Arizona Guidelines for Field Triage of Injured Patients  
(Regional modifications are permissible)  

FIELD TRIAGE DECISION SCHEME

Measure vital signs and level of consciousness

<table>
<thead>
<tr>
<th>Step One</th>
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| Glasgow Coma Scale | ≤13  
| Systolic blood pressure (mmHg) | <90 mmHg  
| Respiratory rate | <10 or >29 breaths per minute (<20 in infant aged < 1 year), 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.

<table>
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<tr>
<th>Step Two</th>
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| • 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  

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.

<table>
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<th>Step Three</th>
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| • Falls  
  o Adults: >20 feet (one story is equal to 10 feet)  
  o Children*: >10 feet or two or three times the height of the child  
  o High-risk auto crash  
    o Intrusion*, including roof: >12 inches occupant site; >18 inches any site  
    o Ejection (partial or complete) from automobile  
    o Death in same passenger compartment  
    o Vehicle telemetry data consistent with high risk of injury  
  • Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact*  
  • Motorcycle crash >20 mph  
| YES | NO  

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

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

WHEN IN DOUBT, TRANSPORT TO A TRAUMA CENTER
### 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.

Revised: 6/2012