

Date: _____

TRAUMA TEAM DATA				ADMITTING DATA			
TRAUMA TEAM ACTIVATED BY			TEAM RESPONSE		Name		
<input type="checkbox"/> Field <input type="checkbox"/> ED <input type="checkbox"/> Transfer Time _____			<input type="checkbox"/> Full <input type="checkbox"/> Modified		Arrival Time		
Time Called	Time Arrived	Name		Arrival Date	Trauma ID #		
Trauma Surgeon				Age	Sex	D.O.B.	Weight
Anesthesiologist				Medications			Last Tetanus
Neurosurgeon				Allergies			
Orthopedic Surgeon				Last Meal			LNMP
ED Physician				Medical History			

PREHOSPITAL DATA		PREHOSPITAL TREATMENT		TRIAGE CRITERIA		
METHOD OF ARRIVAL		Ambulance Co.	<input type="checkbox"/> Oral Airway _____ <input type="checkbox"/> Nasal _____ <input type="checkbox"/> Oxygen _____ L Via _____ <input type="checkbox"/> Suctioning _____ <input type="checkbox"/> Endotracheal Intubation Attempts _____ <input type="checkbox"/> _____ Nasal _____ Oral _____ mm <input type="checkbox"/> IV _____ g <input type="checkbox"/> Location _____ <input type="checkbox"/> IV _____ g <input type="checkbox"/> Location _____		Vital Signs/Levels of Consciousness <input type="checkbox"/> Systolic blood pressure <90mmHg <input type="checkbox"/> Resp. distress with rate <10 or >29 <input type="checkbox"/> Glasgow Coma Scale ≤12 Anatomy of Injury <input type="checkbox"/> Penetrating injury of the head, neck, torso, groin <input type="checkbox"/> Amputation above the wrist or ankle <input type="checkbox"/> Spinal cord injury <u>with</u> limb paralysis <input type="checkbox"/> Flail chest <input type="checkbox"/> Two or more fractures of the femur or humerus	
<input type="checkbox"/> Ambulance <input type="checkbox"/> Helicopter <input type="checkbox"/> Private Auto		Unit # _____	<input type="checkbox"/> Assisted Ventilation <input type="checkbox"/> Hyperventilation <input type="checkbox"/> Control Bleeding <input type="checkbox"/> Full Spinal Immobilization <input type="checkbox"/> Splints _____ <input type="checkbox"/> Traction _____ <input type="checkbox"/> Foley _____ <input type="checkbox"/> NG Tube _____ <input type="checkbox"/> Restraints _____ <input type="checkbox"/> Monitor _____ <input type="checkbox"/> PSAG <input type="checkbox"/> Legs Inflated <input type="checkbox"/> Abdomen Inflated <input type="checkbox"/> Other _____		Mechanism of Injury <input type="checkbox"/> Death of a same car occupant <input type="checkbox"/> Ejection of patient from an enclosed vehicle <input type="checkbox"/> Heavy extrication time >20 minutes Hi-Energy Transfer Situation <input type="checkbox"/> Fall > 20 feet <input type="checkbox"/> Pedestrian hit at 20 mph or thrown 15 feet <input type="checkbox"/> Vehicle rollover <input type="checkbox"/> Motorcycle, ATV or bicycle crash <input type="checkbox"/> Significant impact or intrusion into vehicle Comorbid Factors <input type="checkbox"/> Extremes of age <5 or >55 years of age <input type="checkbox"/> Patient with bleeding disorder or anticoagulated <input type="checkbox"/> Medical illness: cardiac or resp. disease, IDDM, cirrhosis, or morbid obesity <input type="checkbox"/> Pregnancy <input type="checkbox"/> Immunosuppressed patients <input type="checkbox"/> Presence of intoxicants	
MECHANISM OF INJURY		Site of Accident				
<input type="checkbox"/> Auto <input type="checkbox"/> Seatbelt <input type="checkbox"/> Airbag <input type="checkbox"/> Lap <input type="checkbox"/> 3 pt <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Pedestrian <input type="checkbox"/> Fall _____ feet <input type="checkbox"/> Crush <input type="checkbox"/> GSW _____ type <input type="checkbox"/> Motorcycle, ATV <input type="checkbox"/> Bicycle <input type="checkbox"/> Helmet <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Blunt Assault <input type="checkbox"/> Stabbing <input type="checkbox"/> Other _____		Time of Accident				
		Description of Incident				
		Medications Prior to Arrival				

INITIAL ASSESSMENT			
TIME:	WNL	ABN	DETAILS OF ABNORMALITIES
Airway Breathing			
Circ/Rhythm			
Neuro			<input type="checkbox"/> Lethargic <input type="checkbox"/> Uncooperative <input type="checkbox"/> Confused <input type="checkbox"/> Combative <input type="checkbox"/> Hysterical
Pupils			<input type="checkbox"/> Pinpoint <input type="checkbox"/> Sluggish <input type="checkbox"/> Fixed <input type="checkbox"/> Dilated <input type="checkbox"/> Brisk
Skin			<input type="checkbox"/> Pale <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Cyanotic <input type="checkbox"/> Hot <input type="checkbox"/> Cold
Head			
Neck			
Chest/Lungs			
Abdomen			
Pelvis			
Back			
Extremities			

