TC 8-800

MEDICAL EDUCATION AND DEMONSTRATION OF INDIVIDUAL COMPETENCE

SEPTEMBER 2014

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HEADQUARTERS
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MEDICAL EDUCATION AND DEMONSTRATION OF INDIVIDUAL COMPETENCE

CONTENTS

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TABLES

PREFACE

This training circular (TC) focuses on continuing education (CE) and validation of skills. It provides the commander guidelines for the Medical Education and Demonstration of Individual Competence. The goal of this endeavor is the knowledgeable precise administration of mission oriented critical tasks on which the tactical combat casualty care (TC3) of injured Soldiers depends. Medical skills and procedures are perishable. To ensure utmost proficiency and preparedness, Soldiers with military occupational specialty (MOS) 68W (Health Care Specialist), regardless of additional skill identifier (ASI), should demonstrate their medical skills at least ANNUALLY. This TC explains how commanders use the selected individual tasks and skill sheets addressed in this publication to develop, implement, and validate a training program to enhance and demonstrate the critical skills proficiency of these Soldier Medics. The tasks selected for training and testing address the three leading causes of preventable death on the battlefield: *hemorrhage, tension pneumothorax, and airway problems.* These are the critical life-saving skills indispensable at the point of wounding.

This publication discusses the Medical Operational Data System (MODS). It explains how commanders use the MODS' 68W module to record and track the training requirements of their Soldier Medics.

This publication includes guidance for commanders and trainers on the employment of individual training to support the unit's mission essential task list (METL) and collective training for Role 1 Army Health System units (unit-level medical care). It also supports the METL and patient treatment for medical units at Role 2 (treatment platoon of medical companies/troops) and Role 3 (medical treatment facility staffed and equipped to provide care to all categories of patients).

For MOS qualification, Soldier Medics must meet certain requirements. TC 8-800 explains these requirements and how the Training and Skills Validation Tables satisfy these requirements.

The skill sheets in this TC were prepared by United States (U.S.) Government employees. Although some are based, in part, on National Registry of Emergency Medical Technicians (NREMT) skill sheets, they represent the work product of U.S. Government employees and have not been produced or approved by NREMT. Reproduction is only allowed for nonprofit educational purposes in conjunction with this TC. Any other use may constitute a copyright infringement. Grateful acknowledgement is expressed to the NREMT for allowing the generous use of their material.

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This publication applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the United States Army Reserve unless otherwise stated.

The proponent of this publication is the U.S. Army Medical Department Center and School (AMEDDC&S). Send comments and recommendations on Department of the Army (DA) Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the Commander, AMEDDC&S, ATTN: MCCS-HCC-S, 3599 Winfield Scott Road Suite B0204, JBSA Fort Sam Houston, Texas 78234-4669. Electronic submission of DA Form 2028 is authorized.

The use of trade names in this TC is for clarity purposes only and does not constitute product endorsement by the Department of Defense.

Unless otherwise stated, whenever the masculine gender is used, both men and women are included.

Disposition of Forms: Disposition of forms used to train and test 68W skills is in accordance with Army Regulation (AR) 25-400-2 [The Army Records Information Management System (ARIMS)]. Please refer to the specific record number (see Reproducible Forms).

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Chapter 1
INTRODUCTION

1-1. General

a. The mission of the Army is to be organized, trained, and equipped primarily for prompt and sustained combat incident to operations on land. The mission of the Soldier Medic is to provide the medical treatment necessary to sustain the combat Soldier in support of the mission. Training Soldiers, leaders and units is the vital ingredient that ensures the readiness of the force to accomplish this mission. To be effective, training must provide Soldier Medics with opportunities to practice their skills in an operational environment. Conditions should be tough and realistic as well as physically and mentally challenging.

b. The skills of the Soldier Medic must be sustained because they are perishable. Many 68W duty positions do not allow opportunities for Soldier Medics to practice their skills on a routine basis. The Training and Skills Tables (table 1-1) include seven medical and trauma skills training tables and a skills validation test. These tables support the requirement for Skills Validation; scenarios based lanes testing comprised of select critical skills.

c. Training tables I through VII include individual tasks that are trained and used for treating patients in military operations. Documented training of Tables I through VII skills and the skills validation test provide the required credit for the biennial NREMT refresher course and CE hours to maintain NREMT certification. The training must be conducted by a qualified 68W noncommissioned officer (NCO), 18D (Special Forces Sergeant) or medical officer. A medical officer must authenticate or document the training before it can be entered for record in the MODS' 68W module. For the purpose of this TC, a medical officer is considered to be a physician, registered nurse, or physician assistant.

d. It must be understood that CE hours are based on completion of Training Tables I through VII, not simply having the Soldier Medic complete Skills Validation Testing in Table VIII. In other words, having the Soldier Medic simply "test out" on Table VIII is not authorized; *CE hours will not be awarded on that basis.*

1-2. MOS Qualification

For MOS qualification, the Soldier Medic must meet the requirements below. Failure to meet these requirements can result in adverse personnel actions, including reclassification.

a. Biennial Emergency Medical Technician (EMT) recertification by the NREMT in accordance with AR 40-68 (Clinical Quality Management).

b. Basic Life Support Healthcare Provider *certification* at healthcare provider level.

c. American Heart Association or Military Training Network, Basic Life Support Healthcare Provider certification.

Table 1-1. Training and Validation Test Tables

TRAINING TABLES	**Table I**	**Trauma**
	Table II	**Airway**
	Table III	**Intravenous Access and Medication Administration**
	Table IV	**Medical**
	Table V	**Triage and Evacuation**
	Table VI	**Force Health Protection**
	Table VII	**Obstetrics, Gynecology and Pediatrics**
SKILLS VALIDATION	**Table VIII**	**Skills Validation**

1-3. National Registry of Emergency Medical Technicians Recertification

The following are required for biennial NREMT recertification. These requirements are built into the training tables in chapter 2. In a two-year cycle, completing the training outlined, Soldier Medics will satisfy all necessary requirements to sustain their NREMT certification.

a. Basic Lifesaver certification at the healthcare provider level.

b. Twenty-four hours of CE equivalency refresher training.

c. Forty-eight hours of additional continuing education.

d. Verification of skills validation.

1-4. Key Skills

a. Combat casualty care is the primary mission of the Soldier Medic. These casualty care skill sets include —

- Casualty assessment.
- Hemorrhage control.
- Airway management.
- Prevention and treatment of shock.

b. The core skills of the Soldier Medic largely overlap the competencies of the EMT. However, the Soldier Medic is more uniquely skilled than an EMT. These advanced tactical combat casualty care core skills are related to advanced airway management, combat trauma management, medicine administration and advanced casualty movement. These advanced skills are comparable to those of an Advanced Emergency Medical Technician (AEMT) or Emergency Medical Technician - Paramedic (EMT-P) and must be sustained. The EMT skills are drawn from Department of Transportation and National Emergency Medical System standards. They are used by civilian state and federal agencies and our sister military services.

Chapter 2

TRAINING STRATEGY

2-1. Introduction

a. To be successful on the battlefield, commanders must know the capabilities of their weapons, support systems and Soldiers. Commanders should develop, document and implement a cyclic and progressive sustainment strategy. It must be able to maintain the critical perishable skills of all Soldiers, specifically the Soldier Medic. The Soldier Medic must maintain current certification as an EMT and as a Basic Life Support Healthcare Provider to remain 68W MOS qualified.

b. TC 8-800 augments the unit training of Soldier Medics. It provides seven training tables with associated training support packages (TSP). This training is the Army-recommended method for attainment of CEs. The TSPs have CE and refresher course credit that can be used for EMT recertification. The tasks in the training tables are —

(1) Trained to standard by a qualified 68W NCO or medical officer.

(2) Documented by a medical officer on the *appropriate form identified in tables 2-2 through 2-7*.

(3) Placed into the MODS' 68W module by qualified personnel.

Soldier Medics completing annual training per the TSPs will receive a maximum of 48 hours of CE for tables I through VII, with a total of 96 hours every two years. This meets the CE and biennial refresher course requirements for NREMT recertification. As previously stated, CE hours are awarded for completion of the training in Tables I through VII, not simply completing the testing in Table VIII. If a 68W NCO or medical officer is not assigned, the documentation is forwarded to the next higher medical authority for validation of training.

c. Proof of training will include: DA Form 7442 [Tracking Sheet – (Table VIII)] and a copy of training schedule. All training listed on the Soldiers' DA Form 7442 must have a corresponding training schedule or some other documentation stating subject taught and duration. Soldiers will need this documentation if audited by the NREMT. The NREMT randomly audits personnel each certification year.

d. For a commander's training strategy to be productive, the trainer must be effectively trained. A review of this TC provides a good start in training the trainer on the basics of the critical lifesaving skills proficiency required in Tables I through VII. If trainers are not trained to standard first, resources are wasted and Soldier deaths and injuries may occur.

e. Throughout the year, commanders and unit leaders use both scheduled and unscheduled time to accomplish collective and individual training. Unit leaders know what individual training is required for their Soldiers. They are in the best position to conduct training to meet those individual training requirements.

f. Unit leaders must also identify a baseline for their Soldier Medic's knowledge and skills proficiency. When unit leaders are trained to standard in the tasks in Training Tables I through VII, they can clearly identify the training shortcomings of their Soldier Medics. They can then rectify those shortcomings before proficiency testing or actual combat casualty care treatment. The ability for unit leaders to retrain or reinforce training is absolutely critical. Many of these skills are such that they may not be accomplished except in a combat environment. Retraining or reinforcement must be conducted as training shortcomings are identified.

g. The process of cyclic training begins with individual training; the trainer using the "crawl-walk-run" method of training to achieve proficiency. Table 2-1 shows the training cycle and its relationship to Training Tables I through VII and Table VIII Skills Validation. The "When" column depicts when the training may occur based on the unit's operational tempo, training cycle or ongoing operations. If individual tasks have been trained and Soldiers are proficient in their skills, the lanes portion can be integrated into ongoing operations at the treatment site. In this TC, individual tasks are combined collectively to treat various patient conditions as they would develop and change using realistic scenarios. The training objectives are to develop individual skills proficiency. This will enable the Soldier Medic to assess the patient's condition, apply task skill sets collectively and treat the critical elements associated with the patient's wound(s) and condition.

Soldier Medics must also understand “why and how” each task relates to the treatment process based on TC3 and acceptable medical practices.

Table 2-1. Training cycle

		When
Individual tasks	"Crawl"	Sergeant’s time Concurrent training Formal classes
Training Tables allow individual tasks to be performed collectively to treat casualty conditions to standard	"Walk"	Lanes training Concurrent training pre/post field training exercises
Skills Validation	"Run"	Skills validation

h. Tables 2-2 through 2-9 show training matrixes relating individual critical tasks with the training tables, suggested TSP and the CE credit given for each task. Each table/task can be trained separately. However, it is recommended the sequence be adhered to if trying to establish a knowledge baseline for Soldier Medics.

i. The reference materials used to conduct this training are —

- The TSPs that support each Training Table. The associated TSPs are available at the 68W website http://www.cs.amedd.army.mil/68w/
- Prehospital Trauma Life Support and Healthcare Provider Basic Life Support courses.
- Supplementary educational material from the EMT reference texts.

j. As trainers complete each training table, they ensure that CE hours are awarded through the MODS’ 68W module. This ensures proper documentation of training and prevention of accounting errors. This is absolutely crucial to maintaining EMT certification and MOS qualification. The MODS’ 68W module also allows commanders to determine the training and certification status of their Soldier Medics.

k. When Soldier Medics have completed a train-up of critical tasks in Training Tables I through VII and have performed skills to standard, commanders should conduct Table VIII, Skills Validation. All Soldier Medics in grades E7 and below must take and pass Skills Validation by demonstrating proficiency on each skill. The validating official will ensure that each Soldier Medic has completed all tasks and annotate the results on DA Form 7442. The MODS' 68W module will only be updated when Soldiers provide proof of training.

l. Commanders should use situational training exercises to train their Soldiers, combat lifesavers and Soldier Medics in Warrior Tasks/Battle Drills and medical, trauma and evacuation skills. The use of TC3 in tactics, techniques and procedures reinforces care under fire and tactical field care.

Note. The training support packages cited in tables 2-2 through 2-9 are on the Army EMS web page at http://www.cs.amedd.army.mil/ems.aspx. Under external links, click on TC8-800 Slides & Lesson Plans (AKO Accessed). After logging in on Army Knowledge Online (AKO), this link takes you to a page entitled “Medical Education and Demonstration of Individual Competence.” There you will find the tasks from Tables I through VII. The Lesson Plans column contains links to the TSP. The center column contains a link to the PowerPoint slides associated with the TSP.

Table 2-2. Medic Table I

Trauma			
Training Table	**Task Numbers**	**Individual Tasks**	**Training Support Packages**
Table I	081-833-0067	Perform a Combat Casualty Assessment (DA Form 7595-1-1)	C168W001 Combat Casualty Assessment (6)
	081-833-0053	Perform an Emergency Medical Technician Trauma Assessment (DA Form 7595-1-2)	Brady Emergency Care, 12th ed., ch 13 Assessment of the Trauma Patient (2)
	081-833-0028	Initiate Treatment for an Open Abdominal Injury (DA Form 7595-1-3)	C168W013 Abdominal Trauma (1)
CE:	081-833-0029	Initiate Treatment for an Impaled Object (DA Form 7595-1-4)	C168W010 Musculoskeletal Trauma (3)
24	081-833-0075	Perform a Needle Chest Decompression (DA Form 7595-1-5)	C168W014 Thoracic Trauma (4)
Hours	081-833-0030	Initiate Treatment for an Open Chest Injury (DA Form 7595-1-6)	C168W014 Thoracic Trauma (4)
	081-833-0069	Apply an Occlusive Dressing (DA Form 7595-1-7)	C168W014 Thoracic Trauma (4)
	081-833-0051	Initiate Treatment for Burns (DA Form 7595-1-8)	C168W005 Burns (2)
	081-833-0047	Initiate Treatment for Hypovolemic Shock (DA Form 7595-1-9)	C2601060 Advanced Management of Hemorrhagic Shock (3)
	081-833-0065	Apply a Combat Application Tourniquet® (DA Form 7595-1-10)	C2601058 Advanced Hemorrhage Control (1)
	081-833-0212	Apply a Pressure Dressing to an Open Wound (DA Form 7595-1-11)	C2601058 Advanced Hemorrhage Control (1)
	081-833-0124	Control Bleeding (DA Form 7595-1-12)	C2601058 Advanced Hemorrhage Control (1)
	081-833-0211	Apply a Hemostatic Dressing (DA Form 7595-1-13)	C2601058 Advanced Hemorrhage Control (1)
	081-833-0061	Initiate Treatment for an Amputation (DA Form 7595-1-14)	C2601058 Advanced Hemorrhage Control (2)
	081-833-0141	Apply a Traction Splint (DA Form 7595-1-15)	Brady Emergency Care, 12th ed., Trauma to the Head, Neck and Spine (4)
	081-833-0038	Initiate Treatment for a Head Injury (DA Form 7595-1-16)	Brady Emergency Care, 12th ed., Trauma to the Head, Neck and Spine (4)
	081-833-0039	Initiate Treatment for Foreign Bodies of the Eye (DA Form 7595-1-17)	C168W006 Ocular Trauma (2)
	081-833-0079	Initiate Treatment for Axillary Wounds (DA Form 7595-1-18)	C2601058 Advanced Hemorrhage Control (2)
	081-833-0081	Initiate Treatment for Inguinal Wounds (DA Form 7595-1-19)	C2601058 Advanced Hemorrhage Control (2)
	081-833-0091	Initiate Treatment for Neck Wounds (DA Form 7595-1-20)	C2601058 Advanced Hemorrhage Control (2)

NOTE: The number in parentheses following the TSP title reflects the number of CE hours available upon completion of requirements for that particular TSP. The CE hours in the first column reflect the maximum number of hours from Table I that may be applied toward EMT recertification.

