



[Healthcare facility name]

The [Healthcare facility name] is a tool for emergency healthcare providers to report trauma related activities within the region. Your answers will be kept confidential, however DO NOT include any patient related information or identifiers. Thank you for your participation.

Demographics

Patient Age

Gender

_____ Male Female

Time of Injury

6a-2p

2p-10p

10p-6a

Mechanism:

Motorcyclist

Rollover

Ejected

Death other occupant

Pedestrian

Cyclist

Explosion

Fall > 6ft

Burns

Other

Injury Patterns:

Penetrating

Blunt

Region: Head Neck Chest Abdomen Pelvis Axilla Groin Limbs

Injury Description: Amputation Tourniquet applied? Burns Facial Burns >20%

Tension Pneumothorax Crush Spinal Rigid Abdomen Fractures of ≥ 2 long bones Fractured Pelvis

Initial Observations

BP

Pulse

GCS

RR

Temp

Skin

SpO2

Left Pupil


Right Pupil

Treatment:

- | | | |
|--|--|--|
| <input type="checkbox"/> O.P./N.P airway | <input type="checkbox"/> LMA | <input type="checkbox"/> ETT |
| <input type="checkbox"/> RSI | <input type="checkbox"/> Ventilated | <input type="checkbox"/> Chest Decompression |
| <input type="checkbox"/> IV Access | <input type="checkbox"/> Fluid Resuscitation | <input type="checkbox"/> CT |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> X-ray |

Other: _____

Critical episodes, treatment and response:

 _____

Personal Information (Your info will not be shared)

First Name	Last Name
_____	_____
Facility	Department
_____	_____
Email	Phone
_____	_____