COMPANION GUIDE TO ONLINE TRAINING

MED-06: PATIENT CARE DOCUMENTATION

STUDENT COMPANION WORKBOOK

PCR Writing Exercises | Scenario Worksheets | Blank Forms

fortunefavorstheprepared.com
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MEDICAL DISCLAIMER & SCOPE OF PRACTICE

This workbook is for educational purposes only. It does not authorize medical practice. Advanced skills referenced in this course are for documentation literacy only — so you can record and communicate what trained providers do. Not instructions to perform procedures without proper training. In any emergency, call 911 first.

HOW TO USE THIS WORKBOOK

This workbook has three parts: (1) a one-page quick reference card explaining the key scales and tools used in documentation, (2) PCR (Patient Care Report — your written record of a patient encounter) writing exercises for all four scenarios, and (3) blank printable forms to write on during each exercise.

Before each scenario exercise: print the blank form from Part 3 that matches the required documentation type. Write your PCR on paper as you would in the field. Then check your work against the annotated answer key in the online lesson portal: fortunefavorstheprepared.com/med-06-00/

Answer keys are online only and are not included in this workbook.

Prerequisite courses: MED-01 MARCH-PAWS Rapid Assessment, MED-02 Medical History, MED-03 DCAP-BTLS Secondary Assessment.

EXTENDED AND WILDERNESS CARE — MED-09

Documentation for prolonged or wilderness scenarios — tracking vital signs over many hours, monitoring urine output, problem lists, and patient packaging for evacuation — is covered in MED-09: Wilderness & Extended Care. fortunefavorstheprepared.com/med-09-landing/

QUICK REFERENCE

Documentation Field Reference

Glasgow Coma Score (GCS) — A Standard Test of Consciousness Level

GCS measures how alert and responsive a patient is using three components. Always document all three component scores AND the total. Example: E3 V4 M5 = 12. Never write just the total number alone — the breakdown tells providers exactly what is impaired.

EYE OPENING (E)	BEST VERBAL (V)	BEST MOTOR (M)
4 — Opens eyes on own (spontaneously)	5 — Knows who/where/when (oriented)	6 — Follows two-step commands
3 — Opens eyes when spoken to	4 — Talking but confused	5 — Moves hand toward the pain source
2 — Opens eyes only to pain	3 — Random words, no real exchange	4 — Pulls away from pain
1 — No response	2 — Moans only	3 — Arms curl inward (decorticate)
	1 — No response	2 — Arms/legs extend outward (decerebrate)
		1 — No response

GCS 13–15 = Minor impairment | 9–12 = Moderate | 8 or below = Severe — patient cannot protect own airway

Revised Trauma Score (RTS) — A Quick Way to Communicate Injury Severity

The RTS turns three vital signs into a single number from 0 to 12. The lower the score, the more severely injured the patient. An RTS below 11 means the patient likely needs a trauma center. Add up the points from each column.

CONSCIOUSNESS (GCS)	BLOOD PRESSURE (SYSTOLIC)	BREATHING RATE (PER MIN)	POINTS
15–13 (alert or near-normal)	>89 mmHg (normal or near)	10–29 (normal range)	4
12–9 (moderately impaired)	76–89 mmHg (slightly low)	>29 (too fast)	3
8–6 (seriously impaired)	50–75 mmHg (significantly low)	6–9 (too slow)	2
5–4 (severe impairment)	1–49 mmHg (critically low)	1–5 (near-apneic)	1
3 (no response)	0 (no measurable BP)	0 (not breathing)	0

RTS = GCS points + Blood Pressure points + Breathing Rate points. Max 12. Below 11 = trauma center needed.

Normal Vital Signs by Age — Reference for Comparing Your Readings

AGE GROUP	BREATHING RATE (/MIN)	HEART RATE (BPM)	BLOOD PRESSURE
Adult	12–20	60–100	90–140 / 60–90
Child (1–12 yr)	20–30	70–130	70–120 / 50–80
Infant (under 1 yr)	30–40	100–160	70–100 / 50–70

Peripheral Pulse Scale — How Strong Is the Pulse at the Wrist or Foot?

GRADE	DESCRIPTION
0	Absent — cannot feel any pulse; no circulation reaching the extremity
1+	Weak or thready — barely palpable; reduced circulation or early shock
2+	Normal — easily felt with light pressure
3+	Bounding — forceful, hard to compress; may indicate severe allergic reaction or infection

Pitting Edema Scale — How Deep Is the Swelling? (Press with a finger, measure how long the dent stays)

GRADE	DENT DEPTH	WHAT IT SUGGESTS
+1	¼ inch or less	Mild swelling; early heart failure or prolonged time in one position
+2	¼ to ½ inch	Moderate swelling; worsening heart or kidney issues
+3	½ to 1 inch	Significant swelling; decompensated heart failure
+4	More than 1 inch	Severe whole-body swelling; multi-organ involvement

Wilderness Evacuation Category — How Fast Does This Patient Need Hospital Care?

Improvement does NOT change a RAPID category. If a patient starts as RAPID, they stay RAPID even if they seem better. Document the finding that drove the category, not just the category itself.

CATEGORY	TIMELINE	EXAMPLES OF CONDITIONS
RAPID (get out now)	Hours	Airway or chest injury • Uncontrolled bleeding • Shock • Decreased consciousness • Head or spine injury • Severe allergic reaction (anaphylaxis) • Severe hypo/hyperthermia • Cardiac chest pain
URGENT (today)	Under 24 hours	Broken long bone • Burns covering 10–20% of body • Spreading infection • Worsening abdominal pain • High altitude illness (HACE/HAPE)
NON-URGENT (monitor)	Can wait	Sprain or strain • Small closed wound • Minor allergic reaction • Stable and able to self-care

TQ TIME — THE MOST CRITICAL DOCUMENTATION ELEMENT IN TRAUMA

TQ = Tourniquet. Write the exact time the tourniquet was tightened at the moment you apply it — not later. Write it on the documentation card AND on the patient's forehead in marker. The surgeon needs to know how long the limb has been without blood flow. Six hours is the critical threshold. A missing or wrong time can cost a limb or a life.

MEDICATION DOCUMENTATION — FOUR REQUIRED ELEMENTS EVERY TIME

Every medication entry must include all four: Drug name / Dose (how much) / Route (how given: PO = by mouth, SQ = injection under skin, IV = into vein, IM = into muscle) / Time (exact clock time administered).

Also document allergy confirmation separately. "Gave aspirin" is not documentation. "Aspirin 324mg by mouth at 14:35, patient confirmed no aspirin allergy" is documentation.

PART 2 PCR Writing Exercises — Four Scenarios

PCR stands for Patient Care Report — the written record of your patient encounter. Complete your PCR before checking the answer key. Answer keys are in the online lesson portal: fortunefavorstheprepared.com/med-06-00/

SCENARIO 01 Pedestrian vs. Vehicle — Urban / Trauma

Form to use: TCCC Card (Tactical Combat Casualty Care Card, DD Form 1380) + MIST Report (verbal handoff)

SCENE	PATIENT	VITALS	FINDINGS	TREATMENTS
Male approximately 40s struck by vehicle at about 30 mph, thrown 15 feet, found face-up in roadway. Urban intersection. EMS (Emergency Medical Services) approximately 6 minutes away.	Unknown identity. Unknown allergy status.	Heart rate 124 (radial/weak). BP (blood pressure) 88/60. RR (breathing rate) 28, labored. SpO2 (blood oxygen level, measured by pulse oximeter) 88%. AVPU: P (responds to Pain only — this is the third-worst level on the Alert/Voice/Pain/Unresponsive scale). GCS (Glasgow Coma Score): E2 V2 M4 = 8 total.	Gurgling airway. Left femur (thigh bone) deformity. Scalp laceration (cut) with active bleeding. Right pupil 6mm and sluggish; left pupil 3mm and brisk (unequal pupils = anisocoria, a sign of possible brain pressure). Absent breath sounds right lower lobe. Right chest contusion (bruise). Pelvis stable. Trachea (windpipe) midline (not shifted — an important negative finding).	NPA (nasopharyngeal airway — a soft rubber tube placed in the nostril to hold the airway open) 28Fr (size) right nostril with lubricant at 14:09. SpO2 improved to 94%. Direct pressure + pressure bandage to scalp laceration. Left femur traction splint applied.

Before you write your PCR, answer these questions:

1. GCS is 8. What does this level of consciousness mean for airway protection? (Hint: the online lesson covers the threshold at which patients can no longer protect their own airway.)
2. Right pupil 6mm / left pupil 3mm. What does unequal pupil size suggest in a head trauma patient, and why must you document the exact size in millimeters for each eye — not just "pupils unequal"?
3. Calculate the RTS (Revised Trauma Score): GCS 8, blood pressure 88 mmHg systolic, breathing rate 28. What evacuation category does the total score indicate?
4. Patient has no ID. What do you write in the name field on the TCCC card? What do you write in the allergy field?
5. Trachea (windpipe) is midline. Why does this negative finding — something that is NOT present — need to be explicitly written down?

PCR Workspace — use blank form from Part 3:

Answer key: fortunefavorstheprepared.com/med-06-00/

SCENARIO 02 Cardiac Event at the Gym — Urban / Medical

Form to use: Patient Encounter Form Page 1 + HPI/Subjective Form (History of Present Illness) + MIST Report

SCENE	PATIENT	VITALS	FINDINGS	TREATMENTS
58-year-old male collapsed during workout. Now conscious. EMS approximately 4 minutes away.	PMH (Past Medical History): HTN (hypertension = high blood pressure), NIDDM (non-insulin-dependent diabetes mellitus = Type 2 diabetes, managed without insulin). Medications: Metformin 1000mg twice daily (BID = bis in die, Latin for "twice a day"), Lisinopril 10mg once daily. NKDA (No Known Drug Allergies). Last food: protein shake approximately 45 minutes ago.	Heart rate 110 and irregular (rhythm is abnormal, not just fast). Breathing rate 22. Blood pressure 162/94. SpO2 (oxygen level) 94%.	Alert, GCS 15 (fully conscious), oriented to person/place/time. Anxious, diaphoretic (sweating heavily). Crushing substernal (under the breastbone) chest pain, 8/10 severity, began during exercise, radiates to left arm and jaw, constant. Shortness of breath, heavy sweating at onset, one episode of nausea. Lung sounds clear on both sides.	Patient placed supine (lying flat on back). Oxygen by NRM (non-rebreather mask — a mask with a reservoir bag that delivers high-concentration oxygen). Aspirin 324mg by mouth (PO = per os, Latin for "by mouth") at 14:35. Patient confirmed no aspirin allergy.

