

RESUSCITATION RECORD

Part I, Nursing Flow Sheet

1. PATIENT INFORMATION

1.1 TRAUMA TEAM DATA <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Service</th> <th style="width: 15%;">Time Called</th> <th style="width: 15%;">Time Arrived</th> <th style="width: 30%;">Name</th> </tr> </thead> <tbody> <tr><td>ED Physician</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Trauma Surgeon</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Respiratory Therapy</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Anesthesiology</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Lab/Blood Bank</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Radiology</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Pharmacy</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Consult (i.e., Ortho)</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	Service	Time Called	Time Arrived	Name	ED Physician	_____	_____	_____	Trauma Surgeon	_____	_____	_____	Respiratory Therapy	_____	_____	_____	Anesthesiology	_____	_____	_____	Lab/Blood Bank	_____	_____	_____	Radiology	_____	_____	_____	Pharmacy	_____	_____	_____	Consult (i.e., Ortho)	_____	_____	_____	1.4 MODE OF ARRIVAL <input type="checkbox"/> Walked/Carried <input type="checkbox"/> CASEVAC - Air <input type="checkbox"/> CASEVAC - Ground <input type="checkbox"/> MEDEVAC - Air Mission # _____ <input type="checkbox"/> MEDEVAC - Ground Mission # _____ <input type="checkbox"/> CCATT <input type="checkbox"/> Ship EVAC <input type="checkbox"/> AE <input type="checkbox"/> Other _____ 1.5 INJURY TYPE <input type="checkbox"/> Blunt <input type="checkbox"/> Burn <input type="checkbox"/> Penetrating	1.6 INJURY CLASSIFICATION <input type="checkbox"/> Battle <input type="checkbox"/> Non-Battle <input type="checkbox"/> Unknown 1.7 TRIAGE CATEGORY <input type="checkbox"/> Immediate <input type="checkbox"/> Delayed <input type="checkbox"/> Minimal <input type="checkbox"/> Expectant 1.8 VALUABLES FOUND <input type="checkbox"/> None <input type="checkbox"/> Given to Patient <input type="checkbox"/> Secured by PAD Time _____	1.9 PATIENT CATEGORY <input type="checkbox"/> USA <input type="checkbox"/> USAF <input type="checkbox"/> USMC <input type="checkbox"/> USN <input type="checkbox"/> USCG <input type="checkbox"/> USPHS <input type="checkbox"/> Civilian - Local <input type="checkbox"/> Civilian - Other <input type="checkbox"/> Contractor <input type="checkbox"/> EPW <input type="checkbox"/> NATO - Coalition <input type="checkbox"/> Non-NATO - Coalition <input type="checkbox"/> Other _____	1.10 INJURY CAUSE <input type="checkbox"/> Building Collapse <input type="checkbox"/> Bullet/GSW/Firearm <input type="checkbox"/> Burn <input type="checkbox"/> EFP <input type="checkbox"/> Fall <input type="checkbox"/> Fire/Flame <input type="checkbox"/> IED <input type="checkbox"/> Inhalation Injury <input type="checkbox"/> Mine <input type="checkbox"/> Mortar/Rocket/Artillery Shell <input type="checkbox"/> Multi-Frag <input type="checkbox"/> MVC <input type="checkbox"/> Sports <input type="checkbox"/> UXO <input type="checkbox"/> Other _____
Service	Time Called	Time Arrived	Name																																					
ED Physician	_____	_____	_____																																					
Trauma Surgeon	_____	_____	_____																																					
Respiratory Therapy	_____	_____	_____																																					
Anesthesiology	_____	_____	_____																																					
Lab/Blood Bank	_____	_____	_____																																					
Radiology	_____	_____	_____																																					
Pharmacy	_____	_____	_____																																					
Consult (i.e., Ortho)	_____	_____	_____																																					
1.2 ARRIVAL Date _____ Time of Arrival _____ Time of Injury _____ Date of Injury _____ Transit Time minutes _____	1.3 EVAC FROM <input type="checkbox"/> 1st Responder <input type="checkbox"/> Forward Resuscitative Care <input type="checkbox"/> Theater Hospital Location _____																																							

