

McLaren Print System Order

Order No: 87778
 Order Date: 2024-08-30
 User: Luai Fakhoury
 Phone: 9892691528

Ship Location: 1100 S. Van Dyke Rd
 Emergency Department
 Bad Axe, Michigan 48413

Forms

Quantity: 1
 Paragon Dept No: 21600
 Dept Name: Emergency Department
 Company Number: 530

Order Total Price: 58.00

Item Number: MTR-028
 Item Description: ED TRAUMA FLOW SHEET
 Revision Date: 07/2024

Print:
 Paper:
 Size:
 Fold:
 Finish:
 Drill:
 Poster:
 Misc Info: 100 per package Finish size: 11 x 25 1/2 inches; color; DS

ED TRAUMA FLOW SHEET



INJURY DATE	INJURY TIME	PRE-HOSPITAL																																											
DATE OF ARRIVAL	TIME OF ARRIVAL	SP	CAUSE																																										
Type of Trauma Activation		<input type="checkbox"/> Fall <input type="checkbox"/> Hit <input type="checkbox"/> Assault <input type="checkbox"/> Fire <input type="checkbox"/> Explosion <input type="checkbox"/> Vehicle <input type="checkbox"/> Drowning <input type="checkbox"/> Bite <input type="checkbox"/> Poison <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other																																											
Change to: <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3		<input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other																																											
<table border="1"> <thead> <tr> <th>TITLE</th> <th>NAME</th> <th>ARRIVAL TIME</th> </tr> </thead> <tbody> <tr> <td>ED Attending</td> <td></td> <td></td> </tr> <tr> <td>Primary Nurse</td> <td></td> <td></td> </tr> <tr> <td>Secondary Nurse</td> <td></td> <td></td> </tr> <tr> <td>Scribe</td> <td></td> <td></td> </tr> <tr> <td>ER Technician</td> <td></td> <td></td> </tr> <tr> <td>Respiratory</td> <td></td> <td></td> </tr> <tr> <td>Lab</td> <td></td> <td></td> </tr> <tr> <td>Radiology</td> <td></td> <td></td> </tr> <tr> <td>Other</td> <td></td> <td></td> </tr> <tr> <td>Other</td> <td></td> <td></td> </tr> <tr> <td>Other</td> <td></td> <td></td> </tr> <tr> <td>Other</td> <td></td> <td></td> </tr> <tr> <td>Other</td> <td></td> <td></td> </tr> </tbody> </table>		TITLE	NAME	ARRIVAL TIME	ED Attending			Primary Nurse			Secondary Nurse			Scribe			ER Technician			Respiratory			Lab			Radiology			Other			Other			Other			Other			Other			EPICEM: <input type="checkbox"/> Yes <input type="checkbox"/> No ICD9: <input type="checkbox"/> Yes <input type="checkbox"/> No ICD10: <input type="checkbox"/> Yes <input type="checkbox"/> No ICD9-CM: <input type="checkbox"/> Yes <input type="checkbox"/> No ICD10-CM: <input type="checkbox"/> Yes <input type="checkbox"/> No ICD9-PCS: <input type="checkbox"/> Yes <input type="checkbox"/> No ICD10-PCS: <input type="checkbox"/> Yes <input type="checkbox"/> No	
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Arrival Mode: <input type="checkbox"/> EMS <input type="checkbox"/> Car <input type="checkbox"/> Police <input type="checkbox"/> History: <input type="checkbox"/> Patient <input type="checkbox"/> EMS <input type="checkbox"/> Family		MEDICAL BACKGROUND All: <input type="checkbox"/> Height <input type="checkbox"/> Weight <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Pulse <input type="checkbox"/> RR <input type="checkbox"/> SpO2 All: <input type="checkbox"/> Height <input type="checkbox"/> Weight <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Pulse <input type="checkbox"/> RR <input type="checkbox"/> SpO2 All: <input type="checkbox"/> Height <input type="checkbox"/> Weight <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Pulse <input type="checkbox"/> RR <input type="checkbox"/> SpO2 All: <input type="checkbox"/> Height <input type="checkbox"/> Weight <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Pulse <input type="checkbox"/> RR <input type="checkbox"/> SpO2																																											
MECHANISM OF INJURY <input type="checkbox"/> MOTOR VEHICLE VS. <input type="checkbox"/> SPEED <input type="checkbox"/> WPH <input type="checkbox"/> Impact: <input type="checkbox"/> Front <input type="checkbox"/> Driver side <input type="checkbox"/> Passenger side <input type="checkbox"/> Rear <input type="checkbox"/> Other: <input type="checkbox"/> Passenger <input type="checkbox"/> Driver <input type="checkbox"/> Back <input type="checkbox"/> Seatbelt: <input type="checkbox"/> CAR Bag <input type="checkbox"/> Other Seat <input type="checkbox"/> Unknown <input type="checkbox"/> Pedestrian <input type="checkbox"/> Ejected from vehicle <input type="checkbox"/> From vehicle <input type="checkbox"/> VS. <input type="checkbox"/> BICYCLE <input type="checkbox"/> <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Hit <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> THROWN <input type="checkbox"/> FT Type of vehicle: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> SPEED: <input type="checkbox"/> WPH <input type="checkbox"/> FALL: <input type="checkbox"/> From Standing <input type="checkbox"/> Steps <input type="checkbox"/> Height Landed on: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ASSAULT: <input type="checkbox"/> Gunshot <input type="checkbox"/> Blasting <input type="checkbox"/> Physical <input type="checkbox"/> Police notified Weapon: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> SPORTS INJURY Injured: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> OTHER: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		INJURES/COMPLAINTS All: <input type="checkbox"/> Ankle <input type="checkbox"/> Forearm/Body <input type="checkbox"/> Neck All: <input type="checkbox"/> Ankle <input type="checkbox"/> Forearm/Body <input type="checkbox"/> Neck All: <input type="checkbox"/> Ankle <input type="checkbox"/> Forearm/Body <input type="checkbox"/> Neck All: <input type="checkbox"/> Ankle <input type="checkbox"/> Forearm/Body <input type="checkbox"/> Neck All: <input type="checkbox"/> Ankle <input type="checkbox"/> Forearm/Body <input type="checkbox"/> Neck																																											

Spec Info:

