Oregon Trauma Registry Patient:

Recorded by__________________ Recorder Date _____________________

Trauma Band #____________________________ **Hospital Acct #** _______________________ **Med Rec #** _________________________

PATIENT INFORMATION

Last Name ________________ First Name ________________ MI _____ DOB ____/____/____

Gender M F   Race (circle one): W B NAT A H PI OTH   Social Sec # ____--____--____

Res. Zip __________ Res. City ________________ Res. County ________________ Res. State __________

Hospital Arrival Date __/__/__ Hospital Arrival Time ____:____ Trauma System Entry: Field ED Transfer Retrospective

Patient Category: Trauma CBRNE SPecial Population

INJURY EVENT

Injury Date __/__/__ Injury Time ____:____ Act/Est?____ Location: E849.____ Address of Injury ________________

Injury Zip __________ Injury City ________________ Injury County ________________ Injury State __________

1st Ecode ________ 2nd Ecode _________ Safety Equipment: AIRBAG CHILD CLOTH FLOAT GLASs HELMet BELT (3-point) LAP NONE OTHER SAFETY (nos) SHOULD

Location of Pt (detail) ________________________________

Cause of Injury (detail) ________________________________ * MV Speed _____mph * Fall Height ________ft.

Work Related? Y / N   Occupation ________________ Employer ________________

Injury Comments: ________________________________

____

EMS (Transporting Agency)

Transport Type: ❑ TP ❑ IF   **Agency #** ___________ PCR? ❑ Y ❑ N PCR # ___________ Date Called __/__/__ Time Called ____:____

At Scene ____:____ Pt. Contact ____:____ Dpt Scene ____:____ Dest. Time ____:____ Multiple Pt. Scene? Y / N Intubation Attempts ___ Successful? Y N

Vitals Date	/ /	Time	:	Pulse		Resp		SBP		DBP	
	Eyes		Verb		Motor		GCS		Airway		End Tidal? Y / N If Yes: _______

Triage Criteria: (Circle all that apply)

SHOCK	PEN	EJECT	FALL	AGE	COAG
RATE	AMP	EXTRIC	PED	IMM	EMT disc.
MENT	PARAL	DEATH	ROLL	MED	OTHER
	FLAIL		MCA	TOX	
	FX		IMPACT	PREG	

Treatments: (Circle all that apply)

NONE	SPLINT	IV
NEED	COLLAR	IO
MAST	PAD-BACK	INTUB
CPR	MEDS	BLOOD
	SP-IMM	

EMS (Assisting Agency)

Transport Type: ❑ TP ❑ IF   **Agency #** ___________ PCR? ❑ Y ❑ N PCR # ___________ Date Called __/__/__ Time Called ____:____

At Scene ____:____ Pt. Contact ____:____ Dpt Scene ____:____ Dest. Time ____:____ Multiple Pt. Scene? Y / N Intubation Attempts ___ Successful? Y N

Vitals Date	/ /	Time	:	Pulse		Resp		SBP		DBP	
	Eyes		Verb		Motor		GCS		Airway		End Tidal? Y / N If Yes: ________

Triage Criteria: (Circle all that apply)

SHOCK	PEN	EJECT	FALL	AGE	PREG
RATE	AMP	EXTRIC	PED.	IMM	COAG
MENT	PARAL	DEATH	ROLL	MED	EMT disc.
	FLAIL		MCA	TOX	OTHER
	FX		IMPACT		

Treatments: (Circle all that apply)

NONE	SPLINT	IV
NEED	COLLAR	IO
MAST	PAD-BACK	INTUB
CPR	MEDS	BLOOD
	SP-IMM	

REFERRING HOSPITAL

Date of Arrival ___/___/___ Time of Arrival ___:___ Date of Exit ___/___/___ Time of Exit ___:___

Referring Hospital ____________ Referring Physician ____________ Nature of Transfer: ❑ HIGH ❑ DIV ❑ REQ ❑ SPEC Record Avail? ❑ Y ❑ N

Vitals Date	/ /	Time	:	Pulse		Resp		SBP		DBP		
	Eyes		Verb		Motor		GCS		Temp		❑ C ❑ F	Airway on DC

Treatment: NONE BLOOD AF7 FFP PROD CHEST tube CPR DPL THORAcotomy ART line SG/CVP

Date	Time	Treatment		Date	Time	Treatment
/ /	:			/ /	:	
/ /	:			/ /	:	

Study: CT Scan MRI Plain Films US FAST Body Part: Head Chest Abd Pelvis Cspine Tspine Lspine

Date	Time	Study	Body Part		Date	Time	Study	Body Part
/ /	:				/ /	:		
/ /	:				/ /	:		

EMERGENCY DEPARTMENT

Arrived From ____________ Transport Mode ____________ Airway on Arrival ____________ Exit Date ___/___/___ Exit Time ___:___

ED Activation Criteria: UNVS MENT ANAT MECH ENERG COMORB POS STAFF OTHER

ED Physician ____________ Disposition ____________ Admit Physician ____________ Admit Service ____________

