox"/> R																	
<input type="checkbox"/> Fluorescein	<input type="checkbox"/> - / <input type="checkbox"/> +																		
Chest: <div style="border: 1px solid black; height: 100px; margin-top: 5px;"></div>		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><u>Needle Decompression</u></td> <td style="width: 33%;"><input type="checkbox"/> R <input type="checkbox"/> L</td> <td style="width: 34%;"><u>Pericardial FAST</u></td> </tr> <tr> <td><u>Output</u></td> <td><input type="checkbox"/> Air</td> <td>Describe _____</td> </tr> <tr> <td><input type="checkbox"/> Blood (ml) _____</td> <td></td> <td><u>Thoracic FAST</u></td> </tr> <tr> <td><input type="checkbox"/> Pericardiocentesis</td> <td></td> <td>Site <input type="checkbox"/> L CTS <input type="checkbox"/> R CTS</td> </tr> </table>			<u>Needle Decompression</u>	<input type="checkbox"/> R <input type="checkbox"/> L	<u>Pericardial FAST</u>	<u>Output</u>	<input type="checkbox"/> Air	Describe _____	<input type="checkbox"/> Blood (ml) _____		<u>Thoracic FAST</u>	<input type="checkbox"/> Pericardiocentesis		Site <input type="checkbox"/> L CTS <input type="checkbox"/> R CTS			
<u>Needle Decompression</u>	<input type="checkbox"/> R <input type="checkbox"/> L	<u>Pericardial FAST</u>																	
<u>Output</u>	<input type="checkbox"/> Air	Describe _____																	
<input type="checkbox"/> Blood (ml) _____		<u>Thoracic FAST</u>																	
<input type="checkbox"/> Pericardiocentesis		Site <input type="checkbox"/> L CTS <input type="checkbox"/> R CTS																	
Abdomen/Back and Spine: <div style="border: 1px solid black; height: 100px; margin-top: 5px;"></div>		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><u>DPL</u></td> <td style="width: 33%;">Gross Blood: <input type="checkbox"/> - / <input type="checkbox"/> +</td> <td style="width: 34%;">Describe _____</td> </tr> <tr> <td colspan="3" style="height: 40px;"></td> </tr> <tr> <td colspan="3"> Serial AFAST <input type="checkbox"/> - / <input type="checkbox"/> + Site <input type="checkbox"/> DH <input type="checkbox"/> CC <input type="checkbox"/> SR <input type="checkbox"/> HR </td> </tr> </table>			<u>DPL</u>	Gross Blood: <input type="checkbox"/> - / <input type="checkbox"/> +	Describe _____				Serial AFAST <input type="checkbox"/> - / <input type="checkbox"/> + Site <input type="checkbox"/> DH <input type="checkbox"/> CC <input type="checkbox"/> SR <input type="checkbox"/> HR								
<u>DPL</u>	Gross Blood: <input type="checkbox"/> - / <input type="checkbox"/> +	Describe _____																	
Serial AFAST <input type="checkbox"/> - / <input type="checkbox"/> + Site <input type="checkbox"/> DH <input type="checkbox"/> CC <input type="checkbox"/> SR <input type="checkbox"/> HR																			
Pelvis: <input type="checkbox"/> Stable <input type="checkbox"/> Unstable		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><u>Rectal Exam</u></td> <td style="width: 33%;">WNL <input type="checkbox"/> Weak/Absent Tone <input type="checkbox"/></td> <td style="width: 34%;">Gross Blood: <input type="checkbox"/> - / <input type="checkbox"/> +</td> </tr> </table>			<u>Rectal Exam</u>	WNL <input type="checkbox"/> Weak/Absent Tone <input type="checkbox"/>	Gross Blood: <input type="checkbox"/> - / <input type="checkbox"/> +												
<u>Rectal Exam</u>	WNL <input type="checkbox"/> Weak/Absent Tone <input type="checkbox"/>	Gross Blood: <input type="checkbox"/> - / <input type="checkbox"/> +																	
