

Emergency Services Trauma Flow Sheet

Example

Hospital Logo

Patient Sticker

Date: _____ Patient Arrival Time: _____

N/A Pre-Hospital Treatment		
<input type="checkbox"/> Transporting Ambulance _____		
<input type="checkbox"/> O2 @ _____ L/min/ <input type="checkbox"/> NC <input type="checkbox"/> NRB <input type="checkbox"/> Ambu	<input type="checkbox"/> IV: Needle size _____ <input type="checkbox"/> LR <input type="checkbox"/> _____	<input type="checkbox"/> Backboard <input type="checkbox"/> Long <input type="checkbox"/> Short <input type="checkbox"/> Ked
<input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Other <input type="checkbox"/> ET tube # _____ @ _____ cm	<input type="checkbox"/> Medications _____	<input type="checkbox"/> Scoop <input type="checkbox"/> Bilateral Head Supports
<input type="checkbox"/> CPR started @ (time) _____	<input type="checkbox"/> C-Collar on: Yes _____ No _____	<input type="checkbox"/> Splint on _____ <input type="checkbox"/> Ice on _____ <input type="checkbox"/> Dressing _____ <input type="checkbox"/> Other _____

Date of Injury: _____ Time of Injury: _____ Pre-hospital trauma team alert notification:
 Yes No

Hospital Trauma Team Activation Yes _____ No _____ Time of Trauma Team Activation: _____

Trauma Team Members		
Team members notified:	Time Called	Time Arrived
<input type="checkbox"/> Nurses x _____		
<input type="checkbox"/> Physician / CNP / PA		
<input type="checkbox"/> Lab		
<input type="checkbox"/> X-ray		
<input type="checkbox"/> Other _____		

Type of Vehicle	
<input type="checkbox"/> Car	<input type="checkbox"/> Pedestrian
<input type="checkbox"/> Truck	<input type="checkbox"/> ATV
<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Boat
<input type="checkbox"/> Bicycle	
<input type="checkbox"/> Other _____	

Mechanism of Injury	
<input type="checkbox"/> Speed of vehicle _____ MPH	<input type="checkbox"/> Rollover
<input type="checkbox"/> Number of vehicles 1 2 3 >3	<input type="checkbox"/> Ejected
<input type="checkbox"/> Steering wheel deformity	<input type="checkbox"/> Rearend
<input type="checkbox"/> Starred windshield	<input type="checkbox"/> T-Bone
	<input type="checkbox"/> Head on

Restraint Devices	
<input type="checkbox"/> Lap belt	<input type="checkbox"/> Airbag deployed
<input type="checkbox"/> Shoulder belt	<input type="checkbox"/> Helmet
<input type="checkbox"/> Car seat	<input type="checkbox"/> Unrestrained

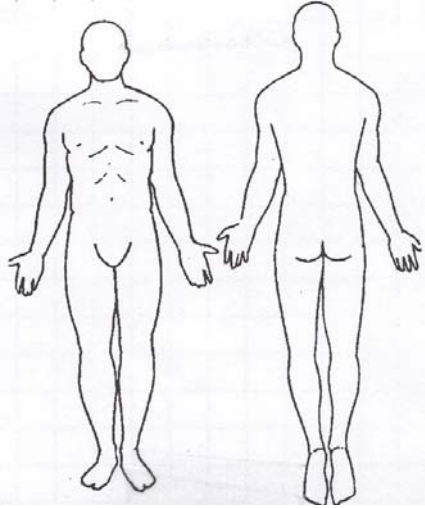
Fall	Penetrating	Blunt	Thermal	Other
<input type="checkbox"/> Fell from: _____	<input type="checkbox"/> GSW _____	<input type="checkbox"/> Assault _____	<input type="checkbox"/> Burn _____	<input type="checkbox"/> Hanging _____
	<input type="checkbox"/> Stabbing _____	<input type="checkbox"/> Crush _____	<input type="checkbox"/> Heat exposure	<input type="checkbox"/> Near drowning
Height _____ ft.	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Cold exposure	<input type="checkbox"/> Animal related

