

FM 4-02.10

THEATER HOSPITALIZATION

HEADQUARTERS, DEPARTMENT OF THE ARMY

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THEATER HOSPITALIZATION

TABLE OF CONTENTS

	Page
Preface	vii
CHAPTER 1. HOSPITALIZATION SYSTEM IN A THEATER OF OPERATIONS	1-1
1-1. Combat Health Support in a Theater of Operations.....	1-1
1-2. Principles of Combat Health Support.....	1-2
1-3. Echelons of Combat Health Support.....	1-3
1-4. Medical Evacuation and Medical Regulating.....	1-5
1-5. Theater Hospital System.....	1-6
CHAPTER 2. THE COMBAT SUPPORT HOSPITAL	2-1
2-1. Mission.....	2-1
2-2. Allocation.....	2-1
2-3. Assignment and Capabilities.....	2-1
2-4. Hospital Support Requirements.....	2-2
2-5. Hospital Organization and Functions.....	2-3
2-6. Headquarters and Headquarters Detachment.....	2-3
2-7. The 84-Bed Hospital Company.....	2-9
2-8. The 164-Bed Hospital Company.....	2-15
CHAPTER 3. COMMAND, CONTROL, AND COMMUNICATIONS OF THE COMBAT SUPPORT HOSPITAL	3-1
3-1. Command and Control	3-1
3-2. Communications.....	3-1
CHAPTER 4. DEPLOYMENT AND EMPLOYMENT OF THE COMBAT SUPPORT HOSPITAL	4-1
4-1. Threat Environment	4-1
4-2. Medical Threat Assessment	4-1
4-3. Planning Combat Health Support	4-4
4-4. Mobilization	4-5
4-5. Deployment	4-6
4-6. Concept of Employment	4-8
4-7. Hospital Displacement	4-10
4-8. Emergency Displacement	4-15

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		Page
	4-9. Nuclear, Biological, and Chemical Operations	4-15
	4-10. Risk Management	4-19
	4-11. Force Protection and Security Measures	4-19
CHAPTER	5. INFORMATION SYSTEMS OF THE COMBAT SUPPORT	
	HOSPITAL	5-1
Section	I. Theater Army Medical Management Information System	5-1
	5-1. Theater Army Medical Management Information System Support	5-1
	5-2. Medical Assemblage Management	5-2
	5-3. The Medical Maintenance System	5-2
	5-4. Medical Patient Accounting and Reporting	5-3
	5-5. The Medical Supply System	5-4
Section	II. Force XXI Army Medical Management Information System	5-7
	5-6. Medical Communications for Combat Casualty Care	5-7
	5-7. System Description	5-8
	5-8. Software Capability	5-8
	5-9. Hardware Systems	5-8
	5-10. Communications Systems	5-9
	5-11. Operational Concept	5-9
	5-12. Medical Communications for Combat Casualty Care in Combat Support Hospitals	5-12
	5-13. Software Applications	5-15
APPENDIX	A. MEDICAL DETACHMENT, MINIMAL CARE, TOE 08949A000	A-1
	A-1. Introduction	A-1
	A-2. Mission	A-1
	A-3. Assignment	A-1
	A-4. Capabilities	A-1
	A-5. Limitations	A-2
	A-6. Basis of Allocation	A-2
	A-7. Mobility	A-2
	A-8. Employment	A-2
	A-9. Concept of Operations and Functions	A-3
APPENDIX	B. MEDICAL DETACHMENT, TELEMEDICINE, TOE 08539AA00	B-1
	B-1. Introduction	B-1
	B-2. Mission	B-1
	B-3. Assignment	B-1
	B-4. Capabilities	B-1
	B-5. Limitations	B-1
	B-6. Basis of Allocation	B-2
	B-7. Mobility	B-2
	B-8. Employment	B-2

	Page
B-9. Concept of Operations and Functions	B-2
APPENDIX C. HOSPITAL AUGMENTATION TEAM, HEAD AND NECK, TOE 08527AA00	C-1
C-1. Introduction	C-1
C-2. Mission	C-1
C-3. Assignment	C-1
C-4. Capabilities	C-1
C-5. Limitations	C-1
C-6. Basis of Allocation	C-2
C-7. Mobility	C-2
C-8. Employment	C-2
C-9. Concept of Operations and Functions	C-2
APPENDIX D. HOSPITAL AUGMENTATION TEAM, SPECIAL CARE, TOE 08538AA00	D-1
D-1. Introduction	D-1
D-2. Mission	D-1
D-3. Assignment	D-1
D-4. Capabilities	D-1
D-5. Limitations	D-1
D-6. Basis of Allocation	D-2
D-7. Mobility	D-2
D-8. Employment	D-2
D-9. Concept of Operations and Functions	D-2
APPENDIX E. HOSPITAL AUGMENTATION TEAM, PATHOLOGY, TOE 08537AA00	E-1
E-1. Introduction	E-1
E-2. Mission	E-1
E-3. Assignment	E-1
E-4. Capabilities	E-1
E-5. Limitations	E-1
E-6. Basis of Allocation	E-2
E-7. Mobility	E-2
E-8. Employment	E-2
E-9. Concept of Operations and Functions	E-2
APPENDIX F. MEDICAL TEAM, RENAL HEMODIALYSIS, TOE 08537LB00	F-1
F-1. Introduction	F-1
F-2. Mission	F-1
F-3. Assignment	F-1
F-4. Capabilities	F-1

