Oregon Trauma Registry - TRAUMA SYSTEM PATIENT

TRAUMA SYSTEM ID ______________________________

RECORDED BY ___________________ DATE _____/_____/______

HOSPITAL CODE __________________________________

MEDICAL RECORD NO. ____________________________

PATIENT DATA

Designation: Field ED Transfer Retrospective   Hospital Response: Full Modified NO activation

Last Name ________________________________ First Name ____________________________

FOR HEALTH DIVISION USE

Residence: OR County ___________________________ or WA ID CA NV OTHER UNK

Social Security # ____ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of Birth ________ /________ /_________ (MM/DD/YY)   Sex: M F

Race (circle one): White Black NAT- American Asian Hispanic OTHER UNK

INJURY DATA

Was the injury on the job? Y N If Yes: Occupation ___________________________ Employer Name __________________________

Injury Date _______ /_______ /________ (MM/DD/YY)   Nearest Town ______________________________

OR County of Injury ________________________________ or WA ID CA NV OTHER UNK

Location: HOME FARM LOGging INDUSTrial REC/sport STREET FWY/Hwy PB bldg RES. Inst. OTHER UNK

Injury Address or Latitude & Longitude:____ Injury ZIP Code ____________________

Description of Cause of Injury (What Happened?): ____

____

E Code: 1) E____ ____ ____.____   2) E____ ____ ____.____   Trauma Type: Blunt Penetrating (Circle one)

Protective Devices Used (circle all that apply): NONE LAPbelt SHOULDerbelt SAFETYbelt (NOS) AIRBAG CHILDseat HELmet FLOATation safety GLASses protective CLOTHing NA UNK OTHER

ETOH test status: NOT   Enter results, if tested: __.________g/100cc

Other inTOX test status: NOT   Circle results, if tested: NONE CANNabis COCaine PCP BENzodiazepines BARBiturates AMPHETamines OPIATes OTHER: ___________________________

TRANSFER DATA

Transfer mode from referring hospital (circle all that apply): gr-AMB HELI fixed-WG POV Other ______________(specify)

Transfer Data: Referring Hospital ______________ Transfer Agency _____________ Depart Time _______ : _______Arrival Time ______ : ______

Assist. Agency _____________ Depart Time _______ : _______Arrival Time ______ : ______

PREHOSPITAL DATA

Transport mode from the injury scene (circle all that apply): gr-AMB HELI fixed-WG POV Other ________________(specify)

Transport agency data:

Run Number	______________________	Assisting Agency	______________________	*Cert Levels
Transport Agency	____________________	Highest certification level	________	RN
Highest certification level	________	Call Received	_____:_____	EMTP
Call Received	_____:_____	Arrived at scene	_____:_____	EMTI
Arrived at scene	_____:_____	Left scene	_____:_____	EMTB
Left scene	_____:_____	Arrived at Dest.	_____:_____	OTHER
Arrived at Dest.	_____:_____	Intubation Attempts	________	
Intubation Attempts	________			

Triage Criteria (mark all that appear on the prehospital report):

I. Vital Signs/LOC
- ❑ SHOCK - Syst. BP <90
- ❑ Resp. distress: RATE < 10 or > 29
- ❑ Altered MENTation: GCS ≤ 12

II. Anatomy of Injury
- ❑ PENetration, mid-thigh to head
- ❑ AMPutation above wrist or ankle
- ❑ Spinal cord injury with PARALysis
- ❑ FLAIL chest
- ❑ 2 or more obvious FX's of femur/humerus

III. Mechanism of Injury
- ❑ DEATH of same car occupant
- ❑ Pt. EJECTed from enclosed vehicle
- ❑ Heavy EXTRICation > 20 minutes

IV. Hi-Energy Transfer Situation
- ❑ FALL > 20 feet
- ❑ PED. hit 20 mph or thrown 15 feet
- ❑ Vehicle ROLLover
- ❑ MCA/ATV/Bicycle crash
- ❑ IMPACT or significant intrusion

