1st Medical Battalion, 1st Marine Logistics Group
Bravo Company, 1st Platoon
Camp Pendleton, California

From: Commanding Officer, Bravo Company, 1st Platoon, 1st Medical Battalion
To: All 1st Platoon, Bravo Company Personnel

Subj: STANDARD OPERATING PROCEDURE FOR BLOOD PRODUCTS MANAGEMENT, WALKING BLOOD BANK, AND MASSIVE TRANSFUSION PROTOCOL, 1ST PLATOON, BRAVO COMPANY, 1ST MEDICAL BATTALION

Ref: (a) JTS Clinical Practice Guideline — Damage Control Resuscitation (current edition)
(b) JTS Clinical Practice Guideline — Valkyrie Emergency Fresh Whole Blood Transfusion (current edition)
(c) ASBP Walking Blood Bank Program Guidance (current edition)
(d) MCRP 4-11.1F, Health Service Support Operations
(e) Theater Medical Data Store (TMDS) Theater Blood Management User Guide
(f) 1st Platoon, Bravo Co, 1st Med Bn MASCAL SOP (separate)

Encl: (1) Blood Officer and Lab Officer Appointment Letter Template
(2) Donor Registry and Panel Roster
(3) Paper-Based Transfusion Record (TMDS Degraded Backup)
(4) Donor Health Questionnaire
(5) Donor Card Template (DD 572 equivalent)
(6) MTP Activation Checklist (JTS Form recommended)

1. Purpose. To establish standard procedures for blood products management, walking blood bank (WBB) operations, and massive transfusion protocol (MTP) for 1st Platoon, Bravo Company, 1st Medical Battalion operating in a Role 2 (R2) construct. This SOP encompasses pre-deployment donor screening, in-theater blood management and documentation, product prioritization, resuscitation endpoints, massive transfusion, and donor return-to-action standards.

2. Cancellation. None.

3. Action. All 1st Platoon, Bravo Company personnel shall comply with the provisions of this SOP. The Blood Officer and Lab Officer bear primary responsibility for implementation and currency of this SOP.

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Company Commander, Bravo Company
1st Medical Battalion, 1st Marine Logistics Group

STANDARD OPERATING PROCEDURE
BLOOD PRODUCTS MANAGEMENT, WALKING BLOOD BANK, AND MASSIVE TRANSFUSION PROTOCOL

1st Platoon, Bravo Company, 1st Medical Battalion

1. PURPOSE

This SOP governs all aspects of blood product management for 1st Platoon as part of Class VIII Bravo management. It covers pre-deployment donor panel establishment, in-theater blood product prioritization, activation of the walking blood bank, massive transfusion protocol, vascular access strategy, blood product warming, resuscitation endpoints, donor return-to-action standards, and Theater Medical Data Store (TMDS) blood management documentation. Blood products are a strategic resource; this SOP treats them as such in all operational environments.

2. SCOPE

a. This SOP applies to all assigned and attached personnel of 1st Platoon, Bravo Company, 1st Medical Battalion.

b. This SOP is self-contained. In deployed or exercise contexts, it shall be read in conjunction with the unit MASCAL SOP (Reference (f)) and applicable theater blood management directives.

c. This SOP does not govern cold-chain storage of blood products. Cold-chain protocols are addressed in the 1st Medical Battalion Cold Storage Chain SOP (separate).

3. RESPONSIBILITIES

a. Blood Officer. Appointed in writing by the OIC. The Blood Officer is the primary authority for unit blood program management. Responsibilities include: maintaining the donor registry, managing product inventory, coordinating ASBP resupply, maintaining TMDS Theater Blood Tab access, authorizing WBB activation (with OIC concurrence), and submitting blood usage reports to higher headquarters. The Blood Officer shall be a physician or advanced practice provider.

b. Lab Officer. The highest-ranking Advanced Lab Tech serves as Lab Officer. The Lab Officer is responsible for: all blood type verification and titer confirmation, donor screening at point of collection, TMDS documentation of all donations and transfusions, paper-based backup documentation when TMDS is degraded, and daily inventory reconciliation. The Lab Officer reports to the Blood Officer on all blood program matters.

c. Senior Medical Officer. The senior physician present retains clinical authority for all transfusion decisions, MTP activation and termination, resuscitation endpoint assessment, and donor return-to-action determinations.

d. OIC. Provides dual authority concurrence for WBB activation, MTP stand-down, and ASBP resupply requests. Notifies higher headquarters on WBB activation and MTP events.

4. PROGRAM BASIS — PROJECT VALKYRIE / EFWBT

This SOP is grounded in the Joint Trauma System (JTS) Valkyrie Emergency Fresh Whole Blood Transfusion (EFWBT) program and ASBP walking blood bank guidance. 1st Platoon personnel with clinical roles have completed JTS Valkyrie training prior to deployment. This SOP operationalizes Valkyrie best practices within the specific T/O and capabilities of this unit. All procedures shall be executed in accordance with current JTS Valkyrie CPG (Reference (b)) and ASBP standards; where this SOP provides additional specificity, the more specific guidance applies. Where conflict exists, JTS CPG takes precedence.

5. BLOOD PRODUCT PRIORITY LADDER

5a. The following priority order governs blood product selection for all hemorrhagic resuscitation. Providers shall always use the highest available product on the priority ladder. Downward substitution is authorized only when higher-priority products are unavailable or exhausted.

Pri	Product	Source	Shelf Life / Storage	Notes
1	LTOWB	ASBP cold-chain	21 days / 1-6°C	First-line resuscitation product; request through Blood Officer via JBPO
2	LTOWB – WBB	Walking Blood Bank (organic donor panel)	4 hrs room temp from draw	Activated on Blood Officer + OIC dual authority; see para 8
3	Component Therapy (balanced)	ASBP / higher echelon	Per component type	pRBC : FFP : PLT at 1:1:1 ratio; reference JTS DCR CPG for current guidance
4	FGDP (isolated)	ASBP / higher echelon	5 days / 1-6°C	Austere last resort only; bridge product — reassess for upgrade when higher-priority product becomes available; not a standalone resuscitation endpoint

5b. Frozen Group O Dried Plasma (FGDP) as isolated last-resort product. FGDP is a bridge product only. When FGDP is the sole available product, the provider shall simultaneously initiate resupply request for higher-priority products, document the austere indication, and reassess for upgrade at each product delivery. FGDP as a standalone resuscitation endpoint is not clinically optimal; its use signals a supply crisis requiring immediate higher headquarters notification through the Blood Officer and OIC.

