

INJURY DATE _____	INJURY TIME _____	PRE-HOSPITAL	
DATE OF ARRIVAL _____	TIME OF ARRIVAL _____	BP _____ / _____ <input type="checkbox"/> AUSC <input type="checkbox"/> PALP HR _____ Rhythm _____	
Time of Trauma Activation _____		RR _____ O ₂ Sat _____ GCS _____ AccuCheck _____	
*Level 1 *Level 2 *Level 3		<input type="checkbox"/> CPR <input type="checkbox"/> on scene <input type="checkbox"/> en route <input type="checkbox"/> length of time _____	
Change to _____ Time _____		<input type="checkbox"/> LOC <input type="checkbox"/> on scene <input type="checkbox"/> en route <input type="checkbox"/> length of time _____	
TITLE	NAME	ARRIVAL TIME	Oxygen <input type="checkbox"/> NC _____ L/min <input type="checkbox"/> NRB <input type="checkbox"/> Peds Mask <input type="checkbox"/> BVM
ED Attending			Airway <input type="checkbox"/> OET _____ <input type="checkbox"/> NET _____ Size _____ FR Lip line: _____ cm
Primary Nurse			<input type="checkbox"/> LMA <input type="checkbox"/> Combitude <input type="checkbox"/> Cricothyrotomy
Secondary Nurse			<input type="checkbox"/> C-Spine <input type="checkbox"/> collar <input type="checkbox"/> backboard <input type="checkbox"/> immobilized in car seat
Scribe			IV gauge/site #1 _____ Total IV infused _____
ER Technician			IV gauge/site #2 _____ Total IV infused _____
Respiratory			Splint: _____
Lab			<input type="checkbox"/> Medications given: Morphine Fentanyl Zofran Aspirin nitro x1 x2 x3 Narcan
Radiology			MEDICAL BACKGROUND
Other			Adult: Height _____ ft _____ in Weight _____ kg
Other			Peds: Weight _____ kg _____ lbs _____ kg/Broselow
Other			ALLERGIES: <input type="checkbox"/> Denies <input type="checkbox"/> Unknown
Other			MEDS: <input type="checkbox"/> see EMR <input type="checkbox"/> None <input type="checkbox"/> Unknown
Other			_____/_____/_____
Other			PAST MEDICAL/SURGICAL HX: <input type="checkbox"/> Denies <input type="checkbox"/> Unknown <input type="checkbox"/> EMR
Other			_____/_____/_____
Other			<input type="checkbox"/> LMP _____ <input type="checkbox"/> pregnant _____ wks <input type="checkbox"/> N/A
Other			Peds IMMUNIZATIONS: <input type="checkbox"/> Current <input type="checkbox"/> Not current <input type="checkbox"/> Unknown
Other			TETANUS: < 5 yrs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Arrival Mode: <input type="checkbox"/> EMS <input type="checkbox"/> Car <input type="checkbox"/> Police <input type="checkbox"/> _____			INJURIES/COMPLAINTS
Historian: <input type="checkbox"/> Patient <input type="checkbox"/> EMS <input type="checkbox"/> Family: _____			
MECHANISM OF INJURY			
<input type="checkbox"/> MOTOR VEHICLE VS. _____ SPEED _____ MPH			
Impact: <input type="checkbox"/> front <input type="checkbox"/> driver side <input type="checkbox"/> passenger side <input type="checkbox"/> rear			
<input type="checkbox"/> Intrusion _____ Extrication Time: _____ min			
<input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Front <input type="checkbox"/> Back			
<input type="checkbox"/> Seatbelt <input type="checkbox"/> Air Bag <input type="checkbox"/> Child Seat <input type="checkbox"/> Unknown			
<input type="checkbox"/> Rollover <input type="checkbox"/> Ejected found _____ ft from vehicle			
<input type="checkbox"/> MOTORCYCLE <input type="checkbox"/> BICYCLE <input type="checkbox"/> _____			
VS. _____ SPEED _____ MPH			
<input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Helmet <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> THROWN _____ FT			
Type of vehicle: _____			
SPEED _____ MPH			
<input type="checkbox"/> FALL <input type="checkbox"/> From Standing <input type="checkbox"/> Stairs # _____ Height _____			
Landed on: _____			
<input type="checkbox"/> ASSAULT <input type="checkbox"/> Gunshot <input type="checkbox"/> Stabbing <input type="checkbox"/> Physical <input type="checkbox"/> Police Notified			
Weapon: _____			
<input type="checkbox"/> SPORTS INJURY _____			
Helmet <input type="checkbox"/> Yes <input type="checkbox"/> No _____			
<input type="checkbox"/> OTHER _____			
			AB: Abrasion AMP: Amputee B: Bum BR: Bruise C: Confusion D: Deformity FB: Foreign Body G: Gunshot Wound L: Laceration P: Pain PU: Puncture Wound R: Rash



