

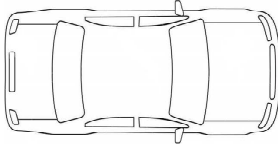
Adult Trauma Resuscitation Record

Arrival Date: _____ (dd/mm/yyyy) Arrival Time: _____ (hhmm)

Direct from Scene Transfer From _____ Allergies _____

Method of Transport Land Air Walk-in Police (Badge Number _____)

Date of Incident: <input type="checkbox"/> Same OR _____ (dd/mm/yyyy)	Time of Incident: _____ (hhmm)
Type of Incident: <input type="checkbox"/> MVC <input type="checkbox"/> Bicycle <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian <input type="checkbox"/> Recreation <input type="checkbox"/> Fall <input type="checkbox"/> Violence <input type="checkbox"/> Fire <input type="checkbox"/> Industrial <input type="checkbox"/> Electrocutation <input type="checkbox"/> Blast <input type="checkbox"/> Drowning <input type="checkbox"/> Stab Wound <input type="checkbox"/> GSW <input type="checkbox"/> Other: _____	

Pre-Hospital Care	Pre-Arrival VS: BP _____ HR _____ RR _____ SpO ₂ _____ GCS /4 /5 /6 = /15					
Pre-Hospital Care	MVC Crash History <input type="checkbox"/> Single Car <input type="checkbox"/> Extricated _____ <input type="checkbox"/> Ejected from Car <input type="checkbox"/> Roll Over <input type="checkbox"/> Speed Reported _____	Restraints Reported <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Airbag Deployed	Patient Position <input type="checkbox"/> Driver: Passenger: <input type="checkbox"/> Front <input type="checkbox"/> Rear Left <input type="checkbox"/> Rear Right	Vehicle Damage Reported (indicate site with V) Other comment: _____		

Assessment on Arrival	A	<input type="checkbox"/> Patent <input type="checkbox"/> Drooling <input type="checkbox"/> Stridor <input type="checkbox"/> Swelling <input type="checkbox"/> Obstructed <input type="checkbox"/> ETT <input type="checkbox"/> NTT <input type="checkbox"/> Burns	<input type="checkbox"/> ETT <input type="checkbox"/> OPA <input type="checkbox"/> NTT <input type="checkbox"/> NPA Size _____ Tip to Tip _____	C-Spine Precautions <input type="checkbox"/> Collar <input type="checkbox"/> Board <input type="checkbox"/> In-Situ <input type="checkbox"/> On arrival	
	B	Rhythm <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Deep Depth <input type="checkbox"/> Adequate <input type="checkbox"/> Shallow <input type="checkbox"/> Wheezy Quality <input type="checkbox"/> Easy <input type="checkbox"/> Laboured <input type="checkbox"/> Asymmetrical	<input type="checkbox"/> Assisted Ventilations <input type="checkbox"/> Chest Tube <input type="checkbox"/> Right <input type="checkbox"/> Left Output _____ Size _____		
	C	Pulse Rhythm/ Quality <input type="checkbox"/> Regular <input type="checkbox"/> Strong <input type="checkbox"/> Irregular <input type="checkbox"/> Weak Skin Colour <input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Flushed Skin <input type="checkbox"/> Warm <input type="checkbox"/> Dry <input type="checkbox"/> Hot <input type="checkbox"/> Moist <input type="checkbox"/> Cool <input type="checkbox"/> Diaphoretic	IV Access #1 _____ / _____ #2 _____ / _____ IO Access #1 _____ / _____ #2 _____ / _____ <input type="checkbox"/> Central Venous Catheter _____ Total Volume Admin _____ <input type="checkbox"/> Blood Given #units given _____ <input type="checkbox"/> Other _____		
	D	<input type="checkbox"/> Alert <input type="checkbox"/> Combative <input type="checkbox"/> Lethargic <input type="checkbox"/> Oriented x3 <input type="checkbox"/> Unconscious <input type="checkbox"/> Event Amnesia <input type="checkbox"/> Facial Droop <input type="checkbox"/> Anxious <input type="checkbox"/> Slurred Speech <input type="checkbox"/> Agitated <input type="checkbox"/> Extreme Weakness <input type="checkbox"/> Confused	Capillary Glucose _____	<input type="checkbox"/> NG Total Output _____ <input type="checkbox"/> Foley Total Output _____ <input type="checkbox"/> Art Line <input type="checkbox"/> Pelvic Binder <input type="checkbox"/> Splints <input type="checkbox"/> Other _____	