Legend:

ch	chapter	EMT	emergency medical technician
CE	continuing education	TSP	training support package
ed	edition		

Table 2-3. Medic Table II

Airway			
Training Table	**Task Numbers**	**Individual Tasks**	**Training Support Packages**
Table II CE: 4 Hours	081-831-0019	Clear an Upper Airway Obstruction (DA Form 7595-2-1)	Brady Emergency Care, 12th ed., ch 8, Airway Management (1)
	081-833-0016	Insert an Oropharyngeal Airway (DA Form 7595-2-2)	Brady Emergency Care, 12th ed., ch 8, Airway Management (0.5)
	081-833-0017	Ventilate a Patient with a Bag-Valve-Mask (BVM) (DA Form 7595-2-3)	Brady Emergency Care, 12th ed, ch 8, Airway Management (1)
	081-831-0164	Measure a Patient's Pulse Oxygen Saturation (DA Form 7595-2-4)	Brady Emergency Care, 12th ed., ch 8, Airway Management (.05)
	081-833-0098	Set Up an Oxygen Tank (DA Form 7595-2-5)	C2601064 Advanced Airway (.05)
	081-833-0099	Perform Oral Suctioning (DA Form 7595-2-6)	Brady Emergency Care, 12th ed., ch 8, Airway Management (1)
	081-833-0142	Insert a Nasopharyngeal Airway (DA Form 7595-2-7)	Brady Emergency Care, 12th ed., ch 8, Airway Management (.05)
	081-833-0158	Administer Oxygen (DA Form 7595-2-)	C2601064 Advanced Airway (0.5)
	081-833-0230	Insert a King LT® (DA Form 7595-2-)	C2601064 Advanced Airway (1)
	081-833-3005	Perform a Surgical Cricothyroidotomy (DA Form 7595-2-8)	C2601064 Advanced Airway (2)
	081-831-0010	Measure a Patient's Respirations (DA Form 7595-2-9)	Brady Emergency Care, 12th ed., ch 12, Vital Signs and Monitoring Devices (0.5)
NOTE: The number in parentheses following the TSP title reflects the number of CE hours available upon completion of requirements for that particular TSP. The CE hours in the first column reflect the maximum number of hours from Table II that may be applied toward EMT recertification.			
Legend: ch chapter CE continuing education ed edition EMT emergency medical technician TSP training support package			

Table 2-4. Medic Table III

Intravenous Access and Medication Administration			
Training Table	**Task Numbers**	**Individual Tasks**	**Training Support Packages**
Table III CE: 4 Hours	081-833-0033	Initiate an Intravenous Infusion DA Form 7595-3-1)	C168W055 Vascular Access (2)
	081-833-0034	Manage an Intravenous Infusion DA Form 7595-3-2)	C168W055 Vascular Access (1)
	081-833-0185	Initiate an Intraosseous Infusion (FAST1®) DA Form 7595-3-3)	C168W055 Vascular Access (2)
	081-835-3025	Initiate a Saline Lock DA Form 7595-3-4)	C168W055 Vascular Access (1)
	081-833-0088	Prepare an Injection for Administration DA Form 7595-3-5)	C168W243 Injections (1)
	081-833-0301	Administer an Intramuscular Injection DA Form 7595-3-6)	C168W243 Injections (1)
	081-833-0302	Administer a Subcutaneous Injection DA Form 7595-3-7)	C168W243 Injections (1)
NOTE: The number in parentheses following the TSP title reflects the number of CE hours available upon completion of requirements for that particular TSP. The CE hours in the first column reflect the maximum number of hours from Table III that may be applied toward EMT recertification.			
Legend: **CE continuing education** **EMT emergency medical technician** **TSP training support package**			

Table 2-5. Medic Table IV

Medical			
Training Table	**Task Numbers**	**Individual Tasks**	**Training Support Packages**
Table IV CE: 8 Hours	081-833-0005	Initiate Treatment for a Diabetic Emergency (DA Form 7595-4-1)	Brady Emergency Care, 12th ed., ch 21, Diabetic Emergencies and Altered Mental Status (2)
	081-831-0011	Measure a Patient's Pulse (DA Form 7595-4-2)	Brady Emergency Care, 12th ed., ch 12, Vital Signs and Monitoring Devices (1)
	081-833-0002	Manage a Seizing Patient (DA Form 7595-4-3)	Brady Emergency Care, 12th ed. Ch 21, Diabetic Emergencies and Altered Mental Status (2)
	081-833-0003	Initiate Treatment for Anaphylactic Shock (DA Form 7595-4-4)	Brady Emergency Care, 12th ed., ch 33, Environmental Emergencies (2)
	081-833-0193	Perform Visual Acuity Testing (DA Form 7595-4-5)	C168W206 EENT Primary Care, (3)
	081-833-0145	Document Medical Care: SOAP Note Format (DA Form 7595-4-6)	C168W053 Sick Call and Medical Documentation (2)
	081-833-0156	Perform a Medical Patient Assessment (DA Form 7595-4-7)	Brady Emergency Care, 12th ed., ch 14, Assessment of the Medical Patient (3)
	081-833-0014	Operate an Automated External Defibrillator (DA Form 7595-4-8)	Brady Emergency Care, 12th ed., ch 20, Cardiac Emergencies (2)
	081-833-0011	Initiate Treatment for Chest Pain (DA Form 7595-4-9)	Brady Emergency Care, 12th ed., ch 20, Cardiac Emergencies (2)
	081-833-0268	Perform an Examination of the Knee (DA Form 7595-4-10)	C2601051 Advanced Management of Lower Extremity Disorders(3)
	081-833-0269	Perform an Examination of the Shoulder (DA Form 7595-4-11)	C2601049 Advanced Management of Upper Extremity Disorders (3)
	081-833-0273	Perform an Examination of the Wrist (DA Form 7595-4-12)	C2601049 Advanced Management of Upper Extremity Disorders (3)
	081-833-0271	Perform an Examination of the Back (DA Form 7595-4-13)	C2601050 Advanced Management of Back Disorders (2)
	081-833-0272	Perform an Examination of the Ankle (DA Form 7595-4-14)	C2601051 Advanced Management of Lower Extremity Disorders (3)
	081-833-0254	Perform an HEENT Examination (DA Form 7595-4-15)	C168W206 EENT Primary Care (2)
	081-833-0270	Perform an Examination of the Elbow (DA Form 7595-4-16)	C2601049 Advanced Management of Upper Extremity Disorders (3)

NOTE: The number in parentheses following the TSP title reflects the number of CE hours available upon completion of requirements for that particular TSP. The CE hours in the first column reflect the maximum number of hours from Table IV that may be applied toward EMT recertification.

Legend:

ch	chapter	EENT	eyes, ears, nose and throat
CE	continuing education	HEENT	eyes, ears, nose and throat
ed	edition	SOAP	subjective, objective assessment plan
EMT	emergency medical technician	TSP	training support package

Table 2-6. Medic Table V

Triage and Evacuation			
Training Table	**Task Numbers**	**Individual Tasks**	**Training Support Packages**
Table V CE: 4 Hours	081-833-0001	Initiate a Tactical Combat Casualty Care Card (DA Form 7595-5-2)	C168W035 Battlefield Documentation and Communication (3)
	081-833-0281	Triage Casualties (DA Form 7595-5-3)	C2601056 Advanced Mass Casualty Movement (2)
	081-833-0283	Initiate a 9-Line MEDEVAC Request (DA Form 7595-5-4)	C168W035 Battlefield Documentation and Communication (3)
	081-833-0282	Perform Manual Evacuation (DA Form 7595-5-5)	C2601070 Advanced Tactical Casualty Movement (3)
	081-833-0298	Transport a Casualty Using a Litter (DA Form 7595-5-6)	C2601070 Advanced Tactical Casualty Movement (3)
	081-833-0299	Prepare a SKEDCO® for Hoist Operations (DA Form 7595-5-7)	FM 4-02.2 (Medical Evacuation) (2)
	081-833-0181	Apply a Long Spine Board (DA Form 7595-5-8)	C2601070 Advanced Tactical Casualty Movement (3)
NOTE: The number in parentheses following the TSP title reflects the number of CE hours available upon completion of requirements for that particular TSP. The CE hours in the first column reflect the maximum number of hours from Table V that may be applied toward EMT recertification.			
Legend: CE continuing education EMT emergency medical technician		FM field manual MEDEVAC medical evacuation TSP training support package	

Table 2-7. Medic Table VI

Force Health Protection			
Training Table	**Task Numbers**	**Individual Tasks**	**Training Support Packages**
Table VI CE: 4 Hours	081-831-9018	Implement Suicide Prevention Measures (DA Form 7595-6-1)	C168W071 Suicide Prevention (2)
	081-833-0035	Initiate Treatment for Altitude Illness (DA Form 7595-6-2)	C2601069 Advanced Management of Altitude Disorders (1)
	081-831-0038	Treat a Casualty for a Heat Injury (DA Form 7595-6-3)	C168W245 Environmental Threats (3)
	081-831-0039	Treat a Casualty for a Cold Injury (DA Form 7595-6-4)	C168W245 Environmental Threats (3)
	081-833-0072	Treat a Casualty for Insect Bites and Stings (DA Form 7595-6-5)	C168W245 Environmental Threats (3)
	081-833-0073	Treat a Casualty for a Snake Bite (DA Form 7595-6-6)	C168W245 Environmental Threats (3)
NOTE: The number in parentheses following the TSP title reflects the number of CE hours available upon completion of requirements for that particular TSP. The CE hours in the first column reflect the maximum number of hours from Table VI that may be applied toward EMT recertification.			
Legend: CE continuing education EMT emergency medical technician		TSP training support package	

Table 2-8. Medic Table VII

Obstetrics, Gynecology and Pediatrics			
Training Table	**Task Numbers**	**Individual Tasks**	**Training Support Packages**
Table VII	081-833-0116	Assist in Vaginal Delivery	Brady Emergency Care, 12th ed., ch 34 Obstetrics and Gynecologic Emergencies (3)
	081-833-0156	Perform a Medical Patient Assessment	Brady Emergency Care, 12th ed., ch 35 Pediatric Emergencies (4)
CE: 2 Hours			
NOTE: The number in parentheses following the TSP title reflects the number of CE hours available upon completion of requirements for that particular TSP. The CE hours in the first column reflect the maximum number of hours from Table VII that may be applied toward EMT recertification.			
Legend: ch chapter; CE continuing education; ed edition		EMT emergency medical technician; TSP training support package	

Table 2-9. Medic Table VIII

Training Table	Task Numbers	Individual Tasks	Training Support Packages
Table VIII Skills Validation	All except Table VII	Tables I-VI	Appendix A contains scenarios and checklists to complete Table VIII.

2-2. Validation of Training

a. All Soldier Medics are required to obtain and maintain —

(1) National Registry of Emergency Medical Technicians – EMT certification.

(2) Basic Life Support certification at healthcare provider level.

b. The NREMT requires the following for Soldier Medics to maintain a two-year EMT certification:

(1) Forty-eight hours of CE.

(2) Twenty-four hours of EMT refresher training.

(3) Basic Life Support certification at healthcare provider level.

(4) Verification of skills proficiency.

c. Validation of skills proficiency using Table VIII will satisfy the direct observation of skills requirement.

d. Training Tables I through VII also have associated CEs. Training support packages support each training table. They provide the CE hours the Soldier Medic can attain when the trainer validates that the TSP has been instructed to standard and properly documented. Training must be conducted by a 68W NCO or medical officer. Training must be —

(1) Performed didactically and hands-on.

(2) Documented on the unit's training schedule.

(3) Validated by the commander, medical officer, or senior NCO designated by the commander.

e. Report through the MODS' 68W module, each individual's training specifics regarding:

(1) Subject course, training and/or TSP and associated hours.

(2) Lanes training, with associated training hours; included would be collective training in live fire exercises or field training exercises.

(3) Skills Validation and date the Soldier Medic successfully passed all tasks associated with the patient condition in Table VIII.

Note. Trainers earn CE hours for the time spent training Soldiers/Soldier Medics in medical subjects that are documented and validated by a medical officer. This includes Warrior Tasks/Battle Drills and the combat lifesaver course; as well as subjects instructed in support of TC 8-800.

2-3. Medical Operational Data System

a. The MODS' 68W module training database tracks the skill readiness of 68W Soldiers. The MODS' 68W module allows commanders to track the MOS qualification and CE status of their Soldiers.

b. Commanders and their designated representatives can obtain the information above on Soldier Medics to assess their training status. This information can be tracked at the company level through major Army command levels.

c. Commanders and their representatives can obtain information on the MODS' 68W module website at: http://www.mods.army.mil. The MODS' 68W module interfaces with data in numerous Army and Department of Defense databases and presents it in a concise package. Among others, the MODS' 68W module is linked to:

(1) The Total Army Personnel Database (Active, Reserve, & National Guard).

(2) The Enlisted Master File.

(3) The Personnel Manning Authorization Document.

(4) The Army Authorization Documenting System.

(5) The Army Training Requirements and Resources System.

(6) The National Registry of Emergency Medical Technicians.

Note. Commanders can also email their questions or comments regarding the MODS' 68W module to: usarmy.jbsa.medcom-ameddcs.mbx.army-ems@mail.mil

Note. The U.S. Army Emergency Medical Service Director has authorized the unit training NCO, training director and training officer to sign the recertification form as the verifying signature for Basic Life Support certification. The recertification form can be downloaded from the NREMT website: http://www.nremt.org

Chapter 3

SKILLS VALIDATION TESTING

3-1. Introduction

a. Skills validation testing ensures that Soldier Medics maintain critical skills proficiency. It supports the unit's mission training objective because the selected individual tasks support the collective tasks that are necessary to support the combat casualty care mission. Soldier Medics also remain MOS qualified by retaining their EMT certification and their annual skills validation in assuring the commander's training program is on track.

b. The key to skills validation is the Soldier Medic's demonstrated ability to perform hands-on life-saving tasks to standard. In administering the skills validation, this essential concept must not be lost or obscured by enthusiasm for simulators and high-tech simulations. The use of simulations and realistic scenarios to add variety, realism and interest is authorized. However, simulation must not detract from training and testing. It is ultimately the Soldier Medic's performance of these medical skills to prescribed standard that must be tested and validated.

c. Medical Simulation Training Centers have the capability to host units for Table VIII testing in a combat-simulated environment.

3-2. Skills Validation

a. Objective. The objective is to validate the Soldier Medic's ability to apply 68W skills in scenarios consistent with casualties in a prehospital environment.

b. Requirements.

(1) The Soldier Medic must demonstrate proficiency on Table VIII scenarios.

> **Note.** Employ safety and environmental protection procedures in accordance with AR 385-10 (The Army Safety Program), AR 200-1(Environmental Protection and Enhancement) and applicable tactical standard operating procedures. Risk management process must be used in accordance with Army Techniques Publication (ATP) 5-19 (Risk Management).

(2) The Soldier Medic is placed in multiple testing lanes using a scenario specifically for that lane. Authorized testing scenarios are included in appendix A and are to be used for testing. At a minimum, the Soldier Medic will –

(a) Assess, treat and stabilize two trauma casualties.

(b) Perform appropriate life-saving measures on two medical casualties.

(c) Triage and evacuate the casualties.

(d) Treatment of casualties in Skills Validation will include all subtasks in the scenario. For example, if the scenario requires the Soldier Medic to initiate intravenous (IV) fluids, the Soldier Medic will start IV fluids on his casualty. Verbalization is not allowed during Table VIII testing.

(3) The Soldier Medic will use a medical aid bag stocked with unit-specific basic load or whichever system the unit uses for field casualty management. A recommended minimum packing list is in appendix B.

(4) Retesting of a failed skill station or skill sheet will be accomplished after immediate retraining or a more formalized training session. Either approach is based on available resources and the Soldier Medic's performance.

> **Note.** Soldier Medics being evaluated will not be used as casualties.

3-3. Coordinator Instructions

a. Any 68W above the rank of sergeant may serve as an evaluator. To ensure that the skills validation goes smoothly, evaluators should rehearse their roles and responsibilities during the rehearsal/evaluation process. To ensure consistent performance, the coordinator should give procedural instructions prior to the start of testing. The coordinator may find the planning matrix in table 3-1and the utilization of DA Form 7441 (Coordinator's Checklist) helpful in skills validation planning, execution and recovery.

b. The coordinator is ultimately responsible for collecting DA Forms 7442, skills validation sheets and training schedules. The coordinator should file the originals for two years and give copies to each Soldier for their records.

Table 3-1. Planning Matrix

Prepare For Validation Testing	Conduct Validation Testing	Recover From Validation Testing
Select tasks Plan training Train trainers Recon site Identify training equipment Conduct risk assessment Issue training/operations plan Retrain at first opportunity Rehearse Conduct pre-execution checks	Conduct precombat checks Supervise Evaluate hazard controls Implement hazard controls Execute training Conduct after action review	Conduct after operations maintenance checks and services Account for equipment Turn in support items Close out training sites Conduct after action reviews Conduct individual Soldier recovery Conduct final inspections Conduct risk management assessment and review

3-4. Evaluator Instructions

a. It is essential that once a lane is established for skills validation, it be used for all Soldier Medics being testing. This ensures consistency of the evaluation.

b. The test is comprised of scenarios that require some dialogue between the evaluator and Soldier Medic. The evaluator should not coach the Soldier Medic, except to start or stop an evaluation. All procedures, interventions and assessments must be performed on a simulator or another Soldier. There is no verbalization in skills validation. For example, a Soldier Medic takes a real blood pressure and pulse and reports the values to the evaluator. This validates the Soldier Medic's ability to take a blood pressure and pulse. The evaluator can then provide the vital signs to be used in treating the casualty, such as, "a blood pressure of 100/40, and pulse of 120 and thready." Another example is for needle chest decompression. This procedure requires a simulator that will accept needle chest decompression. Unless a safety issue is involved, the evaluator should not react, either positively or negatively, to anything the Soldier Medic says or does in the treatment process.

c. The Soldier Medic is required to accomplish all assessment steps listed on the graded scenario skill sheet. Because of moulage limitations, the evaluator must establish a dialogue and provide feedback to the Soldier Medic. If a Soldier Medic quickly inspects, assesses, or palpates the casualty in a manner that lends uncertainty to the areas or functions being assessed, immediately ask the Soldier Medic to explain those actions. For example, if the Soldier Medic stares at the casualty's face, the evaluator should ask "what is being assessed?" The evaluator will supply information pertaining to sight, sound, touch, smell and injury that cannot be realistically moulaged, but would be immediately evident in a real casualty encounter. This information will be supplied as soon as the Soldier Medic exposes or assesses that area of the casualty.

d. All skills validation stations require a live simulated casualty or a mannequin. The evaluator will brief the live simulated casualty as to how to respond to treatment as the Soldier Medic conducts the assessment.

e. Trauma moulage should be used as appropriate. Avoid excessive or overly dramatic use of moulage; it must not interfere with the Soldier Medic's ability to expose the victim for assessment.

f. Vital signs are obtained after the scene assessment and initial assessment are completed and critical life-saving interventions, such as hemorrhage, airway, breathing, circulation have been performed. As previously stated, the scenario format for trauma assessment and airway skill stations require the evaluator to provide the Soldier Medic with essential information pertaining to sight, sound, smell, or touch throughout the evaluation process.

g. The Soldier Medic may direct an assistant to obtain casualty vital signs. The evaluator must provide the Soldier Medic with the casualty's pulse rate, respiratory rate and blood pressure when asked. This allows the Solder Medic to confirm, if necessary, the vital signs provided and ensure that they are consistent. For example, if a Soldier Medic provides correct treatment for hypoperfusion, do not offer inconsistent vital signs that deteriorate the casualty's condition; this may cause the Soldier Medic to assume that inadequate or inappropriate care was rendered. Likewise, if a Soldier Medic provides inappropriate treatment for hypoperfusion, do not offer vital signs that improve the casualty's condition; this may cause the Soldier Medic to assume that adequate care was provided . The evaluator should not offer information that overly improves or deteriorates a casualty. Significant changes may invite the Soldier Medic to discontinue treatment or to initiate cardiopulmonary resuscitation (CPR), resulting in a failure for that skill station.

h. Each Soldier Medic is required to complete a secondary assessment or a detailed physical examination of the casualty. The evaluator should be aware that the Soldier Medic may accomplish portions of the secondary assessment during the initial assessment. For example, the Soldier Medic must inspect the neck prior to placing a cervical collar. The Soldier Medic will receive a failure for the task if he fails to assess a body area prior to covering the area with a casualty care device. However, the Soldier Medic will receive a pass for the task if they–

(1) Unfasten the device while maintaining inline cervical stabilization.