		Page
	F-5.	Limitations F-1
	F-6.	Basis of Allocation F-1
	F-7.	Mobility F-1
	F-8.	Employment F-2
	F-9.	Concept of Operations and Functions F-2
APPENDIX	G.	MEDICAL TEAM, INFECTIOUS DISEASE, TOE 08537LC00 G-1
	G-1.	Introduction G-1
	G-2.	Mission G-1
	G-3.	Assignment G-1
	G-4.	Capabilities G-1
	G-5.	Limitations G-1
	G-6.	Basis of Allocation G-1
	G-7.	Mobility G-1
	G-8.	Employment G-2
	G-9.	Concept of Operations and Functions G-2
APPENDIX	H.	HOSPITAL PLANNING FACTORS H-1
Section	I.	Corps Hospital Planning Factors H-1
	H-1.	Personnel Deployment Planning Factors H-1
	H-2.	Logistics Planning Factors (Classes I, II, III, IV, VI, and VIII) H-2
	H-3.	Hospital Operational Space Requirements H-6
	H-4.	Estimated Hospital Water Planning Factors H-7
Section	II.	Echelons Above Corps Hospital Planning Factors H-9
	H-5.	Personnel Deployment Planning Factors H-9
	H-6.	Logistics Planning Factors (Classes I, II, III, IV, VI, and VIII) H-10
Section	III.	84-Bed Hospital Company (Corps) First Increment (44-Bed) H-11
Section	IV.	Strategic Movement Requirements H-12
APPENDIX	I.	FIELD WASTE I-1
Section	I.	Overview I-1
	I-1.	General I-1
	I-2.	Responsibility for Disposal of Waste I-1
	I-3.	Categories of Waste I-1
Section	II.	General and Hazardous Waste I-2
	I-4.	General I-2
	I-5.	Sources of General and Hazardous Waste I-2
	I-6.	Disposal of General and Hazardous Waste I-3
Section	III.	Medical Waste I-3
	I-7.	General I-3
	I-8.	Responsibility for Disposal of Medical Waste I-4
	I-9.	Source of Medical Waste I-5

		Page
	I-10. Handling and Transporting Medical Waste	I-5
	I-11. Disposal of Medical Waste	I-6
Section	IV. Human Waste	I-8
	I-12. General	I-8
	I-13. Responsibility for Disposal of Human Waste	I-8
	I-14. Patient Facilities	I-9
Section	V. Wastewater	I-10
	I-15. General	I-10
	I-16. Requirement for Disposal	I-10
	I-17. Responsibility for Disposal	I-10
	I-18. Wastewater Sources and Collection	I-11
	I-19. Disposal of Wastewater	I-12
APPENDIX	J. SAFETY	J-1
Section	I. Introduction	J-1
	J-1. Safety Policy and Program	J-1
	J-2. Responsibility for Accident Prevention	J-1
	J-3. Principles of Accident Prevention	J-1
	J-4. Safety Plan	J-2
	J-5. Accident Investigation and Reporting	J-4
Section	II. Deployed Medical Unit Safety Considerations	J-4
	J-6. X-Ray Protective Measures and Standards	J-4
	J-7. Hearing Conservation	J-8
	J-8. Compressed Gas Cylinders	J-8
	J-9. Flammable, Explosive, or Corrosive Materials	J-8
	J-10. Special Equipment	J-9
	J-11. Department of Defense Federal Hazard Communication Training Program	J-9
	J-12. United States Army Center for Health Promotion and Preventive Medicine	J-9
	J-13. Infection Control	J-9
APPENDIX	K. COMMANDERS' CHECKLIST	K-1
Section	I. Personnel Checklist—Mobilization	K-1
	K-1. Personnel and Administration	K-1
	K-2. Finance	K-2
	K-3. Medical	K-3
	K-4. Discipline, Law, and Order	K-4
	K-5. Religion	K-4
	K-6. Legal	K-4
	K-7. Public Affairs	K-5
Section	II. Operations Checklist—Mobilization	K-5
	K-8. Operations	K-5

		Page
	K-9. Security and Intelligence	K-6
	K-10. Training	K-8
Section	III. Logistics Checklist—Mobilization	K-9
	K-11. Subsistence	K-9
	K-12. Supplies and Equipment	K-9
	K-13. Petroleum, Oils, and Lubricants	K-10
	K-14. Ammunition	K-11
	K-15. Major End Items	K-11
	K-16. Medical Supplies and Equipment	K-11
	K-17. Prescribed Load List	K-12
	K-18. Maintenance	K-12
	K-19. Laundry	K-12
	K-20. Transportation	K-13
	K-21. Miscellaneous Logistics	K-14
	K-22. Contracting	K-15
Section	IV. Personnel Checklist—Deployment	K-15
	K-23. Personnel and Administration	K-15
	K-24. Medical	K-17
	K-25. Discipline, Law, and Order	K-17
	K-26. Religion	K-17
	K-27. Legal	K-17
	K-28. Public Affairs	K-18
Section	V. Operations Checklist—Deployment	K-18
	K-29. Operations	K-18
	K-30. Security and Intelligence	K-18
Section	VI. Logistics Checklist—Deployment	K-20
	K-31. Subsistence	K-20
	K-32. Supplies	K-21
	K-33. Ammunition	K-21
	K-34. Major End Items	K-21
	K-35. Medical Items	K-21
	K-36. Repair Parts	K-22
	K-37. Maintenance	K-22
	K-38. Transportation	K-22
	K-39. Miscellaneous Logistics	K-24
APPENDIX	L. LAW OF WAR OBLIGATIONS FOR MEDICAL PERSONNEL	L-1
	L-1. Law of War	L-1
	L-2. Medical Implications of Geneva Conventions	L-1
	L-3. Compliance with the Geneva Conventions	L-5
APPENDIX	M. EXAMPLE OF HOSPITAL LAYOUT	M-1

