

ED TRAUMA FLOW SHEET PAGE 1 OF 4 TRAUMA

OAKLAND

	Time of Arriv Upgraded Time:	
Title	Name	Arrival Time
Trauma Surgeon		
ED Attending		
Primary Nurse		
Secondary Nurse/Scribe		
Resident		
Orthho		
Respiratory		
*Anesthesia		
Neurosurgeon		
Lab		
ED Tech.		
Other		
here injury occured:	MPH MOTO enger: front back front side rear	
•	ed Extrication Time:	minutes
	Airbag & Belt / Child Seat	
☐ BICYCLE / DIRTBII	KE Helmet: ☐ Yes ☐ No)
☐ PEDESTRIAN	MPH	
☐ FALL : Stair	s#H	eight
☐ ASSAULT		
☐ Stabbing to		
_ ,	/ to	
	Type	
	Electrical Chemical	
OTHER:		
PRE-H	OSPITAL (circle all that	t apply)
	hyth RR	
	cuCheck	
	time	
	time	
	nin NRB Peds Mask E FR Lip Li	
Cricothyrotom		ile Cili
•	y ard immobilized in car sea	t
· ·	Total	
	Total	
Splint:		
	Time applied	d:

 Code Crimson activate 	d □Yes □No						
PI	RIMARY ASSESSMEN	Т					
ALERTNESS Alert	□ Verbal □ Pain □	Unresponsive					
A = AIRWAY □ Paten		-					
	gonal 🗆 Absent	·					
C = CIRCULATION							
	strong weak ab						
	strong weak	-					
	c □ > 2 sec □ External h	iemormaging					
D = DISABILITY GLASGOW COMA SCALE (GCS)							
EYE OPENING	VERBAL RESPONCE	MOTOR RESPONSE					
Spontaneous 4	Oriented 5	Obeys Commands 6					
To Voice 3	Confused 4	Vocalizes Pain 5					
To Pain 2	Inappropriate Words 3	Withdraws w/ Pain 4					
None 1	Incomprehensible 2	Flexion w/ Pain 3					
	None 1	Extension w/ Pain 2					
		None 1					
Initial GCS Total	Chemically para	lyzed/sedated on arrival					
Pupil Respon	se – MM Scale	L =					
• • • •		R =					
	Brisk □ Sluggish □ Fi						
E = EXPOSE AND WA		ACU .					
	d Time:						
_	ets □ Bair Hugger □	Radiant Heat					
Time Started:							
F = Full Set Vitals TI							
TEMP: HR:							
	CONDARY ASSESSME	ENT					
G = GIVE COMFORT -							
Family Notified: By Whom Present							
Contact Name/Relation:							
Phone No.:		Time:					
H = HEAD TO TOE AS	SESSMENT						
HEAD/NECK: □ Norma	al □ Ear drainage □ N	ose drainage					
☐ Deviated: Trachea: ☐	R □L □JVD □Cre	oitus Other:					
CHEST: ☐ Normal ☐ S	Symmetrical Asymme	trical Crepitus					
☐ Flail ☐ Other:							
SKIN: ☐ Warm ☐ Co	•						
☐ Diaphoretic ☐ Clammy ☐ Dusky ☐ Cyanotic							
ABDOMEN: ☐ Normal ☐ Rigid ☐ Tender to:							
☐ Distended ☐ Bowel Sounds ☐ Present ☐ Absent							
EXTREMITIES: Mov	es all Extremities	formities:					
I = INSPECT POSTER							
☐ Logroll time: ☐ Yes ☐ No Backboard removed ☐ Normal Tenderness to:							
☐ Deformities:							
Rectal Tone: Norm		Ahsent					
	A □ Positive □ Ne						
		3					

MTP Activated ☐ Yes ☐ No Call Blood Bank ☐ Yes ☐ No

Place patient demographic label here



ED TRAUMA FLOW SHEET PAGE 2 OF 4 TRAUMA

MEDICAL BACKGROUND											
Height cm Weight kg											
Last Oral Intake:											
Allergies: ☐ Denies ☐ Unknown											
MEDS: ☐ See attached med list ☐ None ☐ Unknown//											
PAST MEDICAL/SURGICAL HX: Denies Unknown											
☐ Smoke	er I	PPD				х				year	
□ Drug ເ	ıse	·				Freque	ncy:				
☐ Alcoho	olι	ıse				Alcohol	odor				
_					_						
		ınizations:								1	
Tetanus:	<	5 years $\ \square$	Yes [□No		Jnknown		Up to D	ate		
			ME	EDIC	ΔTI	ONS					
		dap Lot#:_									
Time:		Dose	:		Site	e:		RN:			
Time		Med	Do	se	R	T/Site	F	ain	I	Initials	
						20					
			ľ	V AC	CE	SS					
IV/IO Sta	art		g. Sit	te:		St	arted	by:			
IV/IO Sta	art		g. Sit	te:		St	arted	by:			
IV/IO Sta	art		g. Sit	te:		St	arted	by:			
						UID INF					
Start Time		Solution		Site	е	Amt Infu	ised	Stop Ti	ne	Initials	
	Ĺ										