6. SUPPLY ENVIRONMENT AND RESUSCITATION APPROACH

6a. The resuscitation approach and product usage ceilings are modulated by the operational supply environment. The Senior Medical Officer, in coordination with the Blood Officer, shall assess the supply environment at the time of each MTP activation and reassess at each resupply update.

Environment	Resuscitation Approach	MTP Trigger	Unit Ceiling / Reassessment
Permissive Resupply	Clinical gestalt drives decisions; ABC Score and Shock Index used as	Clinical gestalt; ABC Score ≥2 and/or Shock Index ≥1 as supporting anchors	No fixed ceiling; reassess goals of care at each

	supporting tools; full product ladder available		provider handoff and with each product tier transition
Contingency (contested resupply)	Prioritize LTOWB-WBB as primary product; conservative component use; coordinate ASBP resupply early	Clinical gestalt; lean toward earlier activation given anticipated resupply delays	Ceiling of 10 units pRBC equivalent; reassess goals of care; escalate resupply request to Blood Officer and OIC
Emergency (supply-denied / isolated)	WBB as primary; FGDP as bridge only; all products treated as irreplaceable; consider permissive hypotension aggressively	Clinical gestalt; ABC Score and Shock Index as supporting tools; activate early	Ceiling of 2 units; reassess goals of care; escalate to expectant consideration if no response; mandatory report to OIC and Blood Officer

6b. Permissive Hypotension. In hemorrhagic shock, permissive hypotension (targeting SBP ≥80 mmHg in non-TBI patients) is the standard approach until surgical hemorrhage control is achieved. In contested/supply-denied environments, providers shall apply permissive hypotension more aggressively to conserve products. See paragraph 9 for resuscitation endpoints.

6c. ABC Score and Shock Index as supporting tools. These validated tools (ABC Score ≥2; Shock Index ≥1) are decision-support instruments. Clinical gestalt — integrating mechanism, vital signs trend, response to initial resuscitation, and available resources — is the primary driver. Do not delay MTP activation pending score calculation when the clinical picture is clear.

7. PRE-DEPLOYMENT DONOR PANEL ESTABLISHMENT

7a. Scope. All organic Platoon personnel shall be offered enrollment in the walking blood bank donor panel prior to deployment. Supported unit Marines and sailors shall be screened and enrolled where feasible and with command authorization. Maximizing donor panel size directly increases WBB operational capacity.

7b. Pre-Deployment Blood Drive. A formal pre-deployment blood drive shall be conducted at an ASBP-affiliated MTF (e.g., Naval Hospital Camp Pendleton or Naval Medical Center San Diego) prior to deployment. The Blood Officer coordinates with ASBP to schedule the blood drive, ensure FDA-required infectious disease testing is performed, and receive results before departure. The blood drive serves as the baseline infectious disease screen for all donors.

7c. Screening Requirements.

Screening Element	Method / Standard	Notes / Disposition
ABO / Rh Blood Typing	MTF laboratory typing; confirm with unit blood drive	Record on donor card and unit roster; O-type donors (both O-pos and O-neg) enrolled; O-neg preferred as universal; O-pos acceptable given tactical context
Low-Titer Confirmation	Anti-A and anti-B titer ≤120 by tube method (ASBP standard)	High-titer donors (>256) excluded from LTOWB panel; may be enrolled as same-type or component donors; Lab Officer maintains titer records

Infectious Disease Screen	ASBP pre-deployment blood drive; FDA-required testing panel (HIV 1/2, HBsAg, HCV, HTLV, syphilis, West Nile, Zika per current requirements)	Testing conducted at MTF / ASBP facility prior to deployment; results recorded in donor registry; any reactive screen = permanent exclusion from panel pending ASBP review
Medical History Review	Donor health questionnaire per ASBP / JTS Valkyrie standards	Temporary deferrals: recent illness, antibiotics, tattoo/piercing <3 months, recent surgery; permanent deferrals per ASBP policy; Blood Officer reviews questionnaires
Hemoglobin / Hematocrit	Hgb ≥12.5 g/dL (female) or ≥13.0 g/dL (male) at time of pre-deployment screen	iSTAT or point-of-care method acceptable; recheck prior to in-theater donation if >60 days since screen
Donor Card Issuance	DD 572 or ASBP-equivalent donor identification card	Donor carries card; Blood Officer maintains master registry; Medical Regulator maintains backup copy

7d. Rescreening. For deployments exceeding 90 days, rescreening of donor panel members is recommended. Rescreening intervals are not a fixed requirement but should be considered when: a donor reports a new medical condition or medication, a donor has been outside the wire in high-risk environments, or the Blood Officer determines clinical risk warrants reassessment. Organic rescreening capability using iSTAT (hemoglobin) and available POC testing is acceptable for in-theater rescreening; full infectious disease panel requires MTF support or ASBP coordination.

7e. Donor Registry. The Blood Officer maintains a current donor registry (Enclosure 2) containing: donor name, rank, unit, blood type, titer status, last donation date, infectious disease screen date, and current eligibility status. The Lab Officer maintains a backup copy. The registry shall be updated within 24 hours of any donation or eligibility change.

8. WALKING BLOOD BANK (WBB) ACTIVATION AND OPERATIONS

8a. WBB activation requires dual authority concurrence from the Senior Medical Officer and OIC. The Senior Medical Officer initiates the request based on clinical determination that LTOWB from ASBP is unavailable or insufficient to meet immediate patient needs. The OIC concurs and notifies higher headquarters.

8b. WBB Activation and Collection Workflow.

Step	Who	Action	Documentation
1 — Trigger	Senior Medical Officer	Determine LTOWB (ASBP) unavailable or insufficient; recommend WBB activation	Record time, clinical indication, ASBP status in transfusion log
2 — Authority	Senior Medical Officer + OIC	Dual concurrence required; OIC notifies higher headquarters	Document dual authority concurrence and time of activation

3 — Donor Call	Blood Officer	Contact donor panel roster; confirm donor eligibility (last donation interval, health status); direct donor to draw station	Record donor name, blood type, last donation date, current health attestation
4 — Screening	Lab Officer / Advanced Lab Tech	Confirm blood type (ABO/Rh); verify low-titer O status per ASBP threshold (anti-A/anti-B ≤256 by tube method); infectious disease screen per pre-deployment record	Complete DD 572 or equivalent donor card; record in TMDS Theater Blood Tab or paper backup form
5 — Collection	Advanced Lab Tech / trained FMT	Draw 1 unit (450–500 mL) using sterile technique into CPDA-1 collection bag; label immediately with donor ID, blood type, draw time, expiration (4 hrs)	Label per ASBP standards; initiate chain of custody log
6 — Delivery	Lab Officer / FMT courier	Transport to treatment area; warm per para 10; connect to Belmont or blood warmer as indicated; confirm with receiving provider	Record delivery time, recipient ID, provider receiving
7 — Transfusion	Transfusion provider (physician or nurse)	Two-person verification of label; confirm compatibility; begin transfusion; monitor for transfusion reactions per para 11	Document start time, rate, volume, patient response in TMDS SF600 or paper backup
8 — Resupply Trigger	Blood Officer	After 4 units drawn from WBB panel, or after 2 hrs of continuous WBB activation: submit ASBP resupply request to higher headquarters through OIC	Record resupply request time and channel in blood management log

8c. Resupply Trigger. The Blood Officer shall submit an ASBP resupply request to higher headquarters, through OIC, after any of the following occur:

- Four (4) or more units drawn from the WBB donor panel in a single activation period.
- Two (2) or more hours of continuous WBB activation.
- LTOWB (ASBP) inventory falls below four (4) units at any time.
- Any MTP activation in an environment where resupply is not assured within 24 hours.