(2) Assess the area.

(3) Replace the device without compromising casualty care.

i. If two evaluators are not available, the preferred method of evaluating a Soldier Medic is to record the exact sequence followed while performing the task. You may then use this documentation to complete the skill validation after the Soldier Medic completes the station. This documentation validates the sequence on the scenario if questions arise later. Be sure to keep DA Form 7442 current.

3-5. Skill Sheet Instructions

The evaluation process consists of at least one evaluator at each station observing the Soldier Medic's performance and recording it on a skill sheet. The evaluator's role is that of an observer and recorder of events. Skill sheets have been developed for each of the stations. Instructions are provided within each skill sheet. Table VIII skills validation testing will be conducted using only the 25 provided scenarios (15 trauma and 10 medical) found in appendix A. These scenarios focus on the process of identifying and treating critical life threats at the 68W10 level. Units will conduct medical training in addition to EMT recertification/68W10 level to be proficient with local scope and protocols. This training should be documented and utilized as additional education units for recertification and competency.

3-6. Soldier Medic Orientation

An important aspect of the skills validation is the initial briefing and orientation of Soldier Medics. Assemble the Soldier Medics and instruct them in the skills validation procedures that are delineated in the orientation script. A recommended orientation script is provided below. Give the Soldier Medics clear and concise directions as to what is expected of them during the skills validation. Make a special effort to put the Soldier Medics being evaluated at ease. Solicit questions regarding the skills validation scenarios and answer them. Instruct the Soldier Medics being evaluated not to discuss the skills validation with those waiting to be tested.

a. Orientation script. A standardized orientation script should be read aloud before each skills validation testing. The skills validation coordinator normally reads the script. The following sample script contains the necessary and appropriate information:

“Welcome to Table VIII Skills Validation Testing. I am [name and title]. By successfully completing two medical and two trauma scenarios, you will have validated the skills required of a 68W Health Care Specialist.”

“The evaluator will call you to the lane when ready for testing. You are not permitted to remain in the lane area while waiting for the next lane. You must wait outside the testing area until the lane is open and you are called.”

“Books, pamphlets, brochures and other study material are prohibited in the testing area. You are not permitted to make copies or recordings of any testing lane.”

“Each lane evaluator will read aloud the "Instructions to the Soldier Medic" exactly as printed on the scenario skill sheet. This information will be read aloud to each Soldier Medic being evaluated in the same manner to ensure consistency and fairness. Pay close attention to the instructions. You will be provided information pertaining to the scenario and given instructions for actions to take on that specific lane.”

“The evaluator will offer to repeat the instructions and ask if you understand them. Do not ask for additional information as the evaluator is not permitted to provide any additional information.”

“Evaluators will avoid casual conversation with you to assure fair and equal treatment of all Soldier Medics being evaluated.”

“Evaluators will remain neutral so as not to indicate to you a judgment regarding your performance on any lane. Do not interpret any of the evaluator's remarks as an indication of your overall performance. Demonstrate your skills to the best of your ability.”

“As you progress through skills validation, the evaluators will observe and record your performance in relation to the criteria listed on the scenario skill sheets. Do not let their documentation practices influence your performance. There is no correlation between the volume of documentation and the quality of your performance.”

“You are encouraged to explain the things you do during your performance on the lanes.”

“The evaluator will inform you if a scenario has a time limit during reading of the instructions. Inform the evaluator when you are finished. You may be asked to remove equipment from the casualty before leaving the testing lane.”

“Each lane is supplied with equipment for your selection. You will be given time at the beginning of lane testing to survey and select the equipment necessary for the appropriate management of the casualty. Do not feel obligated to use all the equipment.”

“You are not permitted to discuss details of any skill station with fellow Soldier Medics at any time. Please be courteous to the Soldier Medics being evaluated by keeping noise to a minimum. Be prompt in reporting to each test station.”

“Skills validation results are reported as either pass or failure. You will receive a detailed critique of your performance.”

“Please remember that today's evaluation is a skills validation test. The purpose of skills validation is to validate your competency in the critical skills necessary to the 68W Health Care Specialist.”

"Are there any questions at this time?”

b. Minimum instructions. The following are the minimum instructions to be given:

(1) Follow the staff’s instructions.

(2) Move only to areas directed by the staff.

(3) Give your name when you arrive at each station.

(4) Listen carefully as the evaluator reads the testing scenario.

(5) Ask questions if the instructions are not clear.

(6) Do not talk about skills validation with anyone other than the skill station evaluator, simulated casualty and, if applicable, Soldier Medic assistant.

(7) Equipment will be provided. Select and use only that which is necessary to care for your casualty adequately.

3-7. Simulated Casualty's Role

The simulated casualty is responsible for an accurate and consistent portrayal as the casualty in the station scenario. The evaluator will brief the casualties on their particular roles. The casualty's comments concerning the Soldier Medic's performance should be noted on the reverse side of the scenario sheet. These comments should be as brief and objective as possible so that they can be used in the final scoring of the Soldier Medic's performance.

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APPENDIX A

TABLE VIII SCENARIOS

The following validated scenarios are provided for Table VIII Skills Validation. The Table VIII coordinator will select 2 medical and 2 trauma scenarios from the 25 scenarios provided for the entire skills validation day. The evaluators will utilize BOTH the scenario and the appropriate grade sheet, DA Form 7741 (Medical Scenario Grade Sheet) or DA Form 7742 (Trauma Scenario Grade Sheet), when evaluating Table VIII candidates.

A-1. Trauma Scenario Number 1, Left Lower Leg Amputation

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and individual first aid kit (IFAK). A Warrior Aid and Litter Kit (WALK)™ is available in a vehicle nearby.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request evacuation within 30 minutes overall.	
Scenario History: Your mounted high-mobility, multipurpose wheeled vehicle (HMMWV) patrol is struck by an improvised explosive device (IED) ambush. The platoon leader's vehicle directly in front of yours was hit and is on fire. One of the occupants of the vehicle is lying on the ground. The platoon sergeant directs you to care for casualties while he takes over the platoon.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty unable and uncooperative.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	Left below knee amputation with significant bleeding.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	HASTY tourniquet required.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take body substance isolation (BSI) precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Responsive. Casualty is moaning in pain and uncooperative. Casualty begins to go in and out of consciousness.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	No other bleeding found.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1) Nasopharyngeal airway (NPA). (2)Surgical cricothyroidotomy.	NPA indicated.
c. Position casualty to maintain an open airway.	Supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment if injuries are present.	No chest wall injuries.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)Needle chest decompression (NCD).	No penetrating chest wall injuries.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal bilateral.
d. Inspect and palpate for deformity, contusions, abrasions, punctures/penetrating (DCAP) burns, lacerations, swelling (BLS) and tenderness, instability, crepitus (TIC) in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression. (Identify second intercostal space (ICS) midclavicular line (MCL). Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	No distress/NCD not required.
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine.
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during CUF.	No injury or treatment.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	Must convert hasty tourniquet now.
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	If applied correctly, bleeding is controlled, Unable to check distal pulse due to amputation.
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	If applied incorrectly must complete this step.
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	None indicated.
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulses present.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	Saline lock indicated.
(3) Significant injuries, absent radial pulses, and altered mental status equal direct intravenous (IV) cannulation and fluid resuscitation.	
(4) Intraosseous (IO) placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	IO access not indicated at this time.
(5) Initiate 500 milliliters (ml) Hextend® wide open. Continue Combat Casualty Assessment.	Not indicated.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	No injury or treatment.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3 A1, Line 4 A, Line 5 L1
9. Reassess interventions.	Tourniquet, NPA, saline lock.

10.Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies. Pain medication not indicated at this time due to altered mental status (AMS).
Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for pupil's equal, round, reactive to light (PERRL).	No injury or treatment.
c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	Loss of consciousness (LOC) changed to unresponsive.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins. e. Manage any injuries appropriately.	No injury or treatment.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla. b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	No injury or treatment.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and tenderness, rigidity, distention (TRD). b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	Left lower leg amputation.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Pulses absent.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	Tourniquets required.
f. Manage any injuries appropriately.	Stump and open wound dressed/splinted.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Pulses absent.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	No injury or treatment.
f. Manage any injuries appropriately.	500 ml Hextend® required. Convert saline lock to IV

7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.
Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	
3. Elicit allergies, medications, past history, last oral intake, events leading up to illness or injury (AMPLE) history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until medical evacuation (MEDEVAC) arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Responsive if 500 ml Hextend® given. Blood pressure - 80/P if 500 ml Hextend® given. Respirations - 24 Regular. Pulse - 124. Skin temperature cool, pale, clammy	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - IED on mounted patrol.

A-2. Trauma Scenario Number 2, Burns to Head, Neck, and Arms

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is in a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request evacuation within 30 minutes overall.	
Scenario History: Your mounted HMMWV patrol is struck by an IED ambush. The platoon leader's vehicle directly in front of yours was hit and is on fire. One of the occupants of the vehicle is lying on the ground. The platoon sergeant directs you to care for casualties while he takes over the platoon.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty unable.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	None.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	No hasty tourniquet required. Drags casualty to cover
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Unresponsive. Carotid pulse present.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	No bleeding found.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Burns to face, oral burns, carbonaceous sputum, stridor present.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	Cricothyroidotomy indicated.
c. Position casualty to maintain an open airway.	Supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment if injuries are present.	Burns to anterior chest.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	No chest wall injuries.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal bilateral, if cricothyroidotomy completed. (Absent if no cricothyroidotomy completed.)
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC.
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression. (Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	No distress/NCD not required.
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine.
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during CUF.	No injury or treatment.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	No injury or treatment.
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulses present.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	Saline lock equals lactated ringer's required per BURN protocols (27% total body surface area) Weight approximately 175 pounds. Drops per minute depend on drip set used.
(3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	Required after two failed saline lock attempts
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	Not indicated.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	No injury or treatment.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3 - B1, Line 4 - D, Line 5 - L1.
9. Reassess interventions.	Cricothyroidotomy, IV.

10.Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies. Pain medication NOT indicated due to mental status.
Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL.	Burns to face, head, oral burns, carbonaceous sputum
c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	Dry sterile gauze.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC.	Burns to neck.
c. Check position of trachea. d. Check jugular veins.	No injury or treatment.
e. Manage any injuries appropriately.	Cricothyroidotomy in place.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	No injury or treatment.
b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	No injury or treatment.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Pulse, motor, sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Pulse, motor, sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	No injury or treatment.
f. Manage any injuries appropriately.	Dry sterile gauze.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.

Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	H - ABC
3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher echelon surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Responsive. Blood pressure - 80/P No blood pressure if cricothyroidotomy is not performed. Respirations - 20 if cricothyroidotomy complete Pulse - 120. No palpable pulse if cricothyroidotomy is not performed. Skin temperature cool, pale, clammy	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - IED on mounted patrol.

A-3. Trauma Scenario Number 3, Maxillofacial Injury

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is available in a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request evacuation within 30 minutes overall.	
Scenario History: Your mounted HMMWV patrol is struck by an IED ambush. The platoon leader's vehicle directly in front of yours was hit and is on fire. One of the occupants of the vehicle is lying on the ground. The platoon sergeant directs you to care for casualties while he takes over the platoon.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Unable.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	No visible blood on extremities.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	No hasty tourniquets required. Drag casualty to cover.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Unconscious, carotid pulse present.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	Blood found on casualty's face. Bleeding is minimal and should not be treated at this time. No deliberate tourniquets required.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Gurgling. Mouth full of blood and mucus.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	Cricothyroidotomy indicated.
c. Position casualty to maintain an open airway.	Supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment if injuries are present.	No chest wall injuries.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	No penetrating chest wall injuries.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal bilateral, if cricothyroidotomy completed; absent if not.
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC.
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression. (Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	No respiratory distress. No distress/NCD not required.
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine.
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during Care Under Fire.	Non-life threatening bleeding on face. May apply dressing/Combat gauze to face or wait till secondary examination to treat.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	No injury or treatment.
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulse present. Saline Lock indicated.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	
(3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	No injury or treatment.
(4) IO placed after second saline lock/IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	No fluid resuscitation indicated.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	No injury or treatment.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3. A1, Line 4. A, Line 5. L1.
9. Reassess interventions.	Cricothyroidotomy, saline lock.
10. Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies.

Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL.	Facial injury, may apply dressing if not completed yet.
c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	Dressing/Combat gauze to face.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins.	No injury or treatment.
e. Manage any injuries appropriately.	Cricothyroidotomy in place.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	No injury or treatment.
b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	Lung sounds available IF cricothyroidotomy completed.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Pulse, motor sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	No injury or treatment.
f. Manage any injuries appropriately.	
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Pulse, motor sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	No injury or treatment.
f. Manage any injuries appropriately.	
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.
Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket, and straps.
2. Reassess casualty.	H - ABC

3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Unconscious. Blood pressure - 80/P. No blood pressure if cricothyroidotomy is not performed. Respirations - 24 Rapid and shallow. Pulse - 100 Weak. No palpable pulse if cricothyroidotomy is not performed. Skin temperature cool, pale, clammy	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - Unconscious, unable to provide.

A-4. Trauma Scenario Number 4, Spinal Injury

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is available in a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request evacuation within 30 minutes overall.	
Scenario History: You are the medic assigned to your commander's personal security detail on a dismounted patrol. Shortly after making a turn down a side street that has not been cleared by Route Clearance; an IED that was placed under a pile of trash explodes 10 meters in front of the point man. The point man is thrown 10 meters and strikes a barrier cracking his rear interceptor body armor (IBA) plate. There is small arms fire from multiple directions.	
Care Under Fire Phase (CUF)	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty unable and uncooperative.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	None indicated.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	No tourniquet required. Drag casualty to safety.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Responsive to verbal. Casualty is unable to move lower extremities.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	No other bleeding found.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	NPA indicated.
c. Position casualty to maintain an open airway.	Supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment if injuries are present.	No chest wall injuries.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	No penetrating chest wall injuries.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal bilateral.
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC.
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression. (Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	No distress/NCD not required.
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine.
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during CUF.	No major bleeding found.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	No injury or treatment.
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	No injury or treatment.
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Absent radial pulses.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	Direct IV cannulation.
(3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	Required after two failed attempts.
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	500 ml Hextend® wide open.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	No injury or treatment.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3. A1, Line 4. A, Line 5. L1
9. Reassess interventions.	Tourniquets, NPA, IV.
10. Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies, pain medication NOT indicated at this time.

Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL.	Minimal bleeding and edema.
c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	Responsive to verbal stimuli.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins. e. Manage any injuries appropriately.	No injury or treatment.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla. b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	No injury or treatment.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC.	Casualty has no feeling in abdomen.
c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	Priapism present.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	Casualty has no feeling in his lower extremities.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Pulses weak.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	None indicated.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Pulses weak.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	No injury or treatment.
f. Manage any injuries appropriately.	None indicated.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine.	Step off deformity at T8.
c. Manage any injuries appropriately.	C-spine and long board.
Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	H - ABC

3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Responsive. Blood pressure - 60/P. Respirations - 18 Regular. Pulse - 100. Skin temperature warm and pink.	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - IED on dismounted patrol.

A-5. Trauma Scenario Number 5, Gunshot Wound to Chest

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is available in a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request evacuation within 30 minutes overall.	
Scenario History: You are the medic assigned to your commander's personal security detail on a mounted patrol. Shortly after making a turn down a route that has not been cleared by route clearance, an explosive formed penetrator (EFP) that was placed on top of a barrier explodes in front of the lead vehicle. The vehicle's windshield is destroyed and rolls to a stop. From your seat in the third vehicle, you see the vehicle commander fall out of the vehicle. There is small arms fire audible from multiple directions.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty mumbles a few garbled words.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	No visible blood on extremities.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	No hasty tourniquets required. Drags casualty to cover.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Responsive. Casualty is complaining of pain to right side of chest and shortness of breath.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	No injury or treatment.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	No adjunct indicated.
c. Position casualty to maintain an open airway.	Casualty comfortable lying supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment if injuries are present.	Exposes chest, removes IBA.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	Occlusive dressing to entry and exit wounds.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal rise and fall.
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC.
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression. (Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	Mild respiratory distress (Unable to determine if casualty has progressive respiratory distress at this time.)
f. If other injuries permit, position casualty to facilitate respiratory effort.	
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during CUF.	No injury or treatment.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	No injury or treatment.
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulses present.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	Saline lock indicated.
(3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	No injury or treatment.
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	No fluid resuscitation indicated.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	No injury or treatment.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3. A1, line 4. A, line 5. L1
9. Reassess interventions.	Occlusive dressings X2, saline lock

10. Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies, pain medications not indicated due to respiratory distress.
Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL. c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	No injury or treatment.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins. e. Manage any injuries appropriately.	No injury or treatment.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	NO progressive respiratory distress noted.
b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	Lung sounds present.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	Moans on palpation.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Pulse, motor sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Pulse, motor sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment
Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	H - ABC

3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Responsive. Blood pressure. - 80/P. Respirations. - 24 Spontaneous. Respirations 36 and shallow if no occlusive dressing was applied. Pulse - 120 Weak bilateral. Radial pulses absent if occlusive dressing is not applied. Skin temperature cool, pale, clammy	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - EFP on mounted patrol.