		BLOOD P							
_		sfuse produ							
Start Time	Bag#	PRBC/FI	-P/Platele	et/Cryo	Site	Stop 1	Time	Initials	
					1				
	+								
□Yes	Docum	nented in th	e Bridge	annlicati	ion (C	erner	<u> </u>		
□ Yes		nented on N						lmin	
		bank form		gocy	.004	pi oda	00711		
	INTA	AKE			OUT	PUT			
IVF:			U	Irine:					
Blood:				Sastric:					
PO:				hest:					
Other:				BL:					
TOTAL:				OTAL:					
Notes:									
		INT	ERVEN	TIONS					
Time				E/DIAGNO	STIC	S			
	O2:	L/MIN							
		n: ☐ Oral E						FR	
		:C						_ ' ' \	
	Denture	s removed	☐ Yes	□No					
	Vent Se	s removed ttings: FiO2	:	Tv:		Rate:			
	EKG sho	own to Dr.: _							
	ICP Mor	nitor inserted	by Dr.:						
	Labs dra	awn by:							
	CVC: Si	te t	уре	Dr					
	Art Line:			Dr					
		nfuser with: _							
	Ranger	Warmer with	า:						
		gger:							
	Foley Ca	ath: Size		FR by					
	Foley Cath: Size FR by:								
		ine Sent 🗌					JCG		
		regnancy Te							
	Gastric Tube: NGT OGT inserted by:								
		FR							
T	Chest Tube: R Size: FR by:								
	Chest To	ube: 🗆 L 🗆	R Size	:	FR by	/:			
	Portable Xray: ☐ Chest ☐ C-Spine ☐ Pelvis ☐ Other								
		n to Transfer						,,	
		fied Yes							
		orted/time		with n	iurse/	monito	r		
	CT notif	ed □Yes	□No						
	Thoracotomy performed ☐ Yes ☐ No								
	MRI notified ☐ Yes ☐ No								
	Transpo	ort/time							
		am: Dr			Near	ative [eitiva	
							_		
		lead □ Che		WITH NURSE	WITH	JUNITUR	TIME	RETURNED	
		☐ Pelvis ☐							
	C-Spine	cleared by:							

Place patient demographic label here



ED TRAUMA FLOW SHEET PAGE 3 OF 4 TRAUMA

TIME	ВР	HR	RHYTHM	RR	SPO2/02 Amt	TOTAL GCS	Temp	Pain	MAP	ICP	CAPNO	OTHER
	/				/							
	/				/							
	/				/							
	/				/							
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	/				/							
								SEE	ELECTRO	ONIC MEI	DICAL RE	CORD

Abbreviation Code:

AB – abrasion

AMP - amputee

 $\mathsf{AV}-\mathsf{avulsion}$

B – burn

BR - bruise

C-contusion

D – deformity

FB – foreign body

G – gunshot wound

L – laceration

P – pain

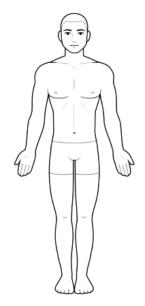
PU – puncture

R – Rash

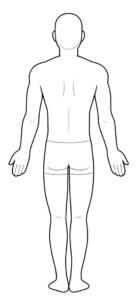
REMINDER
Give Antibiotic within
1 hour for all open fractures.
Offer patients with abrasiions
Tetanus booster.



☐ Antibiotic given Time: _____

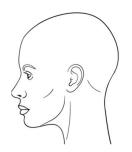


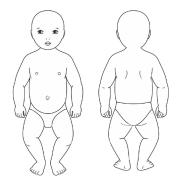














ED TRAUMA FLOW SHEET PAGE 4 OF 4 TRAUMA

		NURSING NOTES / REASSESSMENT						
DATE	TIME							
		☐ SEE ELECTRONIC MEDICAL RECORD						
		DISPOSITION						
A dmi	ttad ta	Room: Report called at/to: ED Departure Time:						
		to: Home Other Date/Time of Departure:						
Trans	sferred	to: Mode of Transport: Ground PV						
Decis	sion Tin	ne: Time EMS Called: EMS Arrival time: Departure Time:						
Acco	Accompanied patient: Copy of Chart Lab Reports Imaging Personal Belongings Other							
Expir	Expired i ED: Tod: Medical Examiner Contacted: No							
Mode of Transport: ☐ Ground ☐ PV ☐ Wheelchair ☐ Stretcher ☐ Ambulatory ☐ Helicopter								
RN/S	RN/Scribe Signature: Date/Time:							
RN/S	Scribe S	Signature: Date/Time:						
RN/S	Scribe S	Signature: Date/Time:						
		** Items in yellow must be completed before submission.						

106

Place patient demographic label here