Past Medical History Unknown
 Diabetes Epilepsy HTN CVA/Stroke MI/ACS Cardiac Other: _____
 Mental Health Other: _____

Medication Pre-Trauma Room				Medication History - From Home		
Time (hhmm)	Medication	Dose	Route	<input type="checkbox"/> Unknown		

Rev. 08/2015 (v7)



ER22

Adult Trauma Resuscitation Record

		Time (hhmm)															Time (hhmm)							
C O M A S C A L E	Eyes Open	Spontaneously																		Eyes closed by swelling = C				
		To Speech																						
		To Pain																						
		None																						
	Best Verbal Response	Oriented																		Endotracheal Tube of Tracheostomy = T				
		Confused																						
		Inappropriate Words																						
		Incomprehensible Sounds																						
	Best Motor Response	None																		Usually Record the Best Arm Response				
		Obey Commands																						
		Localize Pain																						
		Flexion / Withdrawal																						
		Flexion to Pain																						
		Extension to Pain																						
		None																						
1mm •	2mm ●	3mm ●	4mm ●	5mm ●	6mm ●	7mm ●	8mm ●	BP V Peripheral	220											Temperature Ⓟ – Rectal Ⓞ – Oral Ⓐ – Axillary				
								Arterial	200															
								HR •	180															
									160															
									140															
									120															
									100															
									80															
									60															
									40															
	20																							
Respiratory Effort																		N Normal						
Respiratory Rate																		L Laboured						
Temperature																		A Asymmetrical						
Oxygen Saturation																		N < 3 seconds						
FiO ₂																								
Capillary Refill																		D > 4 seconds						
Pain (Pain Scale 0 – 10)																								
Pupils	Right	Size																+ Reacts - No Reaction C Eye Closed						
		Reaction																						
Left	Size																							
	Reaction																							
L I M B M O V E M E N T	A R M S	Normal Power																Record Right (R) and Left (L) separately if there is a difference between the two sides						
		Mild Weakness																						
		Severe Weakness																						
		Spastic Flexion																						
		Extension																						
	No Response																							
	L E G S	Normal Power																						
		Mild Weakness																						
		Severe Weakness																						
		Extension																						
No Response																								

Rev. 08/2015 (v 7)



ER22

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IV / IO Access													
Time (hhmm)		Site		Size		IV Fluid				By			
Fluid / Blood	Pressure	Warmed	Time (hhmm)										
0.9% Sodium Chloride	<input type="checkbox"/>	<input type="checkbox"/>	Hung										
			Infused										
Ringers Lactate	<input type="checkbox"/>	<input type="checkbox"/>	Hung										
			Infused										
Blood (Packed Red Blood Cells)	<input type="checkbox"/>	<input type="checkbox"/>	Hung										
			Infused										
FFP	<input type="checkbox"/>	<input type="checkbox"/>	Hung										
			Infused										
Platelets	<input type="checkbox"/>	<input type="checkbox"/>	Hung										
			Infused										
Medications	<input type="checkbox"/>	<input type="checkbox"/>	Hung										
			Infused										
Running Totals:													
Blood Administration Records													
[<input type="checkbox"/> Massive Transfusion Protocol (MTP) Order Set – ORD46, activated if applicable]													
Time (hhmm)		Blood Donor No. or Sticker			Time (hhmm)				Blood Donor No. or Sticker				
		Sticker goes here							Sticker goes here				
		Sticker goes here							Sticker goes here				
		Sticker goes here							Sticker goes here				
		Sticker goes here							Sticker goes here				
		Sticker goes here							Sticker goes here				
		Sticker goes here							Sticker goes here				
		Sticker goes here							Sticker goes here				
		Sticker goes here							Sticker goes here				
		Sticker goes here							Sticker goes here				
Time (hhmm)													
Urine													
NG/OG Tube													
Chest Tube													
Output Total													