8d. WBB Panel Integrity. No donor shall be called for re-donation within 56 days of a prior whole blood donation except in extremis as determined by the Senior Medical Officer with documented clinical justification. The Blood Officer tracks donation dates in the registry and is responsible for preventing premature re-donation.

9. RESUSCITATION ENDPOINTS

9a. The following endpoints guide transfusion decisions and MTP management. These represent simplified field-adapted targets. Providers shall additionally reference JTS Damage Control Resuscitation

CPG (Reference (a)) for current comprehensive endpoint guidance, as that document takes precedence in matters of clinical detail.

Parameter	Target (non-TBI)	Target (TBI / suspected TBI)	Notes
Systolic BP	≥80 mmHg (permissive hypotension)	≥90 mmHg	Avoid over-resuscitation; normalize only after hemorrhage control
Mentation	Improving or baseline	GCS stable or improving	Decline in mentation = resuscitation inadequate or ongoing hemorrhage
Radial Pulse	Present and palpable	Present and palpable	Loss of radial pulse = immediate reassessment
Lactate / Base Excess	Trending toward normal; BE > -6	Same	Use iSTAT if available; trend more important than single value; reference JTS DCR CPG
Skin / Cap Refill	Improving perfusion; cap refill ≤2s	Same	Field-expedient end-organ perfusion marker
Temperature	>35°C; avoid hypothermia	Same	Active warming measures; see blood warmer / Belmont protocol; hypothermia worsens coagulopathy
Urine Output	≥0.5 mL/kg/hr if Foley placed	Same	R2 context; catheterize critical patients when feasible

9b. The Lethal Triad (hypothermia, acidosis, coagulopathy) shall be actively managed throughout resuscitation. These three conditions are mutually reinforcing; failure to address all three simultaneously degrades resuscitation effectiveness. Aggressive rewarming of products and patient, correction of acidosis through hemorrhage control and adequate perfusion, and balanced product administration addressing coagulopathy are concurrent priorities — not sequential ones.

9c. Transition to Damage Control Surgery. When resuscitation endpoints are not met after appropriate product administration, or when ongoing surgical hemorrhage is the identified source, the Senior Medical Officer shall notify the surgeon immediately for transition to damage control surgery. Do not continue indefinite medical resuscitation of a surgical problem.

10. BLOOD PRODUCT WARMING AND BELMONT RAPID INFUSER PROTOCOL

10a. Cold blood product administration contributes directly to hypothermia and worsens the lethal triad. All blood products shall be warmed prior to or during administration except in immediate life-threatening hemorrhage where warming devices are not immediately available and delay of transfusion would cause death. In that circumstance, administer product and apply aggressive concurrent patient warming.

Device / Method	Indication	Protocol / Notes
Dedicated Blood Warmer (Ranger / enFlow / Level 1 equivalent)	All stored ASBP LTOWB and component products prior to transfusion; FGDP; routine resuscitation in field conditions	Target effluent temperature 37°C; prime warmer per manufacturer SOP before first use; confirm temperature display before connecting to patient; do not exceed manufacturer max flow rate for warming efficacy; primary warming device for non-MTP transfusions
Belmont Rapid Infuser	Massive transfusion; high-flow resuscitation requirement; MTP activation; any situation requiring rapid volume delivery with simultaneous warming	Provides simultaneous high-flow delivery AND active warming; set warming to 39-41°C for blood products; confirm line patency and access size (≥16g PIV, proximal humerus IO, or CVC introducer) before priming; dedicated FMT or nurse assigned to Belmont during MTP; Belmont allocated to Immediate Treatment Bay on MASCAL declaration; returns to FRSS on first operative case preparation; second warmer (dedicated blood warmer) remains with FRSS throughout
Passive Warming (adjunct only)	When device warmers unavailable; prolonged storage in warm environment	NOT recommended as primary method; acceptable only in extremis when devices are non-functional; allow refrigerated product to reach room temperature ≤30 min maximum before administration; never warm blood in hot water, microwave, or direct heat source — hemolysis risk
Patient Warming (concurrent)	All MTP patients; hypothermic patients; any patient receiving >2 units blood products	Apply external warming measures concurrently with blood product warming: warm blankets, hypothermia prevention kit, remove wet clothing; hypothermia below 35°C dramatically worsens coagulopathy and mortality — treat aggressively

10b. Belmont Allocation During MASCAL. The Belmont Rapid Infuser is allocated to Shock Trauma Platoon upon MASCAL declaration. It returns to FRSS on preparation of the first operative case. The dedicated blood warmer remains with FRSS throughout. The Blood Officer coordinates reallocation in scenarios where both bays require simultaneous high-flow resuscitation.

11. VASCULAR ACCESS STRATEGY FOR BLOOD RESUSCITATION

11a. Adequate vascular access is a prerequisite for effective blood resuscitation. Access strategy shall be established before or concurrent with first product administration. The following priority order is recommended:

Priority	Access Type	Recommended Site / Size	Clinical Notes
First Line	Peripheral IV (PIV)	Antecubital or external jugular; ≥16g, ideally 14g	Largest bore possible; two PIV lines preferred for MTP; EJ access is underutilized and highly effective in shock states with collapsed peripheral veins

Second Line	Intraosseous (IO)	Proximal humerus preferred for blood; tibia acceptable	Proximal humerus IO provides higher flow rates than tibial; preferred IO site for blood product infusion; use EZ-IO or FAST-1; confirm placement before product administration
Third Line	Central Venous Access (CVC)	Internal jugular or subclavian; 8.5Fr introducer sheath if available	Introducer sheaths (Cordis) allow high-flow infusion comparable to large-bore PIV; prefer over triple-lumen catheters for rapid resuscitation; anesthesiologist primary operator
Belmont Integration	Any access ≥16g PIV, IO proximal humerus, or CVC introducer	Connect per Belmont operator guide; confirm access patency before priming circuit	Belmont Rapid Infuser provides simultaneous warming and high-flow delivery; confirm line size compatibility; do not use with small-bore (20g+) PIV for high-flow resuscitation — line may fail under pressure

11b. Two-Line Standard for MTP. All MTP patients shall have a minimum of two large-bore access points established as rapidly as feasible — one dedicated to blood product administration (connected to warming device / Belmont) and one available for medications, fluids, and monitoring draws. The Anesthesiologist leads vascular access establishment in the forward triage area prior to transition to the first operative case.