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Initial Assessment

AIRWAY				DISABILITY					
<input type="checkbox"/> Patent		<input type="checkbox"/> Suctioning		Glasgow Coma Score		Initial	Disch		
<input type="checkbox"/> Oral Airway		<input type="checkbox"/> Bag Mask		Eye Opening					
<input type="checkbox"/> Nasal Airway		<input type="checkbox"/> O2 _____ L.		Spontaneously	4				
<input type="checkbox"/> ET _____		Comments _____		To Speech (Shout)	3				
<input type="checkbox"/> Trach				To Pain	2				
<input type="checkbox"/> Crico				No Response	1				
BREATHING				Verbal Response					
Spontaneous		Respiratory Effort		Oriented (Coos, Babbles)	5				
R	L	<input type="checkbox"/> Normal	<input type="checkbox"/> Agonal	Confused (Consolable, Cry)	4				
		<input type="checkbox"/> Shallow	<input type="checkbox"/> Nasal flaring	Inappropriate Words (Persistent Cries, Screams)	3				
		<input type="checkbox"/> Stridor	<input type="checkbox"/> Tachypnea	Incomprehensible Words (Grunts, Restless)	2				
		<input type="checkbox"/> Clear	<input type="checkbox"/> Grunting	No Responses	1				
		<input type="checkbox"/> Rales	<input type="checkbox"/> Absent						
		<input type="checkbox"/> Rhonchi/Wheezes	<input type="checkbox"/> Paradoxical						
		<input type="checkbox"/> Decreased	<input type="checkbox"/> Cough						
		<input type="checkbox"/> Absent	<input type="checkbox"/> Substernal						
Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				Motor					
CIRCULATION				Obeys (Spontaneous)					
Capillary Refill:		<input type="checkbox"/> None	<input type="checkbox"/> Delayed (> 2 sec)	<input type="checkbox"/> Normal (< 2 sec)	Localized Pain	6			
Pulses Present:		<input type="checkbox"/> Carotid	<input type="checkbox"/> Femoral	<input type="checkbox"/> Radial	<input type="checkbox"/> Pedal	Withdrawal to Pain			5
Palpated Pulse		<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular	<input type="checkbox"/> Absent		Flexion to Pain (Decorticate)			4
Heart tones		<input type="checkbox"/> Audible	<input type="checkbox"/> Absent			Extension to Pain			3
Jugular Vein Distension		<input type="checkbox"/> No	<input type="checkbox"/> Yes			No Response to Pain			2
Bleeding		<input type="checkbox"/> Controlled	<input type="checkbox"/> Uncontrolled	<input type="checkbox"/> NA					1
Skin Color		<input type="checkbox"/> Pink	<input type="checkbox"/> Dusky	<input type="checkbox"/> Cyanotic	<input type="checkbox"/> Mottled				
				Total GCS Score					

Procedures			Area of Injury																	
Allergies _____																				
Tetanus: _____ LMP: _____ Wt: _____																				
Time	Procedure	Results																		
	ET Tube _____ Combitube _____	Size _____ Secured @ _____ cm FiO2 _____ %	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>A = Abrasion</td> <td>Fc = Closed Fracture</td> <td>OW = Open Wound</td> </tr> <tr> <td>B = Burns</td> <td>Fd = Dislocation</td> <td>P = Paralysis</td> </tr> <tr> <td>C = Crepitus</td> <td>Fo = Open Fracture</td> <td>S = Edema</td> </tr> <tr> <td>D = Deformity</td> <td>L = Laceration</td> <td>Ta = Total Amputation</td> </tr> <tr> <td>E = Ecchymosis</td> <td></td> <td>Na = Near Amputation</td> </tr> </table>			A = Abrasion	Fc = Closed Fracture	OW = Open Wound	B = Burns	Fd = Dislocation	P = Paralysis	C = Crepitus	Fo = Open Fracture	S = Edema	D = Deformity	L = Laceration	Ta = Total Amputation	E = Ecchymosis		Na = Near Amputation
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	Central Line/ IV	Size _____ Fr Site _____ Solution _____																		
	Warming Measures	<input type="checkbox"/> Fluids <input type="checkbox"/> Mechanical <input type="checkbox"/> Bair Hugger <input type="checkbox"/> Blankets																		
	NG Tube	Size _____ Color _____																		
	Foley / Quick Cath	Size _____ Color _____																		
	Neck immobilization C-Collar Applied: _____	CMS: Before _____ After _____																		
	Splinting _____	Location: _____																		

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Secondary Assessment

Head/Scalp		Eyes		Mouth		Ears						
<input type="checkbox"/> Intact	<input type="checkbox"/> Rash	<input type="checkbox"/> PEARL	<input type="checkbox"/> Intact	<input type="checkbox"/> No drainage	<input type="checkbox"/> Intact	<input type="checkbox"/> Drainage	<input type="checkbox"/> Right <input type="checkbox"/> Left					
<input type="checkbox"/> Laceration	<input type="checkbox"/> Burns	<input type="checkbox"/> Raccoon eyes	<input type="checkbox"/> Teeth	<input type="checkbox"/> Missing teeth	<input type="checkbox"/> Missing teeth	<input type="checkbox"/> Clear	<input type="checkbox"/> Clear					
<input type="checkbox"/> Abrasions	<input type="checkbox"/> Pain	<input type="checkbox"/> EOMS follows	<input type="checkbox"/> Dentures intact	<input type="checkbox"/> Comments _____	<input type="checkbox"/> Blood	<input type="checkbox"/> Clear	<input type="checkbox"/> Clear					
<input type="checkbox"/> Bruising	<input type="checkbox"/> Battle Signs	<input type="checkbox"/> Visual Acuity OD ____/____ OS ____/____										
Neck		Chest		Heart Sounds								
<input type="checkbox"/> Intact	<input type="checkbox"/> C-Collar	<input type="checkbox"/> Symmetrical	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Present	<input type="checkbox"/> Present							
<input type="checkbox"/> Swelling	<input type="checkbox"/> Pain	<input type="checkbox"/> Asymmetrical	Location _____	Location _____	<input type="checkbox"/> Distant							
<input type="checkbox"/> Trachea midline		<input type="checkbox"/> Paradoxical movement	Time of onset _____	Time of onset _____	<input type="checkbox"/> Absent							
<input type="checkbox"/> Trachea deviated		Location _____	Activity @ onset _____	Activity @ onset _____								
<input type="checkbox"/> Sub-q emphysema		<input type="checkbox"/> Crepitus	<input type="checkbox"/> Flail chest	<input type="checkbox"/> Flail chest								
<input type="checkbox"/> Difficulty swallowing		Location _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____								
Abdomen / Pelvis / GU												
Abdomen				Bowel Sounds		Pelvis						
<input type="checkbox"/> Soft	<input type="checkbox"/> Distended	<input type="checkbox"/> Last Intake:	<input type="checkbox"/> Present	<input type="checkbox"/> Absent	<input type="checkbox"/> Intact							
<input type="checkbox"/> Nontender	<input type="checkbox"/> Rigid	Food _____	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Hypoactive	<input type="checkbox"/> Pain _____							
<input type="checkbox"/> Tender		Liquid _____			<input type="checkbox"/> Blood at meatus _____							
<input type="checkbox"/> Comments: _____					<input type="checkbox"/> Blood at rectum _____							
					<input type="checkbox"/> Instability _____							
Posterior				Extremities								
<input type="checkbox"/> Intact				<input type="checkbox"/> Intact								
<input type="checkbox"/> Deformity				<input type="checkbox"/> Fracture								
<input type="checkbox"/> Pain				<input type="checkbox"/> Pain								
<input type="checkbox"/> Comments _____				<input type="checkbox"/> Deformity								
_____				<input type="checkbox"/> Comments _____								
_____				_____								
_____				_____								
Time	Temp	P	R	BP	SaO2	O2 L/min	Pupil Reaction		Pain Scale		Comments	
							S-slow	U-unequal	0-10			
				/			B-brisk	D-dilated	Pain			
				/			F-fixed	= - Equal	Scale	Type		
				/			C-closed by swelling					
				/			Right	Left				
				/								
				/								
				/								
				/								
				/								
				/								
				/								
				/								
				/								
				/								
Medications Given												
Medication				Dose		Route		Time Given		Initials		