	Page
GLOSSARY	Glossary-1
REFERENCES	References-1
INDEX	Index-1

PREFACE

Hospitalization is one of the major Army Medical Department (AMEDD) functional areas. Under the Medical Force 2000 (MF2K) concept, theater hospitalization is provided by three hospitals, the combat support hospital (CSH), the field hospital (FH) and the general hospital (GH). These hospitals were designed and based upon the North Atlantic Treaty Organization (NATO) scenario and workloads. Current MF2K hospital doctrine is provided in Field Manual (FM) 8-10-14 for the CSH and FM 8-10-15 for the FH and the GH.

Under Force XXI and the medical reengineering initiative (MRI), theater hospitalization will be provided by a single CSH. The new CSH is designed based on lessons learned from Desert Shield/Desert Storm, recent contingency operations, and the requirements of the future warfight. Hospital size and bed mix, in particular, are based upon these experiences as well as the casualty rates, disease and nonbattle injury (DNBI) rates, and projected evacuation policy for the major regional conflict scenarios.

The purpose of this publication is to describe the new CSH and theater hospitalization to support a Force Projection Army into the 21st Century. It embodies doctrine based on the MRI and the A-edition Tables of Organization and Equipment (TOE) 08955A000 (corps CSH) and 08855A000 (echelon above corps [EAC]). The organizational structures presented in this publication reflect those established in the A-edition TOE in effect on the date of this publication. For a copy of your modified TOE (MTOE), contact the Authorizations Documentation Directorate, 9900 Belvoir Road, Suite 120, ATTN: MOFI-FMA, Fort Belvoir, Virginia 22060-2287.

As the AMEDD transitions to the 91W military occupational specialty (MOS), positions for 91B and 91C will be replaced by 91W when new unit MTOE take effect.

The use of the term *echelon of care* in this publication is synonymous with *level of care* and *role of care*. The term *echelon of care* is the old NATO term. The term *role of care* is the new NATO and American, British, Canadian, and Australian term.

This publication is designed for the hospital commander, his staff, and assigned personnel. The structural layout of the hospital is flexible and situationally determined (for example, mission requirements, commander's guidance, and terrain features). It requires intensive prior planning and training of all personnel to establish the facility.

FM 4-02.10

Users should be familiar with FM 100-5 and FM 100-10.

The proponent of this publication is the United States (US) Army Medical Department Center and School (AMEDDC&S). Users of this publication are encouraged to submit comments and recommendations to improve the publication. Comments should include the page, paragraph, and line(s) of the text where the change is recommended. Comments and recommendations should be forwarded directly to **Commander, AMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-6175**, or by using the E-mail addresses on the Doctrine Literature website at <http://dcdd.amedd.army.mil> (click on Doctrine Literature).

This publication implements the following NATO International Standardization Agreements (STANAG):

STANAG	TITLE
2068	Emergency War Surgery (Edition 4) (Amendment 3)
2931	Orders for the Camouflage of the Red Cross and Red Crescent on Land in Tactical Operations

Unless this publication states otherwise, masculine nouns and pronouns do not refer exclusively to men.

Use of trade or brand names in this publication is for illustrative purposes only and does not imply endorsement by the Department of Defense (DOD).

CHAPTER 1

**HOSPITALIZATION SYSTEM IN A
THEATER OF OPERATIONS****1-1. Combat Health Support in a Theater of Operations**

a. A theater of operations (TO) is that portion of an area of war necessary for military operations and for the administration of such operations. The scenario depicts the size of the TO and the US forces to be deployed. The theater is normally divided into a combat zone (CZ) and a communications zone (COMMZ). The CZ begins at the Army/corps rear boundary and extends forward to the extent of the commander's area of influence. The COMMZ begins at the corps rear boundary and extends rearward to include the area(s) needed to provide support to the forces in the CZ. In some instances, the COMMZ may be outside the TO and located in offshore support facilities, third country support bases, or in the continental United States (CONUS).

b. Combat health support (CHS) for the Army component in a TO is the Army Service Component Command (ASCC) commander's responsibility.

c. The medical command (MEDCOM) commander or the senior medical commander in the theater functions as the Assistant Chief of Staff for Medicine (ACSMED) for the ASCC. As the ACSMED, he provides information, recommendations, and professional medical advice to the ASCC commander and special staffs. He also maintains current data regarding the status, capabilities, and requirements for CHS. As the ACSMED, he is responsible to the ASCC commander for staff planning and coordinating and developing policies for CHS of the theater Army forces.