2. CARE DONE PRIOR TO ARRIVAL

2.1 PREHOSPITAL TOURNIQUET Upper Extremities: Type: <input type="checkbox"/> CAT <input type="checkbox"/> SOFTT <input type="checkbox"/> Other _____ Time On _____ Off _____ <input type="checkbox"/> R How many? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 Effective? <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 Effective? <input type="checkbox"/> Y <input type="checkbox"/> N	2.2 PREHOSPITAL VITALS GCS Eye _____ /4 Verbal _____ /5 Motor _____ /6 Total _____ /15 T _____ P _____ RR _____ BP _____ / _____ O2Sat _____	2.3 PREHOSPITAL HEMORRHAGE CONTROL MEASURES <input type="checkbox"/> Celox <input type="checkbox"/> ChitoFlex <input type="checkbox"/> Combat Gauze <input type="checkbox"/> Direct Pressure <input type="checkbox"/> Field Dressing <input type="checkbox"/> HemCon <input type="checkbox"/> QuikClot <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	2.4 PREHOSPITAL WARMING <input type="checkbox"/> Blanket <input type="checkbox"/> Body Bag <input type="checkbox"/> HPMK <input type="checkbox"/> Space Blanket <input type="checkbox"/> Other _____ 2.5 PREHOSPITAL MEDS _____ _____ _____ _____	2.6 PREHOSPITAL INTERVENTIONS Prehospital Airway <input type="checkbox"/> Y <input type="checkbox"/> N Intubated..... <input type="checkbox"/> Y <input type="checkbox"/> N Cric <input type="checkbox"/> Y <input type="checkbox"/> N Trach..... <input type="checkbox"/> Y <input type="checkbox"/> N Needle Decompression <input type="checkbox"/> Y <input type="checkbox"/> N C-spine Immobilized <input type="checkbox"/> Y <input type="checkbox"/> N Pelvic Binder <input type="checkbox"/> Y <input type="checkbox"/> N IO Infusions <input type="checkbox"/> Y <input type="checkbox"/> N Eye Shield OS <input type="checkbox"/> Y <input type="checkbox"/> N OD <input type="checkbox"/> Y <input type="checkbox"/> N CPR prior to arrival.. <input type="checkbox"/> Y <input type="checkbox"/> N
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3. PRIMARY SURVEY

3.1 VITALS P _____ RR _____ BP _____ / _____ O2Sat _____ Pain Scale (0 - 10) _____	3.3 HYPO / HYPERTHERMIA CONTROL MEASURES Arrival Temp _____ <input type="checkbox"/> F <input type="checkbox"/> C Time _____ Date _____ Route <input type="checkbox"/> Oral <input type="checkbox"/> Axillary <input type="checkbox"/> Rectal Temperature Control Procedure: <input type="checkbox"/> Bair Hugger <input type="checkbox"/> Warming Blanket <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Cooling Blanket <input type="checkbox"/> Other _____	3.5 BREATHING <input type="checkbox"/> Unlabored <input type="checkbox"/> Labored <input type="checkbox"/> Flaring <input type="checkbox"/> Retraction <input type="checkbox"/> Absent Breath Sounds: Clear <input type="checkbox"/> R <input type="checkbox"/> L Rales <input type="checkbox"/> R <input type="checkbox"/> L Wheeze <input type="checkbox"/> R <input type="checkbox"/> L Absent <input type="checkbox"/> R <input type="checkbox"/> L Chest Symmetry: <input type="checkbox"/> Equal <input type="checkbox"/> Left > <input type="checkbox"/> Right > Flail <input type="checkbox"/> R <input type="checkbox"/> L Trachea: <input type="checkbox"/> Midline <input type="checkbox"/> Deviated	3.6 CIRCULATION Skin: <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Hot <input type="checkbox"/> Pink <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Diaphoretic Heart Sounds: <input type="checkbox"/> Clear <input type="checkbox"/> Muffled Capillary Refill: <input type="checkbox"/> < 2 Seconds (normal) <input type="checkbox"/> > 2 Seconds (delayed)
3.2 AIRWAY <input type="checkbox"/> Patent <input type="checkbox"/> Stridor <input type="checkbox"/> Drooling <input type="checkbox"/> Obstructed <input type="checkbox"/> Oral/Nasal Airway <input type="checkbox"/> BVM <input type="checkbox"/> Intubated <input type="checkbox"/> Combi Tube <input type="checkbox"/> Other _____	3.4 CPR IN ED <input type="checkbox"/> Y <input type="checkbox"/> N Start Time _____ End Time _____	3.7 DEFICIT / NEURO <input type="checkbox"/> Alert - Obeys Commands <input type="checkbox"/> Responds to Verbal Stimuli <input type="checkbox"/> Responds to Painful Stimuli <input type="checkbox"/> Unresponsive to Painful Stimuli GCS: Eye _____ /4 Verbal _____ /5 Motor _____ /6 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