Before you write your PCR, answer these questions:

1. Heart rate 110 AND irregular. Why is documenting "irregular" more important than just documenting the rate of 110?
2. Aspirin 324mg by mouth at 14:35. List all five required elements for a complete medication entry (the online lesson covers all five).
3. Blood oxygen level (SpO2) is 94% on room air. At what level is supplemental oxygen indicated in suspected cardiac events, and why is giving too much oxygen also a concern?
4. Blood pressure is 162/94 with a known history of high blood pressure and suspected ACS (Acute Coronary Syndrome — the spectrum of heart attacks and unstable angina). Does this require you to treat the blood pressure in the field?
5. Write a 60-second verbal MIST report for the arriving paramedic. MIST = Mechanism / Injuries-Illness / Signs & Symptoms / Treatments Given.

PCR Workspace — use blank form from Part 3:

Answer key: fortunefavorstheprepared.com/med-06-00/

SCENARIO 03 — Diabetic Emergency — Farm Call — Rural / Medical

Form to use: Patient Encounter Form Page 1 + HPI/Subjective Form + Serial Vitals (multiple time points)

SCENE	PATIENT	VITALS	FINDINGS	TREATMENTS
67-year-old female found confused by husband on rural property. Hospital 40 minutes away. No cell service.	PMH: IDDM (insulin-dependent diabetes mellitus = Type 1 diabetes, requires insulin injections), HTN (high blood pressure), CVA 3 years ago with residual right-side weakness (CVA = Cerebrovascular Accident = stroke; the weakness is her known baseline and was present before today). Medications: Insulin glargine 20 units injected under skin (SQ = subcutaneous) at bedtime each night (QHS = quaque hora somni, Latin for "every hour of sleep" = at bedtime), Metformin 1000mg twice daily, Lisinopril 10mg daily, Aspirin 81mg daily. NKDA. Last food: supper the prior evening (approximately 14 hours ago). Last insulin: glargine 20 units at bedtime last night.	T+0 (time of your arrival): Heart rate 96, breathing rate 16, blood pressure 148/88, oxygen level (SpO2) 98%, BGL (blood glucose level) 38 mg/dL (severely low — normal is 70–100 mg/dL). T+15 minutes (after treatment): Heart rate 88, BGL 64 mg/dL.	AVPU: V (responds to Voice — second-best level). GCS: E3 V4 M5 = 12 (moderately impaired). Confused and disoriented to date and location. Right-side weakness present, consistent with her known stroke baseline. Skin pale, diaphoretic (sweating), warm.	Oral glucose paste at T+0 (given by mouth; airway was intact and patient was able to swallow). At T+15: AVPU improved to A (Alert), GCS improved to 15 (fully conscious).

Before you write your PCR, answer these questions:

1. Blood glucose (BGL) is 38 in a diabetic patient who took long-acting insulin at bedtime and has not eaten in 14 hours. Why must you document the last insulin dose time AND the last food time together, not just one or the other?
2. She has right-side weakness that is her normal state after her stroke. How do you document the current neurological exam in a way that distinguishes her known baseline from any new problem?
3. GCS improved from 12 to 15 after the glucose paste. Why must you document BOTH the before-treatment score AND the after-treatment score?
4. She takes both Metformin (a diabetes pill) AND insulin glargine (an injected insulin). Why is it important to document both medications, not just the insulin?
5. Hospital is 40 minutes away. What should you continue monitoring, and what worsening sign would change how urgently you need help?

PCR Workspace — use blank form from Part 3:

Answer key: fortunefavorstheprepared.com/med-06-00/

SCENARIO 04 — Tree Stand Fall — Deteriorating Patient — Rural / Trauma

Form to use: Patient Encounter Form Page 1 + Physical Exam (Trauma) Form + Serial Vitals (T+0 and T+30) + MIST Report

SCENE	PATIENT	VITALS	FINDINGS	TREATMENTS
Bow hunter, 18-foot fall from tree stand, no helmet. Rural woodland. 2-mile carry to trailhead. EMS 90 minutes away, no cell service.	Male, 44 years old. No past medical history. NKDA (No Known Drug Allergies). No medications. Last food: granola bar approximately 3 hours ago.	T+0: Heart rate 108, breathing rate 20, blood pressure 112/78, oxygen level (SpO2) 96%, GCS 14 (slightly confused about time — one component off). T+30 minutes: Heart rate 118 (rising), blood pressure 104/74 (falling), breathing rate 22 (rising), GCS 13 (worsening confusion).	T+0: Midline tenderness over C4–C6 (the 4th through 6th bones of the neck — cervical spine; tenderness here indicates possible spinal injury). LUQ (left upper quadrant = upper-left area of the abdomen) tenderness and guarding (muscle tightness when you press). Left wrist deformity, radial pulse (pulse at wrist) 2+ (normal). Head contusion (bruise). Trachea midline. T+30: Abdominal tenderness spreading, guarding worsening.	Cervical spine (C-spine) manual immobilization applied at T+0 (hands-on stabilization of the neck). CSM (Circulation, Sensation, Movement — a three-part check of nerve and blood flow to the limbs) checked before and after immobilization. Left wrist splinted. Patient kept still and warm. Serial reassessment every 15 minutes.

