

Trauma Resuscitation Record

Patient Tag/Sticker		Patient Name _____			Admit Date ____ / ____ / ____																
		Arrival Time _____																			
		Trauma Team Notification/Arrival																			
		Trauma Team Activated? <input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____																			
Date of Birth _____		Name		Time called	Time arrived	Present upon Pt arrival?															
Gender _____		General Surgeon		:	:	<input type="checkbox"/> Yes <input type="checkbox"/> No															
Medical Record # _____		ED Physician		:	:	<input type="checkbox"/> Yes <input type="checkbox"/> No															
		Anesthesia		:	:	<input type="checkbox"/> Yes <input type="checkbox"/> No															
				:	:	<input type="checkbox"/> Yes <input type="checkbox"/> No															
Arrived via: <input type="checkbox"/> Ambulance <input type="checkbox"/> Helicopter <input type="checkbox"/> Police <input type="checkbox"/> Self <input type="checkbox"/> <input type="checkbox"/> Transfer from: <input type="checkbox"/> EMS report in Pt chart		Pre-hospital Interventions Airway: <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Intubated <input type="checkbox"/> O ₂ <input type="checkbox"/> IV size _____ site _____ <input type="checkbox"/> IV #2 size _____ site _____ <input type="checkbox"/> Blood sugar _____ mg/dl <input type="checkbox"/> CPR <input type="checkbox"/> LBB <input type="checkbox"/> C collar <input type="checkbox"/> MAST <input type="checkbox"/> Splint type _____ location _____ Meds: <input type="checkbox"/> Morphine _____ mg <input type="checkbox"/> Versed _____ mg <input type="checkbox"/> _____ mg		Pt. Medications <input type="checkbox"/> unknown		Past History <input type="checkbox"/> unknown last tetanus _____ last P.O. _____		Allergies <input type="checkbox"/> unknown													
Mechanism of Injury																					
Motor Vehicle			Fall/Jump		Burn		Penetrating														
Involved: <input type="checkbox"/> Auto <input type="checkbox"/> Light truck <input type="checkbox"/> Heavy truck <input type="checkbox"/> Motorcycle <input type="checkbox"/> ATV <input type="checkbox"/> Bicycle <input type="checkbox"/> Pedestrian <input type="checkbox"/> Watercraft <input type="checkbox"/> Sporting _____ <input type="checkbox"/>		Patient was: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger-front <input type="checkbox"/> Passenger-back <input type="checkbox"/> Pedestrian struck by auto <input type="checkbox"/> Bicyclist struck by auto <input type="checkbox"/> Unknown		<input type="checkbox"/> Seatbelt <input type="checkbox"/> Airbag <input type="checkbox"/> Child seat <input type="checkbox"/> Helmet <input type="checkbox"/> Ejected <input type="checkbox"/> Extrication <input type="checkbox"/> Death of another occupant		Impact: <input type="checkbox"/> Front <input type="checkbox"/> Side <input type="checkbox"/> Rear <input type="checkbox"/> Rollover <input type="checkbox"/> T-bone		Approx. height: _____ Landing surface: <input type="checkbox"/> Grass/dirt/earth <input type="checkbox"/> Stone <input type="checkbox"/> Concrete/brick <input type="checkbox"/> Tile/wood <input type="checkbox"/> Carpet <input type="checkbox"/> Water <input type="checkbox"/>		<input type="checkbox"/> Flame <input type="checkbox"/> Steam <input type="checkbox"/> Chemical <input type="checkbox"/> Radiation <input type="checkbox"/> Inhalation <input type="checkbox"/> Electrical voltage: _____		<input type="checkbox"/> GSW caliber _____ distance _____ <input type="checkbox"/> Stab blade length _____ <input type="checkbox"/> Self inflicted <input type="checkbox"/> Impalement									
Primary Survey and Preliminary Interventions						Initial ED Vital Signs															
Airway		<input type="checkbox"/> Patent/talking <input type="checkbox"/> Clear <input type="checkbox"/> Partially obstructed <input type="checkbox"/> Completely obstructed <input type="checkbox"/> Breathing assisted <input type="checkbox"/> Intubated <input type="checkbox"/> _____		<input type="checkbox"/> Jaw thrust <input type="checkbox"/> Suction <input type="checkbox"/> Foreign object removal/laryngoscopy <input type="checkbox"/> Oral airway <input type="checkbox"/> Nasal airway <input type="checkbox"/> Combitube/LMA/King time: _____:____		<input type="checkbox"/> Intubation <input type="checkbox"/> RSI tube size _____ time: _____:____ _____ cm @ _____ #attempts: _____ <input type="checkbox"/> Confirmed by: <input type="checkbox"/> End tidal CO ₂ <input type="checkbox"/> Aspirator <input type="checkbox"/> CXR		Time: _____:____													
