TASMANIAN HEALTH SERVICE

Tasmanian Government

EMERGENCY DEPARTMENT (ED) TRAUMA RECORD

FACILITY: _____

THS – South

PT ID										

SURNAME..... D.O.B. .....

OTHER NAMES .....

ADDRESS.....

Attach Patient Sticker Label

FT042645

☑ *tick box where applicable*

THIS FORM IS COMPLETED BY MEDICAL STAFF AS CLINICAL NOTES FOR TRAUMA PATIENTS. DRUG CHARTS AND FLUID ORDERS WILL ALSO NEED COMPLETING.

PRE-HOSPITAL NOTIFICATION

Date: DD / MM / YYYY	**Time:** HH : MM	**Caller:** PRINT NAME

DETAILS OF INCIDENT

Place:	Time: HH : MM	
☐ Pedestrian	☐ Stabbing	
☐ Cyclist	☐ Gunshot	
☐ Motorbike *km/h*	☐ Burns	
☐ Motor vehicle *km/h*	☐ Hanging	
☐ Driver	☐ Fall *metres*	
☐ Passenger	☐ Sporting	
☐ Death in incident	☐ Other *(specify)*:	
☐ Ejected		

VITALS

Airway:
☐ Patent
☐ Compromised
☐ Intubated
Pulse:
SBP:
GCS: __/4 __/5 __/6
Total GCS: __/15
SaO_2:

TRANSPORT

☐ Ambulance
☐ Helicopter
☐ Fixed Wing
☐ Other
☐ Primary retrieval
☐ Secondary transfer

TRAUMA CALL

☐ Trauma call (Level 1)
☐ Trauma alert (Level 2)

HANDOVER

Arrival date: DD/MM/YYYY	Time: HH : MM		Triage Category: ☐ 1 ☐ 2	
Mechanism of injury:	P:	SBP:	Fluids: Crystalloids *mls*	
			Packed cells *units*	
Injuries identified:	RR:	SaO_2:	Medications administered:	
	GCS: __/4 __/5 __/6 Total GCS: __/15			Dose:
	Temp:	Pain:		Dose:

TREATMENT PRE-HOSPITAL

AIRWAY:	BREATHING:	CIRCULATION:
☐ O_2 by mask	☐ Ventilated ☐ NGT	☐ IV (1) Site: Size:
☐ LMA ☐ Endotracheal tube (ETT) Size: Length: *cm at teeth*	☐ Thoracostomy ☐ Right ☐ Left	☐ IV (2) Site: Size:
	☐ Intercostal catheter - right Size:	☐ Artline: ☐ CVC:
☐ Cervical spine collar / spinal precautions	☐ Intercostal catheter - left Size:	☐ Pelvic binder ☐ IDC ☐ CPR

Emergency Physician: PRINT / STAMP NAME

Registrar: PRINT / STAMP NAME

Designation: **Signature:**

ED TRAUMA RECORD

THS-S 182181 9/16 F&P 51015 – OCT16 M2

☑ *tick box where applicable*

PRIMARY SURVEY	INTERVENTIONS
AIRWAY AND CERVICAL SPINE:	☐ O_2: therapy: *L/min*
	☐ ETT: Size: cm at teeth:
	Time: HH : MM
	☐ Cervical collar ☐ Philadelphia collar
BREATHING:	☐ ICC-R Size: Time: HH : MM
	☐ ICC-L Size: Time: HH : MM
	☐ NGT / OGT Size:
CIRCULATION:	☐ Peripheral IV (1)
	Site: Size: Time: HH : MM
	☐ Peripheral IV (2)
	Site: Size: Time: HH : MM
	☐ Central line
	Site: Size: Time: HH : MM
	☐ Arterial line
	Site: Size: Time: HH : MM
	☐ IDC time: HH : MM ☐ CPR commenced time: time: HH : MM
DISABILITY:	
EXPOSURE:	☐ Warm fluids ☐ External warming

HISTORY

MECHANISM OF INJURY: _____

_____

_____

PAST HISTORY: _____

_____

_____

ALLERGIES: _____

_____

_____

MEDICATIONS: _____

_____

_____

TIME LAST ATE / DRANK: HH : MM

TETANUS STATUS: ☐ UTD ☐ ADT given

Clinician – primary survey: PRINT / STAMP NAME **Designation:**

Signature: **Date:** DD / MM / YYYY **Time:** HH : MM

ABBREVIATION KEY:							
ADT	adult diphtheria and tetanus	Cr	creatinine	IV	intravenous	pCO_2	partial pressure carbon dioxide
APPT	activated partial thromboplastin time	CVC	central venous catheter	K	potassium	pO_2	partial pressure oxygen
Artline	arterial line	CXR	chest x-ray	Km/h	kilometres per hour	PR	per rectum
BAL	blood alcohol level	ETT	endotracheal tube	L	left	R	right
BE	base excess	FBC	full blood count	LMA	laryngeal mask	RR	respiratory rate
BGH	blood group and hold	FFP	fresh frozen plasma	L/min	litres per minute	SBP	systolic blood pressure
ß HCG	ß human chorionic gonadotropin	GCS	glasgow coma score	Na	sodium	Temp	temperature
BSL	blood sugar level	Hb	haemaglobin	NGT	nasogastric tube	UTD	up to date
Coags	coagulations	HCO_3	bicarbonate	OGT	orogastric tube	WCC	white cell count
cm	centimetres	IDC	indwelling catheter	O_2	oxygen		
CPR	cardiopulmonary resuscitation	INR	international normalised ratio	P	pulse		

