

CBRN MEDICAL REPORT FORM

Name:		Date: / /	Sex: Male / Female	Age:	or	DOB: / /
Nationality:	Rank:	Service No:	Service:		Unit:	
Location:		Incident time (if overt): :	Time of symptom onset: :	Arrival time: :		
Type of Incident:	<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 []					
Physical Protection:	Respiratory [CBRN <input type="checkbox"/> / Particulate <input type="checkbox"/> / Other _____] <input type="checkbox"/> Gloves <input type="checkbox"/> Protective suit <input type="checkbox"/> Other []					
Pre-Exposure MedCM:	<input type="checkbox"/> Chem [] <input type="checkbox"/> Bio [] <input type="checkbox"/> Rad []					

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

INITIAL TRIAGE	T	HAZARD: <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) MANAGEMENT: <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
Catastrophic Haemorrhage:	Site(s): [] [] [] [] [] [] [] [] <input type="checkbox"/> CAT Applied Time: [:] <input type="checkbox"/> Haemostatic Time: [:] <input type="checkbox"/> FFD Site(s): [] [] [] []	
Airway:	<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	
Antidotes / MedCMs & other therapy:	<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	
	ANTIBIOTIC(S): [1:] dose [] [2:] dose [] [3:] dose []	
	OTHERS: <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 []	
Breathing:	<input type="checkbox"/> Oxygen <input type="checkbox"/> BVM Needle decompression <input type="checkbox"/> L <input type="checkbox"/> R Thoracostomy <input type="checkbox"/> / Chest drain <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/>	
Circulation:	<input type="checkbox"/> IV/IO Site: [] Size: [] <input type="checkbox"/> IV/IO Site: [] Size: [] <input type="checkbox"/> CPR duration [mins] FLUIDS: <input type="checkbox"/> Crystalloid: [] Volume: [] <input type="checkbox"/> Blood: [] Volume: []	
Other interventions and comments:		
COLD ZONE TRIAGE CAT	T	OUTCOME <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: []
CDL Handover Time	:	Completed by: _____ Initials

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