

Appendix 3

Department of Defense Trauma Registry

General

Evidence-based medicine allows for identification of best practices and the timely formulation of clinical practice guidelines. Unfortunately, because of the realities of combat trauma, timely and accurate data collection and interpretation of results are difficult. Quality information on casualties for combatant commanders is essential because it facilitates optimal placement, utilization, and resupply of scarce medical resources, and rapid identification of new trends in wounding, prevention, and treatment. Timely, accurate, aggregated theater information is necessary to shorten quality improvement cycles and improve outcomes.

Furthermore, aggregation, evaluation, and reporting of these data provide rapid feedback for providers across the entire chain of care and evacuation in the Joint Trauma System (JTS). Application of these principles to the battlefield, using a set of jointly approved data elements as a means to drive concurrent performance improvement within the JTS, has been a major advancement of the recent conflicts in Afghanistan and Iraq. This effort has led to the adaption of technology and the training of specialists to serve the mission of timely and accurate collection of combat injury data. The trauma documentation tool that facilitates this process should be used as the trauma medical record (for both battle and nonbattle injuries) and should accompany the casualty throughout the chain of care and evacuation.

Situational Awareness

The revolution in warfighting that has digitized the battlefield to display friendly positions, intelligence, and engagements electronically has not been equally applied to the casualty care side of the equation. This places demands on medical organizations to provide online and continuously updated status and location information on killed, wounded, ill, and psychologically impaired combatants and noncombatants, including both the casualty loss to the unit and the return-to-duty patient. This need will only escalate as medical situational awareness plays an increasing role in the tactical risk assessment process. At a minimum, commanders should be able to assess the case fatality rate (CFR; fraction of an exposed group—all those wounded in action [WIA] who die—a measure of the lethality of the battlefield; the calculation includes those WIA individuals who are returned to duty [RTD]) percentage killed in action (KIA; died before reaching medical care/force wounded) and percentage died of wounds (DOW; died after reaching medical care/force wounded) in order to measure risk associated with operations and the capability of the medical force to control mortality.

$$\text{CFR} = \frac{(\text{KIA} + \text{DOW})}{(\text{KIA} + \text{WIA})} \times 100$$

$$\% \text{KIA} = \frac{(\text{Deaths before MTF})}{\text{KIA} + (\text{WIA} - \text{RTD})} \times 100$$

$$\% \text{DOW} = \frac{(\text{Deaths after MTF})}{(\text{WIA} - \text{RTD})} \times 100,$$

where MTF is defined as medical treatment facility or any fixed facility with a medical provider.

Categorization of casualties by type and distribution of injury within the major body regions (ie, face, head and neck, chest, abdomen and pelvis, upper and lower extremities, and skin) enables analysis of injury patterns and assessment of injury severity that can be utilized to design prevention applications

and care interventions, thus decreasing the burden of injury, morbidity, and mortality.

Other Uses

Data on types of wounds, their causes, and appropriate procedures have potential value in constructing predictive models for medical force development and placement, logistical delivery systems, and research on improved medical and surgical interventions and prevention. The history of improvements in medicine and surgery are grounded on the battlefield, and dissemination should not be limited to the isolated innovator with a personal spreadsheet for documentation. Individual providers at individual medical treatment facilities have long recorded clinical data and observations. This Department of Defense Trauma Registry (DoDTR) is an organized and coordinated effort to facilitate documentation of information that is aggregated into the registry that provides the means to better understand the effectiveness of prevention measures and casualty care, as well as the burden of injury, morbidity, and mortality in a population.

Minimum Essential Data

In addition to recording the standard contents of the postprocedure note (ie, who did what, on whom, why, and a plan), the standard data components of a trauma registry are especially helpful (eg, demographics, circumstance and mechanism of injury, injury severity, prehospital monitoring and care, hospital monitoring and care, outcome, participants, direct assessment against standards). Figure A3-1 is a sample of the form that serves as both the trauma medical record and as a source for data capture. The minimum essential elements present on this form have been agreed upon by the US Army, the US Air Force, and the US Navy; official Department of Defense (DoD) forms are pending. Data are collated into the registry, evaluated, and reported by the JTS.