Before you write your PCR, answer these questions:

1. T+0 to T+30: heart rate rising, blood pressure falling, breathing rate rising, GCS declining, abdominal tenderness spreading. What does this combined trend indicate, and what evacuation category does it drive?
2. LUQ (left upper quadrant) guarding after a fall from height. What organ in that area of the body is classically at risk, and why does documenting the specific quadrant matter to the surgeon who will treat him?
3. GCS dropped from 14 to 13. Is a one-point change significant? What does declining consciousness combined with falling blood pressure suggest about what is happening inside this patient?
4. Cervical spine immobilization was applied. What must be documented before you apply it, and what must be documented immediately after? (Hint: think about the CSM checks.)
5. Your documentation will travel with this patient on a 90-minute evacuation. What is the single most important piece of information the receiving surgeon needs to see immediately?

PCR Workspace — use blank form from Part 3:

Answer key: fortunefavorstheprepared.com/med-06-00/

PART 3 Field Documentation Card Reference

These are the actual documentation cards used throughout this course. The appendix at the back of this workbook contains print-ready copies labelled by scenario. The store carries these in waterproof 4x6 format for field use.

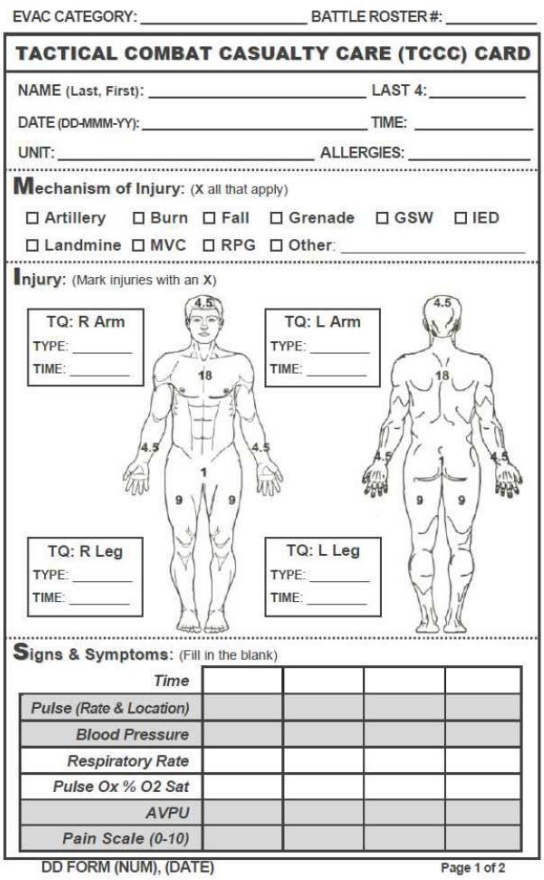
★ Get the Actual Field Cards (waterproof, 4x6 format)
Patient Encounter Cards: fortunefavorstheprepared.com/product/cards-4x6-patient-encounter-documentation-cards
TCCC Cards (pack of 5): fortunefavorstheprepared.com/product/medical-treatment-cards-set-of-5/
TCCC Cards (pack of 10): fortunefavorstheprepared.com/product/medical-treatment-cards-set-of-10/

TCCC CARD (DD FORM 1380) — USE FOR: SCENARIO 01

Front: Patient ID, Mechanism of Injury, Tourniquet Fields, Serial Vital Signs

Every field is critical. TQ (tourniquet) application TIME is the most important field on this card. Write it the instant the tourniquet tightens — not later.

TCCC Card Front (DD Form 1380). Mark injuries with X on the body diagram. TQ TYPE and TIME are required for every tourniquet applied.



EVAC CATEGORY: _____ BATTLE ROSTER #: _____

TACTICAL COMBAT CASUALTY CARE (TCCC) CARD

NAME (Last, First): _____ LAST 4: _____

DATE (DD-MMM-YY): _____ TIME: _____

UNIT: _____ ALLERGIES: _____

Mechanism of Injury: (X all that apply)

☐ Artillery ☐ Burn ☐ Fall ☐ Grenade ☐ GSW ☐ IED

☐ Landmine ☐ MVC ☐ RPG ☐ Other: _____

Injury: (Mark injuries with an X)

TQ: R Arm TYPE: _____ TIME: _____

TQ: L Arm TYPE: _____ TIME: _____

TQ: R Leg TYPE: _____ TIME: _____

TQ: L Leg TYPE: _____ TIME: _____

Signs & Symptoms: (Fill in the blank)

	Time			
Pulse (Rate & Location)				
Blood Pressure				
Respiratory Rate				
Pulse Ox % O2 Sat				
AVPU				
Pain Scale (0-10)				

DD FORM (NUM), (DATE) Page 1 of 2

EVAC CATEGORY: _____ BATTLE ROSTER #: _____

Treatments: (X all that apply, and fill in the blank)

C: ☐ Extremity-TQ ☐ Junctional-TQ ☐ Pressure-Dressing

☐ Hemostatic-Dressing Type: _____

A: ☐ Intact ☐ NPA ☐ CRIC ☐ ET-Tube ☐ SGA Type: _____

B: ☐ O2 ☐ Needle-D ☐ Chest-Tube ☐ Chest-Seal Type: _____

C:	Name	Volume	Route	Time
Fluid				
Blood Product				

MEDS:	Name	Dose	Route	Time
Analgesic (e.g. Ketamine, Fentanyl, Morphine)				
Antibiotic (e.g. Moxifloxacin, Ertapenem)				
Other (e.g. TXA)				

OTHER: ☐ Combat-Pill-Pack ☐ Eye-Shield (☐ R ☐ L) ☐ Splint

☐ Hypothermia-Prevention Type: _____

NOTES: _____

FIRST RESPONDER NAME (Last, First): _____ LAST 4: _____

DD FORM (NUM), (DATE) Page 2 of 2

TCCC CARD (DD FORM 1380) BACK — TREATMENTS

Back: Treatments Given, Organized by MARCH Category

C = hemorrhage (bleeding) control, A = airway, B = breathing/respiration, C = circulation/fluids, H = hypothermia prevention. Every medication entry requires: Drug name / Dose / Route / Time.

