Major Trauma Patient Document

Use addressograph - otherwise write in capitals

Surname: ____________________

First names: ____________________

DOB: ____________________

Health and Care No. ____________________

The scribe must complete pages 1-5 and Drug Page

The Team Leader is responsible for checking the entire document

OPEN FRACTURES - PLEASE COMPLETE ORTHOPLASTIC OPEN FRACTURES PRO FORMA

Date: ____________________ **Arrival time:** ____________________

ED Consultant: ____________________

Present: ☐ Yes ☐ No Name: ____________________

Team Leader: ____________________ Grade: ____________________

Scribe: ____________________

Speciality	Name	Grade	Arrival time	Nurse
ED				A nurse: __________
Anaesthetics				B nurse: __________
General surgery				C nurse: __________
Orthopaedics				Runner: __________
Cardiothoracic				

Please ensure each page is completed in full

Pre-Hospital Information

Time of incident	Time of arrival in ED

Use addressograph - otherwise write in capitals

Surname: ____________________

First names: ____________________

DOB: ____________________

Health and Care No. ____________________

Sex: ☐ M ☐ F

Mechanism of injury				

☐ **HEMS** ☐ **BASICS**

Code RED: ☐ Yes ☐ No Time: __________

Code AMBER: ☐ Yes ☐ No Time: __________

Code GREEN: ☐ Yes ☐ No Time: __________

Activated: ☐ Pre-hospital ☐ ED

RTC: __________ vs. __________ Speed: __________

☐ Pax Front ☐ Pax Rear ☐ Restrained ☐ Airbags

☐ Entrapped ☐ Ejection ☐ Fatality at scene

☐ **Fall**

Height: __________

Blunt assault

☐ GSW ☐ Crush ☐ Burns ☐ Stab

Name: ____________________ Age: __________ Time of incident: __________

Traumatic Cardiac Arrest: ☐ Yes ☐ No

Mechanism: ____________________

____

Injuries: ____________________

____

Signs: ____________________

____

Treatment: ____________________

____

Intubated	GCS	Time of anaesthesia (24hr)	Thoracostomy
☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No ☐ Right ☐ Left
Tube size: __________	Pre tube: __________	__________ : __________	

Drug	Dose	Drug	Dose	Pre-hospital fluids
Antiemetic		Propofol		Crystalloid: ________ mls
Fentanyl		Rocuronium		Blood: ________ mls
Ketamine		Other:		**Tranexamic acid**
Midazolam		Other:		Dose: __________
Morphine		Other:		Time: __________
Paracetamol		Other:		

Allergies					
Medication			☐ Warfarin/NOAC: ________		☐ Antiplatelet: ________
PMH					Pregnant: ☐ Yes ☐ No
Last eaten				LMP: ________	BHCG: ☐ Neg ☐ Pos
Tetanus covered?	☐ Yes ☐ No ☐ Unknown				

Please ensure each page is completed in full

Primary Survey

Initial observations **Time:**

Sa02:	E:	HR:
V:	RR:	M:
Entrapped	Temp:	GSC:

Cervical spine

Collar/blocks	☐ Yes	☐ No
Collar/blocks	☐ Yes	☐ No
Collar/blocks	☐ Yes	☐ No

Cleared by:

Airway

Clear	☐ Yes	☐ No	
Intubated	☐ Yes	☐ No	Tube size:
Comprised	☐ Yes	☐ No	
Surgical airway	☐ Yes	☐ No	

Comments:

Breathing

Equal air entry	☐ Yes	☐ No
Decreased air entry	☐ Right	☐ Left
Needle Decomp	☐ Right	☐ Left
Finger Thoracostomy	☐ **Right** ☐ Air ☐ Blood	☐ **Left** ☐ Air ☐ Blood
Chest drain	☐ **Right** ☐ Air ☐ Blood	☐ **Left** ☐ Air ☐ Blood

Comments:

Use addressograph - otherwise write in capitals

Surname: ____________________

First names: ____________________

DOB: ____________________

Health and Care No. ____________________

Sex: ☐ M ☐ F

Circulation

☐ Warm ☐ Cold ☐ Cap refill Secs: __________

External haemorrhage	☐ Yes	☐ No
Abdomen	☐ Soft	☐ Distended
Pelvis symmetrical	☐ Yes	☐ No
Pelvic binder	☐ Yes	☐ No