d. The mission of the AMEDD is to conserve the fighting strength. This mission of CHS is a continuous and integrated function throughout the TO. It extends from the CZ back through the COMMZ and ends in CONUS. Combat health support maximizes the system's ability to maintain presence with the supported soldier, to return injured, sick, and wounded soldiers to duty, and to clear the battlefield of soldiers who cannot return to duty (RTD). Patients are examined, treated, and identified as RTD or nonreturn to duty (NRTD) as far forward as is medically possible. Early identification is performed by the treating primary care provider and continues in the evacuation chain with constant reassessment. Patients requiring evacuation out of the division who are expected to RTD within the theater evacuation policy are evacuated to a corps and/or COMMZ hospital. Those patients classified as NRTD follow the evacuation chain for evacuation out of the theater.

e. The CHS system is a continuum from the forward edge of the battle area through the CONUS sustainment base. It is a system that provides medical management throughout all echelons of care. The challenge is to simultaneously provide medical support to deploying forces; provide health care services to the CONUS base; and establish a CHS system within the theater. Additionally, there will be a requirement to provide medical support to redeployment and demobilization operations at the conclusion of military combat operations. Furthermore, CHS requirements will surface in support of stability operations and support operations. The basic tenets of CHS for a Force Projection Army involve strict adherence to Army medical battlefield rules. These battlefield rules provide the basis for the development of medical organizations and force structure. Table 1-1 lists these rules in order of precedence.

Table 1-1. Army Medical Battlefield Rules

BE THERE (MAINTAIN A MEDICAL PRESENCE WITH THE SOLDIER)
MAINTAIN THE HEALTH OF THE COMMAND
SAVE LIVES
CLEAR THE BATTLEFIELD OF CASUALTIES
PROVIDE STATE OF THE ART MEDICAL CARE
ENSURE EARLY RETURN TO DUTY OF THE SOLDIER

1-2. Principles of Combat Health Support

a. Conformity. Conformity with the theater plan is the most fundamental element for effectively providing CHS. Only by participating in the development of this operation plan (OPLAN) can the medical planner ensure adequate CHS at the right time and at the right place.

b. Continuity. Combat health support must be continuous since an interruption of treatment may cause an increase in morbidity and mortality. Procedures are standardized at each organizational level to ensure that all required medical treatment is accomplished. No patient is evacuated any farther to the rear than his physical condition or the military situation requires. In the COMMZ, patients are not evacuated to the CONUS support base if they can be returned to duty within the provisions of the theater evacuation policy.

c. Control. Control of medical resources must rest with the medical commander. Combat health support staff officers must be proactive and keep their commanders apprised of the impact of future operations on CHS assets. The medical commander must ensure that the CHS system is responsive to the requirements of the theater. He must be able to tailor his CHS resources and direct them to focal points of demand throughout the area of operations (AO). Since CHS resources are limited, it is essential that their control be retained at the highest CHS level consistent with the tactical situation.

d. Proximity. In the CZ, the location of CHS assets in support of combat operations is dictated by the tactical situation (mission, enemy, terrain, troops, time available, and civilian considerations [METT-TC] factors) and the availability of evacuation resources. In the COMMZ, the hospitals should be located to facilitate access to medical evacuation resources (Army, United States Air Force [USAF], and Navy, if available), host-nation (HN) rehabilitation resources (if applicable), and command and control (C2) facilities.

e. Flexibility. A change in tactical plans or operations may require redistribution or relocation of medical resources. No more medical resources should be committed nor medical treatment facilities (MTFs) established than are required to support the expected patient densities.

f. Mobility. Mobility is measured by the extent to which a unit can move its personnel and equipment with organic transportation. When totally committed to patient care, the CSH can retain its

limited mobility only by immediate patient evacuation. The hospital's limited mobility severely restricts its capability to relocate assigned personnel and equipment. Transportation support organizations should recognize the relocation requirements for these facilities. Each hospital must have contingency plans to affect a move should one be required; they should routinely do those administrative measures that will enhance the facilities' ability to move. For example, load plans must be developed, maintained, and updated as necessary to ensure that all necessary equipment and supplies are included in the move. Transportation requirements that exceed the hospital's capability should be identified and coordinated with the supporting transportation element.

1-3. Echelons of Combat Health Support

The CHS system is organized into five echelons of support. The TO is normally organized into four echelons of support that extend rearward throughout the theater. The fifth echelon is located in CONUS. In the TO, CHS is tailored and phased to enhance patient acquisition, treatment, evacuation, and RTD as far forward as the tactical situation will permit. Hospital resources located at Echelons III and IV will be employed on an area basis to provide the utmost benefit to the maximum number of personnel in the AO. Wounded, sick, or injured soldiers will normally be treated, returned to duty, and/or evacuated to CONUS (Echelon V) through the theater's four echelons.

a. Echelon I. Care is provided by designated individuals or elements organic to combat and combat support (CS) units and elements of the area support medical battalion (ASMB). Major emphasis is placed on those measures necessary to stabilize the patient (maintain airway, stop bleeding, and prevent shock) and allow for evacuation to the next echelon of care.

(1) *Trauma specialist.* The trauma specialist (formerly referred to as the combat medic) is the first individual in the CHS chain who makes medically substantiated decisions based on medical MOS-specific training. First-aid providers in the form of self-aid, buddy aid, and the combat lifesaver support the trauma specialist.

(a) Self-aid and buddy aid. The individual soldier is trained to be proficient in a variety of specific first-aid procedures with particular emphasis on lifesaving tasks. This training enables the soldier, or a buddy, to apply immediate care to alleviate a life-threatening situation.