Recommended Methods and Technology

The process to document emergency trauma care can be used on either the immature or mature battlefield. This would entail utilizing paper or computer-assisted electronic technology, respectively. In the ideal environment, this would be a single-step

process. Reality is much different. It is important to recognize that documentation should occur across the chain of care and evacuation, whereas aggregation of data should occur at the first level of care that can support such activity. At a minimum, paper

RESUSCITATION RECORD							
Part I, Nursing Flow Sheet							
1. PATIENT INFORMATION							
1.1 TRAUMA TEAM DATA			1.4 MODE OF ARRIVAL	1.6 INJURY CLASSIFICATION	1.9 PATIENT CATEGORY	1.10 INJURY CAUSE	
Service	Time Called	Time Arrived					Name
ED Physician				<input type="checkbox"/> Walked/Carried	<input type="checkbox"/> Battle	<input type="checkbox"/> USA	<input type="checkbox"/> Building Collapse
Trauma Surgeon				<input type="checkbox"/> CASEVAC - Air	<input type="checkbox"/> Non-Battle	<input type="checkbox"/> USAF	<input type="checkbox"/> Bullet/GSW/Firearm
Respiratory Therapy				<input type="checkbox"/> CASEVAC - Ground	<input type="checkbox"/> Unknown	<input type="checkbox"/> USMC	<input type="checkbox"/> Burn
Anesthesiology				<input type="checkbox"/> MEDEVAC - Air		<input type="checkbox"/> USN	<input type="checkbox"/> EFP
Lab/Blood Bank				Mission # _____		<input type="checkbox"/> USG	<input type="checkbox"/> Fall
Radiology				<input type="checkbox"/> MEDEVAC - Ground	1.7 TRIAGE CATEGORY	<input type="checkbox"/> USPHS	<input type="checkbox"/> Fire/Flame
Pharmacy				Mission # _____	<input type="checkbox"/> Immediate	<input type="checkbox"/> Civilian - Local	<input type="checkbox"/> IED
Consult (i.e. Ortho)				<input type="checkbox"/> CCATT	<input type="checkbox"/> Delayed	<input type="checkbox"/> Civilian - Other	<input type="checkbox"/> Inhalation Injury
				<input type="checkbox"/> Ship EVAC	<input type="checkbox"/> Minimal	<input type="checkbox"/> Contractor	<input type="checkbox"/> Mine
				<input type="checkbox"/> AE	<input type="checkbox"/> Expectant	<input type="checkbox"/> NATO - Coalition	<input type="checkbox"/> Mortar/Rocket/ Artillery Shell
				<input type="checkbox"/> Other _____	1.8 VALUABLES FOUND	<input type="checkbox"/> EPW	<input type="checkbox"/> Multi-Frag
					<input type="checkbox"/> None	<input type="checkbox"/> NATO - Coalition	<input type="checkbox"/> MVC
					<input type="checkbox"/> Given to Patient	<input type="checkbox"/> Non-NATO - Coalition	<input type="checkbox"/> Sports
					<input type="checkbox"/> Secured by PAD	<input type="checkbox"/> Coalition	<input type="checkbox"/> UXO
					Time _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
1.2 ARRIVAL							
Date	1.3 EVAC FROM			1.5 INJURY TYPE			
Time of Arrival	<input type="checkbox"/> 1st Responder	<input type="checkbox"/> Forward Resuscitative Care		<input type="checkbox"/> Blunt			
Time of Injury	<input type="checkbox"/> Theater Hospital	<input type="checkbox"/> Other _____		<input type="checkbox"/> Burn			
Date of Injury	Location			<input type="checkbox"/> Penetrating			
Transit Time minutes							
2. CARE DONE PRIOR TO ARRIVAL							
2.1 PREHOSPITAL TOURNIQUET		2.2 PREHOSPITAL VITALS		2.3 PREHOSPITAL HEMORRHAGE CONTROL MEASURES		2.4 PREHOSPITAL WARMING	
Upper Extremities:		Lower Extremities:		GCS _____		<input type="checkbox"/> Blanket	
Type:		Type:		Eye _____/4		<input type="checkbox"/> Body Bag	
<input type="checkbox"/> CAT <input type="checkbox"/> SOFTT		<input type="checkbox"/> CAT <input type="checkbox"/> SOFTT		Verbal _____/5		<input type="checkbox"/> HPMK	
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____		Motor _____/6		<input type="checkbox"/> Space Blanket	
