

### CBRN MEDICAL REPORT FORM

<b>Name:</b>		<b>Date:</b> / /	<b>Sex:</b> Male / Female	<b>Age:</b>	or	<b>DOB:</b> / /
<b>Nationality:</b>	<b>Rank:</b>	<b>Service No:</b>	<b>Service:</b>		<b>Unit:</b>	
<b>Location:</b>		<b>Incident time (if overt):</b> :	<b>Time of symptom onset:</b> :	<b>Arrival time:</b> :		
<b>Type of Incident:</b>	<input type="checkbox"/> Chemical [suspected agent] <input type="checkbox"/> Biological [suspected agent] <input type="checkbox"/> Radiological <input type="checkbox"/> Nuclear <input type="checkbox"/> Trauma [type] <input type="checkbox"/> Other [ ]					
	CBRN <input type="checkbox"/> Suspected <input type="checkbox"/> Probable <input type="checkbox"/> Confirmed <input type="checkbox"/> DIM equipment used [ ]    Reading [ ]					
<b>Physical Protection:</b>	Respiratory [CBRN <input type="checkbox"/> / Particulate <input type="checkbox"/> / Other _____] <input type="checkbox"/> Gloves <input type="checkbox"/> Protective suit <input type="checkbox"/> Other [ ]					
<b>Pre-Exposure MedCM:</b>	<input type="checkbox"/> Chem [ ] <input type="checkbox"/> Bio [ ] <input type="checkbox"/> Rad [ ]					

INJURIES & CONTAMINATION:	QUICK LOOK – CBRN												
<p># Fracture    +++ Wound    //// Contaminated area</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td><b>Conscious</b></td> <td> <input type="checkbox"/> Alert   <input type="checkbox"/> Verbal   <input type="checkbox"/> Pain  <input type="checkbox"/> Unconscious                      <input type="checkbox"/> Fitting                 </td> </tr> <tr> <td><b>Respiratory</b></td> <td> <input type="checkbox"/> Normal   <input type="checkbox"/> Abnormal  <input type="checkbox"/> Asymmetrical   <input type="checkbox"/> Absent                      /min                 </td> </tr> <tr> <td><b>Eyes</b></td> <td>   <input type="checkbox"/> Pinpoint    <input type="checkbox"/> Normal    <input type="checkbox"/> Wide                 </td> </tr> <tr> <td><b>Secretions</b></td> <td> <input type="checkbox"/> Normal    <input type="checkbox"/> Secretions    <input type="checkbox"/> Dry                 </td> </tr> <tr> <td><b>Skin</b></td> <td> <input type="checkbox"/> Normal    <input type="checkbox"/> Sweaty                      <b>BURNS</b>  <input type="checkbox"/> Cyanosed   <input type="checkbox"/> Pink                              <input type="checkbox"/> Chemical  <input type="checkbox"/> Purpuric rash                      <input type="checkbox"/> Thermal                 </td> </tr> <tr> <td><b>Other</b></td> <td> <b>Temp</b>    °C/°F (<input type="checkbox"/> Core   <input type="checkbox"/> Peripheral)  <b>Pulse</b> <input type="checkbox"/> Rad   <input type="checkbox"/> Fem   <input type="checkbox"/> Carotid  <b>ECG</b> <input type="checkbox"/> Sinus Rate   /min   <input type="checkbox"/> Abnormal   <b>Radiation:</b>  <input type="checkbox"/> Vomiting or <input type="checkbox"/> Diarrhoea onset [ : ]                 </td> </tr> </table>	<b>Conscious</b>	<input type="checkbox"/> Alert <input type="checkbox"/> Verbal <input type="checkbox"/> Pain <input type="checkbox"/> Unconscious <input type="checkbox"/> Fitting	<b>Respiratory</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Asymmetrical <input type="checkbox"/> Absent                      /min	<b>Eyes</b>	 <input type="checkbox"/> Pinpoint <input type="checkbox"/> Normal <input type="checkbox"/> Wide	<b>Secretions</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Secretions <input type="checkbox"/> Dry	<b>Skin</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Sweaty <b>BURNS</b> <input type="checkbox"/> Cyanosed <input type="checkbox"/> Pink <input type="checkbox"/> Chemical <input type="checkbox"/> Purpuric rash <input type="checkbox"/> Thermal	<b>Other</b>	<b>Temp</b> °C/°F ( <input type="checkbox"/> Core <input type="checkbox"/> Peripheral) <b>Pulse</b> <input type="checkbox"/> Rad <input type="checkbox"/> Fem <input type="checkbox"/> Carotid <b>ECG</b> <input type="checkbox"/> Sinus Rate   /min <input type="checkbox"/> Abnormal  <b>Radiation:</b> <input type="checkbox"/> Vomiting or <input type="checkbox"/> Diarrhoea onset [ : ]
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### EMERGENCY MEDICAL TREATMENT AND HAZARD MANAGEMENT