Breathing		<input type="checkbox"/> Spontaneous <input type="checkbox"/> Labored <input type="checkbox"/> Agonal <input type="checkbox"/> No effort Trachea: <input type="checkbox"/> Midline <input type="checkbox"/> Deviated <input type="checkbox"/> R <input type="checkbox"/> L Chest wall symmetry: <input type="checkbox"/> Symmetrical <input type="checkbox"/> Asymmetrical		Lung sounds: L R <input type="checkbox"/> Present <input type="checkbox"/> Clear <input type="checkbox"/> Diminished <input type="checkbox"/> Absent <input type="checkbox"/> Rales <input type="checkbox"/> Rhonchi <input type="checkbox"/> Wheezes		Assisted: <input type="checkbox"/> BVM <input type="checkbox"/> Ventilator Vent. Rate _____ Supplemental O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> NC _____ l/m		BP: _____/_____ Pulse: _____/min Resp.: _____/min Temp.: _____° C site _____ SaO ₂ : _____% Blood Glucose _____ mg/dl Est. weight: _____ kg													
Circulation		Skin: <input type="checkbox"/> Warm <input type="checkbox"/> Pink <input type="checkbox"/> Cool <input type="checkbox"/> Pale <input type="checkbox"/> Hot <input type="checkbox"/> Flushed <input type="checkbox"/> Dry <input type="checkbox"/> Ashen <input type="checkbox"/> Moist <input type="checkbox"/> Cyanotic <input type="checkbox"/> Diaphoretic		Pulse: <input type="checkbox"/> Central pulse present <input type="checkbox"/> Peripheral pulse present <input type="checkbox"/> No pulse <input type="checkbox"/> Strong <input type="checkbox"/> Thready Capillary refill _____ sec.		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">Time</th> <th style="width: 25%;">IVs: Site</th> <th style="width: 25%;">Size</th> </tr> <tr> <td>_____:</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____:</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____:</td> <td>_____</td> <td>_____</td> </tr> </table> <input type="checkbox"/> Warm IV fluids		Time	IVs: Site	Size	_____:	_____	_____	_____:	_____	_____	_____:	_____	_____	<input type="checkbox"/> Warm blankets <input type="checkbox"/> Warming lights <input type="checkbox"/> Direct pressure bleeding control: site _____	
Time	IVs: Site	Size																			
_____:	_____	_____																			
_____:	_____	_____																			
_____:	_____	_____																			
Disability		Glasgow Coma Scale (GCS)				Pupils															
Eye Opening <input type="checkbox"/> 4 Spontaneous <input type="checkbox"/> 3 To Verbal <input type="checkbox"/> 2 To Pain <input type="checkbox"/> 1 None		Verbal <input type="checkbox"/> 5 Oriented <input type="checkbox"/> 4 Confused <input type="checkbox"/> 3 Inappropriate response <input type="checkbox"/> 2 Incomprehensible <input type="checkbox"/> 1 None/Intubated		Motor <input type="checkbox"/> 6 Obeys <input type="checkbox"/> 5 Localizes pain <input type="checkbox"/> 4 Withdraws from pain <input type="checkbox"/> 3 Flexor posturing <input type="checkbox"/> 2 Extensor posturing <input type="checkbox"/> 1 None/chemically paralyzed		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">L</th> <th style="width: 50%;">R</th> </tr> <tr> <td><input type="checkbox"/> Brisk</td> <td><input type="checkbox"/> Brisk</td> </tr> <tr> <td><input type="checkbox"/> Sluggish</td> <td><input type="checkbox"/> Sluggish</td> </tr> <tr> <td><input type="checkbox"/> Non-reactive</td> <td><input type="checkbox"/> Non-reactive</td> </tr> <tr> <td>_____ mm</td> <td>_____ mm</td> </tr> </table>		L	R	<input type="checkbox"/> Brisk	<input type="checkbox"/> Brisk	<input type="checkbox"/> Sluggish	<input type="checkbox"/> Sluggish	<input type="checkbox"/> Non-reactive	<input type="checkbox"/> Non-reactive	_____ mm	_____ mm				
L	R																				
<input type="checkbox"/> Brisk	<input type="checkbox"/> Brisk																				
<input type="checkbox"/> Sluggish	<input type="checkbox"/> Sluggish																				
<input type="checkbox"/> Non-reactive	<input type="checkbox"/> Non-reactive																				
_____ mm	_____ mm																				