A-6. Trauma Scenario Number 6, Gunshot Wound with Exit Wound

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is available in a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all-life threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request evacuation within 30 minutes overall.	
Scenario History: You are the medic assigned to your commander's personal security detail on a mounted patrol. Shortly after making a turn down a route that has not been cleared by route clearance, an EFP that was placed on top of a barrier explodes in front of the lead vehicle. The vehicle's windshield is destroyed and rolls to a stop. From your seat in the third vehicle, you see the vehicle commander fall out of the vehicle. There is small arms fire audible from multiple directions.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty mumbles a few garbled words.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	No visible blood on extremities
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	No hasty tourniquets required. Casualty is dragged to cover.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Responsive. Casualty is complaining of pain to right side of chest and shortness of breath.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	No injury or treatment.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	NPA indicated.
c. Position casualty to maintain an open airway.	Casualty comfortable lying supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment (IBA) if injuries are present.	Exposes chest, removes IBA.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	Occlusive dressing to entry and exit wounds.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal rise and fall.
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC.
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression. (Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	Mild respiratory distress (unable to determine if casualty has progressive respiratory distress at this time.)
f. If other injuries permit, position casualty to facilitate respiratory effort.	Casualty lying supine.
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during CUF.	No injury or treatment.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	No injury or treatment.
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulses present.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	Saline lock indicated.
(3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	No injury or treatment.
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	No fluid resuscitation indicated.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	No injury or treatment.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3. A1, line 4. A, line 5. L1.
9. Reassess interventions.	Occlusive dressing (OCD), saline lock.
10. Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies. Pain medications not indicated.

Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL.	No injury or treatment.
c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	LOC now unresponsive requires a NPA.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins. e. Manage any injuries appropriately.	No injury or treatment.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Progressive respiratory distress noted.
b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	NCD required at this time.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Pulse, motor sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Pulse, motor sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.
Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	H - ABC

3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Responsive, if OCD and NCD completed. Unresponsive, if no NCD Blood pressure - 80/P. Respirations - 22 spontaneous, if OCD and NCD. Respirations - 36 and shallow if no NCD was performed. Pulse - 124 weak bilateral. No palpable pulse if NCD was not performed. Skin temperature cool.	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - EFP on mounted patrol.

A-7. Trauma Scenario Number 7, Multiple Wounds to Right Leg

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is available in a vehicle nearby.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request evacuation within 30 minutes overall.	
Scenario History: You are a member of a dismounted patrol walking the streets of Taramiyah, Iraq when an EFP explodes on your patrol. You are knocked to the ground by the explosion. When you get up you notice your team leader is 25 meters away and lying on the ground, not moving. You hear small arms fire from multiple directions.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty unable and uncooperative.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	Right leg bleeding.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	HASTY tourniquet required.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Responsive. Casualty is moaning in pain.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	No injury or treatment.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	NPA indicated.
c. Position casualty to maintain an open airway.	Casualty comfortable lying supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment if injuries are present.	No chest wall injuries.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	No chest wall injuries.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal bilateral.
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC.
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression. (Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	No distress/NCD not required.
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine.
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during CUF.	No injury or treatment.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	Must convert HASTY tourniquets now.
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	If applied correctly, distal right pulse absent.
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent. (7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	If applied incorrectly, must complete this step.
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulses present.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock. (3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	Radial pulses present. Saline lock indicated.
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	No injury or treatment.
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	No fluid resuscitation indicated.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	No injury or treatment
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3 A1, Line 4 A, Line 5 L1
9. Reassess interventions.	Tourniquet, saline lock.
10. Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies, pain medication indicated due to pain level and LOC.

Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL. c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	No injury or treatment.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins. e. Manage any injuries appropriately.	No injury or treatment.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla. b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	No injury or treatment.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	Moans on palpation.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Left radial pulse present, right pulse absent if tourniquet.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	Tourniquets required.
f. Manage any injuries appropriately.	Leg wound dressed/splinted.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Pulse, motor sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.
Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	H - ABC

3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Responsive. Blood pressure - 80/P. Respirations - 20 shallow, regular. Pulse - 116. No palpable pulse if tourniquet not placed. Skin temperature cool.	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - EFP on dismounted patrol.

A-8. Trauma Scenario Number 8, Left Open Tension Pneumothorax

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is available in a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request evacuation within 30 minutes overall.	
Scenario History: While on a mounted patrol a deep buried IED explodes on the second vehicle. A large amount of debris is seen flying through the air and a large piece of concrete strikes the gunner in the chest. The vehicle rolls to a stop approximately 100 meters past the explosion site. Over the radio you are being summoned to the scene. Upon exiting your vehicle you hear small arms fire and see the gunner has exited the vehicle and is rolling on the ground in obvious pain.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty unable and complaining about pain.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	No blood noted.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	No hasty tourniquets required.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Responsive. Casualty is complaining of pain to left side of chest and shortness of breath.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	No injury or treatment.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	No injury or treatment
c. Position casualty to maintain an open airway.	Sitting up.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment (IBA) if injuries are present.	Bruising over left lateral chest with portion of rib protruding out of chest.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	Occlusive dressing indicated. No exit injury.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Unequal rise and fall (Left side does not rise and fall).
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	TIC present on left side.
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma requires a needle chest decompression. (Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	Extreme difficulty breathing. Respiratory distress NCD indicated (casualty has progressive respiratory distress at this time).
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine.
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during CUF.	No injury or treatment.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	No injury or treatment.
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulses present.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	
(3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	Radial pulses present. Saline lock indicated.
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	No injury or treatment.
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	No fluid resuscitation indicated
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	No injury or treatment.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3. A1, Line 4. A, Line 5. L1
9. Reassess interventions.	NCD, Saline lock.
10. Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies. Pain medications are not indicated.

Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL.	No injury or treatment.
c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	LOC now unresponsive.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins. e. Manage any injuries appropriately.	No injury or treatment.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Progressive respiratory distress noted.
b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	NCD in place but not effective, repeat NCD.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Pulse, motor sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Pulse, motor sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.
Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	H - ABC.

3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Responsive, if NCD complete. Blood pressure. - 80/P. Respirations. - 24 Regular with NCD/36 shallow without NCD placement. Pulse. - 114 Weak. No palpable pulse without NCD placement Skin temperature cool.	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - IED attack, blunt trauma to chest.

A-9. Trauma Scenario Number 9, Right Hand Amputation

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is available in a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request evacuation within 30 minutes overall.	
Scenario History: You are the medic assigned to your commander's personal security detail on a mounted patrol. Shortly after making a turn down a route that has not been cleared by route clearance, an EFP that was placed on top of a barrier explodes in front of the lead vehicle. The vehicle's windshield is destroyed and rolls to a stop. From your seat in the third vehicle you see the vehicle commander fall out of the vehicle. There is small arms fire audible from multiple directions.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty unable.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	Right hand missing, extensive bleeding.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	HASTY tourniquet required.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Unresponsive, carotid pulse present.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	No injury or treatment.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	NPA indicated.
c. Position casualty to maintain an open airway.	Supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment if injuries are present.	No chest wall injuries.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	No chest wall injuries.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal bilateral.
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC.
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression. (Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	No respiratory distress. No distress/NCD not required.
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine.
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during CUF.	No injury or treatment.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	Must convert hasty tourniquet now.
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	Bleeding controlled if applied correctly, unable to check distal pulse.
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	No injury or treatment.
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulses absent.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	Radial pulses absent equals direct IV cannulation
(3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	Required after two failed IV attempts.
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	500 ML Hextend® wide open.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	No injury or treatment.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3 A1, Line 4 A, Line 5 L1
9. Reassess interventions.	NPA, tourniquet, IV
10. Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies, pain medications not indicated.

Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL. c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	No injury or treatment.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins. e. Manage any injuries appropriately.	No injury or treatment.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla. b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	No injury or treatment.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Pulse, motor sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Right pulse absent, left present if 500 ml Hextend® given.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	No injury or treatment.
f. Manage any injuries appropriately.	Stump and open wound dressed/ splinted. Convert IV to saline lock.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.
Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	H - ABC

3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Unresponsive. Blood pressure - 80/P. No blood pressure if Hextend® is not given. Respirations - 26 Spontaneous. Pulse - 114 Weak. No palpable pulse is Hextend® is not given. Skin temperature cool.	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - EFP on mounted patrol.

A-10. Trauma Scenario Number 10, Right Arm Amputation

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is located on a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request medical evacuation within 30 minutes overall.	
Scenario History: You are a member of a dismounted patrol in Afghanistan when an EFP explodes on your patrol. You are knocked to the ground by the explosion. When you get up you notice your team leader is 25 meters away and lying on the ground, not moving. You hear small arms fire from multiple directions.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty unable and uncooperative.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	Right arm amputation.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	HASTY tourniquet required. Drags casualty to safety.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Unresponsive. Carotid pulse present.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	No other bleeding found.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	NPA indicated.
c. Position casualty to maintain an open airway.	Supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment if injuries are present.	No chest wall injuries.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	No chest wall injuries.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal bilateral.
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC.
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression. (Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	No distress/NCD not required.
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine.
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during Care Under Fire.	No venous bleeding found.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	Must convert hasty tourniquets now.
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	If applied correctly bleeding is controlled, Unable to check distal pulse due to amputation.
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	If applied incorrectly must complete this step.
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	None indicated.
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Absent radial pulse.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	Direct IV cannulation.
(3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	Required after two failed attempts.
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	Indicated – 500ml Hextend wide open.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	None indicated.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3 B1, Line 4 A, Line 5 L1.
9. Reassess interventions.	Tourniquets, NPA, IV.
10. Check for specific drug allergy before administration. Administer appropriate pain management.	No known drug allergies. Pain medications not indicated at this time.

Detailed Physical Exam (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL. c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	No injury or treatment.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins. e. Manage any injuries appropriately.	No injury or treatment.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla. b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	No injury or treatment.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Pulse, motor sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	Right arm amputation.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Pulse present Left arm if IV started.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	No injury or treatment.
f. Manage any injuries appropriately.	Stump and open wound dressed/splinted.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.
Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	

3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Unresponsive. Blood pressure - 80/P if 500ml Hextend® given. No palpable blood pressure if Hextend® is not given. Respirations - 22 Shallow, regular. Pulse - 128 Weak. No pulse if Hextend® is not given. Skin temperature cool, pale, clammy	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - EFP on dismounted patrol.

A-11. Trauma Scenario Number 11, Gunshot Wound to Right Leg

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is located in a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request medical evacuation within 30 minutes overall.	
Scenario History: You are a member of a dismounted patrol walking the streets of Gandez, Afghanistan when an EFP explodes on your patrol. You are knocked to the ground by the explosion. When you get up you notice your team leader is 25 meters away and lying on the ground, not moving. You hear small arms fire from multiple directions.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty unable and uncooperative.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	Bleeding right leg.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	HASTY tourniquet required. Drags casualty to cover.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Responsive.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	If tourniquet completed correctly no other bleeding found and bleeding controlled.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	NO adjunct needed.
c. Position casualty to maintain an open airway.	Supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment if injuries are present.	No chest wall injuries.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	No chest wall injuries.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal bilateral.
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC.
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression.	No respiratory distress.
(Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	No distress/NCD not required.
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during CUF.	No injury or treatment.
(1) Expose injury and assess for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	Convert to a pressure dressing. Tourniquet not required to control bleeding.
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	If pressure dressing is applied incorrectly, bleeding not controlled.
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	No injury or treatment.
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulses present.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	Radial pulses present. Saline lock indicated.
(3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	No fluid resuscitation required at this time.
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	No injury or treatment.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3 B1, Line 4 A, Line 5 L1.
9. Reassess interventions, pressure dressing and saline lock.	

10.Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies. Pain medication not indicated at this time.
Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL. c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	No injury or treatment.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins. e. Manage any injuries appropriately.	No injury or treatment.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla. b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	No injury or treatment.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	Moans on palpation.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Present.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	Converted to pressure dressing.
f. Manage any injuries appropriately.	No injury or treatment.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Pulse, motor sensory intact.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.
Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	H - ABC

3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continue to reassess and reassure.
Vitals	AMPLE History
LOC - Responsive. Blood pressure - 80/P. Respirations - 24 Shallow, regular. Pulse - 124 weak. Skin temperature cool, pale, clammy	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - EFP/GSW on dismounted patrol.

A-12. Trauma Scenario Number 12, Shrapnel Wound to Left Leg

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is available in a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request medical evacuation within 30 minutes overall.	
Scenario History: You are a member of a dismounted patrol walking the streets of Herat, Afghanistan when an EFP explodes on your patrol. You are knocked to the ground by the explosion. When you get up you notice your team leader is 25 meters away and lying on the ground, not moving. You hear small arms fire from multiple directions.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty unable and uncooperative.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	Left leg bleeding.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	HASTY tourniquet required. Drag casualty to safety.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Responsive. Casualty is moaning in pain and uncooperative. Casualty begins to go in and out of consciousness.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	If tourniquet completed correctly, no other bleeding found.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	NPA indicated.
c. Position casualty to maintain an open airway.	Supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment (IBA) if injuries are present.	No chest wall injuries.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	No chest wall injuries.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal bilateral.
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression. (Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	No distress/NCD not required.
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine.
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during CUF.	No venous bleeding found.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	Must convert hasty tourniquet now.
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	If applied correctly bleeding is controlled.
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	If applied incorrectly must complete this step.
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	None indicated.
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulses absent.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	Radial pulses absent requires direct IV cannulation.
(3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	Required after two failed IV attempts.
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	500 ml Hextend® fluid resuscitation required.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3 B1, Line 4 A, Line 5 L1.
9. Reassess interventions.	NPA, tourniquet, IV.
10. Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies. Pain medication not indicated due to AMS.

Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL.	No injury or treatment.
c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins. e. Manage any injuries appropriately.	No injury or treatment.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla. b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	No injury or treatment.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	Moans on palpation.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Pulses present bilaterally, if 500ml Hextend® given.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	Tourniquets required.
f. Manage any injuries appropriately.	Open wound dressed/splinted.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Pulses present if Hextend® given.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	No injury or treatment.
f. Manage any injuries appropriately.	Convert IV to saline lock.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.
Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	H - ABC

3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Responsive if 500 ml Hextend® given. Unresponsive if Hextend® was not given. Blood pressure - 80/P if 500ml Hextend® given. No palpable blood pressure if Hextend® was not given. Respirations - 24 Shallow, regular. Pulse - 116, weak. No pulse if Hextend® was not given. Skin temperature cool.	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - EFP on dismounted patrol.

A-13. Trauma Scenario Number 13, Left Inguinal Wound

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is available in a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request evacuation within 30 minutes overall.	
Scenario History: You are a member of a dismounted patrol walking the streets of Taramiyah, Iraq when an EFP explodes on your patrol. You are knocked to the ground by the explosion. When you get up you notice your team leader is 25 meters away and lying on the ground, not moving. You hear small arms fire from multiple directions.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty moaning, but uncooperative.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signaled for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	Left Inguinal area penetration.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	No hasty tourniquet required. (If hasty applied to left leg, it does not control inguinal bleed). Drags casualty to cover.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Responsive. Casualty is moaning in pain and uncooperative. Casualty begins to go in and out of consciousness.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	Must expose and pack inguinal injury with combat gauze. Pressure must be held for 3 minutes. Soldier Medic may use security to hold pressure at this time. If Hasty tourniquet is placed in CUF, it should be loosened now.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1) NPA. (2) Surgical cricothyroidotomy.	NPA indicated.
c. Position casualty to maintain an open airway.	Supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment (IBA) if injuries are present.	No chest wall injuries.

b. Manage penetrating torso wounds, if present. (1) Occlusive dressing. (2) Check for exit wound. (3) NCD.	No chest wall injuries.
c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal bilateral.
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC.
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression.	No respiratory distress.
(Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	No distress/NCD not required.
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during Care Under Fire.	No injury or treatment.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	No injury or treatment.
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulses absent.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	Radial pulses absent requires direct IV cannulation.
(3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	Required after two failed IV attempts.
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	500ml Hextend® wide open.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	Wrap inguinal wound.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3 B1, Line 4 A, Line 5 L1

9. Reassess interventions.	NPA, Inguinal dressing, IV
10. Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies. Pain medication not indicated due to AMS.
Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL. c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	No injury or treatment.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins. e. Manage any injuries appropriately.	No injury or treatment.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla. b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	No injury or treatment.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	Moans on palpation.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	No injury or treatment.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	No injury or treatment.
f. Manage any injuries appropriately.	Right pulse present, if 500ml Hextend® given.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Radial pulses return, if 500ml Hextend® administered.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	No injury or treatment.
f. Manage any injuries appropriately.	Convert IV to saline lock.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.

Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	H - ABC
3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Responsive if 500 ml Hextend® given. Unresponsive, if Hextend® was not given. Blood pressure - 80/P if 500ml Hextend® given. No palpable blood pressure if Hextend® was not given. Respirations - 26 Shallow, regular. Pulse - 126 Weak. No palpable pulse if Hextend® was not given. Skin temperature cool, pale, clammy	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - EFP on dismounted patrol.

A-14. Trauma Scenario Number 14, Right Side Neck Wound

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is available in a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment to identify all injuries and request evacuation within 30 minutes overall.	
Scenario History: You are a member of a dismounted patrol walking the streets of Taramiyah, Iraq when an IED explodes on your patrol. You are knocked to the ground by the explosion. When you get up you notice your team leader is 25 meters away and lying in a pool of blood holding his neck. You hear small arms fire from multiple directions.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover, and apply self aid, if possible.	Casualty unable and uncooperative.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signals for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	Profuse bleeding right side of neck.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	No hasty tourniquet required. Drags casualty to cover
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Responsive. Casualty is anxious and following commands.
3. Perform blood sweep of neck, axillary, inguinal, and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	Profuse bleeding on right side of neck. Should expose and pack wound with combat gauze. Holds pressure for 3 minutes. May use security to hold pressure at this time.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	No adjunct needed.
c. Position casualty to maintain an open airway.	Supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment if injuries are present.	No chest wall injuries.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	No chest wall injuries.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal bilateral.
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression. (Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	No distress/NCD not required.
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine.
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during CUF.	No injury or treatment.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	No injury or treatment.
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	If packed correctly, bleeding controlled. If not packed correctly, bleeding continues.
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulses present.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	Saline lock indicated.
(3) Significant injuries, absent radial pulses, and altered mental status equal direct IV cannulation and fluid resuscitation.	
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	IO access not indicated at this time.
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	Not indicated.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	Wrap neck wound.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4, and 5 minimum.	Line 3 A1, Line 4 A, Line 5 L1.
9. Reassess interventions.	Neck dressing, saline lock.

10. Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies. Pain medication not indicated at this time.
Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL.	No injury or treatment.
c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	No injury or treatment.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins.	No injury or treatment.
e. Manage any injuries appropriately.	Neck wound should have been dressed during tactical field care.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla. b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	No injury or treatment.
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC. c. Assess motor, sensory and circulatory function. d. Consider splinting extremity. e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Radial pulses present.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	No injury or treatment.
f. Manage any injuries appropriately.	No injury or treatment.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.

Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	H - ABC.
3. Elicit AMPLE history, baseline vital signs, and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Responsive Blood pressure - 80/P R - 24 Shallow, regular. Pulse - 110 weak. Skin temperature cool.	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - IED on dismounted patrol.

A-15. Trauma Scenario Number 15, Right Axillary Wound

Conditions: While in the tactical area of operations, you encounter a combat casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK. A WALK™ is available in a nearby vehicle.	
Standard: Complete a Combat Casualty Assessment. Identify and treat all life-threatening injuries in the correct order within the first 7 minutes. Complete entire assessment, identify all injuries and request medical evacuation within 30 minutes overall.	
Scenario History: You are a member of a dismounted patrol walking the streets of Taramiyah, Iraq when an EFP explodes on your patrol. You are knocked to the ground by the explosion. When you get up you notice your team leader is 25 meters away and lying in a pool of blood. You hear small arms fire from multiple directions.	
Care Under Fire (CUF) Phase	**Evaluator Instructions/Comments**
1. Return fire to gain fire superiority.	"Gained after returning fire."
2. Direct the casualty to return fire, move to cover and apply self aid, if possible.	Casualty unable and uncooperative.
3. Direct security team to provide security for casualty, move to casualty once security team is in place and signals for medic to move forward.	"Security moves to casualty."
4. Major Life-threatening Extremity Hemorrhage.	Right side profuse bleeding to right axilla.
Apply *HASTY* tourniquet(s) high on limb over uniform, to control obvious extremity hemorrhage and move casualty to cover.	No hasty tourniquet required. Drags casualty to cover.
Tactical Field Care Phase (Primary Assessment)	
1. If tactical situation permits, take BSI precautions.	BSI encouraged.
2. If not completed previously, assess responsiveness and chief complaint. a. Unresponsive. b. Responsive. (If unresponsive, assess for presence of carotid pulse and respirations. If absent, respond in accordance with tactical environment).	Responsive. Casualty is moaning in pain and uncooperative. Casualty begins to go in and out of consciousness.
3. Perform blood sweep of neck, axillary, inguinal and extremity areas. Assess effectiveness of previously placed tourniquets. a. Rapidly apply *DELIBERATE* tourniquet(s) to any new wounds discovered on extremities. b. Rapidly apply hemostatic agent (hold pressure for 3 minutes) to neck, axillary and/or inguinal wounds discovered.	Bleeding in right axilla. Pressure must be held for 3 minutes. Soldier Medic may use security to hold pressure at this time. If HASTY placed in CUF, it should be loosened now.
4. Airway.	
a. Open (head tilt) and assess airway (look, listen and feel).	Airway patent.
b. Insert appropriate adjunct, as indicated. (1)NPA. (2)Surgical cricothyroidotomy.	NPA indicated.
c. Position casualty to maintain an open airway.	Supine.
5. Breathing.	
a. Expose and assess torso. Remove casualty's equipment (IBA) if injuries are present.	No chest wall injuries.
b. Manage penetrating torso wounds, if present. (1)Occlusive dressing. (2)Check for exit wound. (3)NCD.	No chest wall injuries.

c. Assess breathing for equal rise and fall of chest, spontaneous respiratory effort. (1) Adequate spontaneous respirations. (2) Manual ventilations necessary.	Equal bilateral.
d. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla.	Negative DCAP BLS/TIC
e. Monitor casualty's respiratory effort. Progressive respiratory distress plus torso trauma equals needle chest decompression. (Identify second ICS MCL. Insert 14 gauge, 3.25 inch needle catheter over third rib to the hub. Remove needle. Secure catheter to chest wall. Reassess respiratory effort.)	No distress/NCD not required
f. If other injuries permit, position casualty to facilitate respiratory effort.	Supine.
6. Circulation.	
a. Treat significant non-pulsatile hemorrhage with packing (as necessary) and pressure bandage. For wounds treated with a HASTY tourniquet during CUF.	No injury or treatment.
(1) Exposes injury and assesses for continued tourniquet need. If indicated, complete the following sequence to convert the HASTY tourniquet to a DELIBERATE tourniquet.	
(2) Apply and tighten *DELIBERATE* tourniquet 2 to 3 inches above the wound.	
(3) Loosen *HASTY* tourniquet after *DELIBERATE* tourniquet has been applied.	
(4) Check distal pulse.	
(5) If distal pulse present, attempt to further tighten *DELIBERATE* tourniquet.	No injury or additional treatment required.
(6) If ineffective, place and tighten additional tourniquet directly above *DELIBERATE* tourniquet until pulse is absent.	
(7) Reassess packing of junctional wounds, if present (neck, axillary, or inguinal).	
b. Need for vascular access (casualty with significant trauma).	
(1) Check radial pulses. If absent, check for carotid pulse. (a) Bilateral radial pulse check. (b) Carotid pulse check.	Radial pulses absent. Carotid pulse present.
(2) Significant injuries, present radial pulses, normal mental status equal saline lock.	Radial pulses absent equals direct IV cannulation.
(3) Significant injuries, absent radial pulses and altered mental status equal direct IV cannulation and fluid resuscitation.	
(4) IO placed after second IV attempt was unsuccessful or not possible, if requiring fluid resuscitation.	Required after two failed IV attempts.
(5) Initiate 500 ml Hextend® wide open. Continue Combat Casualty Assessment.	500ml Hextend® fluid resuscitation required.
7. Wrap any junctional wounds, if present (neck, axillary, or inguinal wounds).	Wrap right axillary wound.
8. Notify the tactical leader for casualty evacuation. Lines 3, 4 and 5 minimum.	Line 3 B1, Line 4 A, Line 5 L1.
9. Reassess interventions.	NPA, IV, saline lock, axillary bandage.

10.Check for specific drug allergy before administration. Administer appropriate pain management.	No known allergies. Pain medication not indicated at this time due to AMS.
Detailed Physical Examination (Secondary Assessment)	
1. Head.	
a. Inspect and palpate for DCAP BLS and TIC. b. Inspect eyes for PERRL. c. Inspect mouth, nose and ears. d. Manage any injuries appropriately.	No injury or treatment.
2. Neck.	
a. Inspect for DCAP BLS. b. Palpate cervical spine for TIC. c. Check position of trachea. d. Check jugular veins. e. Manage any injuries appropriately.	No injury or treatment.
3. Chest.	
a. Inspect and palpate for DCAP BLS and TIC in chest (shoulder girdle, sternum and rib cage) and axilla. b. Auscultate bilaterally for presence or absence of lung sounds. c. Manage any injuries appropriately.	No injury or treatment. Lung sounds present
4. Abdomen/Pelvis	
a. Inspect and palpate abdomen for DCAP BLS and TRD. b. Assess pelvis for TIC. c. Inspect genitalia and perineum. d. Manage any injuries appropriately.	No injury or treatment.
5. Lower Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity.	Pulses present bilaterally, if 500ml Hextend® given.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours. f. Manage any injuries appropriately.	No injury or treatment.
6. Upper Extremities.	
a. Inspect for DCAP BLS. b. Palpate for TIC.	No injury or treatment.
c. Assess motor, sensory and circulatory function. d. Consider splinting extremity if required.	Right radial pulse absent if no Hextend®. Left radial pulse present if Hextend® given.
e. Consider alternate hemorrhage control measures and tourniquet conversion if evacuation time is delayed more than 2 hours.	No injury or treatment.
f. Manage any injuries appropriately.	Convert IV to saline lock.
7. Posterior Thorax, Lumbar and Buttocks.	
a. Inspect for DCAP BLS. b. Palpate for TIC along spine. c. Manage any injuries appropriately.	No injury or treatment.

Tactical Evacuation Care	
1. Prepare casualty to prevent hypothermia and place on evacuation device.	Use litter, blanket and straps.
2. Reassess casualty.	H - ABC.
3. Elicit AMPLE history, baseline vital signs and complete patient care documentation. a. Standard. b. Nonstandard.	See below.
4. If evacuation to higher role of surgical care is delayed up to 3 hours, administer appropriate antibiotic for penetrating trauma.	Evacuate within 3 hours.
5. Secure patient to evacuation device and prepare for transport.	Secures straps.
6. Continue reassuring and reassessing casualty until MEDEVAC arrives.	Continues to reassess and reassure.
Vitals	AMPLE History
LOC - Responsive if 500 ml Hextend® given. Unresponsive if Hextend® was not given. Blood pressure - 80/P if 500ml Hextend® given. No palpable blood pressure if Hextend® was not given. Respirations - 24 Shallow, regular. 32 and shallow if Hextend® is not given. Pulse - 118 Weak. Pulse not detectable if Hextend® is not given. Skin temperature cool.	A - No known allergies. M - No medications. P - No significant past illness. L - 3 hours ago. E - EFP on dismounted patrol.

A-16. Medical Scenario Number 1, Chest Pain

Conditions: While in a garrison environment you encounter a sick call patient in the battalion aid station after sick call hours. You are the sole provider. You have access to a blood pressure cuff, stethoscope, otoscope, ophthalmoscope, reflex hammer, thermometer, oxygen, and pulse oxygen monitor.	
Standard: Complete a medical assessment; perform scene size-up through initial transportation decision in first 5 minutes. Complete entire assessment in 15 minutes. Reassessment will be done en route to medical facility, but must be verbalized.	
Scenario History: You are a medic in a battalion aid station. The battalion physician assistant has gone to work at the consolidated clinic. It is 1530 on Friday and the supply sergeant comes in complaining of chest pain.	
Scene Size Up	
Take BSI precautions.	Dons gloves and eye protection.
Determine if the scene is safe.	Yes.
Determine the nature of the illness.	Cardiac.
Determine the number of casualties.	One.
Request additional assistance, if necessary.	Not needed.
Consider stabilization of the spine.	Considered, but not needed.
Primary Assessment.	
General impression.	47 year old male in obvious pain, pale, diaphoretic sitting in a tripod position.
Responsiveness/level of consciousness alert, (responsive to) verbal, (responsive to) pain, unresponsive (AVPU).	Alert and oriented X 4 (Person, Place, Event, Time).
Chief complaint/apparent life threats.	"All of a sudden I was feeling weak and dizzy, and developed chest pain."
Assess the airway.	Airway is open and patent.
Breathing.	Slightly fast and regular.
Oxygen.	Oxygen at 15 L via non-rebreather.
Assess chest (I, A, and P) Inspect.	You see symmetrical chest rise and fall, no DCAP-burns, tenderness, lacerations, swelling (BTLS) noted.
Auscultate.	Lungs clear to auscultation bilaterally.
Palpate sternum.	Patient denies any tenderness, no instability or crepitus (TIC) noted.
Circulation (Check for bleeding, pulses, and skin [color, condition, temperature (CCT)]).	Patient denies any bleeding or trauma.
Color.	Pale.
Condition.	Diaphoretic.
Temperature.	Cool.
Assess pulses (carotid and radial).	Tachycardiac, regular, and weak.
Treat the casualty for shock.	Position of comfort.
Determine the priority of the patient and transport decision.	Emergent (load and go).
Secondary Assessment (History of Present Illness/Injury) and SAMPLE History (OPQRST and I)	
Signs and symptoms.	"I was doing a commander's 10% inventory, when I started feeling weak and dizzy, and started having chest pain."
Onset of the event.	"All of a sudden."
Provocation or palliation.	"Lying down makes it worse."

Quality of the pain.	"It's a stabbing pain."
Region and radiation.	"Between my shoulders."
Severity 1 to 10 on pain scale.	"The pain is 7 out of 10 on the pain scale."
Time (history).	"It started 15 minutes ago."
Interventions.	None
Allergies.	"No known drug allergies."
Medications.	"I take nitro-pills and I have them in my pocket."
Past medical history.	"Diagnosed with angina 1 year ago."
Last oral intake.	"About 1 hour ago."
Events leading up to injury/illness.	"Performing commander's 10% inventory."
Perform a focused physical examination.	Chest: negative DCAP-BTLS, equal rise and fall of the chest with equal breath sounds bilaterally. Abdomen: negative for DCAP-BTLS palpation negative for masses and bowel sounds x 4 quadrants, soft to touch and nontender upon palpation.
	EVALUATOR: The Soldier Medic performs the focused physical examination by verbalizing the assessment of affected body part.
Obtain vital signs.	
Blood pressure.	130 over 74.
Pulse.	114 and regular.
Oxygen saturation.	96% on 15 L via non-rebreather
Respirations.	22
Temperature.	97.8°F
Call to medical direction or use additional protocols.	Local protocols- assist with prescribed medication of nitroglycerin.
Reassess decision to transport.	En route to hospital.
Reassessment	
Repeat the primary assessment.	No change.
Reassess chief complaint.	No change.
Check interventions.	Mild relief with nitroglycerin, pain still 4 out of 10 on pain scale rating
Repeat vital signs.	Blood pressure - 114 over 70, Pulse - 98, and Oxygen saturation - 98% on 15 L via non-rebreather.
Document the primary and secondary assessments on DD Form 1380 [Tactical Combat Casualty Care (TCCC) Card] (Available through normal forms supply channels).	Document to local standards.
Do not cause further injury to the casualty.	No further injuries sustained.
Medical report received by.	Use local medical treatment facility.

A-17. Medical Scenario Number 2, Asthma Attack

Conditions: While in a garrison environment, you encounter a sick call patient in the battalion aid station after sick call hours. You are the sole provider. You have access to a blood pressure cuff, stethoscope, otoscope, ophthalmoscope, reflex hammer, thermometer, oxygen, and pulse oxygen monitor.	
Standard: Complete a medical assessment; perform scene size up through initial transportation decision in first 5 minutes. Complete the entire assessment in 15 minutes. Reassessment will be done en route to medical facility, but must be verbalized.	
Scenario History: You are a medic pulling sick call in a battalion aid station. Sick call ended earlier and the battalion physician assistant has gone to work at the consolidated clinic. A Soldier is brought in by his platoon sergeant.	
Scene Size Up	
Take BSI precautions.	Dons gloves and eye protection.
Determine if the scene is safe.	Yes.
Determine the nature of the illness.	Respiratory.
Determine the number of casualties.	One.
Request additional assistance, if necessary.	Not needed.
Consider stabilization of the spine.	Considered, but not needed.
Primary Assessment	
General impression.	36 year old male in respiratory distress.
Responsiveness/level of consciousness (AVPU).	Alert and oriented X 4 (Person, Place, Event, Time).
Chief complaint/apparent life threats.	"I am having difficulty breathing."
Assess the airway.	Patient with audible wheezing sounds.
Breathing.	Tachypnea noted, irregular, and shallow.
Oxygen.	Bag valve mask; Patient will not tolerate a bag valve mask, replaces with non-rebreather at 15 L, tolerates.
Assess chest (I, A, and P) Inspect.	Symmetrical bilaterally and negative for DCAP-BTLS.
Auscultate.	Diminished in bases bilaterally, wheezing in all lobes.
Palpate sternum.	Patient denies any tenderness, no instability or crepitus (TIC) noted.
Circulation (Check for bleeding, pulses, and skin (CCT)).	Patient denies any bleeding.
Color.	Pale.
Condition.	Diaphoretic.
Temperature.	Cool.
Assess pulses (carotid and radial).	Tachycardic, regular and bounding.
Treat the casualty for shock.	Position of comfort tripod position.
Determine the priority of the patient and transport decision.	Emergent (load and go).
Secondary Assessment (History of Present Illness/Injury) and SAMPLE History (OPQRST and I)	
Signs and symptoms.	"I was working in the motor pool when I began having a hard time breathing."
Onset of the event.	"All of a sudden."
Provocation or palliation	“Lying down makes it worse."
Quality of the pain.	“It’s hard for me, moving air in and out of my chest."
Region and radiation	“No, just in my chest area."
Severity 1 to 10 on pain scale.	“It’s a 9 out of 10 my difficulty breathing."
Time (history).	“My allergies have been really bad for 3 days."
Interventions	“None."
Allergies.	“I am allergic to Cipro®."
Medications.	“I have an Albuterol Inhaler, Flonase®, and take Zyrtec®."