Front Extremities: <div style="border: 1px solid black; height: 100px; margin-top: 5px;"></div>		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> Closed Reduction</td> <td style="width: 25%;"><input type="checkbox"/> EXT Fixation</td> <td style="width: 25%;"><input type="checkbox"/> Splint</td> <td style="width: 25%;"><input type="checkbox"/> Wound Washout</td> </tr> <tr> <td><input type="checkbox"/> Tourniquet</td> <td><input type="checkbox"/> L # _____</td> <td><input type="checkbox"/> R # _____</td> <td></td> </tr> </table>			<input type="checkbox"/> Closed Reduction	<input type="checkbox"/> EXT Fixation	<input type="checkbox"/> Splint	<input type="checkbox"/> Wound Washout	<input type="checkbox"/> Tourniquet	<input type="checkbox"/> L # _____	<input type="checkbox"/> R # _____								
<input type="checkbox"/> Closed Reduction	<input type="checkbox"/> EXT Fixation	<input type="checkbox"/> Splint	<input type="checkbox"/> Wound Washout																
<input type="checkbox"/> Tourniquet	<input type="checkbox"/> L # _____	<input type="checkbox"/> R # _____																	
Rear Extremities: <div style="border: 1px solid black; height: 100px; margin-top: 5px;"></div>		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> Closed Reduction</td> <td style="width: 25%;"><input type="checkbox"/> EXT Fixation</td> <td style="width: 25%;"><input type="checkbox"/> Splint</td> <td style="width: 25%;"><input type="checkbox"/> Wound Washout</td> </tr> <tr> <td><input type="checkbox"/> Tourniquet</td> <td><input type="checkbox"/> L # _____</td> <td><input type="checkbox"/> R # _____</td> <td></td> </tr> </table>			<input type="checkbox"/> Closed Reduction	<input type="checkbox"/> EXT Fixation	<input type="checkbox"/> Splint	<input type="checkbox"/> Wound Washout	<input type="checkbox"/> Tourniquet	<input type="checkbox"/> L # _____	<input type="checkbox"/> R # _____								
<input type="checkbox"/> Closed Reduction	<input type="checkbox"/> EXT Fixation	<input type="checkbox"/> Splint	<input type="checkbox"/> Wound Washout																
<input type="checkbox"/> Tourniquet	<input type="checkbox"/> L # _____	<input type="checkbox"/> R # _____																	
Interventions Prior to Arrival: <div style="border: 1px solid black; height: 100px; margin-top: 5px;"></div>		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> Sedated</td> <td style="width: 25%;"><input type="checkbox"/> Hypertonic Saline</td> <td style="width: 25%;"><input type="checkbox"/> Mannitol</td> <td style="width: 25%;"><input type="checkbox"/> Seizure Protocol</td> </tr> <tr> <td><input type="checkbox"/> Central Line</td> <td>Loc _____</td> <td>Site _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> IO/IV</td> <td>Loc _____</td> <td>Site _____</td> <td></td> </tr> </table>			<input type="checkbox"/> Sedated	<input type="checkbox"/> Hypertonic Saline	<input type="checkbox"/> Mannitol	<input type="checkbox"/> Seizure Protocol	<input type="checkbox"/> Central Line	Loc _____	Site _____		<input type="checkbox"/> IO/IV	Loc _____	Site _____				
<input type="checkbox"/> Sedated	<input type="checkbox"/> Hypertonic Saline	<input type="checkbox"/> Mannitol	<input type="checkbox"/> Seizure Protocol																
<input type="checkbox"/> Central Line	Loc _____	Site _____																	
<input type="checkbox"/> IO/IV	Loc _____	Site _____																	
PATIENT IDENTIFICATION																			
Name _____		Tattoo # _____		Microchip # _____															
Age _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F		Breed _____		MWD Type _____															
Deployed/Assigned Unit _____		Vet/Tech/HCP Name _____		Handler Name _____															
Facility Name _____		Facility Location _____		Vet/Tech/HCP Signature _____															
Submit by Email dha.mwdtraumaregistry@health.mil																			