Part I, Nursing Flow Sheet

4. SECONDARY SURVEY

4.1 HEAD / NECK / ENT 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"/> Brisk <input type="checkbox"/> Sluggish <input type="checkbox"/> NR Left: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Brisk <input type="checkbox"/> Sluggish <input type="checkbox"/> NR	4.2 HEART / THORACIC 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 _____ R _____ L _____ Femoral _____ R _____ L _____ Brachial _____ R _____ L _____ Radial _____ R _____ L _____ Pedal _____ R _____ L _____	4.3 ABDOMINAL/GU <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 @ _____	4.4 EXTREMITIES 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) _____ _____ _____
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Procedure	Time	Size/Type	Site	Performed By	Results
O ₂ Therapy _____ Lpm	On _____ Off _____	<input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Oral Airway <input type="checkbox"/> NRB Mask _____ % <input type="checkbox"/> Nasal Airway <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 Blood (cc) _____
Chest Tube #2	Time _____		<input type="checkbox"/> L <input type="checkbox"/> R		<input type="checkbox"/> Air Blood (cc) _____
Needle Decompression	Time _____		<input type="checkbox"/> L <input type="checkbox"/> R		<input type="checkbox"/> Air 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

Part II, Physician H&P

1. HISTORY & PHYSICAL - INJURY DESCRIPTION

1.1 ARRIVAL

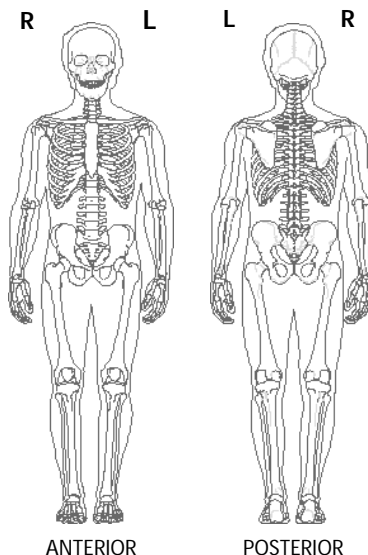
Date _____
Time of Arrival _____

1.2 TRIAGE CATEGORY

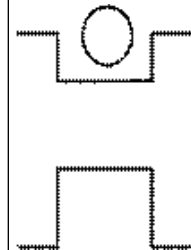
- Immediate
 Delayed
 Minimal
 Expectant

1.4 INJURY DESCRIPTION

- (AB)rasion
(AMP)utation
(AV)ulsion
(BL)eeding
(B)urn %TBSA _____
(C)repitus
(D)eformity
(DG)Degloving
(E)chymosis
(FX)Fracture
(F)oreign Body
(GSW)Gun Shot Wound
(H)ematoma
(LAC)eration
(PW)Puncture Wound
(SS)Seatbelt Sign
(SW)Stab Wound
(P)ain
(PP)Peppering



Pulses Present
S= Strong
W= Weak
D= Doppler
A=Absent



1.3 CHIEF COMPLAINT, HISTORY AND PRESENTING ILLNESS

1.5 HISTORY AND PHYSICAL

Head & Neck :