Past medical history.	"I have asthma, seasonal allergies, open pneumothorax from gunshot wound 1 year ago."
Last oral intake.	"I had lunch 2 hours ago."
Events leading up to injury/illness.	"Just working in motor pool."
Perform a focused physical examination.	Neck: Slight jugular vein distention Chest: Negative DCAP-BTLS and TIC, labored breathing Lungs: Expiratory wheezes throughout both lung fields with diminished sound in bases.
	EVALUATOR: The Soldier Medic performs the focused physical examination by verbalizing the assessment of affected body part.
Obtain vital signs.	
Blood pressure.	160 over 98.
Pulse.	124.
Oxygen saturation.	92% on oxygen at 15 L via non-rebreather.
Respirations.	28
Temperature.	97.8°F
Call to medical direction or use additional protocols.	Local protocol -assist with prescribed medication Albuterol inhaler.
Reassess decision to transport.	En route to hospital.
Reassessment	
Repeat the primary assessment.	No change.
Reassess chief complaint.	No change.
Check interventions.	Mild relief with inhaler use.
Repeat vital signs.	No change.
Document the primary and secondary assessments on DD Form 1380.	Document to local standards.
Do not cause further injury to the casualty.	No further injuries sustained.
Medical report received by.	Use local Medical treatment facility.

A-18. Medical Scenario Number 3, Food Allergy

Conditions: While in the tactical area of operations you encounter a medical casualty. You have an aid bag, weapon, ballistic helmet, individual body armor and IFAK.	
Standard: Complete a medical assessment; perform scene size-up through initial transportation decision in first 5 minutes. Complete entire assessment in 15 minutes. Reassessment will be done en route to medical facility, but must be verbalized.	
Scenario History: You are at a social meeting outside the forward operating base with local national leaders in Afghanistan. They have brought local food and drink for all participating. A Soldier is brought over to you after eating something unfamiliar to him.	
Scene Size Up	
Take BSI precautions.	Dons gloves and eye protection.
Determine if the scene is safe.	Scene safe.
Determine the nature of the illness.	Allergic reaction.
Determine the number of casualties.	One
Request additional assistance, if necessary.	Not needed.
Consider stabilization of the spine.	Considered, but not needed.
Primary Assessment	
General impression.	22 year old male appears anxious, who is scratching his neck. You notice a red rash on his neck and arms.
Responsiveness/level of consciousness (AVPU).	Alert and Oriented X 4 (Person, Place, Event, Time).
Chief complaint/apparent life threats.	"I think I ate something that made be break out with this rash."
Assess the airway.	Airway is open and patent.
Breathing.	Rapid, labored, and you hear audible wheezing on exhalation.
Oxygen.	Oxygen at 15 L via non-rebreather, patient tolerates well.
Assess chest (I, A, and P) Inspect.	Equal rise and fall, negative for DCAP-BTLS.
Auscultate.	Wheezing noted bilaterally upon exhaling.
Palpate sternum.	Patient denies any tenderness and negative for TIC.
Circulation (Check for bleeding, pulses, and skin (CCT)).	Patient denies any bleeding or trauma.
Color.	Reddish.
Condition.	Moist.
Temperature.	Warm.
Assess the pulses (carotid and radial).	Rapid, regular, and strong.
Treat the casualty for shock.	Loosen restrictive clothing and place in position of comfort.
Determine the priority of the patient and transport decision.	Emergent (Load and Go)
Secondary Assessment (History of Present Illness/Injury) and SAMPLE History (OPQRST and I)	
Signs and Symptoms.	"I'm allergic to shellfish, but didn't notice any around. I began itching about 25 minutes ago after eating some sort of dip with the flat bread we were given. I noticed a slight swelling of my throat and itching and now I am feeling

	light headed. I am experiencing abdominal cramps. I normally carry an EpiPen®, but we are in the desert and I didn't think shellfish would be a problem."
Allergies.	"No known drug allergies, allergic to shell fish."
Medications.	"EpiPen®."
Past medical history.	"Unremarkable."
Last oral intake.	"25 minutes ago."
Events leading up to injury/illness.	"Trying local food."
Perform a focused physical examination.	Multiple inflamed red wheals across chest and Auscultation: Stridor noted along with increased respiratory effort and rate, and wheezing noted when inhaling and exhaling. Abdomen soft to touch, negative for mass and pt. states there is no tenderness upon palpating. Bowel sounds x4 quads.
	EVALUATOR: The Soldier Medic performs the focused physical examination by verbalizing the assessment of
Obtain vital signs.	
Blood pressure.	110 over 62
Pulse.	120
Oxygen saturation.	94% on oxygen at 15 L via non-rebreather.
Respirations.	26 labored.
Temperature.	99°F.
Call to medical direction or use additional protocols.	On protocol to give epinephrine 0.3mg SC. Give 0.3mg epinephrine now.
Reassess decision to transport.	En route to medical facility.
Reassessment	
Repeat the primary assessment.	Patient now has swelling in face.
Reassess chief complaint.	Difficulty breathing and possible anaphylaxis.
Check interventions.	Monitor any and all interventions and reassure patient.
Repeat vital signs.	No change.
Document the primary and secondary assessments on DD Form 1380.	Document to local standards.
Do not cause further injury to the casualty.	No further injuries sustained.
Medical report received by.	Battalion aid station.

A-19. Medical Scenario Number 4, Difficulty Breathing

Conditions: While in a garrison environment you are called to your battalion commander's office. No higher medical authority is present. You have access to a blood pressure cuff, stethoscope, otoscope, ophthalmoscope, reflex hammer, thermometer, oxygen, and pulse oxygen monitor.	
Standard: Complete a medical assessment; perform scene size up through initial transportation decision in first 5 minutes. Complete entire assessment in 15 minutes. Reassessment will be done en route to medical facility, but must be verbalized.	
Scenario History: You are called to your battalion commander's office because there is a medical problem with his elderly father who is visiting. The person calling stated that he is complaining of sudden onset of difficulty breathing.	
Scene Size Up	
Take BSI precautions.	Don gloves and eye protection.
Determine if the scene is safe.	Scene is safe.
Determine the nature of the illness.	Shortness of breath.
Determine the number of casualties.	One.
Request additional assistance, if necessary.	Not needed.
Consider stabilization of the spine.	Not needed.
Primary Assessment	
General impression.	Anxious, 70 year old elderly male in the tripod position in a lounge chair with barreled chest gasping for breath through pursed lips receiving oxygen via 6 L nasal cannula.
Responsiveness/level of consciousness (AVPU).	Alert and oriented X 4 (Person, Place, Event, Time).
Chief complaint.	"It's hard for me to catch my breath."
Assess the airway.	Patent airway.
Breathing.	Tachypnea, with labored and shallow breaths.
Oxygen.	Changed to non-rebreather with oxygen at 15 L, tolerating well.
Assess chest (I, A, and P) inspect.	Equal rise and fall, and negative for DCAP-BTLS.
Auscultate.	You see symmetrical chest rise and fall and note expiratory wheezinq from apex to base bilaterally.
Palpate sternum.	Negative for TIC.
Circulation (Check for bleeding, pulses, and skin (CCT)).	Patient denies bleeding.
Color.	Pale.
Condition.	Moist.
Temperature.	Cool.
Assess pulses (carotid and radial).	Rapid, regular and weak.
Treat the casualty for shock.	Shock prevention taken.
Determine the priority of the patient and transport decision.	Load and go/emergent transport patient in position of comfort

Secondary Assessment (History of Present Illness/Injury) and SAMPLE History (OPQRST and I)	
Signs and symptoms.	"I'm having a really hard time with breathing today."
Onset of the event.	"Gradual over the past few hours."
Provocation or palliation.	"It gets worse when I get up and move around."
Quality of the pain.	"It is not pain, I'm having a hard time breathing."
Region and radiation.	"A tightness in my chest."
Severity 1 to10 on pain scale.	"8 out of 10 in difficulty of trying to catch my breath."
Time (history).	"It has gotten worse over the past 2 hours."
Interventions.	"None."
Allergies.	"Morphine."
Medications.	"Oxygen, albuterol inhaler, Lasix® and aspirin."
Past medical history.	"Diagnosed with emphysema 10 years ago."
Last oral intake.	"Supper about 2 hours ago."
Events leading up to injury/illness.	"It started 2 days ago when the weather got hot and humid."
Perform a focused physical examination.	Chest negative for DCAP-BTLS, equal rise and fall of chest, with use of accessory muscles. Expiratory wheezing from apex to base bilaterally. Negative for TIC. Abdomen is soft to touch and patient denies any tenderness upon palpation. Negative for mass and bowel sounds hypoactive in all 4 quadrants.
	EVALUATOR: The Soldier Medic performs the focused physical examination by verbalizing the assessment of affected body part.
Obtain vital signs.	
Blood Pressure.	158 over 92.
Pulse.	138.
Oxygen saturation.	89% on oxygen at 15 L via non-rebreather mask.
Respirations.	32.
Temperature.	Cool, and moist. Cyanosis noted on fingers and toes.
Call to medical direction or use additional protocols.	Assist patient with albuterol inhaler, some relief seen.
Reassess decision to transport	En route to hospital.
Reassessment	
Repeat the primary assessment.	No change.
Reassess chief complaint.	Breathing appears to be better.
Check interventions.	Continue with present plan of care and reassure patient.
Repeat vital signs.	Pulse - 138 beats per minute. Respirations - 24 breaths per minute. Blood pressure - 144 over 78 mm Hg Oxygen Saturation at 92%.
Document the primary and secondary assessments on DD Form 1380.	Document to local standards

Do not cause further injury to the casualty.	No further injuries sustained.
Medical report received by.	Use local medical treatment facility.

A-20. Medical Scenario Number 5, Altered Mental Status

Conditions: While in a field environment you encounter a medical casualty. You have an aid bag, weapon, ballistic helmet, individual body armor, and IFAK.	
Standard: Complete a medical assessment; perform scene size-up through initial transportation decision in first 5 minutes. Complete entire assessment in 15 minutes. Reassessment will be done en route to medical facility, but must be verbalized.	
Scenario History: A Soldier runs into your tent claiming, "Something is wrong with my First Sergeant. You arrive and are met by another Soldier saying "Come quick, my First Sergeant is in trouble!"	
Scene Size Up	
Take BSI precautions.	Don gloves and eye protection.
Determine if the scene is safe.	Scene safe.
Determine the nature of the illness.	Altered mental status.
Determine the number of casualties.	One.
Request additional assistance, if necessary.	Not needed.
Consider stabilization of the spine.	Consider, but not needed.
Primary Assessment	
General impression.	Middle aged man who appears completely confused. He attempts to talk to you, but cannot. His head and body keeps slumping against the tree. His words are inappropriate.
Responsiveness/level of consciousness (AVPU).	Disoriented X 4 (Person, Place, Event, Time)
Chief complaint.	The Soldier tells you, "He's been acting strange since he took his medications."
Assess the airway.	Patent airway.
Breathing.	Within normal limits, irregular and shallow.
Oxygen.	Bag valve mask with 15 L oxygen, does not tolerate. Changed to non-rebreather oxygen at 15 L.
Assess chest (1, A, and P) Inspect.	Symmetrical with equal rise and fall.
Auscultate.	Lungs CTA bilaterally.
Palpate.	Negative for TIC.
Circulation (check for bleeding, pulses, and skin (CCT)).	Soldier informs you “He did not fall, no trauma and no bleeding.”
Color.	Pale.
Condition.	Moist.
Temperature.	Cool.
Assess the pulse (carotid and radial).	Tachycardia, regular and strong.
Treat the casualty for shock.	Shock prevention taken.
Determine the priority of the patient and transport decision.	Load and go/emergent transport.

Secondary Assessment (History of Present Illness/Injury) and SAMPLE History (OPQRST and I)	
Signs and Symptoms.	Soldier tells you, "He was fine until after he took his morning medications with breakfast."
Onset.	Soldier tells you "Approximately 0700."
Provocation or Palliation.	Soldier tells you "I think it might be his medications."
Quality of the pain.	Patient cannot answer.
Region and radiation.	Patient cannot answer.
Severity 1 to 10 on pain scale.	Patient cannot answer.
Time (history).	Battle buddy tells you, "This is the first time he has acted like this."
Interventions.	Battle buddy tells you, "Water, and I had another Soldier go get you."
Allergies.	Patient cannot answer.
Medications.	Soldier gives you all of his medications; Glucophage®, glyburide, Lasix®, and lisinopril.
Past medical history.	Soldier tells you, "He has had a lot of medical appointments lately."
Last oral intake.	Soldier tells you, "He has not eaten anything since breakfast."
Events leading up to injury/illness.	Battle buddy tells you, He was working in the motor pool and we took him outside by this tree. We thought fresh air would help and gave him water to drink."
Perform a focused physical examination.	Head negative for DCAP-BTLS and TIC. No obvious signs and symptoms of trauma noted. Eyes are PERRL; neck negative for jugular venous distention and step-offs, trachea is midline, chest negative for DCAP-BTLS and TIC, lungs CTA bilaterally with equal rise and fall. Still using inappropriate words, appears agitated and intoxicated.
	EVALUATOR: The Soldier Medic performs the focused physical examination by verbalizing the assessment of affected body part.
Obtain vital signs.	
Blood pressure.	106 over 64.
Pulse.	110 beats per minute.
Oxygen saturation.	96% on oxygen at 15 L via non-rebreather.
Respirations.	18 breaths per minute, unlabored.
Temperature.	Cool and clammy.
Call to medical direction or use additional protocols	Administer oral glucose if patient is able to swallow. He swallows with no difficulty and signs and symptoms of distress noted.
Reassess decision to transport	En route to hospital.
Reassessment	
Repeat the primary assessment.	Patient no longer has slurred speech and is more alert now. Not able to recall event.

Reassess chief complaint.	He tells you, "I was recently diagnosed with type *2* diabetes. My medical alert tag will be ready in a few days."
Check interventions.	Continue with present plan of care and monitoring of patient placed in position of comfort.
Repeat vital signs.	Blood pressure - 106 over 64. Pulse - 110 beats per minute. Oxygen saturation - 96% on oxygen via non-rebreather with 15 L. Respirations - 18 breaths per minute, unlabored.
Document the primary and secondary assessments on DD Form 1380.	Document to local standards.
Do not cause further injury to the casualty.	No further injuries sustained.
Medical report received by.	Use local medical treatment facility.

A-21. Medical Scenario Number 6, Abdominal Pain

Conditions: While in a garrison environment you encounter a medical patient. You have an aid bag.	
Standard: Complete a medical assessment; perform scene size up through initial transportation decision in first 5 minutes. Complete entire assessment in 15 minutes. Reassessment will be done en route to medical facility, but must be verbalized.	
Scenario History: You receive a call from headquarters company regarding a Soldier with a chief complaint of severe abdominal pain.	
Scene Size Up	
Take BSI precautions.	Don gloves and eye protection.
Determine if the scene is safe.	Scene is safe.
Determine the nature of the illness.	Abdominal pain.
Determine the number of casualties.	One.
Request additional assistance, if necessary.	Not needed.
Consider stabilization of the spine.	Consider, but not needed.
Primary Assessment	
General impression.	30 year old male in apparent pain, holding his abdomen lying down with knees bent.
Responsiveness/level of consciousness (AVPU).	Alert, but using inappropriate words.
Chief complaint/apparent life threats.	"I am having a lot of pain in my stomach."
Assess the airway.	Patent.
Breathing.	Tachypnea, rapid and shallow.
Oxygen.	Oxygen at 15 L via non-rebreather.
Assess chest (I, A, and P) Inspect.	Symmetrical with equal rise and fall and negative for DCAP-BTLS.
Auscultate.	Clear to auscultation bilaterally (CTA).
Palpate sternum.	Patient denies any tenderness and negative for instability and crepitus.
Circulation (check for bleeding, pulses, and skin (CCT)).	Patient states he is not bleeding.
Color.	Pale.
Condition.	Moist.
Temperature.	Cool.
Assess the pulses (carotid and radial).	Rapid, regular rhythm, and present at both the carotid and radial sites.
Treat the casualty for shock.	Treat for shock.
Determine the priority of the patient and transport decision.	Load and go/emergent transport patient in position of comfort

Secondary Assessment (History of Present Illness/Injury) and SAMPLE History (OPQRST and I)	
Signs and Symptoms.	"My stomach is hurting really, really bad; it has never hurt like this before."
Onset of the event.	"All of a sudden."
Provocation or palliation	"Movement makes it worse and I feel nauseous."
Quality of the pain.	"The pain is sharp and getting worse."
Region and radiation	"The pain stays in my stomach."
Severity 1 to 10 on the pain scale.	"It's an 8 out of 10, it's the worst pain I have ever felt."
Time (history).	"It began approximately 2 hours ago."
Interventions.	"Two extra strength Tylenol® about an hour ago with no relief."
Allergies.	"Codeine."
Medications.	"None."
Past Medical History.	"None; except normal childhood illnesses."
Last Oral Intake.	"I ate supper last night about 7pm."
Events leading up to injury/illness.	"I was sleeping and the pain woke me up."
Perform a focused physical examination.	Patient is negative for DCAP-BTLS, TIC and negative trauma to thorax. Has equal rise and fall and lungs CTA bilaterally; bowels sounds hypoactive in all four quadrants, abdomen soft, negative abdominal masses, negative abdominal rigidity, negative abdominal distention, tenderness noted at umbilicus, guarding and rebound tenderness at right lower quadrant.
	EVALUATOR: The Soldier Medic performs the focused physical exam by verbalizing the assessment of affected body part.
Obtain vital signs.	
Blood pressure.	138 over 68.
Pulse.	104, regular and strong.
Oxygen saturation.	97% on 15 L via non-rebreather.
Respirations.	24.
Temperature.	Cool diaphoretic. No cyanosis noted.
Call to medical direction or use additional protocols.	
Reassess decision to transport.	En route to hospital.
Reassessment	
Repeat the primary assessment.	No change.
Reassess the chief complaint.	No change from initial assessment.