(b) Combat lifesaver. Enhanced first-aid training is provided to selected individuals who are called combat lifesavers. These individuals are nonmedical unit members selected by their commander for additional training to be proficient in a variety of first-aid procedures. A minimum of one individual per squad, crew, team, or equivalent-sized unit is trained per Army Regulation (AR) 350-41. All combat units and some CS and combat service support (CSS) units have combat lifesavers. The primary duty of these individuals does not change. The additional duties of combat lifesavers are performed when the tactical situation permits. They provide enhanced first-aid care for injuries prior to treatment by the trauma specialist. Medical personnel assigned or attached to the unit normally provide the training. A senior medical person designated by the commander manages the training program. Those units without qualifying medical personnel will request training instructor support from the next higher command surgeon or local MTF.

(2) *Treatment squad.* The treatment squad consists of a field surgeon, a physician assistant (PA), two noncommissioned officers (NCOs), and four medical specialists. The personnel are trained and equipped to provide advanced trauma management (ATM) to the battlefield casualty. Advanced trauma management is emergency care designed to resuscitate and stabilize the patient for evacuation to the next echelon of care. Each squad can split into two trauma treatment teams. These squads are organic to medical platoons/sections in maneuver battalions and designated CS units and medical companies of separate brigades, divisions, and echelons above division in the ASMB. When not engaged in ATM, these elements provide routine sick call services on an area basis. Echelon I care for units not having organic Echelon I capability is provided on an area basis by the responsible organization in the AO.

b. Echelon II. Care at this echelon is rendered at the clearing station (division or corps) and the forward surgical team (FST).

(1) At the clearing station, the casualty is examined and his wounds and general status are evaluated to determine his treatment and evacuation precedences, as a single casualty among other casualties. Those patients who can RTD within 1 to 3 days are held for treatment. Emergency medical treatment (EMT) (including beginning resuscitation) is continued and, if necessary, additional emergency measures are instituted; but they do not go beyond the measures dictated by the immediate necessities. The division clearing station has blood replacement capability, limited x-ray and laboratory services, patient-holding capability, and emergency dental care. Clearing stations provide Echelon I CHS functions on an area basis to those units without organic medical elements.

(2) The FST is a corps augmentation for divisional and nondivisional medical companies. The FST provides emergency/urgent initial surgery and nursing care after surgery for the critically wounded/injured patient until he is sufficiently stable for evacuation to a corps hospital. The FSTs not organic to divisions and regiments will be assigned to a medical command or medical brigade and normally attached to a corps hospital when not operationally employed. The FST will be further attached for support to a divisional/nondivisional medical unit. For a detailed discussion on the FST, refer to FM 8-10-25.

(3) Division-level CHS also includes preventive medicine (PVNTMED) activities and mental health, performed by personnel in the organic medical companies of the brigades, divisions, and ASMBs. These are augmented by teams from corps-level PVNTMED and combat stress control (CSC) detachments or companies.

c. Echelon III. The first hospital facility, the corps CSH, is located at this echelon. The CSH is staffed and equipped to provide resuscitation, initial wound surgery, and postoperative treatment. Patients are stabilized for continued evacuation or returned to duty. Those patients who are expected to RTD within the theater evacuation policy will be regulated to an EAC CSH.

d. Echelon IV. At this echelon, the patient will be treated at the CSH (EAC). Those patients not expected to RTD within the theater evacuation policy are stabilized and evacuated to the CONUS.

e. Echelon V. This echelon of care is provided in the CONUS. Hospitals in the CONUS sustaining base will provide the ultimate treatment capability for patients generated within the theater. Department of Defense hospitals (military hospitals of the tri-services) and Department of Veterans Affairs

(DVA) hospitals will be specifically designated to provide the soldier with maximum return of function through a combination of medical, surgical, rehabilitative, and convalescent care. Under the National Disaster Medical System, patients overflowing DOD and DVA hospitals will be cared for in designated civilian hospitals.

1-4. Medical Evacuation and Medical Regulating

a. Definition.

(1) Medical evacuation is the timely, efficient movement and en route care provided by medical personnel of wounded, injured, and ill soldiers from the battlefield or other locations within the TO. Evacuation begins when medical personnel receive the injured or ill soldier and continues as far rearward as the patient's medical condition warrants or the tactical situation allows. The higher echelon is responsible for arranging for the evacuation of patients from the lower echelon of care.

(2) Medical regulating entails identifying the patients awaiting evacuation, locating the available beds, and coordinating the transportation means for movement. Careful control of patient evacuation to the appropriate hospital is necessary to—

- Effect an even distribution of cases.
- Ensure adequate beds are available for current and anticipated needs.
- Route patients requiring specialized treatment to the appropriate MTF.

b. Theater Evacuation Policy.

(1) The theater evacuation policy is established by the Secretary of Defense with the advice of the Joint Chiefs of Staff and upon the recommendation of the theater commander. The policy establishes, in the number of days, the maximum period of noneffectiveness (hospitalization and convalescence) that patients may be held within the TO for treatment. This policy does not mean that a patient is held in the TO for the entire period of noneffectiveness. A patient who is not expected to be ready to RTD within the number of days established in the theater evacuation policy is evacuated to the CONUS or some other safe haven. This is done providing that the treating physician determines that such evacuation will not aggravate the patient's disabilities or medical condition.