FAST findings:

FAST findings:

Right lung	☐ Normal	☐ Inadequate	☐ Postiive
Left lung	☐ Normal	☐ Inadequate	☐ Postiive
Pericardial	☐ Normal	☐ Inadequate	☐ Postiive
RUQ	☐ Normal	☐ Inadequate	☐ Postiive
LUQ	☐ Normal	☐ Inadequate	☐ Postiive
Pelvis	☐ Normal	☐ Inadequate	☐ Postiive

Disability

Right pupil	Size: _______ mm	Reaction: ☐ Yes ☐ No
Left pupil	Size: _______ mm	Reaction: ☐ Yes ☐ No

Priapism: ☐ Yes ☐ No Sensory level: ____________

Limb movement ☐ Right arm ☐ Left arm
☐ Right leg ☐ Left leg

Posturing: Decorticate ☐ Yes ☐ No
Decorticate ☐ Yes ☐ No

BM:

Temperature:

Please ensure each page is completed in full

Trauma Chronology

Body region findings

Use addressograph - otherwise write in capitals

Surname: ____________________

First names: ____________________

DOB: ____________________

Health and Care No. ____________________

Plain films (tick)

Time: __________ ☐ CXR ☐ PXR ☐ C-SPINE

eFAST

Time: __________

☐ Clinician name: __________

☐ Clinician grade/training: __________

Result: ____________________

IV access: ☐ Yes ☐ No Site1: ______ Site2: ______ Site3: ______ Site4: ______

IO access: ☐ Yes ☐ No Site1: ______ Site2: ______ Site3: ______ Site4: ______

☐ Whole body CT ☐ Head ☐ Spine ☐ Chest ☐ Abdomen and pelvis ☐ Other:

Airway+C Spine

Breathing

Circulation

Disability

Exposure

Please ensure each page is completed in full

ED Injury Summary

Performed by:____________________________

Signature:__________________ Date: __________

Use addressograph - otherwise write in capitals

Surname: ____________________________

First names:__________________________

DOB:______________________________

Health and Care No.______________________

eFAST		
Head		
Max Fax		
Neck		
Chest		
Abdomen		
Pelvis		
Upper limbs		
Lower limbs		
Log roll/back		
Rectal		
ECG		
Other		

Time of death:		Admitting Consultant:	
Disposal:		Signature of Team Leader:	

Please ensure each page is completed in full

Secondary Survey

Please indicate location of all injuries and interventions

Signature: ______________________ Date: __________

Use addressograph - otherwise write in capitals

Surname: ______________________

First names: ______________________

DOB: ______________________

Health and Care No. ______________________

Sex: ☐ M ☐ F

Interventions

Collar	☐ Yes	☐ No		
Tracheal tube	☐ Yes	☐ No		
Chest drainage	☐ Yes	☐ No	☐ Left	☐ Right
Pelvic splint	☐ Yes	☐ No		
Traction splint	☐ Yes	☐ No	☐ Left	☐ Right

