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PATIENT IDENTIFICATION \_\_\_\_\_

# ED TRAUMA FLOW SHEET

| NOTIFICATION STATUS                                                                        |                                                                               |                                                                                         |              |
|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------|
| TIME OF NOTIFICATION                                                                       |                                                                               | TIME ARRIVED                                                                            | ROOM #       |
| DATE                                                                                       | CODE YELLOW PAGED<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                         |              |
| MODE OF ARRIVAL                                                                            |                                                                               | <input type="checkbox"/> POLICE                                                         |              |
| <input type="checkbox"/> AMBULANCE                                                         |                                                                               | <input type="checkbox"/> WALK IN                                                        |              |
| <input type="checkbox"/> AUTO                                                              |                                                                               | <input type="checkbox"/> OTHER _____                                                    |              |
| PRE - HOSPITAL CARE                                                                        |                                                                               |                                                                                         |              |
| OXYGEN THERAPY                                                                             |                                                                               | <input type="checkbox"/> NONE                                                           |              |
| VIA                                                                                        | AT                                                                            | USERS                                                                                   |              |
| AIRWAY                                                                                     |                                                                               | <input type="checkbox"/> NONE                                                           |              |
| <input type="checkbox"/> EOA <input type="checkbox"/> ETT <input type="checkbox"/> ORAL    |                                                                               | ACLS <input type="checkbox"/> DEFB <input type="checkbox"/> OTHER                       |              |
| <input type="checkbox"/> LONG <input type="checkbox"/> SHORT <input type="checkbox"/> SCOP |                                                                               | <input type="checkbox"/> COS <input type="checkbox"/> RECS <input type="checkbox"/> NYS |              |
| BACKBOARD                                                                                  |                                                                               | <input type="checkbox"/> NONE                                                           |              |
| <input type="checkbox"/> LONG <input type="checkbox"/> SHORT <input type="checkbox"/> SCOP |                                                                               | <input type="checkbox"/> OTHER                                                          |              |
| DRESSINGS                                                                                  |                                                                               | <input type="checkbox"/> NONE                                                           |              |
| <input type="checkbox"/> LONG <input type="checkbox"/> SHORT <input type="checkbox"/> SCOP |                                                                               | <input type="checkbox"/> OTHER                                                          |              |
| SPLINTS                                                                                    |                                                                               | <input type="checkbox"/> NONE                                                           |              |
| <input type="checkbox"/> LONG <input type="checkbox"/> SHORT <input type="checkbox"/> SCOP |                                                                               | <input type="checkbox"/> OTHER                                                          |              |
| TRAUMA TEAM RESPONSE                                                                       |                                                                               | ARRIVED TIME CALLED IN                                                                  |              |
| ED PHYSICIAN                                                                               |                                                                               |                                                                                         |              |
| FIREST                                                                                     |                                                                               |                                                                                         |              |
| SURGEON                                                                                    |                                                                               |                                                                                         |              |
| NCS SURGE                                                                                  |                                                                               |                                                                                         |              |
| ED TRAUMATRN #1                                                                            |                                                                               |                                                                                         |              |
| ED TRAUMATRN #2                                                                            |                                                                               |                                                                                         |              |
| ANESTHESIA                                                                                 |                                                                               |                                                                                         |              |
| RADIOLOGY                                                                                  |                                                                               |                                                                                         |              |
| RESPIRATORY THERAPY                                                                        |                                                                               |                                                                                         |              |
| CONSULT/DISCIPLINE                                                                         | NAME                                                                          | TIME CALLED                                                                             | TIME ARRIVED |
|                                                                                            |                                                                               |                                                                                         |              |
|                                                                                            |                                                                               |                                                                                         |              |
|                                                                                            |                                                                               |                                                                                         |              |
| VALUES/BS ON ARRIVAL                                                                       |                                                                               | FAMILY NOTIFIED                                                                         |              |
|                                                                                            |                                                                               | TIME:                                                                                   |              |
|                                                                                            |                                                                               | ARRIVAL:                                                                                |              |
|                                                                                            |                                                                               | NAME:                                                                                   |              |

| MECHANISM OF INJURY                     |                                                                                                                                                |
|-----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| INJURY                                  |                                                                                                                                                |
| <input type="checkbox"/> ASSAULT        | COMMENTS: _____                                                                                                                                |
| <input type="checkbox"/> BURN           | <input type="checkbox"/> FRONT <input type="checkbox"/> BACK <input type="checkbox"/> OTHER _____                                              |
| <input type="checkbox"/> CRUSH          | COMMENTS: _____                                                                                                                                |
| <input type="checkbox"/> DROWN          | COMMENTS: _____                                                                                                                                |
| <input type="checkbox"/> FALL           | DISTANCE: _____                                                                                                                                |
| <input type="checkbox"/> GSW            | LOCATION: _____                                                                                                                                |
| <input type="checkbox"/> MVC            | <input type="checkbox"/> BICYCLE <input type="checkbox"/> MOTORCYCLE <input type="checkbox"/> RESTRAINED <input type="checkbox"/> UNRESTRAINED |
| <input type="checkbox"/> NO HELMET      | <input type="checkbox"/> HELMET <input type="checkbox"/> STEERING WHL <input type="checkbox"/> AIRBAG <input type="checkbox"/> EXTRICATED      |
| <input type="checkbox"/> SEATED         | <input type="checkbox"/> DRIVER <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> PASSENGER                                         |
| <input type="checkbox"/> STABBING       | LOCATION: _____                                                                                                                                |
| <input type="checkbox"/> DEATH ON SCENE | COMMENTS: _____                                                                                                                                |
| ESTIMATED TIME OF INJURY _____          |                                                                                                                                                |
| DESCRIBED DETAILS _____                 |                                                                                                                                                |
| _____                                   |                                                                                                                                                |
| _____                                   |                                                                                                                                                |
| _____                                   |                                                                                                                                                |

AGE \_\_\_\_\_ SEX \_\_\_\_\_ DOB \_\_\_\_\_

SIGNIFICANT PAST MEDICAL HISTORY \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MEDICINES \_\_\_\_\_

\_\_\_\_\_

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ALLERGIES \_\_\_\_\_

\_\_\_\_\_

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LAST MEAL \_\_\_\_\_

\_\_\_\_\_

LAST TETANUS \_\_\_\_\_

LMP \_\_\_\_\_

UPT \_\_\_\_\_ TIME DONE \_\_\_\_\_

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**U.S. Army**



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