FM 4-02.2, C1

Change No. 1

HEADQUARTERS
DEPARTMENT OF THE ARMY
Washington, DC, 30 July 2009

MEDICAL EVACUATION

1. Change FM 4-02.2, 8 May 2007, as follows:

Remove old pages	**Insert new pages**
4-1 and 4-2	4-1 and 4-2

2. New or changed material is indicated by a star (★).

3. File this transmittal sheet in front of the publication.

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Chapter 4

Army Medical Evacuation

Medical evacuation operations are planned to provide comprehensive, responsive, flexible, and agile support to the tactical commander in conformity with the commander's intent and OPLANs. This chapter discusses the employment of medical evacuation resources and the coordination and synchronization required to effectively execute medical evacuation operations (to include the transfer of patients between MTFs and to staging facilities) by air and ground evacuation assets.

SECTION I — MEDICAL EVACUATION SUPPORT

EVACUATION PRECEDENCE

4-1. Casualties requiring evacuation are prioritized to ensure the most seriously injured or ill receive timely medical intervention consistent with their medical condition. As with medical treatment, medical urgency is the only factor used to determine the medical evacuation precedence. (Appendix A provides an in-depth discussion of the provisions of the Geneva Conventions.)

★ **This paragraph implements STANAGs 2087 and 3204.**

4-2. The determination to request medical evacuation and assignment of a precedence is made by the senior military person present or, if available, the senior medical person at the scene. This decision is based on the advice of the senior medical person at the scene (if available), the patient's condition, and the tactical situation. Assignment of a medical evacuation precedence is necessary. The precedence provides the supporting medical unit and controlling headquarters with information that is used in determining priorities for committing their evacuation assets. For this reason, correct assignment of precedence cannot be overemphasized; over classification may result in an increase in evacuation which could burden the HSS system.

4-3. The patient's medical condition is the overriding factor in determining the evacuation platform and destination facility. The AA operates wherever needed on the battlefield, dependent on risk and METT-TC factors. The crew of the AA, assisted by onboard patient monitoring and diagnostic equipment, is trained in aeromedical procedures to provide optimum en route patient care. It is the preferred method of evacuation for most categories of patients. Air ambulances are a low-density, high-demand resource and must be managed accordingly. To conserve these valuable resources, medical planners should plan to use AA to primarily move Priority I, URGENT and Priority IA, URGENT-SURG patients with the other categories on a space-available basis. Health service support planners must plan for a synchronized air and ground evacuation plan. Depending on the length of time required for an AA to be dispatched and arrive at the POI, it may be prudent to evacuate the casualty by ground evacuation assets to a BAS and/or Role 2 MTF for stabilization by a physician. Further evacuation could then be accomplished by AA.

4-4. Patients will be picked up as soon as possible, consistent with available resources and pending missions. Table 4-1 depicts the categories of evacuation precedence and the criteria used to determine the appropriate precedence.

Table 4-1. Categories of evacuation precedence

★ ***Priority I—URGENT***	Is assigned to emergency cases that should be evacuated as soon as possible and within a maximum of 1 hour in order to save life, limb, or eyesight, to prevent complications of serious illness, or to avoid permanent disability.
Priority IA—URGENT-SURG	Is assigned to patients who must receive far forward surgical intervention to save life and to stabilize them for further evacuation.
Priority II—PRIORITY	Is assigned to sick and wounded personnel requiring prompt medical care. This precedence is used when the individual should be evacuated within 4 hours or his medical condition could deteriorate to such a degree that he will become an URGENT precedence, or whose requirements for special treatment are not available locally, or who will suffer unnecessary pain or disability.
Priority III—ROUTINE	Is assigned to sick and wounded personnel requiring evacuation but whose condition is not expected to deteriorate significantly. The sick and wounded in this category should be evacuated within 24 hours.
Priority IV—CONVENIENCE	Is assigned to patients for whom evacuation by medical platform is a matter of medical convenience rather than necessity.
The NATO STANAG 3204 has deleted the category of Priority IV—CONVENIENCE; however, it will still be included in the US Army evacuation priorities as there is a requirement for it on the battlefield.	

SECTION II — MEDICAL EVACUATION REQUESTS

4-5. This section discusses requests for medical evacuation. Specific procedures, frequencies, and security requirements for transmittal of medical evacuation requests are delineated through the orders process and are made a part of the unit/command SOPs. Each sector based on the METT-TC may be designated with a different method of evacuation as the primary means to effect evacuation. In sectors which have a high ground-to-air or air-to-air threat may rely on ground evacuation assets to move the majority of patients. In other sectors where the ground threat is high and comprised of small arms, improvised explosive devices, and bombs, medical evacuation operations may be more efficiently and effectively executed by AAs. An additional consideration in planning medical evacuation operations is to determine whether armed escorts are required for either the ground or AA mission. Those missions that require armed escort must be thoroughly coordinated and synchronized between the medical assets and force protection assets that will accompany them.

4-6. Medical evacuation requests often are sent from the POI, through intermediaries, such as higher headquarters, who then transmit the request up to the nearest medical evacuation unit. The unit relaying the request must ensure that it relays the exact information originally received. The radio call sign and frequency relayed (Line 2 of the request) should be that of the requesting unit and not that of the relaying unit. However, the intermediaries contact information can be given as additional information if a callback is necessary to clarify details of the mission. Figure 4-1 depicts the communication flow for evacuation requests.

4-7. The necessity for secure communication in transmitting a 9-line request is METT-TC dependent. A technically capable enemy may be able to intercept a nonsecure 9-line request and strike at the pickup zone causing additional harm to the patients and the medical evacuation crew. In combat and when directed by higher headquarters, always use secure communications when requesting medical evacuation.