IV accesS Site1: ________ Site2: ____________

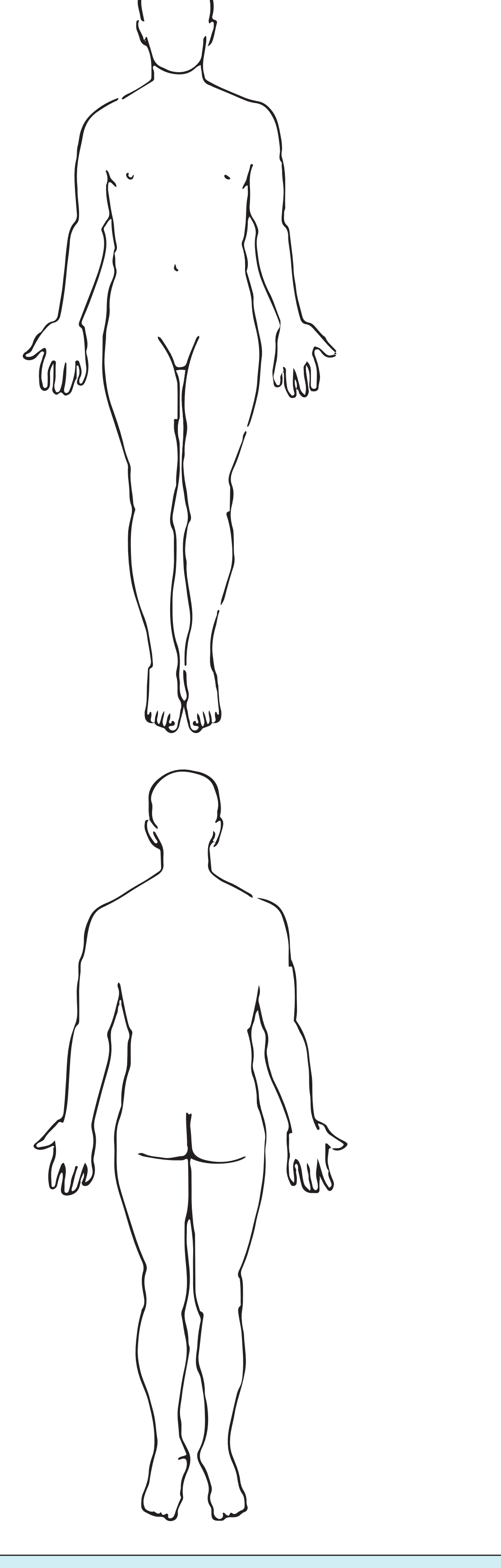
☐ Yes ☐ No Site3: ________ Site4: ____________

IO access Site1: ________ Site2: ____________

☐ Yes ☐ No Site3: ________ Site4: ____________

Central line	☐ Yes	☐ No	☐ Left	☐ Right
Arterial line	☐ Yes	☐ No	☐ Left	☐ Right
Urine catheter	☐ Yes	☐ No		
Pop backslab	☐ Yes	☐ No	☐ Left	☐ Right

Comments:



Secondary Survey

Performed by:____________________

Signature:____________ Date: ________

Use addressogaph - otherwise write in capitals

Surname: ____________________

First names:____________________

DOB:____________________

Health and Care No.____________________

Body Region Findings

Head	☐ None	
Max Fax	☐ None	
Neck	☐ None	
Chest	☐ None	
Abdomen	☐ None	
Pelvis	☐ None	
Upper limbs	☐ None	
Lower limbs	☐ None	
Log roll/back	☐ None	
Rectal	☐ None	
ECG	☐ None	
Other	☐ None	

Please ensure each page is completed in full

Team Leader's notes

Use addressograph - otherwise write in capitals

Surname: ______________________

First names: ______________________

DOB: ______________________

Health and Care No. ______________________

Date: ______________ Time: ______________

Consultant: ______________________

Print name: ______________________

Signature: ______________________ **Date:** ______________

Please ensure each page is completed in full

Team Leader's notes continued

Signature: ______________________ Date: ______________

Please ensure each page is completed in full

Nursing notes

Use addressograph - otherwise write in capitals

Surname: ______________________

First names: ______________________

DOB: ______________________

Health and Care No. ______________________

Date: ____________ Time: ____________

Consultant: ______________________

Print name: ______________________

Signature: ______________________ **Date:** ______________

Please ensure each page is completed in full

Nursing notes continued

Signature: ________________________ Date: ________________

Please ensure each page is completed in full

Anaesthetic notes

Use addressograph - otherwise write in capitals

Surname: ______________________

First names: ______________________

DOB: ______________________

Health and Care No. ______________________

Date: ______________ Time: ______________

Consultant: ______________________

Print name: ______________________

Anaesthetics have reviewed the patient and feel there is no further involvement and are signing off.
We are happy to review patient on request

Signature: ______________________ **Date:** ______________

Please ensure each page is completed in full

Anaesthetic notes continued

Signature: ______________________ Date: ______________

Please ensure each page is completed in full

General Surgery notes

Use addressograph - otherwise write in capitals

Surname: ______________________

First names: ______________________

DOB: ______________________

Health and Care No. ______________________

Date: ______________ Time: ______________

Consultant: ______________________

Print name: ______________________

General Surgeons have reviewed the patient and feel there is no further involvement and are signing off. We are happy to review patient on request

Signature: ______________________ **Date:** ______________

Please ensure each page is completed in full

General Surgery notes continued

Signature: ______________________ **Date:** ______________

Please ensure each page is completed in full

Orthoplastic Open Fracture Pathway

- Indications - Open fractures of Long bones, Hindfoot or Midfoot
- Open fractures require timely MDT input, follow BOAST Open Fractures Standards
- All open fractures must be reported to TARN; accurate completion of proforma is mandatory.