Check interventions.	Continue to monitor and place in position of comfort along with reassure.
Repeat vital signs.	Blood pressure - 140 over 64. Pulse - 88 and strong. Respirations 22 Oxygen saturation 99% with 15 L non-rebreather.
Document the primary and secondary assessments on DD Form 1380.	Document to local standards.
Do not cause further injury to the casualty.	No further injuries sustained.
Medical report received by.	Use local provider or physician assistant.

A-22. Medical Scenario Number 7, Altitude Sickness

Conditions: While in the tactical area of operations you encounter a medical patient. You have an aid bag, weapon, ballistic helmet, individual body armor and IFAK.	
Standard: Complete a medical assessment; perform scene size up through initial transportation decision in first 5 minutes. Complete entire assessment in 15 minutes. Reassessment will be done en route to medical facility, but must be verbalized.	
Scenario History: You have been inserted by Chinooks on a mountain top at 3,000 meters in elevation as a staging area for an assault the following day. After several hours, a Soldier approaches you to get your advice on strange things he is feeling.	
Scene Size Up	
Take BSI precautions.	Dons gloves and eye protection.
Determine if the scene is safe.	Scene safe
Determine the nature of the illness.	Fatigue, shortness of breath and tingling in hands and feet
Determine the number of casualties.	One.
Request additional assistance, if necessary.	None.
Consider stabilization of the spine.	Considered, but not needed.
Primary Assessment	
General impression.	29 year old male appears pale in color and appears to be having a hard time catching his breath.
Responsiveness/level of consciousness (AVPU).	Alert and oriented to person, place, time and event.
Chief complaint/apparent life threat.	"I am having difficulty breathing, and I feel slightly weird."
Assess the airway.	Patent.
Breathing.	Slightly fast, regular, and labored.
Oxygen.	Not available.
Assess chest (I, A, and P) Inspect.	Symmetrical with equal rise and fall noted, negative for DCAP-BTLS or trauma.
Auscultate.	Rales and crackles noted in both lung fields.
Palpate sternum.	Cool.
Condition.	Dry.
Circulation (check for bleeding, pulses, and skin (CCT)).	Patient tells you he is not bleeding.
Color.	Pale.
Condition.	Dry.
Temperature.	Cool.
Assess for and control significant bleeding.	Patient denies bleeding.
Treat the casualty for shock.	Not at this time.
Determine the priority of the patient and transport decision.	Emergent (Load and Go)
Secondary Assessment (History of Present Illness/Injury) and SAMPLE History (OPQRST and I)	
Signs and symptoms.	"I cannot catch my breath for some reason."
Onset of the event.	"It started right after I built up my shelter last night."

Provocation or palliation.	"Nothing makes it better or worse."
Quality of the pain.	"It's not pain, but it feels like a pins and needles sensation."
Region and radiation.	"It's in both my hands and feet."
Severity 1 to 10 on the pain scale.	"Not being able to breathe right, I would say 4 to 5 out of 10."
Time (history).	"Last night, so about 2 to 3 hours."
Interventions.	"I have not done anything except tell you."
Allergies.	"No known drug allergies."
Medications.	"Just the Tylenol® I just took."
Past medical history.	"None."
Last oral intake.	"Light breakfast 6 hours ago."
Events leading up to injury/illness.	"4 hours ago helicopter insertion at 3,000 feet and set up sleeping area."
Perform a focused physical examination.	Eyes: PERRL. Chest: Negative for DCAP-BTLS, trauma and TIC, Skin appears pale. Auscultation reveals crackling (rales) in both lung fields. Cough yields clear sputum. Abdomen is soft, round non-tender with BS slightly hypoactive all 4 quadrants.
	EVALUATOR: The Soldier Medic performs the focused physical examination by verbalizing the assessment of affected body part.
Obtain vital signs.	
Blood pressure.	124 over 80.
Pulse.	108.
Oxygen saturation.	90%.
Respirations.	22.
Temperature.	98.2°F.
Call to medical direction or use additional protocols.	Call for MEDEVAC.
Reassess decision to transport	Awaiting MEDEVAC.
Reassessment	
Repeat the primary assessment.	No change.
Reassess chief complaint.	No change.
Check interventions.	Position of comfort and reassure patient.
Repeat vital signs.	No change
Document the primary and secondary assessments DD Form 1380.	Document to local standards.
Do not cause further injury to the casualty.	If evacuation delayed, descend to lower altitude (below 1,500 meters).
Medical report received by.	Use local medical treatment facility.

A-23. Medical Scenario Number 8, Heat Injury

Conditions: While in a garrison environment you encounter a medical patient. You have an aid bag.	
Standard: Complete a medical assessment; perform scene size up through initial transportation decision in first 5 minutes. Complete entire assessment in 15 minutes. Reassessment will be done en route to medical facility, but must be verbalized.	
Scenario History: Unresponsive 17 year old male, found beside a running track on a day when the outside temperature is 92°F and the humidity is greater than 75%. The skin appears to be red in color and hot to touch. He does not appear to be sweating as you approach him.	
Scene Size Up	
Take BSI precautions.	Don gloves and eye protection.
Determine if the scene is safe.	Scene is safe.
Determine the nature of the illness.	Signs and symptoms of heat stroke.
Determine the number of casualties.	One.
Request additional assistance, if necessary.	Have ALS on stand-by.
Consider stabilization of the spine.	Yes needed, unwitnessed event.
Primary Assessment	
General impression.	27 year old male that is wearing a sweat shirt and sweat pants. Skin appears dry. Evidence of exercise or other activity
NOTE: C-spine stabilization must be gained/performed. Soldier Medic can verbalize how they would perform.	Manually maintain in-line (neutral) c-spine stabilization.
Responsiveness/level of consciousness.	Responsive to painful stimuli.
Chief complaint.	Unable to obtain, patient responsive only to painful stimuli.
Assess the airway (Soldier Medic must verbalize how they would open the casualty's air along with the use of an airway adjunct.).	Open the airway using the jaw thrust maneuver and insert an oropharyngeal airway (OPA).
Breathing.	Rapid and shallow
Oxygen.	Bag valve mask with 15 L oxygen after insertion of an OPA.
Circulation (check for bleeding, pulses and skin (CCT)).	Rapid head to toe blood sweep performed and no bleeding noted.
Color.	Reddish in color.
Condition.	Dry.
Temperature.	Extremely hot.
Assess the pulse (carotid and radial).	Rapid and bounding.
Assess chest (I, A, and P) Inspect.	Expose casualty's chest while still providing privacy from bystanders. Chest is symmetrical with equal rise and fall.
Auscultate.	Lungs are CTA bilaterally
Palpate sternum.	Negative for TIC
Treat the casualty for shock.	Supine position, loosen clothing, pour cool water over patient
Determine the priority of the patient and transport decision.	Load and go.

Secondary Assessment (Rapid Physical Examination Head to Toe) NOTE: Maintain in-line C-spine stabilization.	
Head.	Negative for DCAP-BTLS and TIC,
Neck (anterior and posterior).	Negative for DCAP-BTLS. Trachea is midline and no jugular vein distension noted. Negative for step offs. C-collar applied.
Chest.	Negative for DCAP-BTLS and TIC. Lungs remain CTA bilaterally with equal rise and fall.
Abdomen.	Negative for DCAP-BTLS, soft, round without rigidity or mass(es) noted.
Pelvis.	Negative for DCAP-BTLS and stable.
Lower extremities.	Negative for DCAP-BTLS and TIC. Pedal and posterior tibial pulses strong. No evidence of trauma noted; checked distal sensation by pinching top of feet.
Upper extremities.	Negative for DCAP-BTLS and TIC. Radial pulses rapid and bounding; distal sensation checked by pinching the top of hands.
Posterior.	Log rolled patient as unit while still maintaining manual in-line c-spine stabilization. Negative for DCAP-BTLS and TIC (step offs). No signs or symptoms of trauma noted. Buttocks negative for blood, urine or feces.
NOTE: Log rolled as a unit and placed on a long spine board, secured with litter straps and padding as appropriate.	Verbalized procedure for securing patient to long spine board.
Vital signs.	
Pulse.	138.
Respirations.	24, has OPA and ventilated via bag valve mask with oxygen at 15 L, tolerating well.
Blood pressure.	140 over 90.
Oxygen saturation.	98%.
Skin	Still reddish in color, and extremely hot to the touch.
Past medical history.	Unable to obtain, patient is unresponsive. Bystander has no information.
Interventions.	Place cold packs in armpits, behind each knee, and at side of neck.
Reassessment **Detailed physical examination (head to toe) en route.**	
Head (to include face, eyes, cheeks, nose mouth and ears).	Negative for DCAP-BTLS and TIC, eyes pupils are dilated no ecchymosis noted. Nose negative for blood/CSF. Mouth negative for blood, vomitus and teeth intact. Ears negative for battle signs.
Neck.	Unremarkable, C-collar in place.
Chest.	Unremarkable.
Abdomen.	Unremarkable, BS present all 4 quadrants
Pelvic.	Unremarkable.
Lower extremities.	Unremarkable.
Upper extremities.	Unremarkable.

NOTE: Cannot check posterior, casualty is on long spine board.	
Reassess vital signs every 5 minutes.	
Respirations.	24 has OPA and ventilated via bag valve mask with oxygen at 15 L.
Pulse.	104.
Blood pressure.	98 over 60.
Oxygen saturation.	98%.
Temperature.	Axillary 104^{o}F.
Reassess interventions	Monitor all interventions and place casualty in a supine position
Document the primary and secondary assessments on DD Form 1380.	Document to local standards.
Do not cause further injury to the casualty.	No further injuries sustained.
Medical report received by	Use local medical treatment facility

A-24. Medical Scenario Number 9, Cold Injury

Conditions: While in a field environment you encounter a medical casualty. You have a medical aid-bag, weapon, ballistic helmet, individual body armor and IFAK.	
Standard: Complete a medical assessment; perform scene size up through initial transportation decision in first 5 minutes. Complete entire assessment in 15 minutes. Reassessment will be done en route to medical facility, but must be verbalized.	
Scenario History: It is late January and your unit is in the field. A Soldier comes up to you and tells you that his battle buddy is not doing so well. You grab your aid bag and proceed to the Soldiers' tent. You see a Soldier completely bundled up and shaking.	
Scene Size Up	
Take BSI precautions.	Don gloves and eye protection.
Determine if the scene is safe.	Scene is safe.
Determine the nature of the illness.	Possible cold weather injury.
Determine the number of casualties.	One.
Request additional assistance, if necessary.	Not needed.
Consider stabilization of the spine.	Consider, but not needed.
Primary Assessment	
General impression.	Shivering, young, thin 21 year old Soldier holding his hand close to his body wrapped in blankets.
Responsiveness/level of consciousness (AVPU).	Alert, but using inappropriate words.
Chief complaint/apparent life threats.	Unable to obtain, using inappropriate words.
Assess the airway.	Patent.
Breathing.	Tachypnea, irregular and shallow.
Oxygen.	Bag valve mask with 15 L oxygen; however, patient does not tolerate. Oxygen at 15 L via non-rebreather tolerating well.
Assess chest (I, A, and P) Inspect.	Negative for DCAP-BTLS and trauma, with equal rise and fall of chest.
Auscultate.	CTA bilaterally.
Palpate sternum.	Negative for TIC.
Circulation (check for bleeding, pulses, and skin (CCT)).	No obvious bleeding noted.
Color.	Pale.
Condition.	Dry.
Temperature.	Cold.
Assess the pulses (carotid and radial).	Tachycardic, regular, and weak.
Treat the casualty for shock.	Treat for shock (wrap in hypothermia kit or space blanket).
Determine the priority of the patient and transport decision.	Load and go/emergent transport patient in position of comfort.

Perform a History and a Secondary Assessment	
Signs and symptoms.	Battle buddy tells you, "I noticed him shivering and moaning."
Onset of the event.	Battle buddy tells you, "It all started about an hour ago."
Provocation or palliation	Battle buddy tells you, "I am not sure, he just keeps shivering and moaning "
Quality of the pain.	Battle buddy tells you, "He just sits there shivering."
Region and radiation	Battle buddy tells you, "He just stares, shivering, and moaning; he's cold."
Severity 1 to 10 on the pain scale.	Battle buddy cannot tell you the severity of his condition.
Time (history).	Battle buddy tells you, "Approximately 1 hour ago."
Interventions.	Battle buddy tells, "Nothing except get you."
Allergies.	Battle buddy tells you, "He has no known drug allergies."
Medications.	Battle buddy tells you, "No medications that I'm aware of."
Last oral intake.	Battle buddy tells you, "Supper last night."
Events Leading up to injury/illness.	Battle buddy tells you, "He had guard duty all night."
Perform a focused physical examination.	Eyes are PERRL; skin is pale, cold and dry. Shivering noted. He is alert, but having a difficult time talking. Body posture very ridged and stiff. Chest negative for DCAP-BTLS and TIC, lungs CTA bilaterally. Abdomen is round and soft, no mass upon palpation. With BS hypoactive all 4 quadrants. No obvious signs or symptoms of trauma noted.
	EVALUATOR: The Soldier Medic performs the focused physical examination by verbalizing the assessment of affected body part.
Obtain vital signs.	
Blood Pressure.	100 over 60.
Pulse.	52 beats per minute.
Oxygen saturation.	94% on 15L via non-rebreather.
Respirations.	28.
Temperature.	95°F.
Call to medical direction or use additional protocols.	
Reassess decision to transport	En route to hospital.
Reassessment	
Repeat the primary assessment.	
Reassess chief complaint.	Soldier is still shaking and moaning.
Check interventions.	No change

Repeat vital signs.	Blood Pressure. - 105 over 64. Pulse. - 62 beats per minute. Respirations. - 26. Oxygen saturation. - 96 %. Temperature. - 96^{o}F.
Document the primary and secondary assessments on DD Form 1380.	Document to local standards.
Do not cause further injury to the casualty.	No further injuries sustained.
Medical report received by.	Use local medical treatment facility.

A-25. Medical Scenario Number 10, Snake Bite

Conditions: While in a field environment you encounter a medical casualty. You have an aid bag, weapon, ballistic helmet, individual body armor and IFAK.	
Standard: Complete a medical assessment; perform scene size up through initial transportation decision in first 5 minutes. Complete entire assessment in 15 minutes. Reassessment will be done en route to medical facility, but must be verbalized.	
Scenario History: You are a line medic participating in a two week Intense Training Cycle during early summer. Your battalion has just jumped to a new location and the battalion aid station is not at your location. The scout platoon sergeant brings you a Soldier and a dead brown and tan colored snake with elliptical (non-round) eyes that he has identified as a copperhead that has bitten his Soldier.	
Performed a Scene Size-up	
Take BSI precautions.	Dons gloves and eye protection.
Determine if the scene is safe.	Scene safe.
Determine the nature of the illness.	Snake bite envenomation
Determine the number of casualties.	One.
Request additional assistance, if necessary.	None.
Consider stabilization of the spine.	Considered, but not needed
Primary Assessment	
General impression.	22 year old male holding left forearm with two penetrations oozing minimal blood. Soldier seems anxious and in obvious pain
Responsiveness/level of consciousness (AVPU).	Alert and oriented to person, place, time and event.
Chief complaint/apparent life threat.	"Something bit me right here on my left forearm."
Assess the airway.	Airway is open and patent.
Breathing.	Rapid, regular, and normal
Oxygen.	None available
Assess chest (I, A, and P) Inspect.	Symmetrical with equal rise and fall.
Auscultate.	CTA bilaterally
Palpate sternum.	He denies any tenderness and negative for instability and crepitus.
Circulation (check for bleeding, pulses, and skin (CCT)).	Minimal bleeding noted from bite marks.
Color.	Pale, but slight erythema around bite.
Condition.	Clammy.
Temperature.	Cool.
Assess the pulses (carotid and radial).	Tachycardic, regular and weak in affected limb.
Treat the casualty for shock.	Remove constrictive clothing, watch and rings and lay casualty flat.

Determine the priority of the patient and transport decision.	Emergent (Load and Go).
Secondary Assessment (History of Present Illness/Injury) and SAMPLE History (OPQRST and I)	
Signs and symptoms.	"I was low crawling through the brush when I suddenly felt this sharp pain in my left arm. I grabbed my arm because it was stinging and burning; it felt like fire. Then my battle buddy saw the snake and killed it."
Onset of the event.	"After being bitten."
Provocation or palliation	"Movement makes it slightly worse."
Quality of the pain.	"Sharp burning sensation."
Region and radiation.	"Confined to my left forearm."
Severity 1 to 10 on the pain scale.	"It's an 8 out of 10."
Time (history).	"This happened 5 minutes ago."
Interventions.	"Nothing."
Allergies.	"Penicillin."
Medications.	"None."
Past medical history.	"I've never been sick."
Last oral intake.	"Lunch 4 hours ago."
Events leading up to injury/illness.	"Low crawling in woods."
Perform a focused physical examination.	Breathing adequately on room air. No signs symptoms of respiratory distress noted at present time. Eyes are PERRL. Chest negative for DCAP-BTLS and TIC, has equal rise and fall of chest; lungs. CTA bilaterally. Abdomen is soft, round nontender and BS present all 4 quadrants. Left arm: slight erythema, edema, and ecchymosis. Right arm unremarkable. Immobilized affected limb by splinting and keep below heart level.
	EVALUATOR: The Soldier Medic performs the focused physical examination by verbalizing the assessment of affected body part.
Obtain vital signs.	
Blood pressure.	118 over 60.
Pulse.	90
Oxygen saturation.	99% on room air
Respirations.	24.
Temperature.	98.8^{o}F.
Call to medical direction or use additional protocols.	Call medical direction to determine the best receiving facility where antivenin will be mostly available to treat the patient.
Reassess decision to transport.	En route to treatment facility

Reassessment	
Repeat the primary assessment.	No change.
Reassess chief complaint.	Increased edema to left arm where puncture sites are located.
Check interventions.	Reassess site, splint, vital signs, and place in position of comfort along with reassure patient.
Repeat vital signs;	No change.
Document the primary and secondary assessments on DD Form 1380.	Document to local standards.
Do not cause further injury to the casualty.	Ensure all rings and jewelry removed.
Medical report received by.	Use local medical treatment facility where antivenin is located.