1.6 PRE / INITIAL PROCEDURES / DIAGNOSTICS

- Pre / Initial Cric C-Collar/ Time Removed _____
 ICP Monitor Cantholysis & Canthotomy R L
 Ventric Tympanic Membranes Rupture R L
Blood R L
 Eye Shield R L

Chest:

- Needle Decompression R L Pericardial describe:
FAST - / + _____
 Pericardiocentesis

Abdomen/Back and Spine:

- DPL Gross Blood: - / + describe _____
Log Roll Time _____
Back Exam WNL ABNL describe _____
Rectal Exam WNL Weak/Absent Tone Gross Blood: - / +

Pelvis: Stable Unstable Binder

Prostate _____
Gyn _____

Upper Extremities:

- Closed Reduction EXT Fixation Tourniquet
 Wound Washout Splint R # _____
 L # _____

Lower Extremities:

- Closed Reduction EXT Fixation Tourniquet
 Wound Washout Splint R # _____
 L # _____

Interventions Prior to Arrival:

- Sedated 3% Saline Cntrl Line Loc _____ Site _____
 Chemical Paralyze Mannitol IO Loc _____ Site _____
 Seizure Protocol A-Line Loc _____ Site _____

1.7 PUPILS / VISION

Brisk R L Hand Motion R L
Sluggish R L Light Perception R L
NR R L No Light Perception R L
Size Right mm _____ Left mm _____

1.8 BURN

1st 2nd 3rd
%TBSA _____
>20% Use the Burn Flow Sheet
Cause _____

1.9 EXTREMITIES

	Motor	Sens	ROM
RUE	+ _____ / - _____	+ _____ / - _____	+ _____ / - _____
LUE	+ _____ / - _____	+ _____ / - _____	+ _____ / - _____
RLE	+ _____ / - _____	+ _____ / - _____	+ _____ / - _____
LLE	+ _____ / - _____	+ _____ / - _____	+ _____ / - _____

PATIENT IDENTIFICATION

Name: Last _____ First _____ MI _____ Rank _____

Patient ID/SSN _____ BRN _____ Medical Record # _____ DOB _____ Age _____ Gender M F

Facility Name _____ Facility Location _____ Physician Signature _____

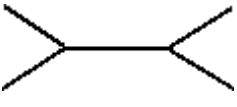
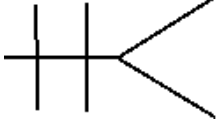
RESUSCITATION RECORD

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"/> 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 <u>not</u> cleared based on: <input type="checkbox"/> Neuro c/o, abnormal exam <input type="checkbox"/> Abnormal imaging <input type="checkbox"/> Unreliable Pt

3. LABORATORY RESULTS

<p style="text-align: center;"><u>3.1 CBC</u></p> 	<p style="text-align: center;"><u>3.2 CHEMISTRY 7</u></p> 	<p style="text-align: center;"><u>3.4 LFT</u></p> Amylase _____ Bili _____ Alk Phos _____ SGOT _____ LDH _____ SGPT _____ Other _____	<p style="text-align: center;"><u>3.5 URINALYSIS</u></p> SpGr _____ Chem _____ Micro _____ HCG _____ pH _____ Bact _____ WBC _____ RBC _____
<u>3.3 PT / INR / PTT</u> _____ / _____ / _____			

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 Yes No INR >1.4 Yes No Base Deficit >5 Yes No FWB Requested Yes No
Damage Control Yes No

6.3 DISPOSITION

 OR ICU ICW Transfer Date: _____ Time: _____

7. DNBI / NBI CATEGORY

 Injury, Sports Injury, Work/Training Surgical _____
 Injury, MVC Injury, Other _____

8. CAUSE OF DEATH

8.1 ANATOMIC

 Airway Neck Abdomen Extremity U / L
 Head Chest Pelvis Other, Specify _____

8.2 PHYSIOLOGIC

 MOF Sepsis Total Body Disruption
 CNS Hemorrhage Breathing
 Other, Specify _____

PATIENT IDENTIFICATION

Name: Last _____ First _____ MI _____ Patient ID/SSN _____
BRN _____ Facility Location _____ Physician Name _____ Physician Signature _____