INITIAL ASSESSMENT		SECONDARY ASSESSMENT																																	
A = AIRWAY <input type="checkbox"/> Patent <input type="checkbox"/> Gurgling <input type="checkbox"/> Obstructed _____		G = Give Comfort, notify family Family Notified: By Whom _____ <input type="checkbox"/> Present Contact Name/Relation: _____ Phone No.: _____ Time: _____																																	
B = BREATHING <input type="checkbox"/> Unlabored <input type="checkbox"/> Labored <input type="checkbox"/> Shallow <input type="checkbox"/> Splinted <input type="checkbox"/> Agonal <input type="checkbox"/> Absent		H = Head to toe assessment HEAD/NECK <input type="checkbox"/> Normal <input type="checkbox"/> Ear drainage <input type="checkbox"/> Nose drainage <input type="checkbox"/> Deviated Trachea <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> JVD <input type="checkbox"/> crepitus <input type="checkbox"/> Other: _____																																	
C = CIRCULATION <input type="checkbox"/> Strong central and peripheral pulses Central pulses: <input type="checkbox"/> strong <input type="checkbox"/> weak <input type="checkbox"/> absent Peripheral pulses: <input type="checkbox"/> strong <input type="checkbox"/> weak <input type="checkbox"/> absent to _____ Cap Refill: <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <input type="checkbox"/> External hemorrhaging: _____		CHEST <input type="checkbox"/> Normal <input type="checkbox"/> Symmetrical <input type="checkbox"/> Asymmetrical <input type="checkbox"/> Crepitus <input type="checkbox"/> Flail <input type="checkbox"/> Other: _____																																	
D = DISABILITY AVPU A = Awake V = Verbal P = Pain U = Unresponsive GLASGOW COMA SCALE <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">EYE OPENING</td> <td style="width:33%;">VERBAL</td> <td style="width:33%;">MOTOR</td> </tr> <tr> <td>Spontaneous 4</td> <td>Oriented 5</td> <td>Obeys Commands 6</td> </tr> <tr> <td>To Voice 3</td> <td>Confused 4</td> <td>Vocalizes Pain 5</td> </tr> <tr> <td>To Pain 2</td> <td>Inappropriate Words 3</td> <td>Withdraws w/ Pain 4</td> </tr> <tr> <td>None 1</td> <td>Incomprehensible 2</td> <td>Flexion w/ Pain 3</td> </tr> <tr> <td></td> <td>None 1</td> <td>Extension w/ Pain 2</td> </tr> <tr> <td></td> <td></td> <td>None 1</td> </tr> </table> Initial GCS Total _____ <input type="checkbox"/> Chemically paralyzed on arrival		EYE OPENING	VERBAL	MOTOR	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	LUNG SOUNDS <input type="checkbox"/> Equal Bilaterally <input type="checkbox"/> Diminished <input type="checkbox"/> Absent <input type="checkbox"/> R <input type="checkbox"/> L HEART TONES <input type="checkbox"/> Normal <input type="checkbox"/> Distant/Muffled <input type="checkbox"/> Absent SKIN <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Hot <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Clammy <input type="checkbox"/> Pink <input type="checkbox"/> Pale <input type="checkbox"/> Dusky <input type="checkbox"/> Cyanotic												
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E = EXPOSURE Initial temperature _____ <input type="checkbox"/> C <input type="checkbox"/> PO <input type="checkbox"/> Rectal <input type="checkbox"/> AX <input type="checkbox"/> Clothing <input type="checkbox"/> secured <input type="checkbox"/> evidence <input type="checkbox"/> with patient <input type="checkbox"/> Released to _____ <input type="checkbox"/> Warm blankets applied <input type="checkbox"/> Valuables: <input type="checkbox"/> secured <input type="checkbox"/> evidence <input type="checkbox"/> with patient <input type="checkbox"/> Released to _____		ABDOMEN <input type="checkbox"/> Normal <input type="checkbox"/> Rigid <input type="checkbox"/> Seatbelt sign <input type="checkbox"/> Distended <input type="checkbox"/> Tender to: _____ <input type="checkbox"/> Bowel Sounds <input type="checkbox"/> Present <input type="checkbox"/> Absent																																	