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APPENDIX B

EQUIPMENT

B-1. Combat Medic Bag

NSN	Nomenclature	Issue
6545-01-539-6450	M9 Bag	1 each
6515-00-935-7138	Scissors, Bandage	1 each
6515-01-540-7226	Leash, Shears	1 each
7520-00-312-6124	Marker, Sharpie	1 each
8465-01-573-4439	Center Pouch	1 each
6515-01-527-8068	Headlamp Medical 4 Intensity Modes Non-Heat Generating	1 each
6515-01-573-0692	Cricothyrotomy Set Emergency Field Pack	2 each
6515-01-515-0151	Tool Kit Rescue Oropharyngeal Airway Size #4	1 each
6515-01-541-0635	Needle Decompression Device 14 gauge by 3.25 inches	4 each
6515-01-521-3082	Airway Pharyngeal 100mm Large Adult Two Per Package	1 package
6530-01-491-5030	Container Sharps Tube 9.25 by 1.5 inches Use In Disp Infectious Biomed Waste	1 each
6515-01-494-1951	Splint Universal Aluminum 36 inches O/A Long 4.25 inches Wide Gray and Olive Drab Reuse	2 each
6510-01-573-0300	Dressing Chest Seal Wound 8 by 6 Inches	4 each
6515-01-484-1327	Catheter IV Introcan Safety 18 Gauge by 1.25 inches Long Winged NDL Teflon 200s	8 each
6505-01-498-8636	Hetastarch In Lactated Electrolyte Injection 500 ml Container 12s	2 Bg
6515-01-519-5778	Adapter Catheter To Luer Syringe Short Locking 5s	1 package
6510-01-519-8421	Dressing Occlusive Adhesive Clear 4.75 by 4 inches 5s	1 package
6515-01-561-6204	Administration Set Intravenous Fluids Needleless Coil Tubing 50s	4 each
6515-01-521-7976	Tourniquet Combat Application One-Handed	6 each
6510-01-503-2117	Bandage Gauze Cotton 6 Ply White 4.5 inches Wide 4.1 yards Long	6 rolls
6510-01-562-3325	Bandage Gauze Impregnated 3 inches by 4 yards Kaolin Hemostatic QuikClo®t	6 each
6510-01-492-2275	Bandage Kit Elastic	4 each
6510-00-935-5823	Bandage Elastic Flesh Rolled Nonsterile 6 inches by 4.5 yards 10s	4 each
6510-01-532-8930	Bandage Elastic 16 by 12 inches Abdominal Wound Pad Sterile (Big Cinch)	1 each
6515-01-568-0193	Resuscitator, Hand Operated Disp Single Patient Use	1 each
6510-00-926-8884	Adhesive Tape Surgical Porous Woven 3 inches by 10 yards 4s	4 rolls
8145-01-573-2533	Shipping And Storage Cas Medication	1 each
6515-01-557-1136	Oximeter Pulse Portable Fingertip Pediatric-Adult Incl Soft Case	1 each
6515-01-559-0741	Holder Injector Syringe Plastic Reusable Full-Length	1 each
6505-01-152-7626	Epinephrine Injection USP 2 ml Automatic Injector	1 each
6505-01-407-0213	Naloxone Hydrochloride Injection USP 1 mg/ml 2 ml Syringe Unit 25s	2 each
6505-01-505-3476	Diazepam Injection USP 5mg/ml 2 ml Unit 10 Per Package	1 package
6505-01-513-1952	Morphine Sulfate Injection USP 10 mg/ml 1ml Carpuject 10 Per Package	5 each
6532-01-525-4062	Blanket Heating Disposable 90 X 90 cm Water Repellent 8s	1 each
6532-01-524-6932	Blanket Survival Blizzard Pack Reflexcell Military Green	1 each
6505-01-539-8069	Sodium Chloride Injection USP 0.9% 10 ml Disposable Syringe 30s	5 each

NSN	Nomenclature	Issue
8465-01-573-4439	Pouch Medical Utility UCP DIA 9 by 3 by 5 inches Cubic In Camo Nylon	1 each
6515-01-519-6764	Tube Drainage Surgical Penrose 1 by 18 inches Rubber Radiopaque Ster 6s	1 package
8465-01-573-3374	Bag Drop Leg Holster Combat Medic	1 each
6510-00-597-7469	Bandage Adh.75 by 3 inches Flesh/Clear Ster Dress Affixed To Plas Adh 100s	30 each
6510-00-786-3736	Pad Isopropyl Alcohol Impregnated Nonwvn Cotton/Rayon White 200s	1 PG
6515-01-516-2554	Suction Kit, Easy, Field Complete	1 each
6515-01-516-3120	Suction Easy, Catheter Adapter	1 each
6515-01-519-4150	Bag, Reclosable Zip Lock Style 3 by 4 inches 2 mil 30s	1 package
6510-01-519-9253	Sponge Surgical 8 PLY 2 by 2 inches 20X12 Mesh Sterile 40s	1 package
6510-00-201-1755	Bandage Muslin Compressed Olive Drab 37 by 37 by 52 inches Triang With Safety Pins	2 each
6135-00-826-4798	Battery Nonrechargeable Alkaline AAA 1.5V 12 Per Package	1 packages
6515-01-314-6694	Stethoscope Combination Littman Classic II 28 inches long Bell-Diaphragm	1 each
6515-01-449-1016	Shield Eye Surgical Fox Single Natural Aluminum 12s	2 each
6515-01-521-5730	Splint Fracture CT-6 Femoral Either Leg Corrosion Resistant	1 each
6515-01-525-1975	Glove Patient Examining & Treatment SZ X-Large Latex/Powder Free	6 each
6515-01-529-1187	Nasal Trumpet 28 fr Sterile	3 each
6515-01-536-9363	Intraosseous Infusion System F/Treating Hemorrhagic Shock	2 each
6515-01-540-7226	Leash Shears Trauma Black High Break Strength	2 each
4240-01-568-3219	Strap Cutter, Combat	1 each
8345-01-573-3304	Panel Marker Battlefield Combat Medic 2 by 2 feet	1 each

B-2. Improved First Aid Kit

NSN	Nomenclature	Issue
6545-01-530-0929	First Aid Kit	1 each
Components		
8465-01-531-3647	100 Round SAW/Utility Pouch, MOLLE II	1 each
6510-01-492-2275	Bandage Kit, Elastic	1 each
	OR	
6510-01-460-0849	Bandage Kit, Elastic	1 each
6510-01-503-2117	Bandage GA4-1/2” 100’s	1 each
6510-00-926-8883	Adhesive Tape Surg 2” 6’s PG	1 each
6515-01-180-0467	Airway, Nasopharyngeal	1 each
6515-01-519-9161	Glove, Patient Exam 100’s	4 each
6545-01-586-7691	Contents Kit, IFAK Resupply Kit	1 each
6545-01-531-3147	Insert (folding panels with cord)	1 each
6510-01-562-3325	Dressing, Combat Gauze	1 each*
6515-01-521-7976	Tourniquet®, Combat Application One-Handed	1 each

*The Combat Gauze has a 36-month shelf life, so it is shipped separately.

Glossary

ACRONYMS AND ABBREVIATIONS

ADRP	
AEMT	advanced emergency medical technician
AKO	Army Knowledge Online
AMEDDC&S	U.S. Army Medical Department Center and School
AMPLE	allergies, medications, past history, last oral intake, events leading up to illness or injury
AMS	altered mental status
AR	Army regulation
ARIMS	Army Records Information Management System
ASI	additional skill identifier
AVPU	alert, (responsive to) verbal, (responsive to) pain, unresponsive
BLS	burns, lacerations, swelling
BSI	body substance isolation
BTLS	burns, tenderness, lacerations, swelling
C-A-T	combat application tourniquet
CCT	Color, condition, temperature
CE	continuing education
ch	chapter
CPR	cardiopulmonary resuscitation
CTA	covered training area
CUF	care under fire
DA	Department of the Army
DCAP	deformity, contusions, abrasions, punctures/penetrating
DD	Department of Defense
ed	edition
EENT	eyes, ears, nose and throat
EFP	explosive formed penetrator
EMT	emergency medical technician
EMT-P	emergency medical technician – paramedic
FM	field manual
H - ABC	Hemorrhage- airway, breathing, circulation
HEENT	head, eyes, ears, nose and throat
HMMWV	high-mobility, multipurpose wheeled vehicle
IBA	Interceptor body armor

ICS	intercostal space
IED	improvised explosive device
IFAK	individual first aid kit
IV	intravenous
JP	joint publication
LOC	loss of consciousness
MCL	midclavicular line
MEDEVAC	medical evacuation
METL	mission essential task list
ml	milliliters
MODS	Medical Operational Data System
MOS	military occupational specialty
NCD	needle chest decompression
NCO	noncommissioned officer
NPA	nasopharyngeal airway
NREMT	National Registry of Emergency Medical Technicians
OCD	occlusive dressing
OPA	oropharyngeal airway
OPQRST	Onset, palliative/provocative, quality, region/radiation, severity, timing
PERRL	pupils equal, round, reactive to light
SOAP	subjective, objective, assessment, plan
TC	training circular
TC3	tactical combat casualty care
TCCC	tactical combat casualty care
TIC	tenderness, instability, crepitus
TRD	tenderness, rigidity, distention
TSP	training support package
U.S.	United States
WALK™	Warrior Aid and Litter Kit

References

Section I. REQUIRED PUBLICATIONS

Most Army publications are available online: http://www.apd.army.mil.

Most joint publications are available online:
http://www.dtic.mil/doctrine/new_pubs/jointpub.htm

ADRP 1-02 Terms and Military Symbols, 24 September 2013.
AR 25-400-2 The Army Records Information Management System (ARIMS), 2 October 2007.
AR 40-68 Clinical Quality Management, 26 February 2004.
AR 200-1 Environmental Protection and Enhancement, 13 December 2007.
AR 385-10 The Army Safety Program, 27 November 2013.
FM 4-02.2 Medical Evacuation, 8 May 2007.
JP 1-02 Department of Defense Dictionary of Military and Associated Terms, 8 November 2010.
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Brady Emergency Care, Twelfth Edition, Limmer, Daniel, and Michael F. O'Keefe, 8 May 2011.

Section II. RELATED PUBLICATIONS

AR 350-1 Army Training and Leader Development, 18 December 2009.
ATP 5-19 Risk Management, 14 April 2014.
FM 4-02 Army Health System, 26 August 2013.
STP 21-1-SMCT Soldier's Manual of Common Tasks, Warrior Skills Level 1, 14 April 2014.
PHTLS Basic and Advanced Prehospital Trauma Life Support: Military Version National Association of Emergency Medical Technicians, Sixth Edition, 2007.

Section III. RECOMMENDED READING

ADRP 7-0 Training Units and Developing Leaders, 23 August 2012.
AR 220-1 Army Unit Status Reporting and Force Registration – Consolidated Policies, 15 April 2010.
ATP 4-02.5 Casualty Care, 10 May 2013.
ATP 4-25.12 Unit Field Sanitation Teams, 30 April 2014.
ATP 4-25.13 Casualty Evacuation, 15 February 2013.
DA Pam 40-11 Preventive Medicine, 22 July 2005.
DA Pam 611-21 Military Occupational Classification and Structure, 22 January 2007.
STP 21-24-SMCT Soldier's Manual of Common Tasks (SMCT) Warrior Leader Skill Level 2, 3 and 4, 9 September 2008.
Emergency Care and Transportation of the Sick and Wounded American Academy of Orthopaedic Surgeons (AAOS), Ninth Edition, March 2005.
Textbook of Basic Nursing,Tenth Edition, Rosdahl, Caroline B., and Mary T. Kowalski, 20 December 2011.

Section IV. PRESCRIBED FORMS

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) Web site: http://www.apd.army.mil

DA Form 7441	Coordinator's Checklist ─ (Table VIII)
DA Form 7442	Tracking Sheet ─ (Table VIII)
DA Form 7595-1-1	Perform a Combat Casualty Assessment
DA Form 7595-1-2	Perform an Emergency Medical Technician Trauma Assessment
DA Form 7595-1-3	Initiate Treatment for an Open Abdominal Injury
DA Form 7595-1-4	Initiate Treatment for an Impaled Object
DA Form 7595-1-5	Perform a Needle Chest Decompression
DA Form 7595-1-6	Initiate Treatment for an Open Chest Injury
DA Form 7595-1-7	Apply an Occlusive Dressing
DA Form 7595-1-8	Initiate Treatment for Burns
DA Form 7595-1-9	Initiate Treatment for Hypovolemic Shock
DA Form 7595-1-10	Apply a Combat Application Tourniquet®
DA Form 7595-1-11	Apply a Pressure Dressing to an Open Wound
DA Form 7595-1-12	Control Bleeding
DA Form 7595-1-13	Apply a Hemostatic Dressing
DA Form 7595-1-14	Initiate Treatment for an Amputation
DA Form 7595-1-15	Apply a Traction Splint
DA Form 7595-1-16	Initiate Treatment for a Head Injury
DA Form 7595-1-17	Initiate Treatment for Foreign Bodies of the Eye
DA Form 7595-1-18	Initiate Treatment for Axillary Wounds
DA Form 7595-1-19	Initiate Treatment for Inguinal Wounds
DA Form 7595-1-20	Initiate Treatment for Neck Wounds
DA Form 7595-2-1	Clear an Upper Airway Obstruction
DA Form 7595-2-2	Insert an Oropharyngeal Airway
DA Form 7595-2-3	Ventilate a Patient with a Bag-Valve-Mask (BVM)
DA Form 7595-2-4	Measure a Patient's Pulse Oxygen Saturation
DA Form 7595-2-5	Set up an Oxygen Tank
DA Form 7595-2-6	Perform Oral Suctioning
DA Form 7595-2-7	Insert a Nasopharyngeal Airway
DA Form 7595-2-8	Administer Oxygen
DA Form 7595-2-9	Insert a King LT®
DA Form 7595-2-10	Perform a Surgical Cricothyroidotomy
DA Form 7595-2-11	Measure a Patient's Respirations
DA Form 7595-3-1	Initiate an Intravenous Infusion
DA Form 7595-3-2	Manage an Intravenous Infusion
DA Form 7595-3-3	Initiate an Intraosseous Infusion (FAST1®)
DA Form 7595-3-4	Initiate a Saline Lock
DA Form 7595-3-5	Prepare an Injection for Administration
DA Form 7595-3-6	Administer an Intramuscular Injection
DA Form 7595-3-7	Administer a Subcutaneous Injection
DA Form 7595-4-1	Initiate Treatment for a Diabetic Emergency
DA Form 7595-4-2	Measure a Patient's Pulse
DA Form 7595-4-3	Manage a Seizing Patient
DA Form 7595-4-4	Initiate Treatment for Anaphylactic Shock
DA Form 7595-4-5	Perform Visual Acuity Testing
DA Form 7595-4-6	Document Medical Care: SOAP Note Format
DA Form 7595-4-7	Perform a Medical Patient Assessment
DA Form 7595-4-8	Operate an Automated External Defibrillator
DA Form 7595-4-9	Initiate Treatment for Chest Pain
DA Form 7595-4-10	Perform an Examination of the Knee

DA Form 7595-4-11	Perform an Examination of the Shoulder
DA Form 7595-4-12	Perform an Examination of the Wrist
DA Form 7595-4-13	Perform an Examination of the Back
DA Form 7595-4-14	Perform an Examination of the Ankle
DA Form 7595-4-15	Perform an HEENT Examination
DA Form 7595-4-16	Perform an Examination of the Elbow
DA Form 7595-5-2	Initiate a Tactical Combat Casualty Care Card
DA Form 7595-5-3	Triage Casualties
DA Form 7595-5-4	Initiate a 9-Line MEDEVAC Request
DA Form 7595-5-5	Perform Manual Evacuation
DA Form 7595-5-6	Transport a Casualty Using a Litter
DA Form 7595-5-7	Prepare a SKEDCO® for Hoist Operations
DA Form 7595-5-8	Apply a Long Spine Board
DA Form 7595-6-1	Implement Suicide Prevention Measures
DA Form 7595-6-2	Initiate Treatment for Altitude Illness
DA Form 7595-6-3	Treat a Casualty for a Heat Injury
DA Form 7595-6-4	Treat a Casualty for a Cold Injury
DA Form 7595-6-5	Treat a Casualty for Insect Bites and Stings
DA Form 7595-6-6	Treat a Casualty for a Snake Bite
DA Form 7741	Medical Scenario Grade Sheet
DA Form 7742	Trauma Scenario Grade Sheet

Section V. REFERENCED FORMS

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) Web site: www.apd.army.mil

DD Forms are available on the Office of the Secretary of Defense (OSD) Web site: www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm

Standard Forms (SF) are available on the U.S. General Services Administration (GSA) Web site: www.gsa.gov

DA Form 2028	Recommended Changes To Publications and Blank Forms
DD Form 1380	Tactical Combat Casualty Care (TCCC) Card

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TC 8-800
15 September 2014

By Order of the Secretary of the Army:

RAYMOND T. ODIERNO
General, United States Army
Chief of Staff

Official:

GERALD B. O'KEEFE
Administrative Assistant to the
Secretary of the Army
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