11c. Failed Access. If peripheral and IO access cannot be established rapidly in a hemorrhaging patient, the Anesthesiologist or senior physician shall proceed directly to CVC / introducer sheath placement. Do not delay product administration pending ideal access — use best available access and upgrade as time permits.

12. MASSIVE TRANSFUSION PROTOCOL (MTP)

12a. MTP is activated when clinical hemorrhagic shock is refractory to initial resuscitation and continued high-volume blood product administration is anticipated. MTP is a team-level event coordinating medical, laboratory, and logistics resources for sustained resuscitation.

12b. MTP Workflow.

Phase	Trigger / Criteria	Actions	Authority / Notes
ACTIVATION	Clinical gestalt: uncontrolled hemorrhagic shock; ABC Score ≥2 and/or Shock Index ≥1 as supporting tools; provider judgment is primary	Declare MTP to team; notify Blood Officer and OIC; begin LTOWB (priority 1 or 2); activate 1:1:1 component backup; assign dedicated transfusion nurse/FMT; initiate blood warmer and Belmont as clinically indicated	Senior Medical Officer or Emergency Physician; dual notify Blood Officer + OIC within 5 min of activation
RESUSCITATION	Ongoing hemorrhage; failure	Administer products per priority ladder; reassess endpoints every 15 min; maintain 1:1:1 ratio; monitor for hypothermia, acidosis,	Blood Officer tracks units administered and donor panel status; Lab Officer documents all transfusions in TMDS

	to meet endpoints; clinical deterioration	coagulopathy triad; aggressive rewarming; Belmont for rapid volume/warming delivery	Theater Blood Tab (or paper backup); apply supply environment ceiling if applicable
REASSESSMENT	Endpoint criteria met; supply ceiling approached; transition to surgery	Reassess goals of care; notify surgeon if operative intervention indicated; transition DCR to DCS; document product totals; update Blood Officer inventory	Transition to FRSS on surgeon determination; update TMDS; apply contingency or emergency ceiling per supply environment
TERMINATION	Hemorrhage controlled; resuscitation endpoints met; transition to definitive care or expectant determination	Declare MTP stand-down; reconcile all units transfused with Lab Officer; update TMDS Theater Blood Tab; request ASBP resupply if panel or product depleted; complete transfusion record; debrief team	Senior Medical Officer + OIC concur on stand-down; Blood Officer submits resupply request within 1 hr of termination if product thresholds met

12c. 1:1:1 Ratio. When component therapy is used (priority 3), products shall be administered at a balanced 1:1:1 ratio of packed red blood cells (pRBC) to fresh frozen plasma (FFP/FGDP) to platelets. Providers shall reference JTS DCR CPG (Reference (a)) for current component ratio guidance and platelet availability considerations in austere environments.

12d. Calcium Administration. Administer calcium chloride (1g IV) or calcium gluconate (3g IV) after every 4 units of blood products to counter citrate-induced hypocalcemia. Ionized calcium monitoring via iSTAT is preferred where available. Target ionized calcium >1.1 mmol/L.

12e. Tranexamic Acid (TXA). Administer TXA 1g IV over 10 minutes within 3 hours of injury in all patients with significant hemorrhagic shock. Follow with 1g IV over 8 hours. Do not administer TXA after 3 hours from time of injury — evidence supports harm in delayed administration. TXA is a complement to blood product resuscitation, not a substitute.

12f. TMDS Documentation During MTP. The Lab Officer or designated FMT shall maintain real-time documentation of all products administered during MTP in TMDS Theater Blood Tab (or paper backup). Product totals shall be reconciled at MTP termination. The Blood Officer submits an ASBP resupply request within 1 hour of MTP termination if any product threshold has been crossed.

13. DONOR RETURN TO ACTION

13a. Donor care following WBB donation is a medical and operational priority. Donors provide a critical resource at personal physiologic cost. The following standards govern post-donation management. Provider discretion is the governing principle within the bounds of JTS Valkyrie guidance (Reference (b)).

Parameter	JTS Valkyrie Recommendation (Reference)	Provider Discretion Notes
Light activity restriction	No strenuous physical activity for minimum 4 hours post-donation	Provider may extend based on donor response, hemodynamic status, environmental conditions; heat and altitude may warrant longer restriction

Combat / operational restriction	No combat operations or high-exertion operational tasks for minimum 24 hours post-donation	Commanding Officer and Senior Medical Officer coordinate operational risk; provider authority to extend restriction; document restriction in donor record
Oral hydration	Minimum 500 mL oral fluid immediately post-donation; continue ad lib hydration x 24 hrs	IV hydration (250–500 mL NS or LR) if donor is symptomatic, hypotensive, or in high heat environment; provider discretion
Nutrition	Caloric replacement meal or snack immediately post-donation; iron-containing foods encouraged	MRE or equivalent acceptable; provider discretion on iron supplementation in prolonged deployment context
Re-donation interval	Minimum 56 days between whole blood donations	Provider may authorize earlier re-donation only in extremis (supply-denied emergency environment); document exception and clinical justification
Monitoring	Observe donor minimum 15 minutes post-donation for vasovagal reaction, hypotension, syncope	FMT assigned to monitor; immediate provider notification if symptoms develop; donor not released to duty until cleared by provider

13b. Vasovagal Management. If a donor experiences vasovagal reaction (pre-syncope, syncope, hypotension, pallor, diaphoresis): lay flat with legs elevated, administer oral or IV fluids per provider judgment, monitor until fully recovered, clear for return to duty only when asymptomatic and hemodynamically normal. Document reaction in donor registry and TMDS.

13c. Operational Coordination. The Blood Officer shall notify the OIC of all donations so that operational planning accounts for donor activity restrictions. Commanders of supported units whose Marines donate shall be notified of the restriction period through the OIC notification chain.

14. THEATER MEDICAL DATA STORE (TMDS) BLOOD MANAGEMENT

14a. TMDS serves as the authoritative theater database for blood product documentation. The TMDS Theater Blood Tab provides real-time visibility of donations, transfusions, inventory, and expiration tracking for all blood products at the R2 facility. TMDS access requires SIPRNet connectivity and is restricted to the Lab Officer and Blood Officer (TBLD role) per theater access policy.