(2) To the degree that an unplanned increase in patients occurs (due perhaps to an epidemic or heavy combat casualties), a temporary reduction in the policy may be necessary. This reduction is used to adjust the volume of patients to be held in the TO hospital system. A reduction in the evacuation policy increases the number of patients requiring out-of-theater evacuation, and it increases the requirement for evacuation assets. This action is necessary to relieve the congestion caused by the patient increases. A decrease in the theater evacuation policy decreases the hospitalization requirements.

(3) The time period established in the theater evacuation policy starts on the date the patient is admitted to the first hospital (CZ or COMMZ). The total time a patient is hospitalized in the TO

(including transit time between MTFs) for a single, uninterrupted episode of illness or injury should not exceed the number of days stated in the theater evacuation policy. Though guided by the evacuation policy, the actual selection of a patient for evacuation is based on clinical judgement as to the patient's ability to tolerate and survive the movement to the next level of CHS.

1-5. Theater Hospital System

The theater hospital system consists of a single CSH structure; a medical detachment, minimal care; a medical detachment, telemedicine; two hospital augmentation teams; three medical teams; and an FST.

- *Combat Support Hospital.* Corps and EAC CSHs provide definitive care and CHS to all patients who will either be returned to duty or stabilized for evacuation out of the corps or theater. Theater hospitalization is discussed in detail in the remaining contents of this publication.

- *Medical Detachment, Minimal Care.* See Appendix A.
- *Medical Detachment, Telemedicine.* See Appendix B.
- *Hospital Augmentation Team, Head and Neck.* See Appendix C.
- *Hospital Augmentation Team, Special Care.* See Appendix D.
- *Medical Team, Pathology.* See Appendix E.
- *Medical Team, Renal Hemodialysis.* See Appendix F.
- *Medical Team, Infectious Disease.* See Appendix G.
- *Forward Surgical Team.* See FM 8-10-25.

CHAPTER 2

THE COMBAT SUPPORT HOSPITAL**2-1. Mission**

The mission of the CSH is to provide hospitalization and outpatient services for all classes of patients within the theater.

2-2. Allocation

a. Corps. This hospital supports the requirement for all intensive care and intermediate care bed requirements (75 percent of the total bed requirements). To support the minimal care bed requirements (remaining 25 percent), the minimal care detachment, TOE 08949A000, must be added to the hospital.

b. Echelon Above Corps. This hospital supports the requirement for all intensive care and intermediate care bed requirements (50 percent of the total bed requirements). To support the minimal care bed requirements (remaining 50 percent), the minimal care detachment, TOE 08949A000, must be added to the hospital.

2-3. Assignment and Capabilities

a. The CSH will normally be assigned to a Medical Brigade (Corps, TOE 08-422A100 or EAC, TOE 08422A200), but may be assigned to a MEDCOM (Corps, TOE 08411A000 or Theater, TOE 08611A000) or a joint/combined task force.

b. The CSH provides hospitalization for up to 248 patients. It provides treatment for all classes of patients.

c. Surgical capacity is based on six operating room (OR) tables staffed for 96 operating table hours per day. The six OR tables are contained in three OR International Organization for Standardization (ISO) shelters. Surgical capabilities include general, orthopedic, thoracic, urological, gynecological, and oral maxillofacial.

d. An ISO tactical shelter is used for C-arm fluoroscopy capability. It will also be used for the operating microscope of the hospital augmentation team, head and neck when attached. The C-arm will be assigned to the 164-bed hospital company.

- e.* Other capabilities include—
- Command and control of organic and attached elements to include CHS planning, policies, and support operations within the hospital's areas of responsibility.
 - Emergency treatment to receive, triage, and resuscitate casualties.
 - Consultation services for inpatients and outpatients to include unit-level support.

FM 4-02.10

- Pharmacy, psychiatry, community health nursing, clinical laboratory, blood banking, radiology, physical therapy, and nutrition care services.
- Medical administrative and logistical services.
- Routine and emergency dental treatment to staff and patients.

f. There are some differences between the corps CSH and the EAC CSH. The corps CSH will have split-based capability, whereas the EAC CSH will not (see Chapter 4). In the corps CSH, the 84-bed and 164-bed hospital companies with their headquarters and headquarters detachments (HHDs) are completely functional hospital companies. In the EAC CSH, the 84-bed hospital company with its HHD is a functional hospital company; the 164-bed hospital company is not a functional element. The EAC 164-bed hospital company can augment the EAC 84-bed company with an additional OR, intensive care unit (ICU), intermediate care ward (ICW), and dental capabilities. The supply and services and the mobility of the EAC CSH is reduced. Also, the EAC CSH has no laundry service capability. Other differences between the corps and the EAC 84-bed and 164-bed companies are shown in Figures 2-4 through 2-7.

2-4. Hospital Support Requirements

a. In deployment and sustainment of operations, the corps/EAC CSH is dependent upon appropriate elements of the MEDCOM or brigade, corps, or theater Army for—

- Personnel administrative services.
- Finance.
- Mortuary affairs (MA).
- Legal services.
- Transportation services. Transportation support will be required for both the corps and EAC hospitals. The corps CSH is 35 percent mobile with organic assets. The EAC CSH has no mobile capability but has limited vehicles for administrative support.
- Laundry and bath services. The corps CSH will require laundry services for other than patient-related linens and bath services. The EAC CSH requires full laundry and bath services.
- Security and enemy prisoner of war (EPW) security during processing and evacuation.
- Transportation and re-equipping for RTD personnel, to include individual clothing and equipment, seasonal outer garments, and chemical protection garments.
- Class I supplies (rations) to include the Medical Diet Supplement required for patient feeding.