Time On _____ Off _____		Time On _____ Off _____		Total _____/15		<input type="checkbox"/> Other _____	
<input type="checkbox"/> R How many? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		<input type="checkbox"/> R How many? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		T _____		2.5 PREHOSPITAL MEDS	
Effective? <input type="checkbox"/> Y <input type="checkbox"/> N		Effective? <input type="checkbox"/> Y <input type="checkbox"/> N		P _____		<input type="checkbox"/> C-spine Immobilized <input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> L How many? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		<input type="checkbox"/> L How many? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		RR _____		<input type="checkbox"/> Pelvic Binder <input type="checkbox"/> Y <input type="checkbox"/> N	
Effective? <input type="checkbox"/> Y <input type="checkbox"/> N		Effective? <input type="checkbox"/> Y <input type="checkbox"/> N		BP _____/____		<input type="checkbox"/> IO Infusions <input type="checkbox"/> Y <input type="checkbox"/> N	
				O2Sat _____		<input type="checkbox"/> Eye Shield OS <input type="checkbox"/> Y <input type="checkbox"/> N	
						<input type="checkbox"/> OD <input type="checkbox"/> Y <input type="checkbox"/> N	
						CPR prior to arrival: <input type="checkbox"/> Y <input type="checkbox"/> N	
3. PRIMARY SURVEY							
3.1 VITALS		3.3 HYPO / HYPERTHERMIA CONTROL MEASURES		3.5 BREATHING		3.6 CIRCULATION	
P _____		Arrival Temp _____ F <input type="checkbox"/> C <input type="checkbox"/>		<input type="checkbox"/> Unlabored		Skin:	
RR _____		Time _____ Date _____		<input type="checkbox"/> Labored		<input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Hot	
BP _____/____		Route <input type="checkbox"/> Oral <input type="checkbox"/> Axillary <input type="checkbox"/> Rectal		<input type="checkbox"/> Flaring		<input type="checkbox"/> Pink <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic	
O2Sat _____		Temperature Control Procedure:		<input type="checkbox"/> Retraction		<input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Diaphoretic	
Pain Scale (0 - 10) _____		<input type="checkbox"/> Bair Hugger <input type="checkbox"/> Warming Blanket		<input type="checkbox"/> Absent		Heart Sounds:	
		<input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Cooling Blanket		Chest Symmetry:		<input type="checkbox"/> Clear <input type="checkbox"/> Muffled	
		<input type="checkbox"/> Other _____		<input type="checkbox"/> Equal <input type="checkbox"/> Left > Right >		Capillary Refill:	
				Flail <input type="checkbox"/> R <input type="checkbox"/> L		<input type="checkbox"/> < 2 Seconds (normal)	
				Trachea:		<input type="checkbox"/> > 2 Seconds (delayed)	
				<input type="checkbox"/> Responds to Verbal Stimuli			
				<input type="checkbox"/> Responds to Painful Stimuli			
				<input type="checkbox"/> Unresponsive to Painful Stimuli			
				3.7 DEFICIT / NEURO		GCS:	
				<input type="checkbox"/> Alert - Obeys Commands		Eye _____/4	
				<input type="checkbox"/> Responds to Verbal Stimuli		Verbal _____/5	
				<input type="checkbox"/> Responds to Painful Stimuli		Motor _____/6	
				<input type="checkbox"/> Unresponsive to Painful Stimuli		Total _____/15	
						Pediatric Broselow Tape Color: _____	
PATIENT IDENTIFICATION							
Name: Last _____ First _____ MI _____ Rank _____							
Patient ID/SSN _____ BRN _____ Medical Record # _____ DOB _____ Age _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F							
Facility Name _____ Facility Location _____ MOS/AFSC/NEC _____ Deployed/Assigned Unit _____							
Nurse Name _____ Nurse Signature _____							

Resuscitation Record continues

Fig. A3-1. Sample resuscitation record.