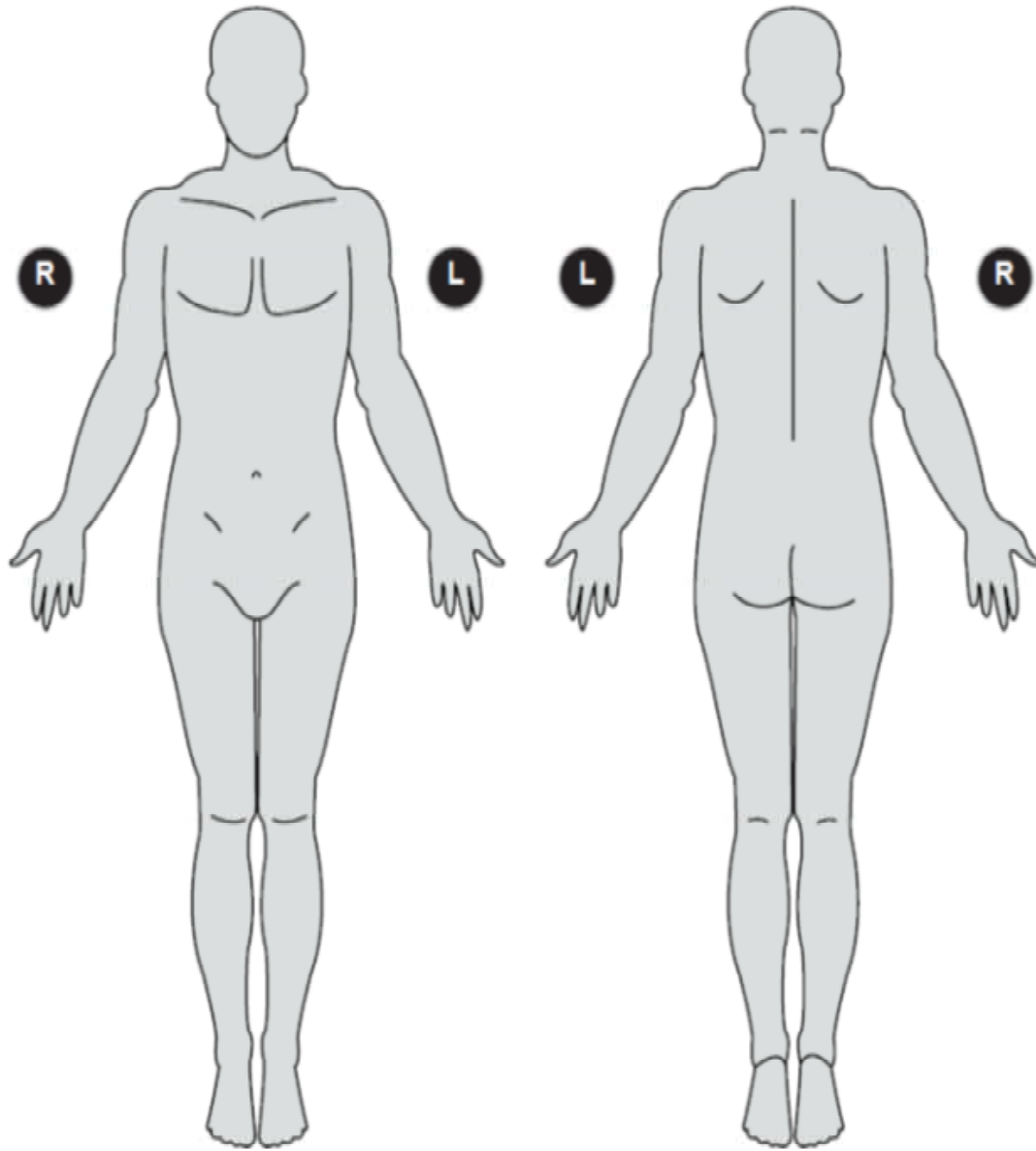
Total Intake: _____ Total Output: _____ + Balance: _____