2-2

b. During deployment and sustainment of operations, engineer support is required for establishment or modification of the hospital site and to construct or modify waste disposal areas (see Training Circular [TC] 8-13).

c. During sustainment of operations—

- Coordination with and assistance from veterinary service units may be required for zoonotic disease control and investigation; inspection of medical and nonmedical rations, to include suspected contaminated rations and disposition recommendations; inspection and procurement of bottled water for consumption by US forces; and investigation of animal bites.

- Coordination with and assistance from PVNTMED units may be required for food facility inspection, vector control, water production and distribution, field sanitation, wet-bulb globe temperatures, and control of medical and nonmedical waste.

- Coordination with and assistance from CSC units may be required for preventive stress control measures for hospital staff and patients which exceed the capability of the organic psychiatric and unit ministry assets, or to staff an inpatient psychiatric ward.

2-5. Hospital Organization and Functions

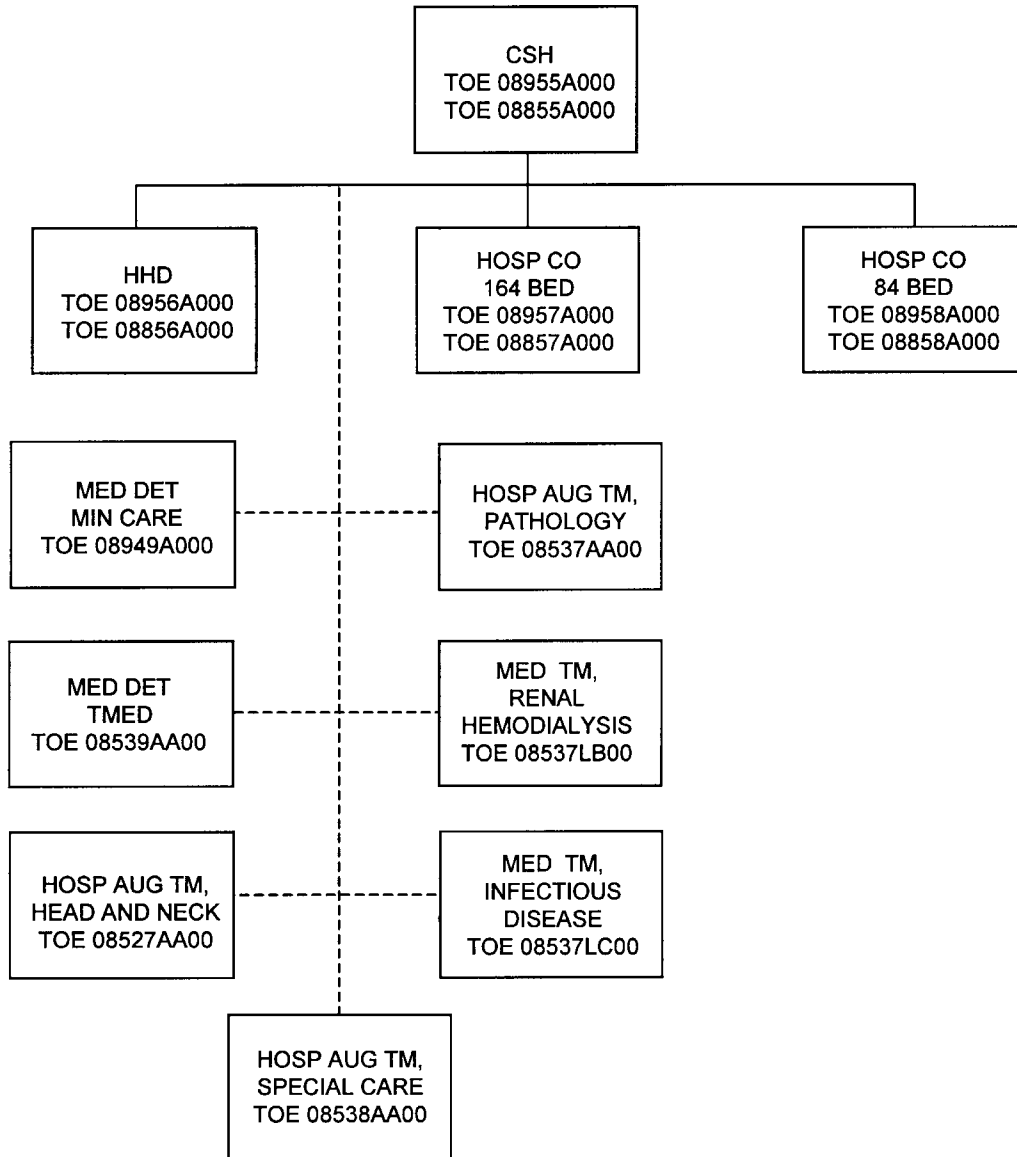
The CSH (corps and EAC) is a modular-designed facility that consists of a HHD and two hospital companies (one 84-bed hospital company and one 164-bed hospital company). (Note the difference of the two CSHs as stated in paragraph 2-3*f*.) Each CSH can be further augmented with medical detachments, hospital augmentation teams, and medical teams to increase its capabilities (Figure 2-1).

