

ARIZONA FIELD TRIAGE DECISION SCHEME
(Regional modifications are permissible)

1

Measure vital signs and level of consciousness

Glasgow Coma Scale	≤13
Systolic blood pressure (mmHg)	<90 mmHg
Respiratory rate	<10 or >29 breaths per min. (<20 in infant aged < 1 year ¹), or need for ventilator support

YES

NO

Transport to a Trauma Center. Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the trauma system.

Assess anatomy of injury

2

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g., flail chest)
- Two or more proximal long-bone fractures
- Crushed, de-gloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis

YES

NO

3

- Falls
 - Adults: >20 feet (one story is equal to 10 feet)
 - Children⁴: >10 feet or two or three times the height of the child
- High-risk auto crash
 - Intrusion⁵, including roof: >12 inches occupant site; >18 inches any site
 - Ejection (partial or complete) from automobile
 - Death in same passenger compartment
 - Vehicle telemetry data consistent with high risk of injury
- Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact⁶
- Motorcycle crash >20 mph

YES

NO

Transport to a trauma center, which, depending on the trauma system, need not be the highest level trauma center⁷.

Assess special patient or system considerations.

4

- Older Adults⁸
 - Risk of injury/death increases after age 55 years
 - SBP<110 might represent shock after age 65 years
 - Low impact mechanisms (e.g., ground level falls) might result in severe injury
- Children
 - Should be triaged preferentially to pediatric-capable trauma centers
- Anticoagulation and bleeding disorders
 - Patients with head injury are at high risk for rapid deterioration
- Burns
 - Without other trauma mechanism: triage to burn facility⁹
 - With trauma mechanism: triage to trauma center
- Pregnancy >20 weeks
- EMS¹⁰ provider judgment

YES

NO

Transport to a trauma center or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control.

Transport according to Protocol¹¹.

WHEN IN DOUBT, TRANSPORT TO A TRAUMA CENTER
(Rev. 6/2012)

FIELD TRIAGE SCHEME FOOTNOTES

¹ The upper limit of respiratory rate in infants is >29 breaths per minute to maintain a higher level of over-triage for infants.

² Trauma centers are designated Level I-IV. A Level I center has the greatest amount of resources and personnel for care of the injured patient and provides regional leadership in education, research, and prevention programs. A Level II facility offers similar resources to a Level I facility, possible differing only in continuous availability of certain subspecialties or sufficient prevention, education, and research activities for Level I designation; Level II facilities are not required to be resident or fellow education centers. A Level III center is capable of assessment, resuscitation, and emergency surgery, with severely injured patients being transferred to a Level I or II facility. A Level IV trauma center is capable of providing 24-hour physician coverage, resuscitation, and stabilization to injured patients before transfer to a facility that provides a higher level of trauma care.

³ Any injury noted in Step Two or Step Three triggers a "YES" response.

⁴ Age <15 years.

⁵ Intrusion refers to interior compartment intrusion, as opposed to deformation which refers to exterior damage.

⁶ Includes pedestrians or bicyclists thrown or run over by a motor vehicle or those with estimated impact >20 mph with a motor vehicle.

⁷ Local or regional protocols should be used to determine the most appropriate level of trauma center; appropriate center need not be Level I.

⁸ Age >55 years.

⁹ Patients with both burns and concomitant trauma for whom the burn injury poses the greatest risk for morbidity and mortality should be transferred to a burn center. If the non-burn trauma presents a greater immediate risk, the patient may be stabilized in a trauma center and then transferred to a burn center.

¹⁰ Emergency medical services.

¹¹ Patients who do not meet any of the triage criteria in Steps One through Four should be transported to the most appropriate medical facility as outlined in local EMS protocols.