Function	TMDS Theater Blood Tab	Responsibility / Notes
Donation Tracking	Record each donation: donor ID, blood type, titer, draw time, unit number	Lab Officer enters within 1 hr of draw; SIPRNet required; TMDS access restricted to Lab Officer and Blood Officer (TBLD role)
Transfusion Documentation	Record recipient, product type, unit number, volume, start/stop time, reaction status	Transfusion provider documents in TMDS SF600; Lab Officer reconciles daily; captures all products including WBB units

Inventory Management	Real-time inventory of all blood products: LTOWB units, component stock, FGDP, WBB units	Blood Officer reviews TMDS inventory daily and after each MTP event; alerts Senior Medical Officer when any product falls below 4-unit threshold
Expiration Monitoring	TMDS flags units approaching expiration; WBB units auto-expire at 4 hrs	Lab Officer performs daily reconciliation; expired units removed and documented; request resupply before depletion — do not wait until zero stock
Reporting	Submit blood usage reports to JBPO per theater requirements; include MTP events	Blood Officer responsible for periodic reporting per higher HQ guidance; OIC reviews prior to submission
DEGRADED / OFFLINE CONTINGENCY	Paper-based backup tracking	When SIPRNet or TMDS is unavailable: use paper Transfusion Record (Enclosure 3) for all donations and transfusions; Lab Officer maintains written log; enter all data into TMDS within 24 hrs of system restoration; notify Blood Officer immediately of TMDS outage

14b. TMDS Account Maintenance. The Blood Officer and Lab Officer shall maintain current TMDS TBLD accounts prior to deployment. Account requests are processed through the Theater Medical Information Program-Joint (TMIP-J) program office. SIPRNet tokens are required. Account access shall be tested during pre-deployment workup. A backup operator (second Advanced Lab Tech) shall also maintain TMDS access in the event the Lab Officer becomes a casualty.

15. TRANSFUSION REACTION MANAGEMENT

15a. All transfusion reactions shall be managed per the following immediate protocol:

- STOP the transfusion immediately upon recognition of a suspected reaction.
- Maintain IV/IO access — do not remove the line.
- Notify Senior Medical Officer immediately.
- Administer supportive care per reaction type: diphenhydramine and/or epinephrine for allergic/anaphylactic; aggressive fluid resuscitation and vasopressors for hemolytic shock; antipyretics for febrile non-hemolytic reactions.
- Save the blood product bag, tubing, and any remaining product for inspection.
- Document reaction in TMDS; notify Blood Officer; submit blood bank investigation request.

15b. Hemolytic transfusion reactions (ABO incompatibility) are the most immediately life-threatening reaction. Two-person label verification prior to every transfusion is mandatory and non-negotiable.

16. ASBP COORDINATION AND RESUPPLY

16a. The Armed Services Blood Program (ASBP) is the primary source of pre-screened, typed, and tested LTOWB for deployed forces. The Blood Officer maintains the ASBP point of contact chain for the operational theater and initiates resupply requests through the OIC to higher headquarters / Joint Blood Program Office (JBPO).

16b. Resupply Requests. All ASBP resupply requests shall include: current inventory by product type, units administered since last resupply, MTP events (number and units used), anticipated operational

tempo and resupply timeline, and WBB panel status. Requests shall be transmitted via the highest-available communications means (SIPRNET preferred; voice as backup).

16c. Proactive Resupply. The Blood Officer shall not wait until product depletion to request resupply. Resupply request thresholds:

- LTOWB (ASBP): request when on-hand falls below 6 units.
- Component products: request when any component falls below 4 units.
- FGDP: request when on-hand falls below 4 units.
- Following any MTP event regardless of current inventory level.

17. TRAINING REQUIREMENTS

17a. All clinical personnel shall complete JTS Valkyrie EFWBT training prior to first deployment with the unit. The Blood Officer maintains training records.

17b. Advanced Lab Techs shall maintain currency in blood typing, titer confirmation, collection technique, and TMDS Theater Blood Tab operations. Annual refresher training is required.

17c. All providers shall be trained in MTP activation procedures, Belmont Rapid Infuser operation, blood warmer operation, and transfusion reaction management prior to deployment.

17d. Vascular access skills — large-bore PIV, IO insertion (proximal humerus and tibial), and CVC/introducer sheath placement — shall be maintained as current clinical skills by all physicians, the PA, and Emergency Nurse. IO insertion shall be maintained by all FMTs.

18. SOP REVIEW AND CURRENCY

18a. This SOP shall be reviewed annually or upon publication of updated JTS CPGs, ASBP guidance, or significant change to unit T/O or mission. The Blood Officer is responsible for initiating annual review.

18b. Changes to JTS CPG or ASBP standards take precedence and shall be incorporated at the next SOP revision. Interim deviations from this SOP required by updated higher guidance shall be documented in a command memorandum signed by the OIC.

19. RECORDS

19a. All blood product transactions (donations, transfusions, wastage, expiration) shall be documented in TMDS Theater Blood Tab. Paper backup (Enclosure 3) shall be maintained when TMDS is unavailable and reconciled within 24 hours of system restoration.

19b. The Donor Registry (Enclosure 2) shall be retained for a minimum of 10 years per DoD records management policy.

19c. MTP After-Action Reports shall be completed within 72 hours of MTP stand-down, reviewed by the Blood Officer and Senior Medical Officer, and submitted to the Company Commander.

ENCLOSURES (1) THROUGH (6)

BLOOD PRODUCTS MANAGEMENT, WALKING BLOOD BANK, AND MASSIVE TRANSFUSION PROTOCOL SOP

1st Platoon, Bravo Company, 1st Medical Battalion

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ENCLOSURE (1)

BLOOD OFFICER AND LAB OFFICER APPOINTMENT LETTER TEMPLATE

1st Platoon, Bravo Company, 1st Medical Battalion

From: Company Commander, Bravo Company, 1st Platoon, 1st Medical Battalion_____

To: _____

Subj: APPOINTMENT AS BLOOD OFFICER / LAB OFFICER, 1ST PLATOON, BRAVO COMPANY, 1ST MEDICAL BATTALION

Ref: (a) 1st Plt, Bravo Co, 1st Med Bn Blood Products, WBB, and MTP SOP

1. BLOOD OFFICER APPOINTMENT

Effective ____

is hereby appointed as Blood Officer for 1st Platoon, Bravo Company, 1st Medical Battalion. This appointment is in accordance with Reference (a).