ER22

Rev. 08/2015 (v7)

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Injuries

# Fractures	<input type="radio"/> Contusion	<input type="checkbox"/> Laceration or Cut	<input type="checkbox"/> Amputation
<input checked="" type="checkbox"/> Open Fracture	<input checked="" type="checkbox"/> Crush	<input type="checkbox"/> Penetrating Wound	<input checked="" type="checkbox"/> Abrasion

Rev. 08/2015 (v7)



ER22

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Abuse Screen and Response – Trauma

- Patient does NOT disclose intimate partner/domestic violence at this time
- Unable to ask (Reason: _____)
- Patient DOES disclose intimate partner/domestic violence
- Immediate safety concerns Yes – see Nursing Note No

Laboratory

Blood Gases			Haematology			Chemistry			Radiology	
Time (hhmm)			Time(hhmm)			Time (hhmm)			Procedures	Done
P.H.			HBG			Sodium			Chest	
PCO ₂			HCT			Potassium			Pelvis	
PO ₂			WBC			Chloride			C-Spine	
Bicarbonate			Platelets			Bicarbonate				
Base Excess			P.T.			Urea				
			P.T.T.			Creatinine				

Family / Next of Kin Information

Name: _____ Number: _____ Notified
 Name: _____ Number: _____ Notified

Police attempting to locate family Time (hhmm): _____

Preliminary List of Injuries / Identified Issues:

Complete Patient Belongings, Money and Valuables Form PT5

Transferred to OR ICU Ward Home

Tertiary Care / Trauma Centre (specify): _____ CritiCall Contacted at _____ (hhmm)

Accepting Physician: _____ Accepting Unit: _____

Report Given To: _____ Comment: _____

Rev. 08/2015 (v7)



ER22

World Health Organization (WHO) Trauma Checklist – Prior to ED Departure

Date: _____ (dd/mm/yyyy)

Time: _____ (hhmm)

1. Is airway secure or do you anticipate further airway intervention? Yes No, and plan discussed with team
2. Is the patient's GCS 8 or below? No Yes, and patient intubated
3. Has chest x-ray been reviewed and hemo/pneumothorax ruled out? Yes
4. Is the pulse oximeter on the patient and functioning? Yes
5. Has the pelvic x-ray been reviewed to rule out a pelvic fracture and pelvic binder considered? Yes No (not indicated for penetrating injury)
6. Has appropriate IV access been obtained and fluid resuscitation initiated? Yes
7. Has an arterial or venous blood gas been performed? Yes
8. Is the patient in shock (base deficit greater than 6 or persistent tachycardia or hypotension)? Yes No
If yes, has the surgeon been notified? Yes No
Has blood been ordered and MTP considered? Yes No
9. Have you assessed for internal bleeding with: Clinical exam (eg. abd GSW) FAST Ultrasound
10. Have you checked for open wounds and controlled external bleeding including from scalp, back, perineum? Yes
11. Have you checked neurovascular status of all four (4) limbs? Yes
12. Has temperature been recorded and hypothermia excluded (temperature less than 35° Celsius)? Yes, and action taken if needed
13. Have analgesics, antibiotics, and tetanus been considered? Yes
14. Plan for Patient Disposition:
 Patient to be transferred out of hospital If yes, has CritiCall been notified? Yes No
 Patient to be operated on in hospital If yes, has the operating room been notified? Yes No
 Further investigation required
15. Have the necessary agents been prepared for transport? Narcotics Anxiolytics Paralytics
16. Has the necessary patient documentation been prepared for transport? Patient Record Diagnostics burned to disc
17. Does any member of the trauma team have any issues or concerns that have not been addressed prior to departure from trauma room?

Nurse – Printed Name

Nurse Signature / Status

Physician – Printed Name

Physician Signature



ER21

Chart Copy – Do Not Destroy