

Adult Trauma Resuscitation Record

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

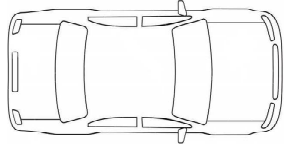
Direct from Scene Transfer From _____ Allergies _____

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

Date of Incident: Same **OR** _____ (dd/mm/yyyy) Time of Incident: _____ (hhmm)

Type of Incident: MVC Bicycle Motorcycle Pedestrian Recreation Fall Violence
 Fire Industrial Electrocutation Blast Drowning Stab Wound GSW
 Other: _____

Pre-Arrival VS: BP _____ HR _____ RR _____ SpO₂ _____ GCS /4 /5 /6 = /15

| | | | | |
|---|---|--|---|---|
| Pre-Hospital Care | MVC Crash History | Restraints Reported | Patient Position | Vehicle Damage |
| | <input type="checkbox"/> Single Car | <input type="checkbox"/> Yes | <input type="checkbox"/> Driver: |  |
| | <input type="checkbox"/> Extricated _____ | <input type="checkbox"/> No | Passenger: | |
| | <input type="checkbox"/> Ejected from Car | <input type="checkbox"/> Airbag Deployed | <input type="checkbox"/> Front | |
| <input type="checkbox"/> Roll Over | | <input type="checkbox"/> Rear Left | | |
| <input type="checkbox"/> Speed Reported _____ | | <input type="checkbox"/> Rear Right | 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 | |
| | 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"/> Oriented x3 <input type="checkbox"/> Lethargic <input type="checkbox"/> Event Amnesia <input type="checkbox"/> Unconscious <input type="checkbox"/> Anxious <input type="checkbox"/> Facial Droop <input type="checkbox"/> Agitated <input type="checkbox"/> Slurred Speech <input type="checkbox"/> Confused <input type="checkbox"/> Extreme Weakness | 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 <input type="checkbox"/> Unknown <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> HTN <input type="checkbox"/> CVA/Stroke <input type="checkbox"/> MI/ACS <input type="checkbox"/> Cardiac Other: _____ <input type="checkbox"/> Mental Health <input type="checkbox"/> Other: _____ | | | | |
| Medication Pre-Trauma Room | | | | Medication History - From Home | |
| Time (hhmm) | Medication | Dose | Route | <input type="checkbox"/> Unknown | |
| | | | | | |
| | | | | | |
| | | | | | |

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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 | | | | | |
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| | | Sticker goes here | | | | | | Sticker goes here | | | | | |
| Time (hhmm) | | | | | | | | | | | | | |
| Urine | | | | | | | | | | | | | |
| NG/OG Tube | | | | | | | | | | | | | |
| Chest Tube | | | | | | | | | | | | | |
| Output Total | | | | | | | | | | | | | |

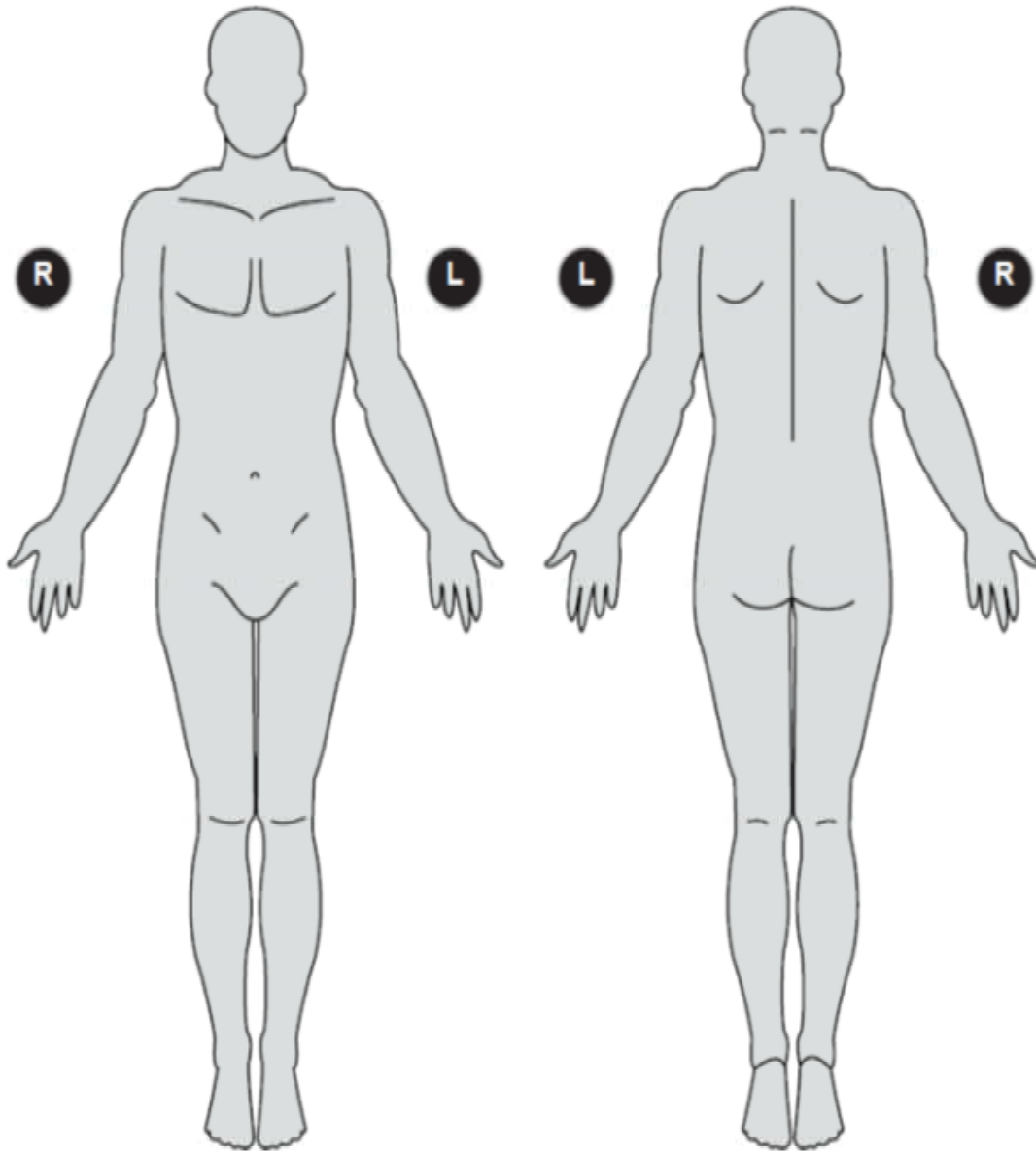
Total Intake: _____ Total Output: _____ + Balance: _____



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Injuries

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

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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



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Chart Copy – Do Not Destroy