Date Transfer Identified ___/___/___ Time Transfer Identified ___:___ Transfer Out Hospital ____________ Transfer Mode Out ____________

Vitals Date	/ /	Time	:	Pulse		Resp		SBP		DBP		
	Eyes		Verb		Motor		GCS		Qualifier		Temp	Airway
End Tidal?	Y / N	If Yes: ________		Wt.	_____ L / K			Ht. (in)	______			

Vitals Date	/ /	Time	:	Pulse		Resp		SBP		DBP		
	Eyes		Verb		Motor		GCS		Qualifier		Temp	Airway
End Tidal?	Y / N	If Yes: ________										

Treatment: NONE BLOOD AF7 FFP PROD CHEST tube CPR DPL THORAcotomy ART line SG/CVP

Date	Time	Treatment		Date	Time	Treatment
/ /	:			/ /	:	
/ /	:			/ /	:	
/ /	:			/ /	:	

RADIOLOGY

Location Options	Location	Date	Start Time	Study	Body Part	Results
ED OR ICU PACU STEPdown FLOOR TELEmetry OBS OTHER POST READmission IR		/ /	:			
		/ /	:			
		/ /	:			
		/ /	:			
		/ /	:			
		/ /	:			
		/ /	:			

LAB INFORMATION

Date	Hgb	HCT	BE	INR	WBC	Glucose	BUN	Creatinine	Lactate
/ /									
/ /									
/ /									

Alcohol Tested? Y / N If Yes .__ __ __

Drugs Tested? Y / N If Yes, circle positive results: NONE CANNabis COCaine PCP BENzodiazepines BARBiturates AMPHETamines OPIATes OTHER METH

TRAUMA TEAM

Hospital Response: FULL MODifed NO Activation Date: / / Activation Time: :

Role (Service)	Member (Code)	Called Time	Arrived Time		Role (Service)	Member (Code)	Called Time	Arrived Time
		:	:				:	:
		:	:				:	:
		:	:				:	:
		:	:				:	:
		:	:				:	:
		:	:				:	:

CONSULTS

Date	Time	Service	Physician Name
/ /	:		
/ /	:		
/ /	:		
/ /	:		

INPATIENT DETAIL

Admission Date: / / Admission Time: :

Location Options	Location	Room	Date In	Date Out	Service
ICU OR STEPDOWN FLOOR TELEmetary OBS OTHER			/ /	/ /	
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	

ALL PROCEDURES

Location Options	Location	Date	Time	ICD9 Code	Treatment	Visit #	Surgeon
FLD ED OR ICU PACU STEPdown FLOO TELEmetry OBS OTHEr POST READmission		/ /	:				
		/ /	:				
		/ /	:				
		/ /	:				
		/ /	:				
		/ /	:				
		/ /	:				
		/ /	:				

DIAGNOSES

ICD9	AIS	Body Part	ICD9 Narrative	ICD9	AIS	Body Part	ICD9 Narrative

Pregnant? ❑ Y ❑ N Anticoagulants? ❑ Y ❑ N

Co-morbidity: (see manual for extensive list) NONE CARDiovascular RESPiratory Anti-COAG Medication LIVER RENAL DIABetes NEUROlogical PSYCHiatric IMM-Disease IMM-Therapy IMM-Post-splenectomy OTHER

DISCHARGE INFORMATION

Exit Date ___/___/___ Exit Time _____:_____

Discharge Disposition HOME HOME-Health SNF-ICF AMA EXPired REHAB ACUTE care OTHER facility

Total Ventilator Support Days __________

Hospital Code/Name _____________ ________________________________

Advance Directives: Advanced Directive POLST Both No

Support Removed? ❑ Y ❑ N

Primary Payor	Secondary Payor	Total Hospital Costs	Total Hospital Charges	Total Hospital Receipts
		$	$	$

Insurance Options: **COMMercial** **CAR** **MEDICAID** **MEDICARE** **OTHER Insurance** **SELF** **WARD** **WORK**

Discharge Assessment

Phase	Date	Feed	Stat	Locomo	Stat	Express	Stat	Total
	/ /							
	/ /							
	/ /							

Phase	Stat	Scoring
PRE- injury POST – injury	P = Permanent T = Temporary	P = Pediatric 4 = Independent 3 = Independent w/devices 2 = Partially dependent 1 = Totally dependent

DEATH INFORMATION

Death Location: ED OR ICU PACU STEPdown FLOOR TELE OBS SPECial Proc. Area RADiology OTHer

Autopsy? ❑ Y ❑ N

Autopsy ID___________

Organ Donation Requested: ❑ Y ❑ N

Organ Donation Granted: ❑ Y ❑ N

Organs Taken: ❑ Yes ❑ No (If Yes, circle all that apply)

Heart Corneas Skin
Liver Pancreas Bone
Kidneys Lung Other Organs NOS

Death Comments

Refer to the Abstract Manual for more complete information and options for specific fields.