<b>INITIAL TRIAGE</b>	<b>T</b>	<b>HAZARD:</b> <input type="checkbox"/> Gas/Vapour <input type="checkbox"/> Liquid <input type="checkbox"/> Dry/particulate <input type="checkbox"/> Wound <input type="checkbox"/> Unknown <input type="checkbox"/> Contagious (suspected) <b>MANAGEMENT:</b> <input type="checkbox"/> Removal of clothing <input type="checkbox"/> Dry contamination <input type="checkbox"/> Rinse <input type="checkbox"/> Full wet contamination <input type="checkbox"/> Isolation
<b>Catastrophic Haemorrhage:</b>	Site(s): [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] <input type="checkbox"/> CAT Applied Time: [ : ] <input type="checkbox"/> Haemostatic Time: [ : ] <input type="checkbox"/> FFD Site(s): [ ] [ ] [ ] [ ]	
<b>Airway:</b>	<input type="checkbox"/> OPA / NPA Size: [ ] <input type="checkbox"/> LMA Size: [ ] <input type="checkbox"/> ETT Size: [ at ] <input type="checkbox"/> RSI Time: [ : ] <input type="checkbox"/> Surgical Airway	
<b>Antidotes / MedCMs &amp; other therapy:</b>	<input type="checkbox"/> ComboPens Number given [ ] <input type="checkbox"/> Oxime [ ] total [ ] <input type="checkbox"/> Atropine total [ ] <input type="checkbox"/> Benzodiazepine [ ] total [ ] <input type="checkbox"/> Naloxone total [ ] <input type="checkbox"/> Amyl nitrite <input type="checkbox"/> Dicobalt edetate <input type="checkbox"/> 300mg <input type="checkbox"/> 600mg   & <input type="checkbox"/> Glucose <input type="checkbox"/> Sodium nitrite <input type="checkbox"/> Sodium thiosulphate	
	<b>ANTIBIOTIC(S):</b> [1: ] dose [ ] [2: ] dose [ ] [3: ] dose [ ]	
	<b>OTHERS:</b> <input type="checkbox"/> Morphine total [ ] <input type="checkbox"/> Fentanyl total [ ] <input type="checkbox"/> Ketamine total [ ] <input type="checkbox"/> Ondansetron dose [ ] [1: ] dose [ ] [2: ] dose [ ] [3: ] dose [ ]	
<b>Breathing:</b>	<input type="checkbox"/> Oxygen <input type="checkbox"/> BVM <b>Needle decompression</b> <input type="checkbox"/> L <input type="checkbox"/> R <b>Thoracostomy</b> <input type="checkbox"/> / <b>Chest drain</b> <input type="checkbox"/> : L <input type="checkbox"/> R <input type="checkbox"/>	
<b>Circulation:</b>	<input type="checkbox"/> IV/IO Site: [ ] Size: [ ] <input type="checkbox"/> IV/IO Site: [ ] Size: [ ] <input type="checkbox"/> CPR duration [ mins] <b>FLUIDS:</b> <input type="checkbox"/> Crystalloid: [ ] Volume: [ ] <input type="checkbox"/> Blood: [ ] Volume: [ ]	
<b>Other interventions and comments:</b>		
<b>COLD ZONE TRIAGE CAT</b>	<b>T</b>	<b>OUTCOME</b> <input type="checkbox"/> Casualty Clearing Station <input type="checkbox"/> Survivor Reception Centre <input type="checkbox"/> RTU/Home <input type="checkbox"/> MTF/Hospital Name: [ ] <input type="checkbox"/> Mortuary <input type="checkbox"/> Other: [ ]
<b>CDL Handover Time</b>	: :	<b>Completed by:</b> _____ <span style="float: right;">Initials</span>

FOR RAD / NUC INCIDENTS: REFER TO RADIATION WORKSHEETS WITH CONTAMINATION CHARTS AND BIOSIMETRY ASSESSMENT