Use addressograph - otherwise write in capitals

Surname: ______________________

First names: ______________________

DOB: ______________________

Health and Care No. ______________________

Date of Injury ________/________/ ________

Mechanism: HIGH ENERGY ☐

____

____

____

______________________ Local ED ☐ Transfer From

____

Limb involved: ______________________

Isolated Open Fracture: ☐ Yes ☐ No

Injury Description

Wound Characteristics (Size, location, dept etc)

____

____

____

____

Heavily Contaminated (Sewage, Agricultural, Aquatic, Blast)

Wound Photography ☐ Yes ☐ No

Wound Dressing

Time: ______ : ______

Type: ______________________

Wound Splintage

____

____

Imaging X-Ray ☐ CT ☐]

Findings

____

____

____

____

____

IV ANTIBIOTICS [< 1 hour from injury achieved ☐]

Agent: ______________________

Time Given: ______ : ______ Date Given: ________

Tetaus Administered ☐

Allergies__________ Significant Co-Morbidities______

____

____

Smoker ☐ Occupation: ______________________

Clinical Assessment

Vascular Status

CRT __________ Secs

Distal Pulses Clinically Palpable ☐ Doppler ☐

Locations Present ______________________

Post Splintage Re-check ☐ ______________

SUSPECTED VASCULAR INJURY ☐

Neurological Status

Sensory ______________________

Motor ______________________

Post Splintage Re-check ______________________

SUSPECTED NEUROLOGICAL INJURY ☐

SUSPECTED COMPARTMENT SYNDROME ☐

Specialist Referral

Orthopaedic Team

Name/Grade ______________________

Consultant ______________________

Time __________ : __________

Plastics Team

Name/Grade ______________________

Consultant ______________________

Time __________ : __________

Combined Orthoplastics Reconstructive Plan

☐ Yes ☐ No ☐ Not recorded

Completed by: ____________ Grade ________ Date ______ / ______ / ______ Time: ______ : ______

Orthoplastic Open Fracture Pathway

Use addressograph - otherwise write in capitals

Surname: ____________________

First names: ____________________

DOB: ____________________

Health and Care No. ____________________

Isolation Open Fracture: ☐ Yes ☐ No

Additional injuries:

____

____

____

____

Injuries Requiring MTC treatment:

Head injury: ____________________

Spinal injury: ____________________

Thoracic injury: ____________________

Pelvic injury: ____________________

Orthoplastic Injury Initial Management

Debridement and Stabilisation within 24 hours:
☐ Yes ☐ No

Definitive Soft Tissue Coverage:
☐ Yes ☐ No

Procedure:

____

____

____

Date: _____ / _____ / ______ Time: ______ : ______

Stabilisation: Temporary / Permanent

Grade of anaesthetist: ____________________

Grade of Seniour Orthopaedic Surgeon: ____________

Grade of Senior Plastic Surgeon: ______________

Grade of Assisting Surgeons: ______________

Location of Surgery: DGH / MTC / OPU

Gustillo-Anderson Classification: ___________(if appropriate)

Peri-operative Antibiotics:

Trust protocol / BAPRAS guidelines met:
☐ Yes ☐ No

Agent: ____________________

Time: _____ : _____

Definitive Reconstructive Management

OPCS Code

1. Fracture ____________________

2. Soft Tissue ____________________

Procedure:

____

____

________________ Location: ____________________

Date: ____________________

Antibiotics Therapy: ____________________

Time: ______ : ______

Grade of anaesthetist: ____________________

Grade and Speciality of Surgeon: ________________

Second Surgeon: ____________________

Supervising Surgeon Present:

☐ Yes ☐ No ☐ Not recorded

AO Classification: ____________________

Alternative Classification System: ______________

Return to Theatre: ☐ Yes ☐ No ☐ Not recorded

Indication: ____________________

Deep Tissue Samples:

☐ Yes ☐ No ☐ Not recorded

Isolated Organism: ____________________

Additional Notes:

____

____

____

____

____

____

____

____

____

____

____

Orthopaedic notes

Use addressograph - otherwise write in capitals

Surname: ______________________

First names: ______________________

DOB: ______________________

Health and Care No. ______________________

Date: ______________ Time: ______________

Consultant: ______________________

Print name: ______________________

Orthopaedics have reviewed the patient and feel there is no further involvement and are signing off.
We are happy to review patient on request

Signature: ______________________ **Date:** ______________

Please ensure each page is completed in full

Orthopaedic notes continued

Signature: ______________________ Date: ______________

Please ensure each page is completed in full

Cardiothoracic notes

Use addressograph - otherwise write in capitals

Surname: ______________________

First names: ______________________

DOB: ______________________

Health and Care No. ______________________

Date: ______________ Time: ______________

Consultant: ______________________

Print name: ______________________

Cardiothoracic have reviewed the patient and feel there is no further involvement and are signing off. We are happy to review patient on request

Signature: ______________________ **Date:** ______________

Please ensure each page is completed in full

Cardiothoracic notes continued

Signature: ______________________________ **Date:** ____________________

Please ensure each page is completed in full

Burn assessment form

Referral: ☐ Acute ☐ Post-acute ☐ Reconst ☐ Rehab
Date: ____________ Time: ____________
T /F from: ____________ Via: ☐ NIAS ☐ Private
Seen by: __________ Consultant ____________

Use addressograph - otherwise write in capitals

Surname: ______________________________
First names: ______________________________
DOB: ______________________________
Health and Care No. ______________________________

Nature of Burn: ☐ Scale ☐ Oil ☐ Flame ☐ Flash ☐ Chemical ☐ Contact ☐ Electrical % TBSA: _________
Date of Burn: _____ / _____ / _____ Time of Burn _____ : _____
Predisposing Factors: ☐ Age ☐ Occupation ☐ Alcohol ☐ Social
Place of Burn: ☐ Indoors ☐ Outdoors Rescued by: ______________________________

First Aid given: ______________________________ Burn in percentage of total BSA: __________ (see overleaf)
Additional injuries: ______________________________

____

Pt Wt: _________ Kg Allergies: _________ Medication: _________ PMH: _________ Last meal: _________

Airway

C-Spine clear ☐ Yes ☐ No
Supraglottic inhal injury: Nose/Mouth Burn: ☐ Yes ☐ No Nose/Mouth soot: ☐ Yes ☐ No
Stained sputum: ☐ Yes ☐ No
Epiglottic inhal injury: Hoarseness ☐ Yes ☐ No Stridor: ☐ Yes ☐ No
Infraglottic inhal injury: Go to breathing

Circulation

Attach 02 Pulse: __________ BP: __________ No. of IV lines: _________ Urinary catheter ☐ Yes ☐ No
Lymbs escharotomy: ☐ Yes ☐ No details: ______________________ Go to fluids

Breathing

Attach 02 Normal chest expansion: ☐ Yes ☐ No Dyspnoea: ☐ Yes ☐ No Stridor: ☐ Yes ☐ No
Added breath sounds: ☐ Yes ☐ No Resp rate: CHest escharotomy ☐ Yes ☐ No

Disability

GCS: ______/15 Pupils normal ☐ Yes ☐ No
Exposure / environment Temp: _________ Clothes/jewellery off: ☐ Yes ☐ No Warmer: ☐ Yes ☐ No
Tetanus toxoid: ☐ Yes ☐ No Corneal injury: ☐ Yes ☐ No

Laryngoscopy: ☐ Direct ☐ Indirect by Dr: _____________ Findings: ☐ Uvula ☐ Epiglottis ☐ Cords Oedema
Intubation: ☐ Yes ☐ No by Dr: _______________ Size of tube: _______ Position at teeth: _________cm

Investigations (order as required): ☐ Direct ☐ U+E ☐ Gp and hold ☐ ABG ☐ CoHb ☐ CXR
☐ ECG ☐ Wound culture

Checklist: ☐ Direct ☐ IV fluids (see overleaf) ☐ Urinary catheter ☐ Warmer ☐ Tetanus cover
☐ Analgesia ☐ Antibiotics (one dose of flucloxacillin)
Dressing Theatre required: ☐ Yes ☐ No ICU required: ☐ Yes ☐ No Photograph: ☐ Yes ☐ No

Outcome and additional notes:

Please ensure each page is completed in full

Burn assessment form Cont'd

Use addressograph - otherwise write in capitals
Surname: ______________________
First names: ______________________
DOB: ______________________
Health and Care No. ______________________

Fluid Resuscitation Required: ☐ Yes ☐ No

% Total Body Surface Area (TBSA): ___________

Weight of patient: ___________ kg

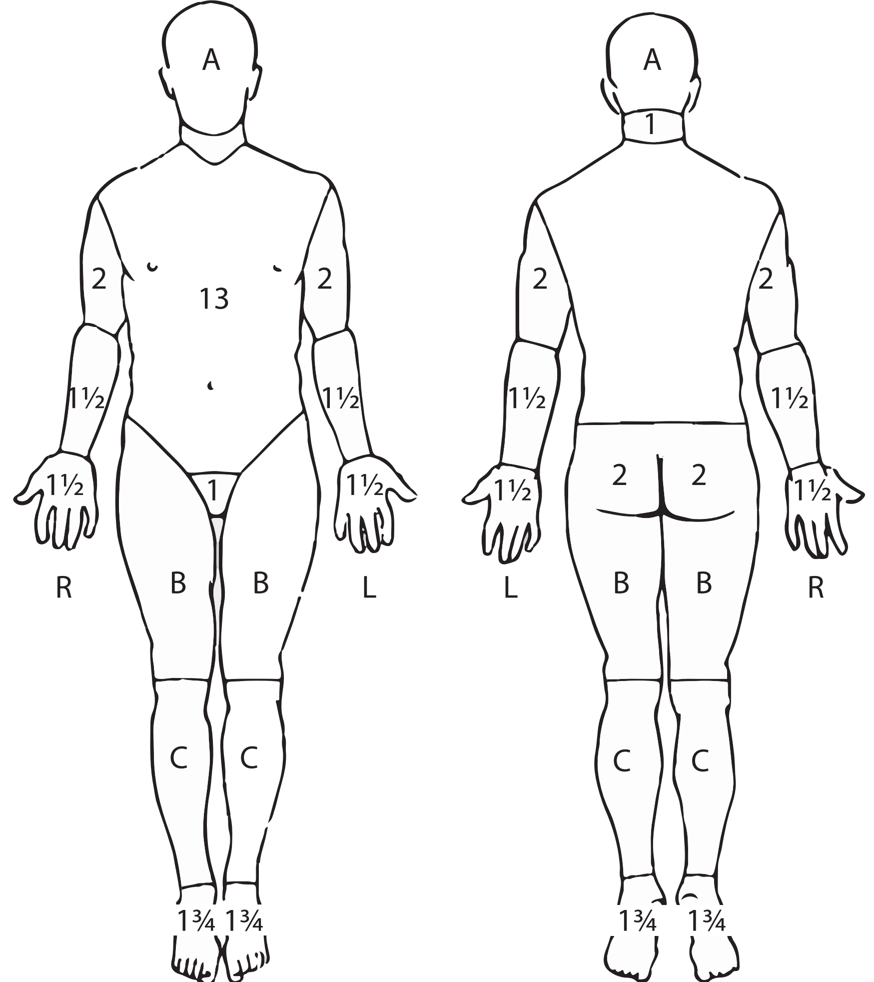
Parkland Formula: **%TBSA burn x weight in kg x 4mls of Hartmann's solution** (Normal saline in children)

(Half of total fluid requirement in first 8 hours from time of burn and half in following 16 hours)

Resuscitation started: Date: ______ / ______ / ______ Time: ______ : ______ Any bolus given: __________mls

Maintenance fluid added: ☐ Yes ☐ No (children 24 hour requirements: 100mls/kg/15t 10kg, 50mls/kg/next 10kg, 20mls/kg/remainder body wt)

Urinary Catheter passed: ☐ Yes ☐ No Initial volume passed: __________mls



Ignore simple erythema

Superficial

Deep

Region	%
Head	
Neck	
Ant. Trunk	
Post. Trunk	
Right Arm	
Left Arm	
Buttocks	
Genitalia	
Right Leg	
Left Leg	

Relative percentage of body surface area affected by age

Area	Age					
	0	**1**	**5**	**10**	**15**	**Adult**
A = 1/2 of head	9 1/2	8 1/2	6 1/2	5 1/2	4 1/2	3 1/2
B = 1/2 of thight	2 3/4	3 1/4	4	4 1/2	4 1/2	4 3/4
C = 1/2 of one lower leg	2 1/2	2 1/2	2 3/4	3	3 1/4	3 1/2

Please ensure each page is completed in full

Burns/Plastics notes

Use addressograph - otherwise write in capitals

Surname: ____________________

First names: ____________________

DOB: ____________________

Health and Care No. ____________________

Date: ____________ Time: ____________

Consultant: ____________________

Print name: ____________________

Burns/Plastics have reviewed the patient and feel there is no further involvement and are signing off. We are happy to review patient on request

Signature: ____________________ **Date:** ____________

Please ensure each page is completed in full

Burns/Plastics notes continued

Signature: ______________________ **Date:** ______________

Please ensure each page is completed in full

Specialty notes

Use addressograph - otherwise write in capitals

Surname: ______________________________

First names: ______________________________

DOB: ______________________________

Health and Care No. ______________________________

Date: ____________________ Time: ________________

Consultant: ______________________________

Print name: ______________________________

Signature: ______________________________ **Date:** ____________________

Please ensure each page is completed in full

Specialty notes continued

Signature: ______________________________ Date: ____________________

Please ensure each page is completed in full

Miscellaneous notes

Use addressograph - otherwise write in capitals

Surname: ____________________

First names: ____________________

DOB: ____________________

Health and Care No. ____________________

Date: ____________ Time: ____________

Consultant: ____________________

Print name: ____________________

Signature: ____________________ **Date:** ____________

Please ensure each page is completed in full

Miscellaneous notes continued

Signature: ______________________ Date: ______________

Please ensure each page is completed in full

Results page

Use addressograph - otherwise write in capitals

Surname: ______________________

First names: ______________________

DOB: ______________________

Health and Care No. ______________________

Results

Time					
HB					
WCC					
PLTS					
INR					
PPT					
APPT					
NA					
K					
Urea					
Crea					
Gluc					

Please ensure each page is completed in full

Results page

Use addressograph - otherwise write in capitals

Surname: ______________________________

First names: ______________________________

DOB: ______________________________

Health and Care No. ______________________________

Affix Arterial Blood Gas Here

Please ensure each page is completed in full

Radiology notes

Use addressograph - otherwise write in capitals

Surname: ____________________

First names: ____________________

DOB: ____________________

Health and Care No. ____________________

Date: ____________________ Time: ____________________

Consultant: ____________________

Print name: ____________________

Brain

- [ ] Mass effect
- [ ] Inta axial blood
- [ ] Extra axial collection

Thorax

- [ ] Large pneumothorax
- [ ] Major vascular injury
- [ ] Pericardial effusion
- [ ] Pleural collection
- [ ] Major lung insult

Peritoneal cavity

- [ ] Free fluid - [ ] Free air - [ ] Extravasation

Major abnormality

☐ Liver	☐ Spleen	☐ Kidneys
☐ Adrenals	☐ Pancreas	☐ Bowel

Skeletal

- [ ] Spinal alignment
- [ ] Pelvic integrity

Transfer Destination

- [ ] Theatre
- [ ] Trauma bed
- [ ] Ward (state speciality)
- [ ] Interventional Radiology
- [ ] ED

Please ensure each page is completed in full

Radiology notes continued

Signature: ______________________ Date: ______________________

Please ensure each page is completed in full

Trauma Team Debrief

1. Contact (team leader starts session)

2. State Event (state what just happened in the room)

3. Appreciation/Thanks (state gratitude to staff)

4. Gather thoughts and feelings (discuss emotions)

5. Support services (state support available)

6. Facilitate (organise if needed extra support for staff members)

Georgia-May Swales 2015
Head of Psychological Services Dr Sarah Meekin 9063 6608
Adult Psychological Service Miss Bridie McElhill 9056 6199

Please ensure each page is completed in full

Trauma Team Debrief continued

Signature: ______________________________ **Date:** ____________________

Please ensure each page is completed in full

Next day MDT Ward Round

Use addressograph - otherwise write in capitals

Surname: ____________________

First names: ____________________

DOB: ____________________

Health and Care No. ____________________

Date: ____________ Time: ____________

Consultant: ____________________

Print name: ____________________

Signature: ____________________ **Date:** ____________________

Please ensure each page is completed in full

Next day MDT Ward Round continued

Signature: ______________________________ Date: ____________________

Please ensure each page is completed in full

Prescribed Drugs

Use addressograph - otherwise write in capitals

Surname: ____________________

First names: ____________________

DOB: ____________________

Health and Care No. ____________________

Drugs	Dose	Route	Date	Time	Drs	Given by	Date	Time

Please ensure each page is completed in full

Prescribed Drugs continued

Use addressograph - otherwise write in capitals

Surname: ______________________________

First names: ______________________________

DOB: ______________________________

Health and Care No. ______________________________

Drugs	Dose	Route	Date	Time	Drs	Given by	Date	Time

Please ensure each page is completed in full

Trauma Ward Notes

Use addressograph - otherwise write in capitals

Surname: ____________________

First names: ____________________

DOB: ____________________

Health and Care No. ____________________

Date: ____________________ Time: ____________________

Consultant: ____________________

Print name: ____________________

Signature: ____________________ **Date:** ____________________

Please ensure each page is completed in full

Trauma Ward notes continued

Signature: ______________________________ **Date:** ____________________

Please ensure each page is completed in full

URGENT TRAUMA TRANSFER FORM

PATIENT DETAILS

Name:

HRC No:

DOB:

NOK Details:

TRANSFER DETAILS

Receiving Hospital:

☐ HDU/ICU
☐ Xray
☐ Theatre
☐ Ward
☐ ED

STAFF ACCEPTING PATIENT

Name:

Position:

Receiving Location Contact No:

REASON FOR TRANSFER

Ongoing assessment
Imaging
Surgery
Critical Care

BACKGROUND

Allergies: ☐ No ☐ Yes

Meds Given:

Tetanus

Infection Status: ☐ No ☐ Yes

RELEVANT PMH & MEDICATIONS

Anticoagulation: ☐ No ☐ Yes

INVESTIGATIONS

Imaging on PACS

Bloods on ECR

WBCT ______________

CXR ________________

WORKING DIAGNOSIS

1.

2.

3.

4.

STATUS PRE-TRANSFER

[A] FM / Trache/Cric / ETT

Grade: I / II / III / IV

Tube size/length:

[B] Chest Drain Yes / No

Unclamped

ABG Pre-transfer

[C] ECG / NIBP / PIVC x 2

O_2 sats / $ETCO_2$

CVC	Yes	No
Art	Yes	No
Inotropes	Yes	No

[D] (Pre-intubation) (Pre-Transfer)

Pupils size R L

GCS M ____ /15 E ____ /4 V ____ /15

If Ventilated TV PEEP PIP Type Ventilator

ESCORT

Dr Nurse Paramedic

Name:

Reg No:

Position:

Signature:

Time Departure Time Arrival

DETAILS TRANSFER

Clinical

Equipment

Organised

		Time (24hrs)	
	250		40˚C
	240		
	230		
	220		
	210		
BP ↕	200		
	190		
	180		
	170		
	160		
	150		
	140		
HR	130		
	120		
	110		
	90		
	80		
	70		
	60		
	50		
	40		
	30		32˚C
SpO_2			
Fi O_2			
$ETCO_2$			

Drugs	
Fluids	

READY TO GO!

Patient

- Airway safe
- TXA
- ETT secured
- Established ventilator
- ABG pre transfer
- HR, BP stable
- No obvious blood loss
- IV access
- Cervical spine protected
- No pneumothorax
- Fractures stabilised
- Secured to trolley
- Wrapped to prevent heat loss
- Lines secure

Staff

- Handover appropriate
- Money
- Phone

Equipment

- Transfer bag complete
- Fluids
- Drugs
- Bag Valve Mask
- Sufficien O_2 supply
- Suction

Organisation

- Trauma documentation
- Other medical notes
- NOK aware
- Receiving unit aware pre departure