2-6. Headquarters and Headquarters Detachment

a. The HHD provides C2 of all organic/attached units, to include medical planning, policies, and support operations within the CSH's AO. The HHD is dependent upon other support units in the corps/EAC and will be located where elements of these support units can provide support. Figure 2-2 (page 2-5) and Figure 2-3 (page 2-6) show the corps and EAC HHD organization.

b. The HHD (TOE 08956A000) of the corps CSH will augment the 84-bed hospital company (TOE 08958A000) for split-base operations. The Adjutant (US Army) (S1), Intelligence Officer (US Army) (S2)/Operations and Training Officer (US Army) (S3), and Supply Officer (US Army) (S4) sections of this HHD are staffed to allow for deployment of functional increments during split-based deployment. For a further discussion on split-base operations, see Chapter 4 and Appendix H.

c. The HHD (TOE 08856A000) of EAC CSH will augment the 84-bed hospital company (TOE 08858A000) for stand-alone capability. The EAC CSH has no split base capability.



NOTE: DEPENDING UPON OPERATIONAL REQUIREMENTS, MEDICAL DETACHMENTS, HOSPITAL AUGMENTATION TEAMS, AND MEDICAL TEAMS MAY OR MAY NOT BE ATTACHED TO THE INDIVIDUAL CLINICAL ELEMENT OF THE CSH.

Figure 2-1. Combat support hospital organization.

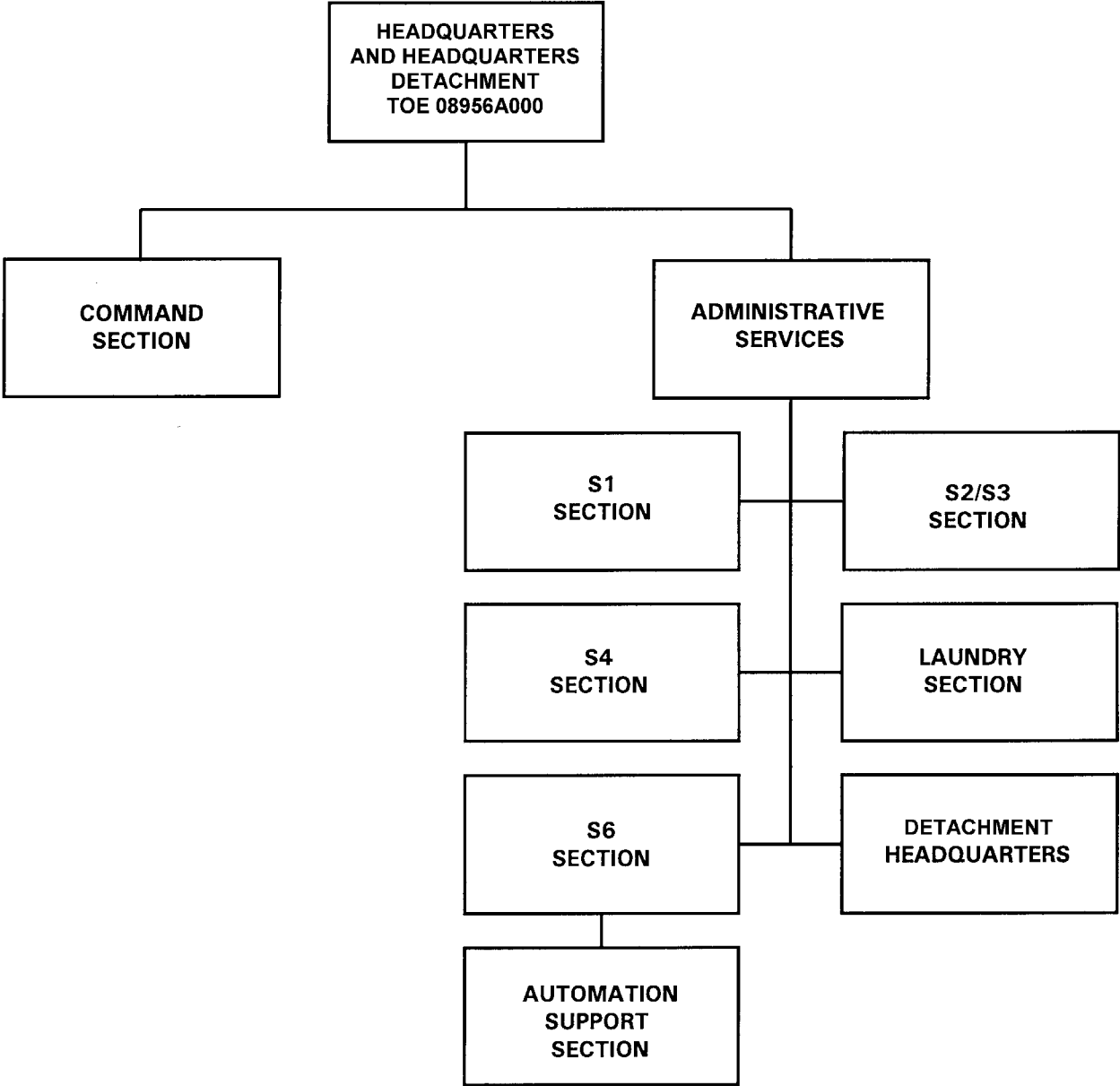


Figure 2-2. Corps headquarters and headquarters detachment organization.