



Wright State University  
Department of Emergency Medicine  
Division of Tactical Emergency Medicine



Emergency Medical Technician - Tactical  
DATA COLLECTION SYSTEM CASUALTY REPORT FORM

**AGENCY INFORMATION**

1. Name \_\_\_\_\_ 4. Agency Case # \_\_\_\_\_  
2. Address \_\_\_\_\_  
3. Casualty Date (mm/dd/yy) \_\_\_\_\_ 5. Agency Casualty ID # \_\_\_\_\_

**REPORTING INDIVIDUAL**

6. Name \_\_\_\_\_ 8. Rank / Title \_\_\_\_\_  
First M. Last  
7. Phone \_\_\_\_\_  
area code number ext

**OPERATION INFORMATION**

9. Type of Operation  
 High Risk Warrant Service  
 Barricade  
 Hostage Rescue  
 Dignitary Protection  
 Crowd Control / Civil Disturbance  
 Training  
 Other \_\_\_\_\_
10. Phase of Operation in which injury was sustained –  
 Containment / Surveillance  
 Approach  
 Entry / Assault  
 Tactical Execution  
 Withdrawal / Extraction  
 Exercise  
 Other \_\_\_\_\_

**CASUALTY INFORMATION**

11. Age \_\_\_\_\_ 15. Casualty Role  
 Law Enforcement Personnel  
 Tactical Team Member  
 Perpetrator  
 Third Party or Bystander  
 Tactical Medic
12. Weight \_\_\_\_\_ lbs  
13. Height \_\_\_\_\_ inches  
14. Sex  Male  Female

**CAUSE OF INJURY**

16. Was injury intentional  
17. Did a weapon cause the injury
18. If answer to 17 is yes, specify weapon (s) used  
 Rifle, assault weapon  
 Shotgun  
 Handgun (specify) \_\_\_\_\_  
 Blunt Instrument  
 Knife, sharp instrument or cutting edge  
 Other \_\_\_\_\_
19. BODY ARMOR / PROTECTIVE GEAR  
 Vest  
 Helmet  
 Ballistic Shield  
 Eye armor  
 Gloves  
 Other \_\_\_\_\_

**INJURY INFORMATION**

20. Injury Number \_\_\_\_\_

## 21. Part of Body

- |   |                                  |                                     |                                      |
|---|----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Left                   | <input type="checkbox"/> Head    | <input type="checkbox"/> Pelvis/Hip | <input type="checkbox"/> Upper Arm   |
| <input type="checkbox"/> Right                  | <input type="checkbox"/> Face    | <input type="checkbox"/> Upper Leg  | <input type="checkbox"/> Elbow       |
| <input type="checkbox"/> Whole Body or Systemic | <input type="checkbox"/> Eye     | <input type="checkbox"/> Lower Leg  | <input type="checkbox"/> Lower Arm   |
|   | <input type="checkbox"/> Neck    | <input type="checkbox"/> Knee       | <input type="checkbox"/> Wrist       |
|   | <input type="checkbox"/> Chest   | <input type="checkbox"/> Ankle      | <input type="checkbox"/> Hand        |
|   | <input type="checkbox"/> Back    | <input type="checkbox"/> Foot       | <input type="checkbox"/> Other _____ |
|   | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Shoulder   |                                      |

## 22. Injury Type

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Fracture           | <input type="checkbox"/> Electric Injury          | <input type="checkbox"/> Puncture         | <input type="checkbox"/> Blunt Internal Injury |
| <input type="checkbox"/> Dislocation        | <input type="checkbox"/> Toxic Exposure           | <input type="checkbox"/> Amputation       | <input type="checkbox"/> Burn                  |
| <input type="checkbox"/> Sprain / Strain    | <input type="checkbox"/> Abrasion (scrape)        | <input type="checkbox"/> Sharp Instrument | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Heat / Dehydration | <input type="checkbox"/> Contusion (bruise)       | cutting edge                              |  |
| <input type="checkbox"/> Cold Injury        | <input type="checkbox"/> Laceration (blunt force) | <input type="checkbox"/> gunshot wound    |  |

20. Injury Number \_\_\_\_\_

## 21. Part of Body

- |   |                                  |                                     |                                      |
|---|----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Left                   | <input type="checkbox"/> Head    | <input type="checkbox"/> Pelvis/Hip | <input type="checkbox"/> Upper Arm   |
| <input type="checkbox"/> Right                  | <input type="checkbox"/> Face    | <input type="checkbox"/> Upper Leg  | <input type="checkbox"/> Elbow       |
| <input type="checkbox"/> Whole Body or Systemic | <input type="checkbox"/> Eye     | <input type="checkbox"/> Lower Leg  | <input type="checkbox"/> Lower Arm   |
|   | <input type="checkbox"/> Neck    | <input type="checkbox"/> Knee       | <input type="checkbox"/> Wrist       |
|   | <input type="checkbox"/> Chest   | <input type="checkbox"/> Ankle      | <input type="checkbox"/> Hand        |
|   | <input type="checkbox"/> Back    | <input type="checkbox"/> Foot       | <input type="checkbox"/> Other _____ |
|   | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Shoulder   |                                      |

## 23. Injury Type

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Fracture           | <input type="checkbox"/> Electric Injury          | <input type="checkbox"/> Puncture         | <input type="checkbox"/> Blunt Internal Injury |
| <input type="checkbox"/> Dislocation        | <input type="checkbox"/> Toxic Exposure           | <input type="checkbox"/> Amputation       | <input type="checkbox"/> Burn                  |
| <input type="checkbox"/> Sprain / Strain    | <input type="checkbox"/> Abrasion (scrape)        | <input type="checkbox"/> Sharp Instrument | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Heat / Dehydration | <input type="checkbox"/> Contusion (bruise)       | cutting edge                              |  |
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| <input type="checkbox"/> Right                  | <input type="checkbox"/> Face    | <input type="checkbox"/> Upper Leg  | <input type="checkbox"/> Elbow       |
| <input type="checkbox"/> Whole Body or Systemic | <input type="checkbox"/> Eye     | <input type="checkbox"/> Lower Leg  | <input type="checkbox"/> Lower Arm   |
|   | <input type="checkbox"/> Neck    | <input type="checkbox"/> Knee       | <input type="checkbox"/> Wrist       |
|   | <input type="checkbox"/> Chest   | <input type="checkbox"/> Ankle      | <input type="checkbox"/> Hand        |
|   | <input type="checkbox"/> Back    | <input type="checkbox"/> Foot       | <input type="checkbox"/> Other _____ |
|   | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Shoulder   |                                      |

## 24. Injury Type

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Fracture           | <input type="checkbox"/> Electric Injury          | <input type="checkbox"/> Puncture         | <input type="checkbox"/> Blunt Internal Injury |
| <input type="checkbox"/> Dislocation        | <input type="checkbox"/> Toxic Exposure           | <input type="checkbox"/> Amputation       | <input type="checkbox"/> Burn                  |
| <input type="checkbox"/> Sprain / Strain    | <input type="checkbox"/> Abrasion (scrape)        | <input type="checkbox"/> Sharp Instrument | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Heat / Dehydration | <input type="checkbox"/> Contusion (bruise)       | cutting edge                              |  |
| <input type="checkbox"/> Cold Injury        | <input type="checkbox"/> Laceration (blunt force) | <input type="checkbox"/> gunshot wound    |  |

**TREATMENT AT SCENE**

23. How long after wounding was emergency care received ? \_\_\_\_\_ minutes

24. Was the casualty able to walk on his own without assistance?     Yes     No

25. Emergency Care Provided (check all that apply)

- Evaluate/Monitor Only
- Bandage / Hemorrhage Control
- Tourniquet
- Splint (Extremity)
- Backboard / Spinal Immobilization
- Pain Medication
- Oxygen Administration
- Airway Adjunct (type) \_\_\_\_\_
- IV Fluids (type) \_\_\_\_\_
- Other \_\_\_\_\_

26. Level of Primary Care Provider

- Tactical EMT / Paramedic
- Law Enforcement Officer / Non EMT
- Tactical Team Member/ Non EMT
- Non-Law Enforcement EMT/Paramedic
- Nurse
- Physician
- None
- Other \_\_\_\_\_

27. Physiological Measurements

How long after wounding were these measurements obtained ? \_\_\_\_\_ minutes

Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ mmHg

Respiratory Rate \_\_\_\_\_ / min

Pulse Rate \_\_\_\_\_ / min

28. Level of Consciousness – Verbal Response (select only one)

Appropriate Words     Inappropriate Words     Incomprehensible Words     None

**DISPOSITION**

29. Evacuation from Scene

- None
- Private Vehicle
- Police Vehicle
- Ambulance
- Other \_\_\_\_\_

30. Outcome

- Lived, Treated and Released
- Lived, Admitted to Hospital
- Died at Scene
- Died Enroute to Hospital

**NARRATIVE**

31. Description of Wounding Circumstances (continued on reverse if needed and diagram if helpful)