Canine Treatment and Resuscitation Record Worksheet, Page 5 of 6

CANINE TREATMENT AND RESUSCITATION RECORD																							
Part II, Veterinarian/Physician			Date _____																				
1. HISTORY & PHYSICAL - INJURY DESCRIPTION (CONT.)																							
1.7 PUPILS / VISION Brisk <input type="checkbox"/> L <input type="checkbox"/> R Sluggish <input type="checkbox"/> L <input type="checkbox"/> R NR <input type="checkbox"/> L <input type="checkbox"/> R Hand Motion <input type="checkbox"/> L <input type="checkbox"/> R Light Perception <input type="checkbox"/> L <input type="checkbox"/> R No Light Perception <input type="checkbox"/> L <input type="checkbox"/> R Anisocoria <input type="checkbox"/> L > R <input type="checkbox"/> R > L		1.9 EXTREMITIES <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Motor</th> <th style="text-align: center;">Sensory</th> <th style="text-align: center;">ROM</th> </tr> </thead> <tbody> <tr> <td>LF +</td> <td>/ -</td> <td>+ / -</td> <td>+ / -</td> </tr> <tr> <td>RF +</td> <td>/ -</td> <td>+ / -</td> <td>+ / -</td> </tr> <tr> <td>LR +</td> <td>/ -</td> <td>+ / -</td> <td>+ / -</td> </tr> <tr> <td>RR +</td> <td>/ -</td> <td>+ / -</td> <td>+ / -</td> </tr> </tbody> </table>			Motor	Sensory	ROM	LF +	/ -	+ / -	+ / -	RF +	/ -	+ / -	+ / -	LR +	/ -	+ / -	+ / -	RR +	/ -	+ / -	+ / -
	Motor	Sensory	ROM																				
LF +	/ -	+ / -	+ / -																				
RF +	/ -	+ / -	+ / -																				
LR +	/ -	+ / -	+ / -																				
RR +	/ -	+ / -	+ / -																				
1.8 BURN Cause _____ <input type="checkbox"/> Super <input type="checkbox"/> Deep PT %TBSA _____ <input type="checkbox"/> Super PT <input type="checkbox"/> Full																							
2. LABORATORY RESULTS																							
2.1 CBC WBC _____ RBC _____ HGB _____ HCT _____ PLT _____	2.2 CHEMISTRY 7/12 Na _____ Gluc _____ TProtein _____ K _____ BUN _____ ALT _____ Cl _____ Crea _____ AST _____ Ca _____ Albumin _____ ALP _____ CO ₂ _____ TBil _____ Lactate _____	2.3 COAG PT _____ PTT _____ INR _____ 2.4 BLOOD TYPE _____	2.5 VBG/ABG VBG _____ ABG _____ pH _____ PaO ₂ _____ PaCO ₂ _____ HCO ₃ _____ SaO ₂ _____																				
2.7 OTHER LABS _____ _____ _____			2.6 URINALYSIS SpGr _____ pH _____ LEU _____ PRO _____ GLU _____ KET _____ UBG _____ BIL _____ HGB _____																				
3. X-RAYS and CT																							
3.1 CT OBTAINED <input type="checkbox"/> Head <input type="checkbox"/> Spine <input type="checkbox"/> Chest <input type="checkbox"/> Abd/Pelvis <input type="checkbox"/> Pan Scan * Select Pan Scan only if all of the above requested	3.2 X-RAYS OBTAINED <input type="checkbox"/> Head <input type="checkbox"/> Extremity <input type="checkbox"/> Spine <input type="checkbox"/> LF <input type="checkbox"/> Chest <input type="checkbox"/> RF <input type="checkbox"/> Abd/Pelvis <input type="checkbox"/> LR <input type="checkbox"/> RR Other _____ Other _____ Other _____	3.4 PENDING STUDIES 																					
3.3 Foreign Body <input type="checkbox"/> Projectile <input type="checkbox"/> Shrapnel <input type="checkbox"/> Debris <input type="checkbox"/> Inondary Device <input type="checkbox"/> Bones <input type="checkbox"/> Other: _____		3.5 RESULTS (Include TEG/Rotam results) 																					
4. IMPRESSION/ASSESSMENT																							
4.1 Severity <input type="checkbox"/> Critical <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild	4.2 Impression/Assessment Comments 																						
5. DIAGNOSES																							
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____																					
PATIENT IDENTIFICATION																							
Name _____		Tattoo # _____	Microchip # _____																				
Age _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Breed _____	MWD Type _____																				
Deployed/Assigned Unit _____		Vet/Tech/HCP Name _____	Vet/Tech/HCP Signature _____																				
Facility Name _____		Facility Location _____																					
		Submit by Email dha.mwdtraumaregistry@health.mil																					

CANINE TREATMENT AND RESUSCITATION RECORD		Date _____
Part II, Veterinarian/Physician		
6. PLAN		
<u>6.1 PLAN</u>		
7. DNBI / NBI CATEGORY		
<input type="checkbox"/> Injury, MVC <input type="checkbox"/> Surgical <input type="checkbox"/> Other _____ <input type="checkbox"/> Injury, Work/Training <input type="checkbox"/> Disease <input type="checkbox"/> Describe _____		
8. CAUSE OF DEATH		
<u>8.1 ANATOMIC</u> <input type="checkbox"/> Airway <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen <input type="checkbox"/> Head <input type="checkbox"/> Chest <input type="checkbox"/> Pelvis <input type="checkbox"/> Extremity <input type="checkbox"/> LF <input type="checkbox"/> RF <input type="checkbox"/> LR <input type="checkbox"/> RR <input type="checkbox"/> Other, Specify _____	<u>8.2 PHYSIOLOGIC</u> <input type="checkbox"/> MOF <input type="checkbox"/> Sepsis <input type="checkbox"/> CNS <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Breathing <input type="checkbox"/> Heart Failure <input type="checkbox"/> Total Body Disruption <input type="checkbox"/> Other, Specify _____	
8.3 DEATH INFORMATION		
Date of Death _____ Time of Death _____ Mortuary Affairs Notified? <input type="checkbox"/> N/A <input type="checkbox"/> Y <input type="checkbox"/> N Euthanized <input type="checkbox"/> Y <input type="checkbox"/> N Method _____ Gross Necropsy by DVM <input type="checkbox"/> Y <input type="checkbox"/> N Necropsy Date _____ Necropsy Time _____ Time between death and necropsy _____ Gross Pathology Report: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown Samples Shipped to JPC <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/> Unknown Death Remarks _____ _____ _____		
PATIENT IDENTIFICATION		
Name _____ Tattoo # _____ Microchip # _____ DOB _____ Age _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F Breed _____ MWD Type _____ Handler Name _____ Deployed/Assigned Unit _____ Vet/Tech/HCP Name _____ Vet/Tech/HCP Signature SIGN HERE _____ Facility Name _____ Facility Location _____ Submit by Email dha.mwdtraumaregistry@health.mil		

General Instructions for Canine Treatment and Resuscitation Record DD Form 3074 (JULY 2020)

PURPOSE: The Canine Treatment and Resuscitation Record is for documenting a canine's illness or traumatic injuries and related medical treatment and resuscitation care provided at DoD Veterinary Treatment Facilities (VTFs) or Medical Treatment Facilities (MTFs) regardless of operational environment.