Blood Officer Responsibilities (IAW Reference (a), Para 3a):

- Maintain the unit Walking Blood Bank donor registry (Enclosure 2 to Reference (a)).
- Manage blood product inventory and coordinate ASBP resupply.
- Maintain TMDS Theater Blood Tab access (TBLD role; SIPRNet token required).
- Authorize WBB activation in concert with the OIC.
- Submit blood usage reports to higher headquarters per theater requirements.
- Ensure currency of this SOP and enclosures; initiate annual review.

I acknowledge receipt of this appointment and accept the responsibilities therein.

Signature: _____

Date: _____ Rank / Name: _____

2. LAB OFFICER APPOINTMENT

The highest-ranking Advanced Lab Tech assigned to 1st Platoon, Bravo Company serves as Lab Officer by virtue of position. A formal designation letter is required when the senior Lab Tech rotates. Complete this section upon each change.

Current Lab Officer (Rank / Name): _____

Effective Date: _____ Previous Lab Officer: _____

Lab Officer Responsibilities (IAW Reference (a), Para 3b):

- Blood type verification and titer confirmation for all donors.

- Donor screening at point of collection.
- TMDS documentation of all donations and transfusions; paper backup when TMDS degraded.
- Daily inventory reconciliation.
- Maintain backup TMDS access for second Advanced Lab Tech operator.

Lab Officer Signature: _____
Date: _____ OIC Signature: _____

3. TMDS ACCOUNT VERIFICATION

Prior to deployment, confirm the following TMDS Theater Blood (TBLD) account status:

- ☐ Blood Officer — TMDS TBLD account active and tested
- ☐ Lab Officer — TMDS TBLD account active and tested
- ☐ Backup operator (2nd Advanced Lab Tech) — TMDS TBLD account active and tested
- ☐ SIPRNet tokens confirmed for all three operators
- ☐ Paper-based backup forms (Enclosure 3) printed and staged

Verified by (Blood Officer): _____
Date verified: _____

ENCLOSURE (2)

DONOR REGISTRY AND PANEL ROSTER

1st Platoon, Bravo Company, 1st Medical Battalion

Maintained by: Blood Officer (primary) and Lab Officer (backup). Update within 24 hours of any donation, eligibility change, or rescreening. Protect as PII/PHI — FOUO.

Unit: 1st Platoon, Bravo Company, 1st Medical Battalion_____ Registry Version / Date: _____

Blood Officer: _____ Lab Officer: _____

SECTION A — DONOR PANEL ROSTER

#	Last, First MI	Rank / Rate	Unit	Blood Type	Rh	Low-Titer Confirmed	ID Screen Date	Last Donation	Next Eligible	Status	Notes
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											

15											
16											
17											
18											
19											
20											
21											

Status Codes: A = Active/Eligible T = Temporarily Deferred P = Permanently Deferred D = Deployed/Unavailable

SECTION B — DONATION LOG (IN-THEATER)

#	Donor Name	Blood Type	Unit # / Label	Draw Date	Draw Time	Volume (mL)	Expiration (Date/Time)	Recipient (Name/ID)	Transfusion Provider / Notes
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

13									
14									
15									

NOTE: Enter all in-theater donations in TMDS Theater Blood Tab within 1 hour of draw. This log serves as the source document and paper backup. Reconcile with TMDS daily.

ENCLOSURE (3)

PAPER-BASED TRANSFUSION RECORD (TMDS DEGRADED / OFFLINE BACKUP)

1st Platoon, Bravo Company, 1st Medical Battalion

USE THIS FORM ONLY WHEN TMDS IS UNAVAILABLE. Enter all data into TMDS within 24 hours of system restoration.

SECTION A — FACILITY AND OPERATOR INFORMATION

Facility: 1st Plt, Bravo Co, 1st Med Bn_____ Date of Record: _____

Lab Officer completing form: _____ TMDS outage start time: _____

Reason for TMDS unavailability: _____ SIPRNet status: _____

SECTION B — TRANSFUSION RECORD (complete one block per unit transfused)

UNIT 1

Product Type: ☐ LTOWB-ASBP ☐ LTOWB-WBB ☐ pRBC ☐ FFP/FGDP ☐ PLT ☐ Other: ___	Unit #: _____
Recipient Name: _____	Recipient DOD ID / SSN (last 4): _____
Recipient Blood Type: _____ Donor Blood Type: _____ Compatible: ☐ Yes ☐ N/A (O-type)	Volume transfused (mL): _____
Start Date/Time: _____	Stop Date/Time: _____
Two-person label verification: Name 1: _____ Name 2: _____	Warming device used: ☐ Blood Warmer ☐ Belmont ☐ None (document reason)
Transfusion reaction: ☐ None ☐ Yes — describe: _____	Provider administering: _____

UNIT 2

Product Type: ☐ LTOWB-ASBP ☐ LTOWB-WBB ☐ pRBC ☐ FFP/FGDP ☐ PLT ☐ Other: ___	Unit #: _____
Recipient Name: _____	Recipient DOD ID / SSN (last 4): _____
Recipient Blood Type: _____ Donor Blood Type: _____ Compatible: ☐ Yes ☐ N/A (O-type)	Volume transfused (mL): _____
Start Date/Time: _____	Stop Date/Time: _____

Two-person label verification: Name 1: _____ Name 2: _____	Warming device used: ☐ Blood Warmer ☐ Belmont ☐ None (document reason)
Transfusion reaction: ☐ None ☐ Yes — describe: _____	Provider administering: _____

UNIT 3

Product Type: ☐ LTOWB-ASBP ☐ LTOWB-WBB ☐ pRBC ☐ FFP/FGDP ☐ PLT ☐ Other: ___	Unit #: _____
Recipient Name: _____	Recipient DOD ID / SSN (last 4): _____
Recipient Blood Type: _____ Donor Blood Type: _____ Compatible: ☐ Yes ☐ N/A (O-type)	Volume transfused (mL): _____
Start Date/Time: _____	Stop Date/Time: _____
Two-person label verification: Name 1: _____ Name 2: _____	Warming device used: ☐ Blood Warmer ☐ Belmont ☐ None (document reason)
Transfusion reaction: ☐ None ☐ Yes — describe: _____	Provider administering: _____

UNIT 4

Product Type: ☐ LTOWB-ASBP ☐ LTOWB-WBB ☐ pRBC ☐ FFP/FGDP ☐ PLT ☐ Other: ___	Unit #: _____
Recipient Name: _____	Recipient DOD ID / SSN (last 4): _____
Recipient Blood Type: _____ Donor Blood Type: _____ Compatible: ☐ Yes ☐ N/A (O-type)	Volume transfused (mL): _____
Start Date/Time: _____	Stop Date/Time: _____
Two-person label verification: Name 1: _____ Name 2: _____	Warming device used: ☐ Blood Warmer ☐ Belmont ☐ None (document reason)
Transfusion reaction: ☐ None ☐ Yes — describe: _____	Provider administering: _____

