

# Medical Record Review

**Healthcare Facility:**

**Surveyor:**

**Survey Date:**

**Chart Category:**

MR#:	Age:	Disposition: <input type="checkbox"/> Admit <input type="checkbox"/> Transfer <input type="checkbox"/> Died <input type="checkbox"/> Treat/Release <input type="checkbox"/> AMA				
Mode of Arrival:	Sex:	Location: <input type="checkbox"/> OR <input type="checkbox"/> ICU <input type="checkbox"/> Floor <input type="checkbox"/> Morgue <input type="checkbox"/> Other				
Mechanism of Injury:		Comments:				
<b>Pre-Hospital Information</b>						
EMS Run Sheet Present: <input type="checkbox"/>		Scene Time:		Transport Time:		
BP:	Resp:	RTS:	C-Collar <input type="checkbox"/>	CPR <input type="checkbox"/>	Intubation <input type="checkbox"/>	
Pulse:	GCS:	Extrication <input type="checkbox"/>	Spinal Immob: <input type="checkbox"/>	Oxygen <input type="checkbox"/>	IV started <input type="checkbox"/>	
<b>ED/Physician Performance</b>						
Trauma Team Activated? <input type="checkbox"/> Yes <input type="checkbox"/> No						
ED Arrival Time:		ED Discharge Time:		ED LOS:		
ED Physician Notified:		Trauma Surgeon Notified:		Orthopedics Notified:		
ED Physician Arrived:		Trauma Surgeon Arrived:		Orthopedics Arrived:		
Admitted to: <input type="checkbox"/> Trauma/General Surgeon <input type="checkbox"/> Orthopedics <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Other Surgical <input type="checkbox"/> Non-Surgical Service						
If Transferred:		Receiving Facility:		Time of Transfer:		
<b>ED Documentation</b>						
Trauma Flow Sheet Used <input type="checkbox"/>		Serial Vital Signs <input type="checkbox"/>				
<i>Initial ED Vital Signs</i>	BP:	Pulse:	Resp:	Temp:	GCS:	
<i>Final ED Vital Signs</i>	BP:	Pulse:	Resp:	Temp:	GCS:	
<b>Treatment</b>						
IV:		Crystalloid infused:                      cc		Central Line Placement:		
Blood T&C:		Transfused:                      Units		Chest Tube:		
Oxygen:		NG/OG Tube:		Foley:		
C-spine clearance:						
<b>Diagnostics</b>						
Plain Films:		CT Scans:				
Chest	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest	<input type="checkbox"/> Yes <input type="checkbox"/> No	
C-Spine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Facial Bones	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdomen	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pelvis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cervical Spine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pelvic	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Extremity films <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Diagnostic Studies:				
<b>Documented Injuries</b>					<b>ISS</b>	
<b>Operative Care</b>						
Operative Care Timely:		Operative Care Appropriate:		Unanticipated Return to OR:		
Operative Care Concerns:						
<b>QI Process</b>						
Reviewed by Trauma Coordinator:		Reviewed by Trauma Director:		M/M Review:		
QI Issues Identified by Trauma Program		Loop Closed?	QI Issues NOT Identified by Trauma Program			
_____		_____				
_____		_____				
_____		_____				
<b>Recommendation by Reviewer:</b>					<b>Meets the Standard of Care?</b>	
					_____	