A canine trauma patient is defined as a canine who has an injury or illness with the potential of requiring a surgical intervention. The form is comprised of two parts. Part I, Animal Technician/Nursing Flow Sheet is completed by the veterinary technician or nurse fulfilling the role as a scribe or the nurse providing bedside care. Part II, Veterinarian/Physician is completed by the trauma veterinarian or physician providing care for the patient.

The Canine Treatment and Resuscitation Record becomes part of the patient's permanent DoD medical record. For US Special Operations Command canines, the Canine Treatment and Resuscitation Record will be filled out and returned to the handler or operator. The handler or operator will route the record(s) to their respective veterinarian to be inputted into the MWD Trauma Registry and the canine's record.

PART I: ANIMAL TECHNICIAN / NURSING FLOW SHEET

GENERAL INSTRUCTIONS

- To be completed by the animal care specialist / veterinary technician / healthcare personnel fulfilling the role as a scribe or providing 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.
- Record date on top of each page. The date should be the day when care is initiated. If the dog receives multiple days of care, use a new, correctly dated form each day.

PATIENT IDENTIFICATION (at bottom of each page). As stated.

NAME. Name of the Military Working Dog (MWD)

TATTOO. Tattoo identifier (located on the inner surface of the MWD's left ear)

MICROCHIP #. Nine, 12 or 15 digit number specific to the MWD. Record if known, verify with scanner if available.

DOB. Date of Birth as listed on the veterinary health record.

AGE. Dog's age in years.

SEX. Male or female.

BREED. Dog's breed as listed on the record or in the electronic Veterinary Health Record (eVHR). Recognized abbreviations are acceptable (e.g. German Shepherd Dog – GSD, Dutch Shepherd – DS, Belgian Malinois – B Mal, Labrador Retriever – Lab).

MWD TYPE. MWD's type of service, e.g. PEDD, MPC

HANDLER NAME. Name of the person accompanying MWD.

DEPLOYED / ASSIGNED UNIT. MWD's owning unit.

VET / TECH / HCP NAME. Name of the person responsible for the care of the MWD.

VET / TECH / HCP SIGNATURE. Signature of the responsible provider completed after reviewing the form for accuracy and completeness.

FACILITY NAME. Record your VTF or MTF unit identifier.

FACILITY LOCATION. Record FOB, COB, or geographic site.

1.0 PATIENT / CANINE 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.

WALKED/CARRIED. As stated.

CASEVAC – Air. Casualty Evacuation via non-medical rotary wing aircraft.

CASEVAC – Ground. Casualty Evacuation via non-medical ground transport vehicle.

MEDEVAC - Air includes DUSTOFF. Medical Evacuation via helicopter. Record mission number when known.

MEDEVAC – Ground. Medical Evacuation via ambulance. Record mission number when known.

CCATT. Critical Care Air Transport Team.

SHIP EVAC. Evacuation via US Navy vessel.

AE. Aeromedical Evacuation. Casualty Evacuation via USAF fixed-wing aircraft.

If Other, describe the method by which the patient arrived, such as USAF Pararescue (PJ or Pedro) or United Kingdom Medical Emergency Response Team (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 (e.g.: 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 (e.g. closed fracture without neurovascular compromise, moderate burns of < 50% TBSA, large muscle wounds, intra-abdominal and/or thoracic wounds).

Minimal - Non-Urgent: Minor Injuries; MWD can be safely cared for by veterinary staff or be monitored by handler. (e.g. minor lacerations, abrasions, fractures of digits/distal tail, 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 (e.g. 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 SAFETY. Check all that apply.

1.9 PATIENT CATEGORY. Check one.

USA MWD. United States Army-owned MWD

USAF MWD. United States Air Force-owned MWD

USMC MWD. United States Marine Corps-owned MWD

USN MWD. United States Navy-owned MWD

USCG MWD. United States Coast Guard-owned MWD

Contractor MWD. Specify Contractor Company

NATO-Coalition MWD. NATO country military forces-owned MWD. Specify country.

Non-NATO Coalition MWD. Non-NATO military forces-owned MWD. Specify country.

Other. If Other, describe the patient's classification as it relates to military, government or civilian organizations.

1.10 PERSONAL PROTECTIVE EQUIPMENT (PPE). Check all that apply. Collect the PPE and ensure it is transported with the canine.

1.11 INJURY CAUSE. Check all that apply. If Other, describe cause of the injury.

IED. Improvised Explosive Device

MVC. Motor Vehicle Crash

GSW. Gunshot Wound

UXO. Unexploded Ordinance

CBRNE. Chemical, Biological, Radiological, Nuclear and Explosives. If known, specify the agent.

