

# Trauma Resuscitation Record

Patient Tag/Sticker		Patient Name _____			Admit Date / /														
		Arrival Time _____																	
		<b>Trauma Team Notification/Arrival</b>																	
		Trauma Team Activated? <input type="checkbox"/> Yes <input type="checkbox"/> No			Time: _____			Tier <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3											
Date of Birth _____		Prompt General Surgeon Communication? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
Gender _____		Name _____		Time called _____	Time arrived _____	Present upon Pt arrival? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Medical Record # _____		General Surgeon _____		: _____	: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No													
		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													
<b>Arrived via:</b> <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		<b>Pre-hospital Interventions</b> Airway: <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Intubated <input type="checkbox"/> O <sub>2</sub> <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 Meds: <input type="checkbox"/> Dilaudid _____ mg <input type="checkbox"/> Morphine _____ mg <input type="checkbox"/> Ketorolac _____ mg <input type="checkbox"/> Ketamine _____ mg <input type="checkbox"/> Midazolam _____ mg <input type="checkbox"/> Ativan _____ mg <input type="checkbox"/> Other _____ mg		<b>Pt. Medications</b>  <input type="checkbox"/> unknown		<b>Past History</b>  <input type="checkbox"/> unknown last tetanus _____ last P.O. _____		<b>Allergies</b>  <input type="checkbox"/> unknown											
<b>Mechanism of Injury</b>																			
<b>Motor Vehicle</b> 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		<b>Fall/Jump</b> 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"/>		<b>Burn</b> <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: _____		<b>Penetrating</b> <input type="checkbox"/> GSW caliber _____ distance _____ <input type="checkbox"/> Stab blade length _____ <input type="checkbox"/> Self inflicted <input type="checkbox"/> Impalement						
<b>Primary Survey and Preliminary Interventions</b>						<b>Initial ED Vital Signs</b>													
<b>Airway</b> <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 <sub>2</sub> <input type="checkbox"/> Aspirator <input type="checkbox"/> CXR		Time: _____:____ BP: _____/_____ Pulse: _____/min Resp.: _____/min Temp.: _____° C site _____ SaO <sub>2</sub> : _____% Blood Glucose _____ mg/dl Est. weight: _____ kg													
<b>Breathing</b> <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 <sub>2</sub> <input type="checkbox"/> Mask <input type="checkbox"/> NC _____ l/m start _____:____ stop _____:____		Blood Glucose _____ mg/dl Est. weight: _____ kg <b>A</b> Awake and alert <b>V</b> Verbal stimuli elicits response <b>P</b> Painful stimuli elicits response <b>U</b> Unresponsive to stimuli													
<b>Circulation</b> 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.		IVs: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Time</td> <td style="text-align: center;">Site</td> <td style="text-align: center;">Size</td> </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	Site	Size	_____	_____	_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Warm blankets <input type="checkbox"/> Warming lights <input type="checkbox"/> Direct pressure bleeding control: site _____	
Time	Site	Size																	
_____	_____	_____																	
_____	_____	_____																	
_____	_____	_____																	
<b>Glasgow Coma Scale (GCS)</b>						<b>Pupils</b>													
<b>Disability</b> 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 style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><b>L</b></td> <td style="text-align: center;"><b>R</b></td> </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>		<b>L</b>	<b>R</b>	<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		
<b>L</b>	<b>R</b>																		
<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"/> Defib/Cardiovert	:				
<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"/> Surgical Airway	:				
<input type="checkbox"/> Tourniquet	:				
<input type="checkbox"/> Urinary Catheter	:				
<input type="checkbox"/>	:				
<input type="checkbox"/>	:				
Laboratory		Imaging			
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"/>	:	<b>Ultrasound</b>	<b>Time Ordered</b>
<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:	Accompanying Pt:
Report called	:	Arrived	:	<input type="checkbox"/> Helicopter	<input type="checkbox"/> Copy of chart
Admitting service:	:	Pt left ED	:	<input type="checkbox"/> Ground	<input type="checkbox"/> EMS report
Admitting physician:	:	Transferred to:	:		<input type="checkbox"/> X-rays & CTs
<input type="checkbox"/> Expired in ED	:	Referral hospital notified	:		<input type="checkbox"/> Lab report
	:		:		<input type="checkbox"/> RN _____
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	