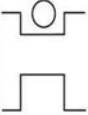
documentation should be used for each casualty, and the chart should accompany the patient to the rear as evacuation occurs. When effective electronic records are available, this process will be expedited and simplified.

RESUSCITATION RECORD Part I, Nursing Flow Sheet							
4. SECONDARY SURVEY							
4.1 HEAD / NECK ENT		4.2 HEART / THORACIC		4.3 ABDOMINAL/GU		4.4 EXTREMITIES	
Drainage: <input type="checkbox"/> Nasal (Color) _____ <input type="checkbox"/> Ear (Color) _____ Dental Injury <input type="checkbox"/> Y <input type="checkbox"/> N CSF (Halo Test) <input type="checkbox"/> + / <input type="checkbox"/> - C-spine Tender <input type="checkbox"/> Y <input type="checkbox"/> N JVD <input type="checkbox"/> Y <input type="checkbox"/> N Reactive Pupils Right: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Brisk <input type="checkbox"/> Sluggish <input type="checkbox"/> NR <input type="checkbox"/> NR Left: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Brisk <input type="checkbox"/> Sluggish <input type="checkbox"/> NR <input type="checkbox"/> NR		Rhythm <input type="checkbox"/> NSR <input type="checkbox"/> Tachy/Brady <input type="checkbox"/> V-fib / V-tach <input type="checkbox"/> PEA <input type="checkbox"/> Asystole <input type="checkbox"/> Other _____ Pulses S = Strong W = Weak D = Doppler A = Absent Carotid <u> </u> R <u> </u> L Femoral <u> </u> R <u> </u> L Brachial <u> </u> R <u> </u> L Radial <u> </u> R <u> </u> L Pedal <u> </u> R <u> </u> L		<input type="checkbox"/> Open Wound <input type="checkbox"/> Flat <input type="checkbox"/> Obese <input type="checkbox"/> Distended <input type="checkbox"/> Tender <input type="checkbox"/> Non-Tender <input type="checkbox"/> Rebound Tenderness <input type="checkbox"/> Guarding <input type="checkbox"/> Rigid <input type="checkbox"/> Unable to Assess Pelvic Binder <input type="checkbox"/> Y <input type="checkbox"/> N Blood at Meatus/Vagina <input type="checkbox"/> Y <input type="checkbox"/> N FAST <input type="checkbox"/> + describe _____ <input type="checkbox"/> - <input type="checkbox"/> Equivocal Last Meal @ _____		Deformities Pulses Present Motor Sensory <input type="checkbox"/> RUE _____ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> LUE _____ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> RLE _____ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> LLE _____ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N Pulses Present: indicate S =Strong W =Weak D =Doppler A =Absent 4.5 ALLERGIES <input type="checkbox"/> Unknown <input type="checkbox"/> NKDA Other _____ 4.6 CURRENT MEDICATIONS <input type="checkbox"/> Unknown <input type="checkbox"/> Last Tetanus Date _____ <input type="checkbox"/> None <input type="checkbox"/> Current Meds: (List med, dose, & route) _____ _____ _____	