Mortar/Rocket/Artillery Shell. Includes Indirect and Direct Fire

2.0 CARE DONE PRIOR TO ARRIVAL

GENERAL INSTRUCTIONS

- Information for this section should be taken from any medical records that accompany the MWD. This may include a K9 Tactical Combat Casualty Card (K9TCCC), SF 600 notes, Veterinary Services Systems Management (VSSM) digital medical records (eNOTE), or handler recollection. Complete as thoroughly and with as much detail as possible.
- 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.

2.1 PREHOSPITAL TOURNIQUET. Check all that apply.

CAT. Combat Application Tourniquet.

SOFFT. SOF Field Tourniquet.

Other. If other, describe the type of tourniquet.

Effective. An effective tourniquet controls active hemorrhage. May be combined with a dressing.

2.2 PREHOSPITAL VITALS. As stated.

SpO2. Do not attempt to obtain an O2 saturation measurement from the lip or tongue of an unsedated MWD. Use the prepuce, vulva, toe webbing or ear pinna as an alternate location.

2.3 HEMORRHAGE CONTROL. Check all that apply.

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.

ChitoFlex. A stuffable wound dressing conducive to narrow wound tracks.

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.

Direct Pressure. Pressure applied directly to a wound, usually with sterile, low-adherent gauze between the wound and source of bleeding.

Field Dressing. A casualty's dressing applied to a wound to control hemorrhaging.

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.

None. Check if no hemorrhage control measures.

Unknown. Check if hemorrhage control measures are unknown.

Other. Describe the not otherwise specified hemorrhage control measure.

2.4 PREHOSPITAL WARMING. Check all that apply.

HPMK. Hypothermia Prevention and Management Kit. Check only if all three components were used: Hat/Hood, Activated Liner, and Outer Shell.

If Other. Describe the not otherwise specified warming device.

2.5 PREHOSPITAL MEDS. Enter medication, dose and route.

2.6 PREHOSPITAL INTERVENTIONS. As stated.

IO Infusions. Intra-osseous administration of fluids

IV Fluids. Intravenous administration of fluids

E-Collar. Elizabethan collar. One of a number of devices placed around the neck of a MWD to prevent licking or chewing at a wound or device. May be a commercial product or a bucket with the bottom removed.

Pain Scale. See below for the explanation of how to determine pain in a MWD.

CPR. Cardiopulmonary resuscitation

3.0 PRIMARY ASSESSMENT

3.1 VITALS. As stated. For Pain Scale, enter level that you estimate the dog to be experiencing.

Score	Behavioral	Palpation	Body Tension
0	Comfortable when resting	Nontender to wound palpation	Minimal
1	Slightly unsettled or restless	Reacts to wound palpation	Mild
2	Uncomfortable at rest, whimpers, licks at wound	Flinches, whimpers, cries	Mild to Moderate
3	Unsettled, crying, groaning, biting, chewing wound	Increased respiratory rate, sharp cry, growl	Moderate
4	Constantly groaning or screaming when unattended, may bite wound	Cries at non-painful palpation, may react aggressively	Moderate to Severe

3.2 NEURO / MENTAL STATUS. As stated. If Other, describe the not otherwise specified.

HYPERACTIVE. Stressed, overly-excited MWD that is alert and conscious but will not follow commands due to repeated panting, pacing and/or aggression. MWD may exhibit frantic searching behavior or excessive, unfocused aggression. Special care should be taken when handling a hyperactive MWD to avoid being bitten.

ALERT. Characterized by a normal level of consciousness. The MWD responds to external stimuli and is able to follow commands when asked.

SEDATED. As stated. The MWD has been administered sedative medication but was alert or hyperactive before administration.

DEPRESSED. Characterized by a conscious but lethargic state. The MWD is relatively unresponsive to the environment and tends to sleep when undisturbed. Often caused by systemic problems like fever, anemia or metabolic disease. When associated with a primary brain problem, indicates diffuse cerebral cortex disease.

DISORIENTED. The MWD can respond to its environment but does so in an inappropriate manner. Special care should be taken when handling a disoriented MWD to avoid being bitten.

STUPOR. Characterized by an animal that tends to sleep when undisturbed, and that is not arousable with gentle stimuli like sound or touch. The MWD will respond slightly to painful stimuli and have some voluntary movements.

COMATOSE. Characterized by a state of deep unconsciousness, where the MWD cannot be aroused even with significant painful stimuli. Simple reflexes may still be intact and their presence should not be confused with level of consciousness.

MGCS. Modified Glasgow Coma Scale. See Table 2. Score interpretation: 3 – 8 Grave; 9 – 14 Guarded; 15 – 18 Good.

TABLE 2. CANINE MODIFIED GLASGOW COMA SCALE

Level of Consciousness	Score	Pt Score
Occasional periods of alertness and responsive to environment	6	
Depression or delirium, capable of responding to environment but response may be inappropriate	5	
Stupor, responsive to visual stimuli	4	
Stupor, responsive to auditory stimuli	3	
Stupor, responsive only to repeated noxious stimuli	2	
Coma, unresponsive to repeated noxious stimuli	1	
Motor Activity		
Normal Gait, normal spinal reflexes	6	
Hemiparesis, tetraparesis, or decerebrate activity	5	
Recumbent, intermittent extensor rigidity	4	
Recumbent, intermittent extensor rigidity with opisthotonus	3	
Recumbent, constant extensor rigidity with opisthotonus	2	
Recumbent, hypotonia of muscles, depressed or absent spinal reflexes	1	
Brainstem Reflexes		
Normal pupillary light reflexes and oculocephalic reflexes	6	
Slow pupillary light reflexes and normal to reduced oculocephalic reflexes	5	
Bilateral unresponsive miosis with normal to reduced oculocephalic reflexes	4	
Pinpoint pupils with reduced or absent oculocephalic reflexes	3	
Unilateral, unresponsive mydriasis with reduced or absent oculocephalic reflexes	2	
Bilateral, unresponsive mydriasis with reduced or absent oculocephalic reflexes	1	

3.3 HYPO / HYPERTHERMIA CONTROL MEASURES. As stated. Other includes Body Bag.

3.4 AIRWAY. As stated.

OPA. Oral Pharyngeal Airway

BVM. Bag-Valve-Mask (Ambu bag)

3.5 BREATHING. As stated.

3.6 NOTES. As stated.

3.7 CIRCULATION. As stated. Use caution when assessing the mucous membranes of a MWD. If unsedated or variably conscious, ask the handler to show you the mucous membrane color and perform the CRT evaluation. Also consider using an alternate location to approximate CRT. The mucosa of the conjunctiva, prepuce or vulva are acceptable alternative locations to evaluate CRT.

4.0 SECONDARY SURVEY

4.1 HEAD / NECK ENT. As stated.

JVD. Jugular Venous Distention

NR. Non-Reactive

4.2 HEART.

Rhythm. As stated. If Other, describe not otherwise specified rhythm.

NSR. Normal Sinus Rhythm

PEA. Pulseless Electrical Activity

V-Fib. Ventricular Fibrillation

V-Tach. Ventricular Tachycardia

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. As stated.

FAST. Focused Assessment with Sonography for Trauma. Check + (plus) if fluid present.

Check – (minus) if no fluid present. Check in the appropriate block if fluid is identified in the evaluated quadrant. Leave blank if not performed.

DH. Diaphragmatic-Hepatic

CC. Cysto-Colic

SR. Spleno-Renal

HR. Hepato-Renal

4.4 EXTREMITIES. Check all that apply. To evaluate for Motor in an extremity: once the MWD has been cleared for spinal fracture, then assist to stand if necessary and evaluate each leg for motor as the dog is walked. If the MWD cannot be walked, then touch each paw and evaluate the response. While testing a recumbent dog, do not confuse the withdrawal reflex with motor function. To evaluate for Sensation in a MWD: superficial pain can be elicited by gently pinching between the toes and watching for a head turn or growl; deep pain is assessed by clamping a digit firmly with hemostats until a response is seen. 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 MEDICAL HISTORY. As stated.

4.8 PROCEDURES. As stated. Hemorrhage Control Measures. Refer to Prehospital Hemorrhage Control Measures.

NOTE: In the 'performed by' block, in addition to name, record the Title / AOC / MOS / Rank of the person performing each intervention.

ET Intubation. Endotracheal Intubation. List endotracheal tube size if used. List tracheostomy tube size if used. Check block if End Tidal CO₂ (ETCO₂) changes post-intubation. Check block if patient has bilateral breath sounds (BBS) post-intubation.

Chest Tube. 75% of MWDs have a fenestrated mediastinum so both sides of the chest should be tapped if there is significant pneumothorax.

4.9 VENT SETTINGS.

MODE. Manual or Mechanical

FiO₂. Fraction of inspired O₂. Start at 100% then reduce to <60%

Rate. Number of breaths delivered per minute. For MWDs, set between 8 – 20 bpm to maintain end tidal CO₂ between 35 – 45 mmHg

PEEP. Positive End-Expiratory Pressure. For normal lungs 0 -2 cm H₂O; for abnormal lungs 2 – 8 cm H₂O

TV. Tidal Volume. To calculate tidal volume in a MWD: 15 x BW (kg) = mL TV

Notes. As stated

4.10 INTRAVENOUS / INTRAOSSEOUS ACCESS AND FLUIDS / BLOOD PRODUCTS. As stated. Initials: Legible initials of person who performed task. Enter time as stated.