TCCC Card Back. Medications table: Name / Dose / Route / Time — all four required for every entry. No exceptions.

PATIENT ENCOUNTER FORM — USE FOR: SCENARIOS 02, 03, 04

Page 1: Demographics, History, and Serial Vital Signs

Use this form when EMS is 30+ minutes away or when you need to track vital signs across multiple assessment cycles. The serial vitals grid at the bottom is the most important part — fill in a new row at each assessment.

DATE	TIME	LOCN	
NAME		PH	
AGE	DOB	WT	M F
ADDRESS			
CONTACT		PHONE	
SCENE			
SYMPTOMS	CP DYSP ALOC N/V DIAPHORESIS SYNCOPE		
ALLERGIES	NKDA PCN ASA SULFA		
MEDICATIONS			
HPI / MOI	TRAUMA ENVIRONMENTAL MEDICAL		
PMH	ANGINA MI ASTHMA COPD CHF IDDM NIDDM HTN CVA/TIA BP ↑ ↓ SEIZURES		
LAST FOOD etc			

TIME	PULSE	RESP	BP	GCS / AVPU	SpO2	ETCO2	TX

Patient Encounter Form Page 1. Serial vitals grid at bottom: document a new row at each assessment. Trend is more valuable than any single reading.

HPI / SUBJECTIVE FORM — USE FOR: SCENARIOS 02, 03

History of Present Illness: OPQRST Framework on Paper

Circle or underline terms that apply. Note Y (yes) or N (no) for every associated symptom — explicitly documented negatives are as clinically valuable as positives.

HPI / SUBJECTIVE	
ONSET	SUDDEN GRADUAL DOING WHAT
PROVOKES	MOVEMENT DEEP BREATHS PALPATION
QUALITY	CRUSHING HEAVINESS SHARP STABBING ACHE BURNING RAMPING FULLNESS DULL SQUEEZING INDIGESTION TEARING PRESSURE **CONSTANT INTERMITTENT PALPITATIONS**
RADIATION	N ARMS L R NECK BACK SHOULDERS
SEVERITY	1-10 ___ WORSE EVER UNABLE SIMILAR **CHANGES:** PALPATION DEEP INSPIRATION MOVEMENT
DYSPNEA	N Y ON EXERTION ORTHOPNEA
DIAPHORESIS	N Y AT ONSET PROFUSE
NAUSEA	N Y
VOMITING	N Y x_____ HEMATEMESIS: RED/BROWN
WEAKNESS	N Y HANDS L R FEET L R FACE L R LIPS
NUMBNESS	N Y HANDS L R FEET L R FACE L R LIPS
TINGLING	N Y HANDS L R FEET L R FACE L R LIPS
HEADACHE	N Y PHOTOPHOBIA TINNITUS "WORSE EVER"
VISUAL DISTORN	N Y
DIZZINESS	N Y STANDING SITTING ORTHOSTATIC VERTIGO
FEVER	N Y DURATION NIGHT SWEATS
GI	N Y DIARRHEA x_____ CONSTIPATION BLOOD COFFEE GROUNDS
GU	N Y ANURIA DYSURIA HEMATURIA POLYURIA NOCTURIA INCONTINENCE LAST URINATED _____
COUGH	N Y HEMOPTYSIS SPUTUM: RED / BRN / YEL / WHI / CLEAR
SIMILAR	N Y LAST EPISODE _____
CAFFEINE	N Y QTY _____ DEPENDENCY
TOBACCO	N Y QTY DURATION CUT DOWN STOPPED
ALCOHOL	N Y QTY TYPE CUT DOWN ANNOYED GUILTY EYE OPENER
STRESS	N Y WORK FAMILY
FAMILY HX	N Y MOTHER: ALIVE/AGE____ HEALTH: CARDIAC / RESP _____ FATHER: ALIVE/AGE____ HEALTH: CARDIAC / RESP _____
DRUG ABUSE	N MARIJUANA HEROINE COCAINE AMPHETAMINES LAST: _____ FX: ____
EXERCISE	N Y FREQUENCY TYPE
GENITAL	ACTIVE Y N PROTECTION Y N GRAVIDA(x) PARA(VIABLE) ABORT LIVING MENSES: LAST REGULAR / IRREGULAR
SLEEP	NORMAL HRS ____ NORMAL BEDTIME _____ WAKE _____ INSOMNIA NARCOLEPSY SLEEP APNEA NOCTURIA DAYTIME NAPS PROBLEM FALLING ASLEEP / STAYING AWAKE SNORING

HPI/Subjective Form. OPQRST = Onset, Provokes, Quality, Radiation, Severity, Time. Use the printed descriptor words exactly — they are clinical terms that carry precise meaning.

PHYSICAL EXAM (TRAUMA) — USE FOR: SCENARIO 04

DCAP-BTLS Applied Region by Region, Head to Toe

For each body region: circle applicable DCAP-BTLS letters and note findings. Document every region even if normal — "Abdomen SNT (soft non-tender)" tells the physician you checked and found it normal. A blank field looks like you skipped it.