F = Full Set Vitals – Document on page 3 Cardiac Monitor Focused Adjuncts NG Foley (Documented Below in interventions)		EXTREMITIES <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td>LUE</td> <td>RUE</td> <td>LLE</td> <td>RLE</td> </tr> <tr> <td>Pulses</td> <td>Y/N</td> <td>Y/N</td> <td>Y/N</td> <td>Y/N</td> </tr> <tr> <td>Sensation</td> <td>Y/N</td> <td>Y/N</td> <td>Y/N</td> <td>Y/N</td> </tr> <tr> <td>Movement</td> <td>Y/N</td> <td>Y/N</td> <td>Y/N</td> <td>Y/N</td> </tr> <tr> <td>Edema</td> <td>Y/N</td> <td>Y/N</td> <td>Y/N</td> <td>Y/N</td> </tr> <tr> <td>Deformity</td> <td>Y/N</td> <td>Y/N</td> <td>Y/N</td> <td>Y/N</td> </tr> </table> Color _____ Temp _____					LUE	RUE	LLE	RLE	Pulses	Y/N	Y/N	Y/N	Y/N	Sensation	Y/N	Y/N	Y/N	Y/N	Movement	Y/N	Y/N	Y/N	Y/N	Edema	Y/N	Y/N	Y/N	Y/N	Deformity	Y/N	Y/N	Y/N	Y/N
	LUE	RUE	LLE	RLE																															
Pulses	Y/N	Y/N	Y/N	Y/N																															
Sensation	Y/N	Y/N	Y/N	Y/N																															
Movement	Y/N	Y/N	Y/N	Y/N																															
Edema	Y/N	Y/N	Y/N	Y/N																															
Deformity	Y/N	Y/N	Y/N	Y/N																															
INTERVENTIONS																																			
TIME	PROCEDURE/DIAGNOSTICS	TIME	PROCEDURE/DIAGNOSTICS																																
	O2: _____ L/min <input type="checkbox"/> NC <input type="checkbox"/> NRB <input type="checkbox"/> BVM _____		Foley cath: size _____ FR by: _____ return: _____ m: color: _____ <input type="checkbox"/> urometer																																
	Intubation: <input type="checkbox"/> Oral ET <input type="checkbox"/> Nasal ET Size: _____ FR Lip line: _____ cm Dr. _____ Placement confirmed via: <input type="checkbox"/> auscultation <input type="checkbox"/> capnography		Urine sent: <input type="checkbox"/> UA <input type="checkbox"/> Urine Drug Screen <input type="checkbox"/> UCG Urine Pregnancy Test Negative Positive QC Pass/Fail																																
	EKG: Shown to Dr. _____		Gastric Tube: <input type="checkbox"/> NG <input type="checkbox"/> OG by: _____ size _____ FR return _____ mL color: _____																																
	IV/IO site _____ g _____ by: _____		Chest Tube: <input type="checkbox"/> L <input type="checkbox"/> R size _____ FR by: _____ Gravity <input type="checkbox"/> Suction <input type="checkbox"/> Output _____																																
	IV/IO site _____ g _____ by: _____		Swallow Screen: Pass: <input type="checkbox"/> Fail: <input type="checkbox"/> see Cerner documentation																																
	Labs drawn by: _____		Portable X-Ray: Chest / C-Spine / Pelvis / Other																																
	CVC: site: _____ type: _____ Art Line: _____		FAST exam: Dr _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative																																
	Level I Rapid Infuser		CT: Head / Chest																																
	Ranger Warmer by: _____		Abd / Pelvis / Spine																																
	Bair Hugger by: _____		WITH NURSE	WITH MONITOR	TIME RETURNED																														
	C-collar applied by: _____																																		
	C-collar cleared: collar removed by _____																																		
<input type="checkbox"/> Refer to Patient Electronic Medical Record for other interventions/documentation.																																			