UNIT 5

Product Type: ☐ LTOWB-ASBP ☐ LTOWB-WBB ☐ pRBC ☐ FFP/FGDP ☐ PLT ☐ Other: ___	Unit #: _____
Recipient Name: _____	Recipient DOD ID / SSN (last 4): _____

Recipient Blood Type: _____ Donor Blood Type: _____ Compatible: ☐ Yes ☐ N/A (O-type)	Volume transfused (mL): _____
Start Date/Time: _____	Stop Date/Time: _____
Two-person label verification: Name 1: _____ Name 2: _____	Warming device used: ☐ Blood Warmer ☐ Belmont ☐ None (document reason)
Transfusion reaction: ☐ None ☐ Yes — describe: _____	Provider administering: _____

UNIT 6

Product Type: ☐ LTOWB-ASBP ☐ LTOWB-WBB ☐ pRBC ☐ FFP/FGDP ☐ PLT ☐ Other: ___	Unit #: _____
Recipient Name: _____	Recipient DOD ID / SSN (last 4): _____
Recipient Blood Type: _____ Donor Blood Type: _____ Compatible: ☐ Yes ☐ N/A (O-type)	Volume transfused (mL): _____
Start Date/Time: _____	Stop Date/Time: _____
Two-person label verification: Name 1: _____ Name 2: _____	Warming device used: ☐ Blood Warmer ☐ Belmont ☐ None (document reason)
Transfusion reaction: ☐ None ☐ Yes — describe: _____	Provider administering: _____

SECTION C — DAILY BLOOD PRODUCT INVENTORY (complete at 0800 and 2000 daily)

Date/Time	LTOWB-ASBP (units)	WBB Eligible Donors (#)	pRBC (units)	FFP/FGDP (units)	PLT (units)	Resupply Requested?

Resupply thresholds: LTOWB <6 units | Any component <4 units | FGDP <4 units | After any MTP event

SECTION D — TMDS RESTORATION RECONCILIATION

TMDS restored (date/time): _____

All units entered into TMDS by (Lab Officer):

_____

TMDS reconciliation verified by (Blood Officer):

_____

Discrepancies noted: _____

ENCLOSURE (4)

DONOR HEALTH QUESTIONNAIRE

1st Platoon, Bravo Company, 1st Medical Battalion

Complete prior to each whole blood donation. All answers are confidential and used solely to protect donor and recipient safety. Administered by the Lab Officer or trained FMT.

SECTION A — DONOR IDENTIFICATION

Last Name, First MI: _____ Rank / Rate: _____

Unit: _____ DOD ID #: _____

Blood Type (from donor card): _____ Date of birth: _____

Date of last whole blood donation: _____

SECTION B — TEMPORARY DEFERRAL SCREENING

Answer YES or NO to each item. Any YES answer requires review by the Lab Officer or Blood Officer before donation proceeds.

Question	YES	NO
In the past 56 days, have you donated whole blood or blood components?	☐	☐
In the past 7 days, have you taken aspirin or aspirin-containing medications?	☐	☐
In the past 48 hours, have you taken ibuprofen (Motrin), naproxen, or other NSAIDs?	☐	☐
In the past 14 days, have you taken antibiotics or been treated for an infection?	☐	☐
In the past 72 hours, have you had a fever (temperature >38°C / 100.4°F)?	☐	☐
In the past 3 months, have you had a tattoo, piercing, or acupuncture?	☐	☐
In the past 12 months, have you had surgery requiring general anesthesia?	☐	☐
In the past 12 months, have you received a blood transfusion?	☐	☐
In the past 3 months, have you been in a malaria-endemic area? (if not currently deployed)	☐	☐
Are you currently taking any prescription medications not previously disclosed to the Blood Officer?	☐	☐
In the past 24 hours, have you consumed alcohol?	☐	☐
Today, have you had adequate food and fluid intake (meals and water)?	☐	☐

SECTION C — PERMANENT DEFERRAL SCREENING

Answer YES or NO. Any YES answer is a permanent deferral — donor is removed from panel and Blood Officer notified.

Question	YES	NO
Have you ever tested positive for HIV, Hepatitis B, Hepatitis C, HTLV, or syphilis?	☐	☐
Have you ever been diagnosed with a bleeding disorder or clotting condition?	☐	☐
Have you ever received a deferral from the American Red Cross, ASBP, or any blood bank?	☐	☐
Have you ever had Chagas disease or been told you are at risk?	☐	☐
Have you ever used intravenous drugs not prescribed by a physician?	☐	☐
Have you ever received human pituitary-derived growth hormone?	☐	☐
Have you spent 5 or more years in the United Kingdom between 1980 and 1996? (vCJD risk)	☐	☐

SECTION D — VITAL SIGNS AT TIME OF DONATION

Hemoglobin (g/dL)	Blood Pressure	Heart Rate	Temperature (°C)
Result: _____ Min: ≥13.0 (M) / ≥12.5 (F)	Result: _____ Acceptable: <180/100	Result: _____ Acceptable: 50–100	Result: _____ Acceptable: <38.0°C

SECTION E — DONOR CERTIFICATION AND SCREENER SIGN-OFF

I certify that the answers I have provided are truthful and complete to the best of my knowledge. I understand that providing false information to obtain blood donation eligibility may disqualify me from future donation and may place recipients at risk.

Donor Signature: _____ Date: _____

SCREENER REVIEW (Lab Officer or Blood Officer):

Screener Name / Rank: _____ Date / Time: _____

Donation Approved: ☐ YES ☐ NO — Reason: _____

Screener Signature: _____

ENCLOSURE (5)

DONOR CARD TEMPLATE (DD 572 EQUIVALENT)

1st Platoon, Bravo Company, 1st Medical Battalion

Print on cardstock if possible. Laminate if available. Donor carries card at all times during deployment. Blood Officer retains master list. Cut along dashed lines.

Each card below represents one donor. Complete all fields before issuing.

