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|  **MRN:**       **Trauma Registry#:**       **ISS:**       |
| **CASE INFORMATION** |
| **Injury Date:**       **Date of Death:**        | **Trauma Activation Level**[ ]  Level I (Red)[ ]  Level II (Yellow)[ ]  Level III (Green/GERI) [ ]  NO ACTIVATION**Mode of Arrival**[ ]  Self[ ]  EMS       |
| **Mechanism of Injury:**       **Probability of Survival:**[ ]  Low[ ]  Moderate[ ]  High |
| **Pre-hospital Information:** [ ]  N/A**EMS Time on Scene:**      **GCS:**      **VS:**      **Pulsara Notification:** [ ]  Yes [ ]  No |
| **ED Diagnosis:**      **Disposition/Hospital Course:**[ ]  Admission[ ]  Transfer[ ]  Deceased in ED      **ED LOS:**        | **Admission Service:** [ ]  N/A[ ]  ICU [ ]  Med/Surg**Admission Team:**[ ]  Trauma [ ]  Hospitalist [ ]  Other Specialty:       |
| **Transfer Service:** [ ]  N/A**Transfer Location:**       **Accepting Provider:**       **Specialty:**       **Transfer by:**[ ]  ALS/CC Ground:       [ ]  Flight:        |
| **Cause of Death:**       |
| **Co-Morbidities:**       |

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| **TRAUMA MORTALITY REVIEW AUDIT** |
| 1. **The patient’s death was deemed:**

[ ]  Preventable[ ]  Potentially Preventable[ ]  Non Preventable1. **Are there any quality concerns that may have contributed to the patient’s death?**

[ ]  No[ ]  Yes\*  \*If yes, please explain:       | 1. **Are there any quality concerns and/or utilization issues that did not directly contribute to the patient’s demise?**

[ ]  No[ ]  Yes\*  \*If yes, please explain:       |
| **Corrective Actions** | **Follow-up/Closure** |
| [ ]  **No Action Needed; Standards Met**[ ]  Focus Audit Trend Identified: [ ]  Yes [ ]  No[ ]  Discuss/Coach       Date:      [ ]  Letter sent to       Date:      [ ]  Referred- Trauma Peer Review Committee[ ]  Midas Entry Needed/Completed Date:        | [ ]  **No Follow-up Needed; Care not affected**[ ]  Discussion/Verbal Reply Sufficient Date:      [ ]  Education Needed/\*Completed \*Date:      [ ]  Response Requested from      [ ]  Follow-up with Trauma Committee[ ]  Other       |
| **Comments**: [ ]  None[ ]        |
| **Verification:**[ ]  Trauma Peer Review Date:       [ ]  N/A[ ]  **Case Closure Date**:       |
| **Trauma Medical Director Signature: Date:**       |
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