THUMB REGION

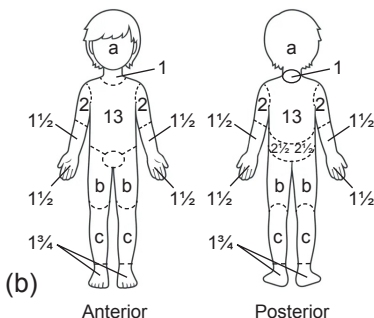
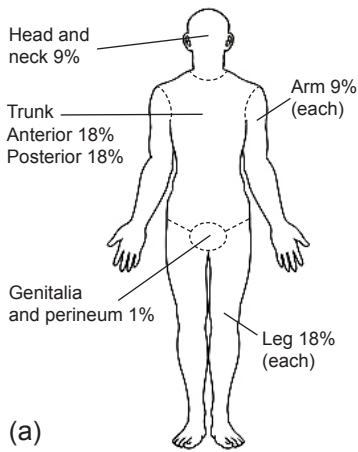
TIME	HR	BP	RHYTHM	RR	SPO ₂ /O ₂ AMT	GCS E V M	PUPILS R L	TEMP	PAIN	URINE	NGT	CT
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For more Vital Signs – Refer to the Electronic Medical Record.

IV RECORD								MEDICATIONS						
Date	Start Time	IV Fluids	Rate	Site#	Stop Time	Initials	Total in ml	Tetanus: <input type="checkbox"/> dT <input type="checkbox"/> Tdap <input type="checkbox"/> TT Lot# _____ Exp _____						
								Time _____	Dose _____	Site _____	RN _____			
								TIME	MEDICATION	DOSE	ROUTE SITE	PAIN 0-10	INT	
									<i>Pain reassessment</i>					
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THUMB REGION



Relative percentage of body surface area (% BSA) affected by growth

Body Part	Age				
	0 yr	1 yr	5 yr	10 yr	15 yr
a = 1/2 of head	9 1/2	8 1/2	6 1/2	5 1/2	4 1/2
b = 1/2 of 1 thigh	2 3/4	3 1/4	4	4 1/4	2 1/2
c = 1/2 of 1 lower leg	2 1/2	2 1/2	2 3/4	3	3 1/4

Temperature Conversion Chart

Centigrade	Fahrenheit	Centigrade	Fahrenheit
34.0	93.2	38.6	101.5
34.2	93.6	38.8	101.8
34.4	93.9	39.0	102.2
34.6	94.3	39.2	102.6
34.8	94.6	39.4	102.9
35.0	95.0	39.6	103.3
35.2	95.4	39.8	103.6
35.4	97.7	40.0	104.0
35.6	96.1	40.2	104.4
35.8	96.4	40.4	104.7
36.0	96.8	40.6	105.1
36.2	97.2	40.8	105.4
36.4	97.5	41.0	105.8
36.6	97.9	41.2	106.2
36.8	98.2	41.4	106.5
37.0	98.6	41.6	106.9
37.2	99.0	41.8	107.2
37.4	99.3	42.0	107.6
37.6	99.7	42.2	108.0
37.8	100.0	42.4	108.3
38.0	100.4	42.6	108.7
38.2	100.8	42.8	109.0
38.4	101.1	43.0	109.4