4.7 PROCEDURES							
Procedure	Time	Size/Type	Site	Performed By	Results		
O ₂ Therapy _____ Lpm	On _____	<input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Oral Airway	<input type="checkbox"/> Nasal Airway	_____	_____		
	Off _____	<input type="checkbox"/> NRB Mask <input type="checkbox"/> BVM	<input type="checkbox"/> BVM	_____	_____		
ET Intubation (Put additional changes in Remarks)	Time _____	Teeth _____ cm	<input type="checkbox"/> Oral <input type="checkbox"/> Nasal	_____	<input type="checkbox"/> ETCO ₂ Change <input type="checkbox"/> BBS Post Intubation		
C-Collar Placed	Time _____	C-Collar Removed	Time _____	_____			
Chest Tube #1	Time _____		<input type="checkbox"/> L <input type="checkbox"/> R	_____	<input type="checkbox"/> Air <input type="checkbox"/> Blood (cc) _____		
Chest Tube #2	Time _____		<input type="checkbox"/> L <input type="checkbox"/> R	_____	<input type="checkbox"/> Air <input type="checkbox"/> Blood (cc) _____		
Needle Decompression	Time _____		<input type="checkbox"/> L <input type="checkbox"/> R	_____	<input type="checkbox"/> Air <input type="checkbox"/> Blood (cc) _____		
Thoracotomy	Time _____		<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Clamshell	_____	_____		
Tourniquet	Time _____	Types _____	Sites _____	_____			
Eye Shield	Time _____		<input type="checkbox"/> OS <input type="checkbox"/> OD <input type="checkbox"/> Both	_____			
A-line	Time _____		<input type="checkbox"/> L <input type="checkbox"/> R	_____			
Gastric Tube	Time _____		<input type="checkbox"/> Oral <input type="checkbox"/> Nasal	_____	Verified <input type="checkbox"/> Y <input type="checkbox"/> N Suction <input type="checkbox"/> Y <input type="checkbox"/> N		
Urinary	Time _____	Amount _____ Color _____ Foley Size _____	<input type="checkbox"/> Meatus <input type="checkbox"/> Suprapubic	_____	Heme Dip <input type="checkbox"/> - / <input type="checkbox"/> + Results _____ cc		
Other Procedure	Time _____	Describe _____					
Other Procedure	Time _____	Describe _____					
Hemorrhage Control Measures	<input type="checkbox"/> Celox <input type="checkbox"/> Combat Gauze <input type="checkbox"/> Field Dressing <input type="checkbox"/> QuikClot <input type="checkbox"/> Unknown	_____					
	<input type="checkbox"/> ChitoFlex <input type="checkbox"/> Direct Pressure <input type="checkbox"/> HemCon <input type="checkbox"/> None <input type="checkbox"/> Other _____	_____					
PATIENT IDENTIFICATION Name: Last _____ First _____ MI _____ Patient ID/SSN _____							
BRN _____	Facility Location _____	Nurse Name _____	Nurse Signature _____				

Resuscitation Record *continues*

RESUSCITATION RECORD Part I, Nursing Flow Sheet													
4. SECONDARY SURVEY, continued													
4.8 INTUBATION MECH/VENT			4.9 ABGs / VBGS										
Time _____			Time _____ FiO ₂ _____ pH _____ pCO ₂ _____ pO ₂ _____ BE _____ HCO ₃ _____ SAT _____										
MODE: _____			<input type="checkbox"/> ABG or <input type="checkbox"/> VBG _____ <input type="checkbox"/> ABG or <input type="checkbox"/> VBG _____ <input type="checkbox"/> ABG or <input type="checkbox"/> VBG _____ <input type="checkbox"/> ABG or <input type="checkbox"/> VBG _____ <input type="checkbox"/> ABG or <input type="checkbox"/> VBG _____ <input type="checkbox"/> ABG or <input type="checkbox"/> VBG _____										
FiO ₂ : _____													
RATE: _____													
PEEP: _____													
TV: _____													
4.10 INTRAVENOUS ACCESS AND FLUIDS							4.11 BLOOD PRODUCTS						
Time _____ Rate _____ Gauge _____ Site _____ IVF Type _____ Amount Up _____ Amount In _____ Stop _____							Unit # _____ Type _____ Start _____ Stop _____ Volume _____ Initials _____						
Total Amount Infused: _____													
4.12 MEDICATIONS						4.13 VITAL SIGNS							
Drug _____ Dose _____ Route _____ Time _____ Initials _____						Time _____ GCS _____ BP _____ P _____ RR _____ Temp _____ SaO ₂ _____ Pain Scale (0-10) _____ Other (ICP) _____							
4.14 LABS			4.15 CT		4.17 DISPOSITION					Date: _____ Time: _____ Evac to: <input type="checkbox"/> Host Nation <input type="checkbox"/> Coalition <input type="checkbox"/> CASF Facility Name: _____			
Time _____ Test _____			Type _____ Time _____		Admit _____					Evac Priority <input type="checkbox"/> Routine <input type="checkbox"/> Priority <input type="checkbox"/> Urgent <input type="checkbox"/>			
CBC _____			<input type="checkbox"/> Head _____		<input type="checkbox"/> OR <input type="checkbox"/> ICU <input type="checkbox"/> ICW _____					Facility Name: _____			
ABG _____			<input type="checkbox"/> C-Spine _____		RTD _____					Evac Transport Vehicle _____			
VBG _____			<input type="checkbox"/> Chest _____		<input type="checkbox"/> Full <input type="checkbox"/> Quarters <input type="checkbox"/> Profile _____					MEDEVAC: <input type="checkbox"/> Rotary Wing - <input type="checkbox"/> MedTech <input type="checkbox"/> Critical Care			
Chemistry _____			<input type="checkbox"/> Abd _____		RTD Unit: _____					<input type="checkbox"/> Fixed Wing - <input type="checkbox"/> AE <input type="checkbox"/> CCATT _____			
PT/PTT _____			<input type="checkbox"/> Pelvis _____		RTD Mode of Transport: _____					Ground: <input type="checkbox"/> Medical <input type="checkbox"/> Non-Medical _____			
TEG _____			<input type="checkbox"/> Pan Scan* _____		<input type="checkbox"/> Ambulatory <input type="checkbox"/> W/C _____					Evac Mode of Transport <input type="checkbox"/> Ambulatory <input type="checkbox"/> W/C _____			
H&H _____			* Select Pan Scan only if all of the above requested		4.18 DEATH INFORMATION					<input type="checkbox"/> Litter <input type="checkbox"/> Vacuum Spine Board _____			
INR _____			4.16 X-RAY		Time of Death _____ Mortuary Affairs Notified? <input type="checkbox"/> Y <input type="checkbox"/> N Time to Morgue _____								
T&S _____			Type _____ Time _____		Death Remarks _____								
T&C x _____			<input type="checkbox"/> C-Spine _____		4.19 REMARKS								
UA _____			<input type="checkbox"/> Chest _____										
HCG _____			<input type="checkbox"/> Abd _____										
Other _____			<input type="checkbox"/> Pelvis _____										
Specify Other: _____			<input type="checkbox"/> Ext _____										
			<input type="checkbox"/> RUE <input type="checkbox"/> LUE _____										
			<input type="checkbox"/> RLE <input type="checkbox"/> LLE _____										
PATIENT IDENTIFICATION Name: Last _____ First _____ MI _____ Patient ID/SSN _____													
BRN _____		Facility Location _____		Nurse Name _____				Nurse Signature _____					