MR#

Procedures			
Procedure	Time	By	Detail
<input type="checkbox"/> Cast/splint	:		
<input type="checkbox"/> Central line	:		
<input type="checkbox"/> Chest tube R	:		
<input type="checkbox"/> Chest tube L	:		
<input type="checkbox"/> Cricothyrotomy	:		
<input type="checkbox"/> Defib/Cardiovert	:		
<input type="checkbox"/> Foley	:		
<input type="checkbox"/> Intraosseous	:		
<input type="checkbox"/> Needle thoracotomy	:		
<input type="checkbox"/> OG/NG tube	:		
<input type="checkbox"/> RSI	:		
<input type="checkbox"/> Suture	:		
<input type="checkbox"/>	:		
<input type="checkbox"/>	:		
<input type="checkbox"/>	:		

Laboratory		Radiology			
Lab	Time Ordered	X-ray	Time Ordered	CT	Time Ordered
<input type="checkbox"/> BAC	:	<input type="checkbox"/> CXR	:	<input type="checkbox"/> Abdomen	:
<input type="checkbox"/> CBC	:	<input type="checkbox"/> Pelvis	:	<input type="checkbox"/> Chest	:
<input type="checkbox"/> Electrolytes	:	<input type="checkbox"/> Skull	:	<input type="checkbox"/> Head	:
<input type="checkbox"/> Glucose	:	<input type="checkbox"/> Spine-Cervical	:	<input type="checkbox"/> Neck	:
<input type="checkbox"/> hCG	:	<input type="checkbox"/> Spine- Lumb/Sac	:	<input type="checkbox"/> Pelvis	:
<input type="checkbox"/> Hgb	:	<input type="checkbox"/> Spine- Thoracic	:	<input type="checkbox"/> Spine	:
<input type="checkbox"/> PT/INR	:	<input type="checkbox"/>	:	<input type="checkbox"/>	:
<input type="checkbox"/> PTT	:	<input type="checkbox"/>	:	<input type="checkbox"/>	:
<input type="checkbox"/> pH	:	<input type="checkbox"/>	:	Ultrasound	Time Ordered
<input type="checkbox"/> Tox. screen	:	<input type="checkbox"/>	:	<input type="checkbox"/> FAST exam	:
<input type="checkbox"/> Type and screen	:	<input type="checkbox"/>	:	<input type="checkbox"/>	:
<input type="checkbox"/> UA	:	<input type="checkbox"/>	:	<input type="checkbox"/>	:

Patient Disposition					
<input type="checkbox"/> Admitted			<input type="checkbox"/> Transferred		
Pt left ED	:	Ordered	:	Transfer via: <input type="checkbox"/> Helicopter <input type="checkbox"/> Ground	Accompanying Pt: <input type="checkbox"/> Copy of chart <input type="checkbox"/> EMS report <input type="checkbox"/> X-rays/CTs <input type="checkbox"/> Lab report <input type="checkbox"/> RN _____
Report called	:	Arrived	:		
Admitting service:	:	Pt left ED	:		
Admitting physician:	:	Transferred to:	:		
<input type="checkbox"/> Expired in ED	:	Referral hospital notified	:		

Patient Information			
SSN	Address		Apt. #
Telephone Number	City	State/Province	Postal Code
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown	Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Unknown	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other	Pay Source <input type="checkbox"/> Medicare <input type="checkbox"/> Uninsured <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown

