

Your  
Hospital's  
Logo  
Here

DATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

PATIENT IDENTIFICATION

# ED TRAUMA FLOW SHEET

NOTIFICATION STATUS			
TIME OF NOTIFICATION		TIME ARRIVED	ROOM #
DATE	CODE YELLOW PAGED <input type="checkbox"/> YES <input type="checkbox"/> NO		
MODE OF ARRIVAL <input type="checkbox"/> AMBULANCE <input type="checkbox"/> POLICE <input type="checkbox"/> AUTO <input type="checkbox"/> WALK IN <input type="checkbox"/> OTHER _____			
PRE - HOSPITAL CARE			
OXYGEN THERAPY <input type="checkbox"/> NONE			
VIA	AT	LITERS	
AIRWAY <input type="checkbox"/> NONE			
<input type="checkbox"/> EOA	<input type="checkbox"/> ETT	<input type="checkbox"/> ORAL	ACLS <input type="checkbox"/> DEFIB <input type="checkbox"/> OTHER
<input type="checkbox"/> LONG	<input type="checkbox"/> SHORT	<input type="checkbox"/> SCOOP	<input type="checkbox"/> OTHER
BACKBOARD <input type="checkbox"/> NONE		CERVICAL COLLAR (TYPES)	
<input type="checkbox"/> LONG <input type="checkbox"/> SHORT <input type="checkbox"/> SCOOP <input type="checkbox"/> OTHER		<input type="checkbox"/> NONE	
DRESSINGS <input type="checkbox"/> NONE		SPLINTS <input type="checkbox"/> NONE	
TRAUMA TEAM RESPONSE		NAME	ARRIVED TIME/CALLED IN
ED PHYSICIAN			
PRIEST			
SURGEON			
NSG SUPER			
ED TRAUMA RN #1			
ED TRAUMA RN #2			
ANESTHESIA			
RADIOLOGY			
RESPIRATORY THERAPY			
CONSULT/DISCIPLINE	NAME	TIME CALLED	TIME ARRIVED
VALUABLES 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"/> EJECTED	<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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ALLERGIES \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

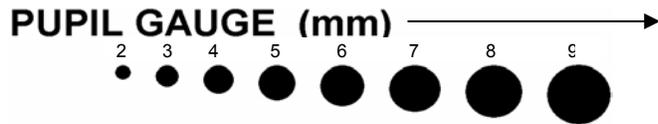
\_\_\_\_\_

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

LMP \_\_\_\_\_

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

**PART OF THE MEDICAL RECORD**



ARTERIAL BLOOD GASSES					
TIME	FI O <sub>2</sub>	Ph	p CO <sub>2</sub>	p O <sub>2</sub>	HCO <sub>3</sub>

MEDICATIONS					
TIME	DRUG	DOSE	ROUTE	SITE	INITIALS

BLOOD PRODUCTS						
TYPE & CROSS:			TIME SPECIMEN SENT:			
EMERGENCY 2 Units of PRBC:			TIME:			
UNIT #	PRBC W/B	SITE	TIME UP	BY	TIME DOWN	TOTAL

TIME	REQUEST	RESULTS
	Lat Cspine Portable	
	Complete Cspine Series	
	Chest (Upright) Portable	
	Chest (Flat) Portable	
	Pelvis Portable	
	Lat Cspine Portable	
	Other:	

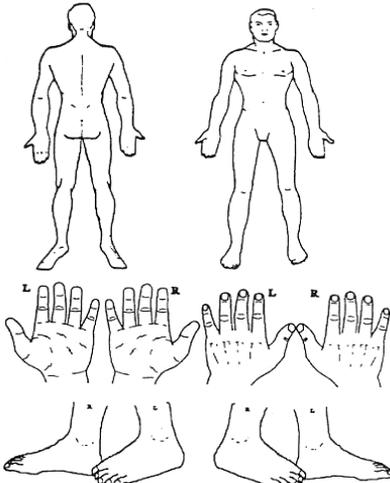
PUPIL LEGEND					
	D=Dilated	E=Equal	F=Fixed	P=Pinpoint	
TIME	1:	2:	3:	4:	5:
BP					
PULSE:					
RESP RATE					
TEMP					
O <sub>2</sub> SAT					
GCS					
PUPILS L/R	/	/	/	/	/
TIME	6:	7:	8:	9:	10:
BP					
PULSE:					
RESP RATE					
TEMP					
O <sub>2</sub> SAT					
GCS					
PUPILS L/R	/	/	/	/	/
TIME	11:	12:	13:	14:	15:
BP					
PULSE:					
RESP RATE					
TEMP					
O <sub>2</sub> SAT					
GCS					
PUPILS L/R	/	/	/	/	/
TIME	16:	17:	18:	19:	20:
BP					
PULSE:					
RESP RATE					
TEMP					
O <sub>2</sub> SAT					
GCS					
PUPILS L/R	/	/	/	/	/

LABWORK		
TIME	SENT	RESULT
BS		
BUN		
Cr		
Na		
K		
Cl		
CO <sub>2</sub>		
Ca		
Phos		
Mg		
CKO		
PT		
PTT		
WBC		
Hgb		
Hct		



<b>E</b> EXPOSE PATIENT	<input type="checkbox"/> COMPLETELY <span style="margin-left: 200px;"><input type="checkbox"/> HEAD TO TOE</span>																						
<b>F</b> FAHRENHEIT	<input type="checkbox"/> BLANKETS <span style="margin-left: 200px;"><input type="checkbox"/> WARMING LIGHTS</span>																						
<b>G</b> GET FULL SET (vs.) TIME  OPEN CARDIAC MASSAGE  CODE BLUE SHEETS  INTERNAL DEFIB  CRIC	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">BP R ARM _____</td> <td style="width:25%;">BP L ARM _____</td> <td style="width:25%;">HEART RATE _____</td> <td style="width:25%;">RATE _____</td> </tr> <tr> <td colspan="4">ORAL/RECTAL TEMPERATURE _____</td> </tr> </table> <div style="text-align: right; margin-top: 5px;">       MONITOR PRINTOUT OF BP+HR:  <input type="checkbox"/> Separate SHEET     </div> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width:80%;">TIME BY</th> <th style="width:20%;">INITIAL OUTPUT</th> </tr> </thead> <tbody> <tr> <td>ELECTROCARDIOGRAM / 12 LEAD</td> <td></td> </tr> <tr> <td>PERITONEAL LAVAGE</td> <td></td> </tr> <tr> <td>CHEST TUBE #1 SITE: _____ SIZE: _____</td> <td></td> </tr> <tr> <td>CHEST TUBE #2 SITE: _____ SIZE: _____</td> <td></td> </tr> <tr> <td>FOLEY SIZE</td> <td></td> </tr> <tr> <td>NG TUBE SIZE</td> <td></td> </tr> </tbody> </table>	BP R ARM _____	BP L ARM _____	HEART RATE _____	RATE _____	ORAL/RECTAL TEMPERATURE _____				TIME BY	INITIAL OUTPUT	ELECTROCARDIOGRAM / 12 LEAD		PERITONEAL LAVAGE		CHEST TUBE #1 SITE: _____ SIZE: _____		CHEST TUBE #2 SITE: _____ SIZE: _____		FOLEY SIZE		NG TUBE SIZE	
BP R ARM _____	BP L ARM _____	HEART RATE _____	RATE _____																				
ORAL/RECTAL TEMPERATURE _____																							
TIME BY	INITIAL OUTPUT																						
ELECTROCARDIOGRAM / 12 LEAD																							
PERITONEAL LAVAGE																							
CHEST TUBE #1 SITE: _____ SIZE: _____																							
CHEST TUBE #2 SITE: _____ SIZE: _____																							
FOLEY SIZE																							
NG TUBE SIZE																							

## MONITOR STRIP

<b>H</b>  HEAD TO TOE  BLEEDING CSF -  EARS NOSE	<input type="checkbox"/> NEEDLE DECOMPRESSION <input type="checkbox"/> LARGE BORE IV <input type="checkbox"/> PERICARDIOCENTESIS <input type="checkbox"/> LARGE BORE IV <input type="checkbox"/> NORMAL / INTACT SKIN <input type="checkbox"/> CENTRAL LINE <input type="checkbox"/> GAUGE: _____ A= ABRASION    L= LACERATION B= BURN    M= AMPUTATING C= CLOSED/SUSPECTED FRACTURE    O= OPEN FRACTURE D= DEFORMITY    P= PAIN E= ECCHYMOYSIS    S= STABWOUND G= GUNSHOT WOUND    V= AVULSION Z= OTHER: _____	
	ABDOMEN: <input type="checkbox"/> VOMITING <input type="checkbox"/> DISTENDED <input type="checkbox"/> BOWEL SOUNDS <input type="checkbox"/> NON-TENDER <input type="checkbox"/> TENDER <input type="checkbox"/> SOFT <input type="checkbox"/> FIRM PELVIS: <input type="checkbox"/> STABL    STOOL GUAIC: _____    RECTAL TONE: _____ <input type="checkbox"/> UNSTABLE TO PALPITATION <input type="checkbox"/> PAIN TO PALPITATION GENITOURINARY: <input type="checkbox"/> SPONT. VOID <input type="checkbox"/> INCONTINENT URINE: <input type="checkbox"/> COLORLESS <input type="checkbox"/> YELLOW <input type="checkbox"/> RED <input type="checkbox"/> BROWN <input type="checkbox"/> UPT <input type="checkbox"/> CLOUDY <input type="checkbox"/> NONE <input type="checkbox"/> URINE DIP VAGINAL BLEEDING: <input type="checkbox"/> NO <input type="checkbox"/> YES    PRIAPISM: <input type="checkbox"/> NO <input type="checkbox"/> YES	
<b>I</b> INSPECT BACK	INSPECT THE BACK: <input type="checkbox"/> TIME _____ LOG ROLL: <input type="checkbox"/> INJURIES _____	

## PART OF THE MEDICAL RECORD

INTAKE						
IV# / AMT	SITE	SOLUTION	TIME UP	BY	TIME DOWN	TOTAL

OUTPUT		
	TIME / AMOUNT	TIME / AMOUNT
URINE:		
GASTRIC / LAVAGE:		
L CHEST:		
R CHEST:		
EMESIS:		
TOTAL:		

TOTAL INTAKE AND OUTPUT	
INTAKE:	OUTPUT:
IV:	FOLEY:
BLOOD:	GASTRIC:
ORAL:	CHEST TUBE:
OTHER:	OTHER:
OTHER:	OTHER:
TOTAL:	TOTAL:

# MONITOR STRIP

**DISPOSITION:**

**ADMITTED:** DX: \_\_\_\_\_ ATTENDING: \_\_\_\_\_  
 TIME ADMIT CALLED: \_\_\_\_\_ ROOM #: \_\_\_\_\_  
 TIME REPORT CALLED: \_\_\_\_\_ TO: \_\_\_\_\_  
 TIME LEFT ED: \_\_\_\_\_  O<sub>2</sub>  RN  
 BELONGINGS: \_\_\_\_\_

**TRANSFERRED:** TO: \_\_\_\_\_ VIA: \_\_\_\_\_  
 BELONGINGS: \_\_\_\_\_  
 TIME LEFT ED: \_\_\_\_\_ TRANSFER FORM COMPLETED: \_\_\_\_\_

**DEATH:** TIME OF DEATH: \_\_\_\_\_ PRONOUNCED BY: \_\_\_\_\_  
 TIME PMD NOTIFIED: \_\_\_\_\_ CODE BLUE SHEET COMPLETED: \_\_\_\_\_  
 TIME CORONER NOTIFIED: \_\_\_\_\_ SIGNED DEATH CERTIFICATE?  YES  NO  
 DONOR FORM COMPLETED:  YES  NO WRTC NOTIFIED:  YES  NO  
 TIME BODY MOVED: \_\_\_\_\_  CORONER  MORGUE

**POLICE/HOMICIDE:** TIME NOTIFIED: \_\_\_\_\_ TIME RESPONDED: \_\_\_\_\_

**MD SIGNATURE:** \_\_\_\_\_ **PRIMARY NURSE'S SIGNATURE /**  
**DATE:** \_\_\_\_\_ **TITLE:** \_\_\_\_\_

## PART OF THE MEDICAL RECORD