Resuscitation Record *continues*

RESUSCITATION RECORD Part II, Physician H&P																							
1. HISTORY & PHYSICAL - INJURY DESCRIPTION																							
1.1 ARRIVAL Date _____ Time of Arrival _____	1.2 TRIAGE CATEGORY <input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minimal <input type="checkbox"/> Expectant	1.4 INJURY DESCRIPTION (AB)Abrasion (AMP)Amputation (AV)Avulsion (BL)Bleeding (B)%TBSA _____ (C)Crepitus (D)Deformity (DG)Degloving (E)Ecchymosis (FX)Fracture (F)Foreign Body (GSW)Gun Shot Wound (H)Hematoma (LAC)laceration (PW)Puncture Wound (SS)Seatbelt Sign (SW)Stab Wound (P)Pain (PP)Peppering	<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>R L L R</p>  <p>ANTERIOR</p> </div> <div style="text-align: center;"> <p>R L L R</p>  <p>POSTERIOR</p> </div> </div> <p>Pulses Present S= Strong W= Weak D= Doppler A= Absent</p> 																				
1.3 CHIEF COMPLAINT, HISTORY AND PRESENTING ILLNESS																							
1.5 HISTORY AND PHYSICAL		1.6 PRE / INITIAL PROCEDURES / DIAGNOSTICS																					
Head & Neck: _____ _____ _____		Pre / Initial _____ <input type="checkbox"/> Cric <input type="checkbox"/> C-Collar/ Time Removed _____ <input type="checkbox"/> ICP Monitor <input type="checkbox"/> Cantholysis & Canthotomy <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Ventric. <input type="checkbox"/> Tympanic Membranes Rupture <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Eye Shield <input type="checkbox"/> R <input type="checkbox"/> L																					
Chest: _____ _____		Needle Decompression <input type="checkbox"/> R <input type="checkbox"/> L Pericardial describe: Output <input type="checkbox"/> Air <input type="checkbox"/> Blood (cc) _____ FAST <input type="checkbox"/> - / <input type="checkbox"/> + <input type="checkbox"/> Pericardiocentesis _____																					
Abdomen/Back and Spine: _____ _____		DPL <input type="checkbox"/> Gross Blood: <input type="checkbox"/> - / <input type="checkbox"/> + describe _____ Log Roll Time _____ Back Exam <input type="checkbox"/> WNL <input type="checkbox"/> ABNL describe _____ Rectal Exam <input type="checkbox"/> WNL <input type="checkbox"/> Weak/Absent Tone Gross Blood: <input type="checkbox"/> - / <input type="checkbox"/> +																					
Pelvis: <input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Binder		Prostate _____ Gyn _____																					
Upper Extremities: _____ _____		<input type="checkbox"/> Closed Reduction <input type="checkbox"/> EXT Fixation <input type="checkbox"/> Tourniquet <input type="checkbox"/> R # _____ <input type="checkbox"/> Wound Washout <input type="checkbox"/> Splint <input type="checkbox"/> L # _____																					
Lower Extremities: _____ _____		<input type="checkbox"/> Closed Reduction <input type="checkbox"/> EXT Fixation <input type="checkbox"/> Tourniquet <input type="checkbox"/> R # _____ <input type="checkbox"/> Wound Washout <input type="checkbox"/> Splint <input type="checkbox"/> L # _____																					
Interventions Prior to Arrival: _____ _____		<input type="checkbox"/> Sedated <input type="checkbox"/> 3% Saline <input type="checkbox"/> Cntrl Line Loc _____ Site _____ <input type="checkbox"/> Chemical Paralyze <input type="checkbox"/> Mannitol <input type="checkbox"/> JO Loc _____ Site _____ <input type="checkbox"/> Seizure Protocol <input type="checkbox"/> A-Line Loc _____ Site _____																					
1.7 PUPILS / VISION Brisk <input type="checkbox"/> R <input type="checkbox"/> L Hand Motion <input type="checkbox"/> R <input type="checkbox"/> L Sluggish <input type="checkbox"/> R <input type="checkbox"/> L Light Perception <input type="checkbox"/> R <input type="checkbox"/> L NR <input type="checkbox"/> R <input type="checkbox"/> L No Light Perception <input type="checkbox"/> R <input type="checkbox"/> L Size Right mm _____ Left mm _____	1.8 BURN <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> %TBSA _____ >20% Use the Burn Flow Sheet Cause _____	1.9 EXTREMITIES <table border="1"> <thead> <tr> <th></th> <th>Motor</th> <th>Sens</th> <th>ROM</th> </tr> </thead> <tbody> <tr> <td>RUE</td> <td>+ / -</td> <td>+ / -</td> <td>+ / -</td> </tr> <tr> <td>LUE</td> <td>+ / -</td> <td>+ / -</td> <td>+ / -</td> </tr> <tr> <td>RLE</td> <td>+ / -</td> <td>+ / -</td> <td>+ / -</td> </tr> <tr> <td>LLE</td> <td>+ / -</td> <td>+ / -</td> <td>+ / -</td> </tr> </tbody> </table>			Motor	Sens	ROM	RUE	+ / -	+ / -	+ / -	LUE	+ / -	+ / -	+ / -	RLE	+ / -	+ / -	+ / -	LLE	+ / -	+ / -	+ / -
	Motor	Sens	ROM																				
RUE	+ / -	+ / -	+ / -																				
LUE	+ / -	+ / -	+ / -																				
RLE	+ / -	+ / -	+ / -																				
LLE	+ / -	+ / -	+ / -																				
PATIENT IDENTIFICATION																							
Name: Last _____ First _____ MI _____ Rank _____		Patient ID/SSN _____ BRN _____ Medical Record # _____ DOB _____ Age _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F																					
Facility Name _____ Facility Location _____		Physician Signature _____																					