4.11 MEDICATIONS. As stated. Initials: Legible initials of person who performed task.

4.12 LABS. As stated. Enter time as stated.

CBC. Complete Blood Count

Chem 7. Actual test will vary based on location and available equipment. Typically includes Sodium (Na), Potassium (K), Chloride (Cl), Bicarbonate (HCO₃), Blood Urea Nitrogen (BUN), Creatinine (Cr), and Glucose

Chem 12. Actual test will vary based on location and available equipment. Typically includes the tests in a CHEM 7 plus Alkaline Phosphatase (ALP), Alanine aminotransferase (ALT), Aspartate aminotransferase (AST), Bilirubin, Total Protein, Albumin and Calcium (Ca).

H&H. Hematocrit and Hemoglobin

ABG. Arterial Blood Gas

VBG. Venous Blood Gas

PT / PTT. Prothrombin Time / Partial Thromboplastin Time

INR. International Normalized Ratio

U/A. Urinalysis

4.13 CT. As stated. Enter time as stated.

4.14 X-RAY. Enter time as stated.

4.15 PENDING STUDIES. Record any additional tests that have been ordered or completed if there is not adequate space in 4.12 LABS, 4.13 CT or 4.14 X-RAY.

4.16 RESULTS. As stated. Excludes results for labs, CT and X-Ray that should be recorded in Part II, Section 2 Laboratory Results and Section 3 X-RAYS and CT

4.17 VITAL SIGNS. As stated.

ICP. Intracranial Pressure Measurement

4.18 DISPOSITION. Describe patient disposition. If death, complete Part II, section 8.3 Death Information. For mode of transport, refer to section 1.4 Mode of Arrival. If no additional information will be completed on this form, refer to the Completion Instructions on Page 10 for instructions on how to finalize and submit this form.

VMCE. Veterinary Medical Center Europe

4.19 NOTES. Enter additional information relevant to the patient's nursing care.

PART II: VETERINARIAN / PHYSICIAN

GENERAL INSTRUCTIONS:

- To be completed by the veterinarian / 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.
- Record date on top of each page. The date should be the day when care is initiated. If the dog receives multiple days of care, use a new, correctly dated form each day.

PATIENT IDENTIFICATION (at bottom of each page). As stated.

NAME. Name of the Military Working Dog (MWD)

TATTOO. Tattoo identifier (located on the inner surface of the MWD's left ear)

MICROCHIP #. Nine, 12 or 15 digit number specific to the MWD. Record if known or scanner available

DOB. Date of Birth as listed on the record or in the Remote Online Veterinary Record (ROVR)

AGE. Dog's age in years

SEX. Male or female.

BREED. Dog's breed as listed on the record or in ROVR. Recognized abbreviations are acceptable (e.g. German Shepherd Dog – GSD, Dutch Shepherd – DS, Belgian Malinois – B Mal, Labrador Retriever – Lab)

MWD TYPE. MWD's type of service, e.g. PEDD, MPC

HANDLER NAME. Name of the person accompanying MWD

DEPLOYED / ASSIGNED UNIT. MWD's owning unit

VET / TECH / HCP NAME. Name of the person responsible for the care of the MWD.

VET / TECH / HCP SIGNATURE. Signature of the responsible provider completed after reviewing the form for accuracy and completeness.

FACILITY NAME. Record your VTF or MTF unit identifier

FACILITY LOCATION. Record FOB, COB, or geographic site

1.0 HISTORY & PHYSICAL – INJURY DESCRIPTION

1.1 ARRIVAL. As stated.

1.2 TRIAGE CATEGORY. Check one. Refer to 1.7 for definitions from Part I Animal Technician / Nursing Flow Sheet.

1.3 CHIEF COMPLAINT, HISTORY AND PRESENTING ILLNESS. As stated.

1.4 INJURY DESCRIPTION. As stated. Annotate on the diagram using the appropriate injury abbreviation. Doppler includes non-palpable, but detected with Doppler. Absent means no pulse, non-palpable and not detected with Doppler. Calculate %TBSA using the guide in section 1.8.

1.5 HISTORY AND PHYSICAL. As stated. Interventions Prior to Arrival is any intervention performed in a prehospital or transferring facility.

Front / Rear Extremities. As stated. Also record and describe if other type of bandage is placed.

1.6 PRE / INITIAL PROCEDURES / DIAGNOSTICS. As stated. Pre means prior to arrival.

Pericardial FAST. Check if presence of fluid or free air. Describe findings as needed.

Thoracic FAST. Check if presence of fluid or free air at Left or Right Chest Tube Site (CTS).

Pericardiocentesis. Check block if performed and record volume of fluid obtained in the space below to distinguish from fluid or blood obtained from the thorax.

DPL. Diagnostic Peritoneal Lavage. Describe technique, locations attempted / performed and findings.

Serial AFAST. Refer to Part I, section 4.3 Abdominal for location definitions.

Seizure Protocol. Check box if medications were administered to control seizures.

Central Line. Describe location, catheter size and number of ports.

Intraosseous / Intravenous Catheter. Describe location and catheter size.

1.7 PUPILS / VISION. As stated.

1.8 BURN. As stated. Describe the cause of burn.

% TBSA. Percent of Total Body Surface Area affected. Head: 9%; Thorax: 18%; Abdomen: 18%; Forelimb: 9% each; Hindlimb: 18% each.