WALKING BLOOD BANK DONOR CARD

1st Plt, Bravo Co, 1st Med Bn

Name: _____
Rank: _____ **DOD ID:** _____
Blood Type: _____ **Rh:** _____
Low-Titer Confirmed: ☐ Yes ☐ No
ID Screen Date: _____
Screened By: _____
Card Issued: _____

IF FOUND: Return to Blood Officer, 1st Plt, Bravo Co, 1st Med Bn

WALKING BLOOD BANK DONOR CARD

1st Plt, Bravo Co, 1st Med Bn

Name: _____
Rank: _____ **DOD ID:** _____
Blood Type: _____ **Rh:** _____
Low-Titer Confirmed: ☐ Yes ☐ No
ID Screen Date: _____
Screened By: _____
Card Issued: _____

IF FOUND: Return to Blood Officer, 1st Plt, Bravo Co, 1st Med Bn

WALKING BLOOD BANK DONOR CARD

1st Plt, Bravo Co, 1st Med Bn

Name: _____
Rank: _____ **DOD ID:** _____
Blood Type: _____ **Rh:** _____
Low-Titer Confirmed: ☐ Yes ☐ No
ID Screen Date: _____
Screened By: _____
Card Issued: _____

IF FOUND: Return to Blood Officer, 1st Plt, Bravo Co, 1st Med Bn

WALKING BLOOD BANK DONOR CARD

1st Plt, Bravo Co, 1st Med Bn

Name: _____
Rank: _____ **DOD ID:** _____
Blood Type: _____ **Rh:** _____
Low-Titer Confirmed: ☐ Yes ☐ No
ID Screen Date: _____
Screened By: _____
Card Issued: _____

WALKING BLOOD BANK DONOR CARD

1st Plt, Bravo Co, 1st Med Bn

Name: _____
Rank: _____ **DOD ID:** _____
Blood Type: _____ **Rh:** _____
Low-Titer Confirmed: ☐ Yes ☐ No
ID Screen Date: _____
Screened By: _____
Card Issued: _____

IF FOUND: Return to Blood Officer, 1st Plt, Bravo Co, 1st Med Bn

IF FOUND: Return to Blood Officer, 1st Plt, Bravo Co, 1st Med Bn

WALKING BLOOD BANK DONOR CARD

1st Plt, Bravo Co, 1st Med Bn

Name: _____

Rank: _____ **DOD ID:** _____

Blood Type: _____ **Rh:** _____

Low-Titer Confirmed: ☐ Yes ☐ No

ID Screen Date: _____

Screened By: _____

Card Issued: _____

IF FOUND: Return to Blood Officer, 1st Plt, Bravo Co, 1st Med Bn

WALKING BLOOD BANK DONOR CARD

1st Plt, Bravo Co, 1st Med Bn

Name: _____

Rank: _____ **DOD ID:** _____

Blood Type: _____ **Rh:** _____

Low-Titer Confirmed: ☐ Yes ☐ No

ID Screen Date: _____

Screened By: _____

Card Issued: _____

IF FOUND: Return to Blood Officer, 1st Plt, Bravo Co, 1st Med Bn

ENCLOSURE (6)

MASSIVE TRANSFUSION PROTOCOL (MTP) ACTIVATION CHECKLIST

1st Platoon, Bravo Company, 1st Medical Battalion

TEAR OUT AND KEEP AT PATIENT BEDSIDE DURING ALL MTP EVENTS

Patient Name / ID: _____ Date / Time of MTP Activation: _____

Activating Provider: _____ Senior Medical Officer notified (time): _____

Supply Environment: ☐ Permissive ☐ Contingency ☐ Emergency_____ Unit ceiling (if applicable): _____

PHASE 1 — MTP ACTIVATION

Trigger criteria met (check all that apply):

- ☐ Clinical gestalt: uncontrolled hemorrhagic shock refractory to initial resuscitation
- ☐ ABC Score ≥2 (penetrating mechanism, SBP ≤90, HR ≥120, FAST positive)
- ☐ Shock Index ≥1 (HR / SBP)

Immediate actions:

- ☐ **Declare MTP** — announce to team
- ☐ **Notify Blood Officer** — time: _____
- ☐ **Notify OIC** — time: _____ (OIC to notify higher HQ)
- ☐ **Establish vascular access** — ≥16g PIV x2, or IO proximal humerus, or CVC introducer
- ☐ **Initiate blood warmer** — target 37°C effluent temperature
- ☐ **Activate Belmont Rapid Infuser** — if high-flow resuscitation needed; confirm line patency
- ☐ **Begin TXA** — 1g IV over 10 min — only if within 3 hours of injury — time of injury: _____
- ☐ **Begin first blood product** — Priority 1 (LTOWB-ASBP) or Priority 2 (WBB) per availability
- ☐ **Assign dedicated transfusion nurse / FMT** — name: _____

PHASE 2 — ONGOING RESUSCITATION

Product administration log (record each unit):

#	Product Type	Unit #	Start Time	Volume (mL)	Warming Device Used	Patient Response / Notes
1						
2						
3						

4						
5						
6						
7						
8						
9						
10						

Calcium protocol: Give CaCl 1g IV (or Ca gluconate 3g IV) after every 4 units of blood products.
Calcium given after units: ☐ Unit 4 ☐ Unit 8 ☐ Unit 12 ☐ Unit 16 ☐ Other: _____

TXA second dose: 1g IV over 8 hours — Start time: _____ (ONLY if first dose given within 3 hrs of injury)

Resuscitation endpoint reassessment (every 15 min):

Time	SBP	HR	Mentation	Radial Pulse	Temp (°C)	Overall Trend

Supply environment ceiling check:
☐ Permissive — no ceiling ☐ Contingency — reassess at 10 units ☐ Emergency — ceiling 2 units; notify OIC if ceiling approached

PHASE 3 — TRANSITION TO SURGERY / REASSESSMENT

- ☐ **Endpoints met — continue resuscitation and reassess**
- ☐ **Endpoints NOT met — notify surgeon for DCS transition** — time: _____
- ☐ **Supply ceiling approached — notify Blood Officer and OIC** — time: _____
- ☐ **Component ratio maintained at 1:1:1 (pRBC:FFP/FGDP:PLT)**

☐ **Patient warming measures in place** — blankets / hypothermia kit applied

PHASE 4 — MTP TERMINATION

Termination criteria met (check all applicable):

☐ Hemorrhage controlled (surgical or procedural)
☐ Resuscitation endpoints achieved
☐ Transition to expectant determination (document clinical justification below)

MTP stand-down time: _____
Concurred: Senior Medical Officer: _____ OIC: _____
Total units pRBC (or equivalent) administered: _____
Total units FFP/FGDP administered: _____
Total units PLT administered: _____
Total units LTOWB (WBB) administered: _____

Post-MTP actions:

☐ **Lab Officer notified — reconcile all units in TMDS (or paper backup)**
☐ **Blood Officer submits ASBP resupply request** — within 1 hr if any threshold crossed
☐ **MTP After-Action Report initiated** — due within 72 hrs to Company Commander

Clinical justification / notes: _____
_____
_____

Checklist completed by: _____ Date/Time: _____