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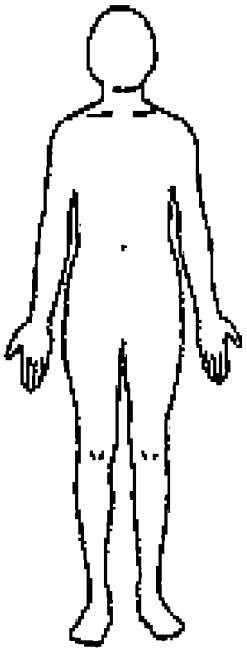
SECONDARY SURVEY *(detail findings)*

R L



HEAD: _____

_____

_____

NECK: _____

_____

CHEST: _____

_____

_____

_____

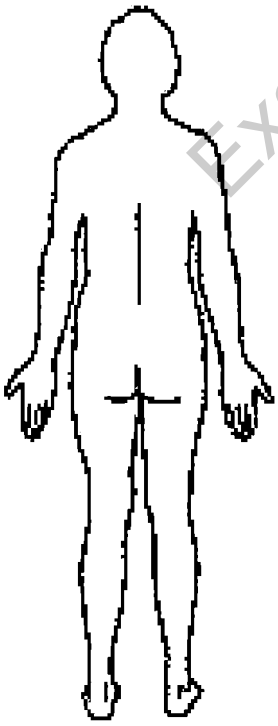
ABDOMEN: _____

_____

_____

_____

R L



PELVIS & GENITALS: _____

_____

_____

BACK INCLUDING THORACIC/LUMBAR SPINE:

☐ Log roll with spinal precautions ☐ PR

_____

_____

UPPER LIMBS: _____

_____

_____

_____

Upper limb neurovascular examination: _____

LOWER LIMBS: _____

_____

_____

_____

Lower limb neurovascular examination: _____

Clinician – secondary survey: PRINT / STAMP NAME	**Designation:**
Signature:	**Date:** DD / MM / YYYY **Time:** HH : MM

☑ *tick box where applicable*

RADIOLOGY

EXTENDED FAST SCAN: ☐ Positive ☐ Negative

☐ Performed by: PRINT NAME ☐ Time: HH : MM

☐ Abdominal free fluid ☐ Pericardial free fluid ☐ Pneumothorax

PLAIN RADIOLOGY:

☐ Cervical spine ☐ CXR ☐ Pelvis ☐ Other *(specify):*

PLAIN X-RAY SIGNIFICANT POSITIVES / RELEVANT NEGATIVES: _____

CT IMAGING ***(tick if completed / ordered):***

☐ Abdominal / pelvis ☐ Cervical spine ☐ Head ☐ Thoracic / lumbar spine

☐ Thorax ☐ Other *(specify):*

CT SIGNIFICANT POSITIVES / RELEVANT NEGATIVES: _____

RESULTS

Blood Gas	Time:	pH	pO_2	pCO_2	HCO_3	BE	Lactate	BSL
FBC/Coags/ XM	Time:	Hb	WCC	Platelets	INR	APTT	BGH	Crossmatch
Biochemistry	Time:	Na	K	Urea	Cr	BAL	Lipase	ßHCG

☐ Electrocardiogram (ECG) Time: HH : MM

Urine: ☐ Clear ☐ Gross haematuria ☐ Urine ßHCG:

PATIENT CONTACT

Next of kin: PRINT NAME Relationship:

Telephone number: ☐ Present ☐ Contacted

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EMERGENCY DEPARTMENT SUMMARY

PHYSIOLOGY: ☐ Stable ☐ Fluid responsive ☐ Unstable ☐ Critical

INJURIES (confirmed or suspected):	**ACTIONS:**

TOTAL FLUIDS RECEIVED IN ED

☐ Crystalloid	***mls***
☐ Packed cells	***units***
☐ FFP	***units***
☐ Platelets	***packs***
☐ Tranexamic acid	***dose***
☐ Massive transfusion protocol (MTP) activated	

SPINAL STATUS

☐ Cleared
- ☐ Clinically by cervical spine guideline
- ☐ By plain x-ray
- ☐ By computerised tomography (CT)

☐ Not cleared
- ☐ Reason:

REFERRALS MADE

UNIT	CONSULTANT / REGISTRAR *(print name)*	NOTIFIED *(date)*	SEEN YES / NO	REQUESTS

DISPOSITION

☐ Intensive care unit ☐ Operating suite ☐ Angiography suite

☐ Ward ☐ Discharged ☐ Died

ADMITTING UNIT

_____

_____

_____

Clinician PRINT / STAMP NAME **Designation:**

Signature: **Date:** DD / MM /YYYY **Time:** HH : MM

ED TRAUMA RECORD

TERTIARY SURVEY
MUST BE COMPLETED WITHIN 24 HOURS OF ADMISSION BY ADMITTING TEAM

INJURY SUMMARY TO DATE:	**OPERATIONS / PROCEDURES TO DATE:**

PHYSICAL ASSESSMENT

REGION:	EXAMINED	NAD	NEW INJURY SUSPECTED *(detail)*
HEAD / NECK	☐ YES ☐ NO		
C-SPINE	☐ YES ☐ NO		
FACE	☐ YES ☐ NO		
CHEST	☐ YES ☐ NO		
ABDOMEN / PELVIS	☐ YES ☐ NO		
UPPER LIMBS	☐ YES ☐ NO		
LOWER LIMBS	☐ YES ☐ NO		
T / L-SPINE	☐ YES ☐ NO		

MANAGEMENT PLAN – INCLUDE CHANGE OF PRIMARY TEAM / NEW INVESTIGATIONS

Clinician – tertiary survey: PRINT / STAMP NAME	**Designation:**
Admitting Consultant: PRINT NAME	
Signature:	**Date:** DD / MM / YYYY **Time:** HH : MM