Super. Superficial – First Degree.

Super PT. Superficial Partial Thickness – Second Degree.

Deep PT. Deep Partial Thickness – severe Second Degree.

Full. Full Thickness – Third Degree if injury limited to the skin and subcutaneous tissues. Fourth Degree if the burn involves muscle and bone.

1.9 EXTREMITIES. As stated. Evaluate and record Motor, Sensory and Range of Motion (ROM) for each extremity.

2.0 LABORATORY RESULTS

2.1 CBC. As stated.

2.2 CHEMISTRY 7/12 (14). As stated. Refer to Part I, Section 4.12 for abbreviation descriptions.

2.3 COAG

PT / PTT / INR. Prothrombin Time / Partial Thromboplastin Time / International Normalized Ratio. As stated.

2.4 BLOOD TYPE. Record if patient is DEA 1.1 positive or negative. Record full blood type if known.

2.5 VBG / ABG. Venous Blood Gas / Arterial Blood Gas. As stated.

2.6 URINALYSIS. As stated.

SpGr. Urine Specific Gravity. Canine USG should be measured on a refractometer, as urine test strips are not always accurate.

LEU. Leukocytes

PRO. Protein

GLU. Glucose

KET. Ketones

UBG. Urobilinogen

BIL. Bilirubin

HGB. Hemoglobin

2.7 OTHER LABS. Record any additional labs performed and appropriate results.

3.0 X-RAY AND CT

3.1 CT OBTAINED. As stated.

3.2 X-RAYS OBTAINED. As stated.

3.3 FOREIGN BODY. Check all that apply. Collect the foreign body and save for handler. Document in the medical record.

3.4 PENDING STUDIES. As stated.

3.5 RESULTS. As stated. Include TEG / Rotem (rotational thromboelastometry) results if performed. Refer to the CPG to evaluate canine TEG results.

4.0 IMPRESSION / ASSESSMENT

Enter impressions and findings.

4.1 SEVERITY (mark the most appropriate)

4.2. IMPRESSION/ASSESSMENT COMMENTS (fill in as appropriate)

5.0 DIAGNOSES

Enter diagnoses and findings, up to 12. If more than 12, record the most life-threatening findings.

6.0 PLAN

6.1 PLAN. Enter the treatment plan and any additional procedures that were or will be performed.

7.0 DNBI / NBI CATEGORY

Check all Disease Non Battle Injuries/Non Battle Injuries that apply. Describe any injury not otherwise specified.

8.0 CAUSE OF DEATH

If death, complete all appropriate 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. MOF. Multi Organ Failure

CNS. Central Nervous System Failure

8.3 DEATH INFORMATION.

Euthanized. Record medication(s) used, volume administered and route. Complete Canine Death Certificate (DD Form 1743).

Necropsy by DVM. Record necropsy date and time (local). Record time between death and start of necropsy if known. Estimate time if unknown.

Gross Pathology Report. Annotate if a gross necropsy was performed, and gross pathology report (DD Form 1626) was completed, and if samples were submitted to the Joint Pathology Center (JPC) or other pathology center. Record where the tissue samples were submitted and date of submission if known.

Death Remarks. Annotate any other information that may be pertinent to the patient's case.

CANINE TREATMENT AND RESUSCITATION RECORD COMPLETION AND SUBMISSION

- After the form has been completed, it should be reviewed by the responsible HCP listed in the Patient Identification block for completeness and detail. The responsible HCP should then sign each page.
- The signed form needs to be submitted to the DoD MWD Trauma Registry by clicking on one of the 'Submit by Email' buttons located on the bottom of each page. If the button does not work, then submit the form to dha.mwdtraumaregistry@health.mil. The subject line should include the MWD Name, Tattoo and Date, i.e. 'Canine Treatment and Resuscitation Record MWD Ayaks L332 16 August 2018'. For US Special Operations Command canines, the Canine Treatment and Resuscitation Record(s) will be filled out and returned to the handler or operator. The handler or operator will route the record(s) to their respective veterinarian to be inputted into the MWD Trauma Registry and the canine's record.

- A printed copy of each signed form **MUST** be included in the MWD's paper record to ensure continuity of care, especially if the dog will be transferred to another level of care.
- A completed copy of the record will be uploaded into the MWD's VSSM record when access is available. This should happen in theater if possible, but if VSSM access is not available, then all records need to be uploaded at the first Role III facility or at the MWD's home station veterinary clinic.
- To upload a form in VSSM:
 - Open the MWD's record, select Imported Files from the Patient Tools menu in the left-hand navigation pane.
 - Select the Upload File button in the upper left-hand corner of the screen. Find the appropriate file by selecting the browse button, then complete each field. Document date is the date listed on the Treatment and Resuscitation Record. Document Type should be 'Canine Treatment and Resuscitation Record, DD Form 3074'. Select Upload to finish.
 - Repeat as necessary for each completed record.