Resuscitation Record *continues*

RESUSCITATION RECORD Part II, Physician H&P				
2. X-RAYS and CT				
2.1 CT OBTAINED	2.2 X-RAYS OBTAINED	2.3 PENDING STUDIES	2.4 RESULTS (include TEG/Rotem results)	2.5 C-SPINE RESULTS
<input type="checkbox"/> Head <input type="checkbox"/> C-Spine <input type="checkbox"/> Chest <input type="checkbox"/> Abd/Pelvis <input type="checkbox"/> Pan Scan* <small>* Select Pan Scan only if all of the above requested</small>	<input type="checkbox"/> C-Spine <input type="checkbox"/> Extremity <input type="checkbox"/> Spine <input type="checkbox"/> RUE <input type="checkbox"/> Chest/Upright <input type="checkbox"/> LUE <input type="checkbox"/> Pelvis <input type="checkbox"/> RLE <input type="checkbox"/> <input type="checkbox"/> LLE Other _____ Other _____			<input type="checkbox"/> CT Scan Normal <input type="checkbox"/> CT Scan Abnormal C-Spine cleared based on: <input type="checkbox"/> Normal exam, reliable Pt <input type="checkbox"/> Normal CT scan, normal exam C-Spine not cleared based on: <input type="checkbox"/> Neuro c/o, abnormal exam <input type="checkbox"/> Abnormal imaging <input type="checkbox"/> Unreliable Pt
3. LABORATORY RESULTS				
3.1 CBC		3.2 CHEMISTRY 7		3.4 LFT
				Amylase _____ Bili _____ Alk Phos _____ SGOT _____ LDH _____ SGPT _____ Other _____
3.3 PT / INR / PTT _____ / _____ / _____				3.5 URINALYSIS
				SpGr _____ Chem _____ Micro _____ HCG _____ pH _____ Bact _____ WBC _____ RBC _____
4. IMPRESSION				
5. DIAGNOSES				
1 _____		4 _____		
2 _____		5 _____		
3 _____		6 _____		
6. PLAN				
6.1 PLAN				
6.2 TRIAD INDICATORS UPON ARRIVAL IN ED				
Temp < 96F/36C <input type="checkbox"/> Yes <input type="checkbox"/> No INR >1.4 <input type="checkbox"/> Yes <input type="checkbox"/> No Base Deficit >5 <input type="checkbox"/> Yes <input type="checkbox"/> No FWB Requested <input type="checkbox"/> Yes <input type="checkbox"/> No Damage Control <input type="checkbox"/> Yes <input type="checkbox"/> No				
6.3 DISPOSITION <input type="checkbox"/> OR <input type="checkbox"/> ICU <input type="checkbox"/> ICW <input type="checkbox"/> Transfer Date: _____ Time: _____				
7. DNBI / NBI CATEGORY				
<input type="checkbox"/> Injury, Sports <input type="checkbox"/> Injury, Work/Training <input type="checkbox"/> Surgical <input type="checkbox"/> Injury, MVC <input type="checkbox"/> Injury, Other				
8. CAUSE OF DEATH				
8.1 ANATOMIC			8.2 PHYSIOLOGIC	
<input type="checkbox"/> Airway <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen <input type="checkbox"/> Extremity <input type="checkbox"/> U / <input type="checkbox"/> L <input type="checkbox"/> Head <input type="checkbox"/> Chest <input type="checkbox"/> Pelvis <input type="checkbox"/> Other, Specify _____			<input type="checkbox"/> MOF <input type="checkbox"/> Sepsis <input type="checkbox"/> Total Body Disruption <input type="checkbox"/> CNS <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Breathing <input type="checkbox"/> Other, Specify _____	
PATIENT IDENTIFICATION Name: Last _____ First _____ MI _____ Patient ID/SSN _____				
BRN _____ Facility Location _____		Physician Name _____		Physician Signature _____