PHYSICAL EXAM (TRAUMA)	
CIRCULATION	GROSS BLEEDING CAP REFILL: NORMAL / DELAYED RADIAL PULSES: Y N WEAK
NEURO	A V P U DAY DATE TIME PERSON PLACE EVENTS
	SPEECH: DYSARTHIA (SLURRED) APHASIA (DIFFICULT)
AIRWAY	PATIENT MANUAL NASAL OPA NPA
BREATHING	NORMAL NASAL FLARING ACCESSORY MUSCLES ASSIST BVM
SKIN	PINK PALE WHITE CYANOTIC JAUNDICE MOTTLED FLUSHED WARM COOL HOT DRY DIAPHORETIC MOIST PERIPHERAL CYANOSIS
HEAD	D C A P P B T L S BATTLE SIGN
FACE	D C A P B T L S
MOUTH	CYANOTIC MEMBRANES
EARS	R: FLUID CLEAR STRAW RED L: FLUID CLEAR STRAW RED
NOSE	R: FLUID CLEAR STRAW RED L: FLUID CLEAR STRAW RED
PUPILS	PERRL EOMI SLUGGISH DYSCONJUGATE
	R mm CONSTRICTED DILATED NYSTAGMUS HYPHEMIA **L** mm CONSTRICTED DILATED NYSTAGMUS HYPHEMIA
NECK	D C A P B T L S JVD TRACHEA DEVIATION R L
CHEST	D C A P B T L S PARADOXICAL PAIN ON PALP ASYMMETRICAL CREPITUS
BACK	D C A P B T L S PAIN ON PALP ASYMMETRICAL CREPITUS
LUNGS	**R** CLEAR WHEEZE RHONCHI RALES STRIDOR PLURAL FRICTION RUB **L** CLEAR WHEEZE RHONCHI RALES STRIDOR PLURAL FRICTION RUB EQUAL
ABD / GI	SNT TENDER PALPABLE MASSES GUARDING
PELVIS / GU	D C A P B T L S STABLE UNSTABLE CREPITUS INCONTINENT
LEGS	D C A P P B T L S PULSES MOTION SENSATION
	R FLEX: 5 4 3 2 1 EXTN: 5 4 3 2 1 EDEMA: +1 +2 +3 +4 PULSE: 0 1 2 3
	L FLEX: 5 4 3 2 1 EXTN: 5 4 3 2 1 EDEMA: +1 +2 +3 +4 PULSE: 0 1 2 3
ARMS	D C A P B T L S MOTION SENSATION DECORTICATE (INWARD) DECERERATE (OUTWARD)
	R PULSE: 0 1 2 3 4 STRENGTH: 5 4 3 2 1
	L PULSE: 0 1 2 3 4 STRENGTH: 5 4 3 2 1

DEFORMITIES | CONTUSIONS | ABRASIONS | PENETRATIONS |
PARADOXICAL BREATHING (CHEST)
BURNS | TENDERNESS | LACERATIONS | SWELLING

Physical Exam (Trauma). Work head to toe without skipping. Strength scale: 5=full, 4=against some resistance, 3=against gravity only, 2=movement without gravity, 1=flicker, 0=none.

SELF-ASSESSMENT RUBRIC

10-Point PCR Quality Checklist

Score your completed PCR against this rubric before checking the online answer key. Answer keys are available at fortunefavorsthepreprepared.com/med-06-00/

#	ELEMENT TO CHECK	DONE?
1	Patient demographics complete: name or physical description, approximate age, sex, weight if known	☐
2	Scene or mechanism described specifically — not vaguely (e.g., "pedestrian struck by vehicle at ~30 mph" not "was hit by a car")	☐
3	All assessment findings documented using correct clinical terms (not "seemed confused" but "GCS 14, oriented to person and place, disoriented to time")	☐
4	Vital signs documented with a timestamp at every assessment point	☐
5	Every medication entry has all four required elements: drug name / dose / route / time	☐
6	All interventions (tourniquet, splint, airway, oxygen) documented with the time applied	☐
7	Significant NEGATIVE findings explicitly noted (e.g., "trachea midline," "abdomen SNT — soft and non-tender," "pelvis stable")	☐
8	Serial assessments show direction of change — is the patient improving or deteriorating?	☐
9	Evacuation category documented with the specific finding that drove it (not just "RAPID" but "RAPID — GCS declining from 14 to 13 with falling blood pressure")	☐
10	Handoff / MIST report complete where applicable	☐

APPENDIX Blank PCR Forms — All Exercises

This appendix contains all blank forms needed to complete the four scenario exercises. You will need multiple copies of each form so print blanks before you begin.

