**The following are considered** **Trauma Patients** **that require this form sent with them for rounding.**

**Emergency RN:** Please check the box(s) of the TRAUMA admission reason.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Head Bleed |  | Chest/Lung/Heart Injury |  | Significant Bleeding |  | Nerve Injury |  | Fracture of *any* Bone:  List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Skull Fracture |  | Rib Fracture **(Anesthesia consult)** |  | Foreign Body |  | Burn |  |
|  | Spinal Fracture/Injury |  | Intraabdominal Trauma |  | Crush Injury |  | Open wound requiring admit |  | Other: |

**Charge Nurse**

When calling for inpatient bed, alert House Supervisor that this is a *Trauma Patient* and mark Trauma box on admission log.

**Nurse Checklist – To be completed at time of Admission**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initial GCS 🗆 | Full Assessment 🗆 | Repeat GCS 🗆 | Inpatient Rounding Statement 🗆 | Activation Order 🗆 OR: NA 🗆 |
| Completed By: **DATE:** | | | | |

**Procedures** completed in ED? (Central line, intubation, moderate sedation/ reduction, ect).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**After this side is completed, send with the patient to admission room with chart.**

**INPATIENT**To be completed daily and initialed by primary nurse when complete.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please date 🡪** | **Day 0** | **Day 1** | **Day 2** | **Day 3** | **Day 4** | **Day 5** | **Day 6** | **Day 7** |
| Patient location: | ICU  Floor | ICU  Floor | ICU  Floor | ICU  Floor | ICU  Floor | ICU  Floor | ICU  Floor | ICU  Floor |
| Intubated? | Yes  No | Yes  No | Yes  No | Yes  No | Yes  No | Yes  No | Yes  No | Yes  No |
| DVT Prophylaxis? | SCD  Medications  None | SCD  Medications  None | SCD  Medications  None | SCD  Medications  None | SCD  Medications  None | SCD  Medications  None | SCD  Medications  None | SCD  Medications  None |
| Prophylactic antibiotics prior to surgery? | Yes  No  N/A | Yes  No  N/A | Yes  No  N/A | Yes  No  N/A | Yes  No  N/A | Yes  No  N/A | Yes  No  N/A | Yes  No  N/A |
| Blood needed and administered. | Yes  No  N/A | Yes  No  N/A | Yes  No  N/A | Yes  No  N/A | Yes  No  N/A | Yes  No  N/A | Yes  No  N/A | Yes  No  N/A |
| Any procedures? (IR, bedside, OR, misc)If yes, please write in | Yes  \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  No |
| Any Complications?  Infection, Pneumonia, VAP, Unplanned procedure, unplanned surgery, Unplanned ICU, Death, Other. | Yes  \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  No | Yes  \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  No |
| Other:  Significant Events |  |  |  |  |  |  |  |  |
| RN Name: |  |  |  |  |  |  |  |  |

**After complete, send to your PCS- Thank you!** Contact Keli Anderson with any questions.