Kilograms to Pounds Conversion

Kilos	Pounds	Kilos	Pounds	Kilos	Pounds	Kilos	Pounds
42 kg	92 lbs	72 kg	159 lbs	102 kg	225 lbs	132 kg	291 lbs
44 kg	97 lbs	74 kg	163 lbs	104 kg	229 lbs	134 kg	295 lbs
46 kg	101 lbs	76 kg	168 lbs	106 kg	234 lbs	136 kg	300 lbs
48 kg	106 lbs	78 kg	172 lbs	108 kg	238 lbs	138 kg	304 lbs
50 kg	110 lbs	80 kg	176 lbs	110 kg	243 lbs	140 kg	309 lbs
52 kg	115 lbs	82 kg	181 lbs	112 kg	247 lbs	142 kg	313 lbs
54 kg	119 lbs	84 kg	185 lbs	114 kg	251 lbs	144 kg	317 lbs
56 kg	123 lbs	86 kg	190 lbs	116 kg	256 lbs	146 kg	322 lbs
58 kg	128 lbs	88 kg	194 lbs	118 kg	260 lbs	148 kg	326 lbs
60 kg	132 lbs	90 kg	198 lbs	120 kg	265 lbs	150 kg	331 lbs
62 kg	137 lbs	92 kg	203 lbs	122 kg	269 lbs	152 kg	335 lbs
64 kg	141 lbs	94 kg	207 lbs	124 kg	273 lbs	154 kg	340 lbs
66 kg	146 lbs	96 kg	212 lbs	126 kg	278 lbs	158 kg	348 lbs
68 kg	150 lbs	98 kg	216 lbs	128 kg	282 lbs	160 kg	353 lbs
70 kg	154 lbs	100 kg	220 lbs	130 kg	287 lbs	162 kg	356 lbs

Parkland Formula

$$\text{Volume of Ringer's lactate} = 4 \text{ mL} \times \% \text{ BSA} \times \text{weight (kg)}$$

1/2

First 8 hours

1/2

Next 16 hours

TROUBLESHOOTING FOR INTUBATED PATIENTS

DOPE MNEMONIC

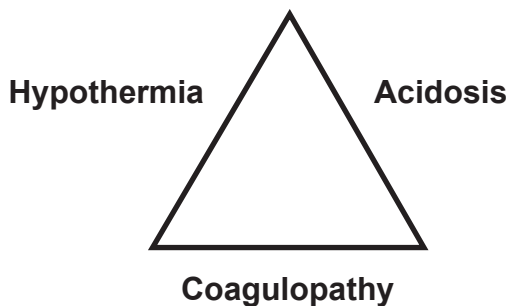
(for endotracheal tube issues)

- D** : Displacement of endotracheal tube
- O** : Obstruction of endotracheal tube
- P** : Pneumothorax
- E** : Equipment Failure

Pediatric Vital Sign Normal Ranges

Age Group	Respiratory Rate	Heart Rate	Systolic Blood Pressure	Weight in Kilos	Weight in pounds
Newborn	30-50	120-160	50-70	2-3	4.5-7
Infant (1-12 mo.)	20-30	80-140	70-100	4-10	9-22
Toddler (1-3 yr.)	20-30	80-130	80-110	10-14	22-31
Preschool (3-5 yr.)	20-30	80-120	80-110	14-18	31-40
School (age 6-12 yr.)	20-30	70-110	80-120	20-42	42-92
Adolescent +13 yr.	12-20	55-105	110-120	>50	>110

Trauma Triad of Death



RASS (Richmond Agitation Sedation Scale)

4	Combative	Overtly combative, violent, immediate danger to staff
3	Very agitated	Pulls or removes tubes or catheters; aggressive
2	Agitated	Frequent non-purposeful mvmt, fights ventilator
1	Restless	Anxious but movements not aggressive or vigorous
0	Alert and calm	
-1	Drowsy	Sustained awakening to voice (≥ 10 sec)
-2	Light Sedation	Briefly awakens with eye contact to voice (< 10 sec)
-3	Moderate Sedation	Movement or eye opening to voice but no eye contact
-4	Deep Sedation	No response to voice but movement or eye opening to physical stimulation
-5	Cannot be aroused	No response to voice or physical stimulation