WHAT TO PRINT AND WHEN
Scenario 01 (Pedestrian vs. Vehicle): TCCC Card front + back, MIST Report
Scenario 02 (Cardiac Event): Patient Encounter Page 1, HPI/Subjective, MIST Report
Scenario 03 (Diabetic Emergency): Patient Encounter Page 1, HPI/Subjective
Scenario 04 (Tree Stand Fall): Patient Encounter Page 1, Physical Exam (Trauma), MIST Report

TCCC Card — Front

EVAC CATEGORY: _____ BATTLE ROSTER #: _____

TACTICAL COMBAT CASUALTY CARE (TCCC) CARD

NAME (Last, First): _____ LAST 4: _____

DATE (DD-MMM-YY): _____ TIME: _____

UNIT: _____ ALLERGIES: _____

Mechanism of Injury: (X all that apply)

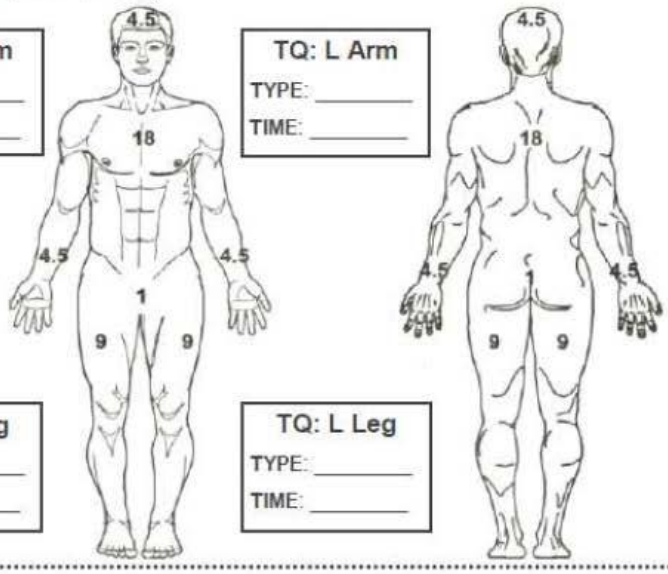
☐ Artillery ☐ Burn ☐ Fall ☐ Grenade ☐ GSW ☐ IED

☐ Landmine ☐ MVC ☐ RPG ☐ Other: _____

Injury: (Mark injuries with an X)

TQ: R Arm
TYPE: _____
TIME: _____

TQ: L Arm
TYPE: _____
TIME: _____



TQ: R Leg
TYPE: _____
TIME: _____

TQ: L Leg
TYPE: _____
TIME: _____

Signs & Symptoms: (Fill in the blank)

Time				
Pulse (Rate & Location)				
Blood Pressure				
Respiratory Rate				
Pulse Ox % O2 Sat				
AVPU				
Pain Scale (0-10)				

DD FORM (NUM), (DATE) Page 1 of 2

TCCC Card — Back (Treatments)

EVAC CATEGORY: _____ BATTLE ROSTER #: _____

Treatments: (X all that apply, and fill in the blank)

C: ☐ Extremity-TQ ☐ Junctional-TQ ☐ Pressure-Dressing

☐ Hemostatic-Dressing Type: _____

A: ☐ Intact ☐ NPA ☐ CRIC ☐ ET-Tube ☐ SGA Type: _____

B: ☐ O2 ☐ Needle-D ☐ Chest-Tube ☐ Chest-Seal Type: _____

C:	Name	Volume	Route	Time
Fluid				
Blood Product				

MEDS:	Name	Dose	Route	Time
Analgesic (e.g. Ketamine, Fentanyl, Morphine)				
Antibiotic (e.g. Moxifloxacin, Ertapenem)				
Other (e.g. TXA)				

OTHER: ☐ Combat-Pill-Pack ☐ Eye-Shield (☐ R ☐ L) ☐ Splint

☐ Hypothermia-Prevention Type: _____

NOTES: _____

_____

_____

_____

_____

_____

FIRST RESPONDER

NAME (Last, First): _____ LAST 4: _____

DD FORM (NUM), (DATE) Page 2 of 2

MIST Report: Mechanism / Injuries / Signs & Symptoms / Treatments

ELEMENT	CONTENT
M — Mechanism or Nature of Illness (exactly how it happened)	
I — Injuries or Illness Found (specific findings, not vague summaries)	
S — Signs & Symptoms (current vital signs + trend)	
T — Treatments Given (name / dose / route / time for every medication; time for every procedure)	

Receiving provider / unit:

Time of handoff:

Patient Encounter Form — Page 1

DATE	TIME	LOCN	
NAME		PH	
AGE	DOB	WT	M F
ADDRESS			
CONTACT		PHONE	
SCENE			
SYMPTOMS	CP DYSP ALOC N/V DIAPHORESIS SYNCOPE		
ALLERGIES	NKDA PCN ASA SULFA		
MEDICATIONS			
HPI / MOI	TRAUMA ENVIRONMENTAL MEDICAL		
PMH	ANGINA MI ASTHMA COPD CHF IDDM NIDDM HTN CVA/TIA BP ↑ ↓ SEIZURES		
LAST FOOD etc			