V. Comorbid Factors
- ❑ AGE < 12 or > 55
- ❑ Hostile ENVironment (heat, cold, etc.)
- ❑ MEDical illness
- ❑ Presence of inTOXicants
- ❑ PREGnancy

VI. OTHER - criteria specified:

____

- ❑ NONE - No criteria marked on PHCF
- ❑ UNK - No prehospital form

Field Procedures (circle all that apply): NONE UNK NEEDle Thoracentesis MAST Inflated CPR SPLINT C-COLLAR MEDS SP-IMMobilize IV Access INTUBated

ED DATA

Hospital Arrival Time: _______ : ________   Hospital Arrival Date: ______/______/________ (MM/DD/YY)

Clinical Data:	Num	Resp* Rate	Pulse Rate	SBP	Eye	Verbal	Motor	GCS	Airway*	End Tidal CO_2*
Field	1									
ED (Admit)	2									
ED (1 hour/Last)	3									

*Unassisted

*Airway Options	
Normal	PEAD
Oral/Nasal	CRIC
P- Trach	TRACH
P- BVM	BVM
P- ET	ET tube
	LMA

* End Tidal CO_2 Options	
No	Not Documented
Yes	Not Applicable
	NOT Available

Provider Times in ED:	Call Time	Arrival Time		Call Time	Arrival Time
Trauma Surgeon	:	:	ANESthesiologist	:	:
NEUROsurgeon	:	:	ED MD	:	:

Resuscitation: Procedures: NONE BLOOD CHEST tube CPR DPL FAST THORAcotomy/Pericardiocentesis ARTI line SG/CVP

Diagnostics: NONE CT Head/neck CT Chest CT Abd/pelvis ANGIO-Head/neck ANGIO-Chest ANGIO-Pelvis/extremities

ED Disposition: (INPT) OR ICU FLOOR DIRECT OTHER ________________________(specify)

(ED) DisCharge EXPired AMA DOA TRANSfer ________________________(specify)

ED Discharge/Death Time: ______:______   ED Discharge/Death Date ______/______/________ (MM/DD/YY)

INPATIENT DATA

Inpt. Admit Date: ______/______/________ (MM/DD/YY)

Admit Service (circle only one): Trauma/GENeral Surg ORTHOpedic NEUROsurg OMFS THOR OTHER surg PEDS NON-surg

Detail (optional)________________________

Consults (circle all that apply): Trauma/GENeral Surg ORTHOpedic NEUROsurg OMFS THOR OTHER surg PEDS NON-surg NONE

OR Procedure Data:

ICD9 Code	MD	Start Time	Start Date	ICD9 Code	MD	Start Time	Start Date
		:	/ /			:	/ /
		:	/ /			:	/ /
		:	/ /			:	/ /

Total ICU Days ______

Medical History (circle all that apply): NONE CARDiovascular RESPiratory Anti-COAG Medication LIVER RENAL DIABetes PREGnancy NEUROlogical PSYCHiatric IMM-Disease IMM-Therapy IMM-Post-splenectomy UNK OTHER __________________(specify)

Inpatient Discharge Disposition: HOME HOME-Health FOSTER Care ASSISTed Living SNF-ICF AMA EXPired

Facility Name______________________ of: REHAB ACUTE care or OTHER facility

Inpt. Discharge/Death Time: ______:______   Inpt. Discharge/Death Date ______/______/________ (MM/DD/YY)

Functional Ability:

Pre-Injury disability (circle one each): Locomotion: Yes No   Communication: Yes No

Post-Injury Functional Status at Discharge:

	IND	MOD/IND	MOD/DEP	DEPEND	PED
Feeding					
Locomotion					
Communication					

Advanced Directive
AD POLST BOTH No NA

Support Withdrawn
Yes No NA

Discharge GCS ________

DIAGNOSIS

ICD9 Code	Narrative	AIS	Body Region

ISS ________

Donation Status: TISSues ORGans BOTH NONE NA   Autopsy: Yes No NA

Oregon Trauma Registry - TRAUMA SYSTEM PATIENT

TRAUMA SYSTEM ID ______________________

LAST, FIRST NAME ______________________

COMPLICATIONS

Mark all that apply and note corresponding ICD-9 code in section below:

I. Hospital - Pulmonary:
- ❑ ABSCess (excludes empyema)
- ❑ Adult respiratory distress syndrome/ARDS
- ❑ EMPYema
- ❑ FAT embolus
- ❑ HEMOthorax
- ❑ PNEUmonia
- ❑ PNEUMOthorax
- ❑ Pulmonary Embolus

II. Hospital - Cardiovascular
- ❑ Myocardial Infarction/MI
- ❑ Pericardial EFFUSion or tamponade
- ❑ SHOCK

III. Hospital - Gastronintestinal (GI):
- ❑ Anastamotic LEAK
- ❑ DEHIScence/evisceration
- ❑ ENTERotomy-iatrogenic
- ❑ FISTulas
- ❑ HEMORRhage
- ❑ PERItonitis
- ❑ Small Bowel Obstruction

IV. Hospital - Hepatic, Pancreatic, Biliary, Splenic:
- ❑ ACALCulous cholecystitis

V. Hospital - Hematologic:
- ❑ COAGulopathy
- ❑ Disseminated intravascular coagulation/DIC

Vi. Hospital - Infection
- ❑ FUNGAL sepsis
- ❑ Intra-ABDominal abscess
- ❑ SEPSIS-like syndrome
- ❑ SEPTicemia
- ❑ SINUSitis
- ❑ Wound INFECTion

VII. Hospital - Renal/Genitourinary (GU):
- ❑ Renal Failure
- ❑ Urinary Tract Infection

VIII.Hospital - Musculoskkeletal/Integumentary:
- ❑ COMPartment syndrome
- ❑ Decubitus (OPEN sore)
- ❑ Decubitus (DEEP)
- ❑ OSTEOmyelitis

IX. Hospital - Neurologic:
- ❑ Diabetes Insipedus
- ❑ MENingitis
- ❑ SEIZure in hospital
- ❑ SIADH
- ❑ Stroke/CVA
- ❑ VENTRiculitis-postsurgical

X. Hospital - Vascular:
- ❑ ANAStomotic hemorrhage
- ❑ Deep Venous Thrombosis
- ❑ Embolus/THROMBosis
- ❑ GRAFT infection

XI. Other:
- ❑ NONE

Complications or additional diagnosis:

ICD9 Code	Narrative	AIS	Body Region

QI INDICATORS

Mark all that apply:

I. Prehospital - Airway:
- ❑ ESOPHageal intubation

II. Prehospital - Miscellaneous:
- ❑ No EMS form
- ❑ INTUBation required 5-10 min. after patient arrival
- ❑ MULTiple patient scene

III.Hospital - Provider errors/delays:
- ❑ DELAY or failure to activate the trauma team
- ❑ Delay/ERROR in diagnosis
- ❑ Intracranial injury w/LOC, CAT scan >2 hours

IV. Hospital - Miscellaneous:
- ❑ ANESthetic complication
- ❑ HYPOthermia
- ❑ POST-OPerative hemorrhage
- ❑ Unplanned return to surgery <48 hrs. of first surgery
- ❑ NON-OPerative management of abdominal GSW
- ❑ SBP <70 mmHg more than one hr. after ED admission

V. Other:
- ❑ NONE

COMMENTS:

(Specify both Primary and Secondary Payor Source in space provided)

Total Charges: $ ______________________

Primary Payor Source: ______________________

Secondary Payor Source: ______________________

MEDICARE	BLUE Cross/Blue Shield
MEDICAID	CAR Insurance Companies
WORKmans Compensation	SELF Pay
HMO	WARD of Federal Government
OTHER Health Insurance	UNKnown