

FRONT

Personal Property Receipt/Evidence Tag Destination _____ Via _____	Barcode Here	
PERSONAL INFORMATION		
Name:		
Gender/DOB/Age:		
Address:		
City, State, Zip:		
Phone		
COMMENTS:		

VITAL SIGNS

Time	B/P	Pulse	Respiration

IV Solutions

Time	IV Solution	Solution Rate	Added Drugs

START Triage (for Adults)

- Move the Walking Wounded ▶ MINOR
- No Respirations After Head Tilt ▶ EXPECTANT
- Respiration > 30 per Min ▶ IMMEDIATE
- Perfusion: Absent radial pulse
OR <2 sec capillary refill time ▶ IMMEDIATE
- Mental Status: Can't Follow Simple Commands ▶ IMMEDIATE
- All Others ▶ DELAYED

BACK

Accident: (1) brief description (2) date/time (3) location

Radiation Exposure

External	Radiation type(s)	Estimated exposure time	Dose Rate
Whole body			
Partial body			

Prodromal symptoms of Acute Radiation Syndrome: Time/Date

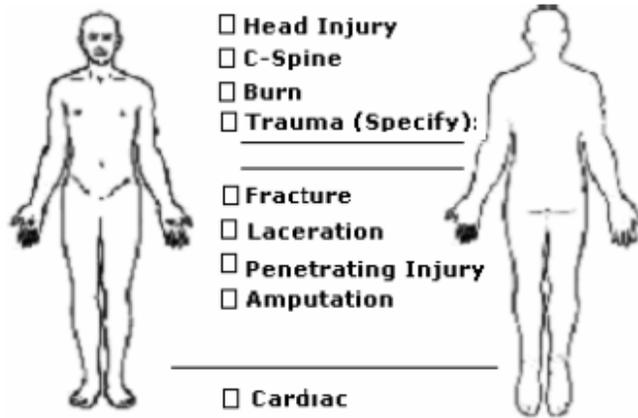
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Tachycardia
<input type="checkbox"/> Nausea	<input type="checkbox"/> Headache	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Apathy	<input type="checkbox"/> Fever	

Surface contamination: Identify Isotope(s):

Body part	Contaminated area ± shrapnel	Initial count	Decontamination performed? Yes/No	F/u Count

Decontamination method and agent used:

Localize Injuries/Contamination



Head Injury
 C-Spine
 Burn
 Trauma (Specify): _____
 Fracture
 Laceration
 Penetrating Injury
 Amputation

Cardiac
 Diabetic
 Respiratory
 OB .GYN
 Other: _____

Medical issues:

Biodosimetry Samples Obtained

	Date/Time	Sent Where	Comments
Nasal smears (R & L)			
CBC			
CBC with diff & PLT Count			
Bioassay samples			