TIME	PULSE	RESP	BP	GCS / AVPU	SpO2	ETCO2	TX

HPI / Subjective Form

HPI / SUBJECTIVE	
ONSET	SUDDEN GRADUAL DOING WHAT
PROVOKES	MOVEMENT DEEP BREATHS PALPATION
QUALITY	CRUSHING HEAVINESS SHARP STABBING ACHE BURNING RAMPING FULLNESS DULL SQUEEZING INDIGESTION TEARING PRESSURE **CONSTANT INTERMITTENT PALPITATIONS**
RADIATION	N ARMS L R NECK BACK SHOULDERS
SEVERITY	1-10 ___ WORSE EVER UNABLE SIMILAR **CHANGES:** PALPATION DEEP INSPIRATION MOVEMENT
DYSPNEA	N Y ON EXERTION ORTHOPNEA
DIAPHORESIS	N Y AT ONSET PROFUSE
NAUSEA	N Y
VOMITING	N Y x_____ HEMATEMESIS: RED/BROWN
WEAKNESS	N Y HANDS L R FEET L R FACE L R LIPS
NUMBNESS	N Y HANDS L R FEET L R FACE L R LIPS
TINGLING	N Y HANDS L R FEET L R FACE L R LIPS
HEADACHE	N Y PHOTOPHOBIA TINNITUS "WORSE EVER"
VISUAL DISTORN	N Y
DIZZINESS	N Y STANDING SITTING ORTHOSTATIC VERTIGO
FEVER	N Y DURATION NIGHT SWEATS
GI	N Y DIARRHEA x_____ CONSTIPATION BLOOD COFFEE GROUNDS
GU	N Y ANURIA DYSURIA HEMATURIA POLYURIA NOCTURIA INCONTINENCE LAST URINATED _____
COUGH	N Y HEMOPTYSIS SPUTUM: RED / BRN / YEL / WHI / CLEAR
SIMILAR	N Y LAST EPISODE _____
CAFFEINE	N Y QTY _____ DEPENDENCY
TOBACCO	N Y QTY DURATION CUT DOWN STOPPED
ALCOHOL	N Y QTY TYPE CUT DOWN ANNOYED GUILTY EYE OPENER
STRESS	N Y WORK FAMILY
FAMILY HX	N Y MOTHER: ALIVE/AGE____ HEALTH: CARDIAC / RESP _____ FATHER: ALIVE/AGE____ HEALTH: CARDIAC / RESP _____
DRUG ABUSE	N MARIJUANA HEROINE COCAINE AMPHETAMINES LAST: _____ FX: ____
EXERCISE	N Y FREQUENCY TYPE
GENITAL	ACTIVE Y N PROTECTION Y N GRAVIDA(x) PARA(VIABLE) ABORT LIVING MENSES: LAST REGULAR / IRREGULAR
SLEEP	NORMAL HRS _____ NORMAL BEDTIME _____ WAKE _____ INSOMNIA NARCOLEPSY SLEEP APNEA NOCTURIA DAYTIME NAPS PROBLEM FALLING ASLEEP / STAYING AWAKE SNORING

Physical Exam (Trauma) Form

PHYSICAL EXAM (TRAUMA)	
CIRCULATION	GROSS BLEEDING CAP REFILL: NORMAL / DELAYED RADIAL PULSES: Y N WEAK
NEURO	A V P U DAY DATE TIME PERSON PLACE EVENTS
	SPEECH: DYSARTHIA (SLURRED) APHASIA (DIFFICULT)
AIRWAY	PATIENT MANUAL NASAL OPA NPA
BREATHING	NORMAL NASAL FLARING ACCESSORY MUSCLES ASSIST BVM
SKIN	PINK PALE WHITE CYANOTIC JAUNDICE MOTTLED FLUSHED WARM COOL HOT DRY DIAPHORETIC MOIST PERIPHERAL CYANOSIS
HEAD	D C A P P B T L S BATTLE SIGN
FACE	D C A P B T L S
MOUTH	CYANOTIC MEMBRANES
EARS	R: FLUID CLEAR STRAW RED L: FLUID CLEAR STRAW RED
NOSE	R: FLUID CLEAR STRAW RED L: FLUID CLEAR STRAW RED
PUPILS	PERRL EOMI SLUGGISH DYSCONJUGATE
	R mm CONSTRICTED DILATED NYSTAGMUS HYPHEMIA **L** mm CONSTRICTED DILATED NYSTAGMUS HYPHEMIA
NECK	D C A P B T L S JVD TRACHEA DEVIATION R L
CHEST	D C A P B T L S PARADOXICAL PAIN ON PALP ASYMMETRICAL CREPITUS
BACK	D C A P B T L S PAIN ON PALP ASYMMETRICAL CREPITUS
LUNGS	**R** CLEAR WHEEZE RHONCHI RALES STRIDOR PLURAL FRICTION RUB **L** CLEAR WHEEZE RHONCHI RALES STRIDOR PLURAL FRICTION RUB EQUAL
ABD / GI	SNT TENDER PALPABLE MASSES GUARDING
PELVIS / GU	D C A P B T L S STABLE UNSTABLE CREPITUS INCONTINENT
LEGS	D C A P P B T L S PULSES MOTION SENSATION
	R FLEX: 5 4 3 2 1 EXTN: 5 4 3 2 1 EDEMA: +1 +2 +3 +4 PULSE: 0 1 2 3
	L FLEX: 5 4 3 2 1 EXTN: 5 4 3 2 1 EDEMA: +1 +2 +3 +4 PULSE: 0 1 2 3
ARMS	D C A P B T L S MOTION SENSATION DECORTICATE (INWARD) DECERERATE (OUTWARD)
	R PULSE: 0 1 2 3 4 STRENGTH: 5 4 3 2 1
	L PULSE: 0 1 2 3 4 STRENGTH: 5 4 3 2 1

DEFORMITIES | CONTUSIONS | ABRASIONS | PENETRATIONS |
PARADOXICAL BREATHING (CHEST)
BURNS | TENDERNESS | LACERATIONS | SWELLING

SCENARIO 04 — MIST REPORT (3 OF 3)

MIST Report: Mechanism / Injuries / Signs & Symptoms / Treatments

ELEMENT	CONTENT
M — Mechanism or Nature of Illness	
I — Injuries or Illness Found	
S — Signs & Symptoms (current vital signs + trend)	
T — Treatments Given (name / dose / route / time)	

Receiving provider / unit:

Time of handoff: