



Trauma Registry Patient Abstraction Form

SECTION 1: DEMOGRAPHICS

ED Arrival Date: ___/___/___ @ ___:___ Trauma Band #: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth (MM/DD/YYYY): ___/___/___ Age: _____ SSN (Last 4 digits): _____

Age unit: Years Months Days Estimated in years Hours NA Not known

Race: Black or African-American White Asian Native Hawaiian or other Pacific Islander American Indian Other race NA Not known

Ethnicity: Hispanic or Latino Not Hispanic or Latino NA Not known

Gender: Male Female NA Not known

Home Address 1: _____

Home Address 2: _____

Home Zip: _____ City: _____ State: ___ County: _____ Country: _____

Alternate Home Residence: Homeless Undocumented Citizen Migrant worker Foreign visitor

SECTION 2: INJURY

Injury Date: ___/___/___ Injury Time: ___:___ Incident Zip: _____ Incident City: _____

Incident State: _____ Incident County: _____ Incident Country: _____

ICD-9 Primary E-code: _____ ICD-10 Primary E-code: _____

ICD-9 Additional E-code: _____ ICD-10 Additional E-code: _____

E-849x: _____

Report of physical Abuse: Yes No NA Not known

Investigation of physical Abuse: Yes No NA Not known

Injury type: Blunt Penetrating Burn NA Not known

Injury details: _____

Work related? Yes No NA Not Known

Patient Occupation: _____ Patient Occupational Industry: _____

Protective Devices (check all that apply):

- None Lap belt Shoulder belt Airbag only Airbag & Seatbelt Helmet Personal Floatation Device
- Eye protection Protective clothing Protective non-clothing gear NA Not known Other
- Child specific restraint: Child car seat Infant car seat Child booster seat
- Airbag not deployed Airbag deployed front Airbag deployed side Airbag deployed other (knee, airbelt, curtain, etc.)



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SECTION 3: PRE-HOSPITAL

EMS Agency: _____

Transport mode: BLS Ground Ambulance ALS Ground Ambulance Specialty Ground Transport Specialty Air Transport Helicopter Ambulance Fixed Wing Ambulance Public/Private Vehicle/Walk-in Police Other: _____ N/A Not known

EMS Level of Provider: EMT Advance EMT Paramedic EMS instructor Nurse Doctor First Responder N/A Not Known

Trip Form Received: Yes No NA Run Number: _____

EMS Notify Date: ___/___/___ @ ___:___ EMS Dispatch Date: ___/___/___ @ ___:___

EMS Arrival Date: ___/___/___ @ ___:___ EMS Respond Date: ___/___/___ @ ___:___

EMS Departure Date: ___/___/___ @ ___:___ EMS Arrival Destination Date: ___/___/___ @ ___:___

Reason for Destination Hospital: Insurance Protocol Specialty care/higher level of care Resources unavailable (Beds, equipment, staff, MD) Patient request Patient physician Family request Law enforcement Online medical direction Lower level of care N/A Not known

Scene Related Delays: Crowd Directions Distance Diversion Extrication > 15 minutes HazMat Language barrier Terrain Equipment Safety Staff delay Traffic Vehicle crash Vehicle failure Weather Other N/A Not known

SBP: ___ Pulse Rate: ___ Respiration Rate: ___ Respiratory Assistance: ___ Oxygen Saturation: ___ Supplemental Oxygen: ___

GCS: EYE: ___ VERBAL: ___ MOTOR: ___ Total: ___

Assessment Qualifiers: Patient intubated Obstruction to patient's eye Patient chemically sedated

SECTIONS 4: REFERRING FACILITY INFORMATION

Inter – Facility Transfer: Yes No N/A Not known

Referring Hospital: _____

Arrival Date: ___/___/___ @ ___:___ Discharge Date: ___/___/___ @ ___:___

Transfer Mode: BLS Ground Ambulance ALS Ground Ambulance Specialty Ground Transport Specialty Air Transport Helicopter Ambulance Fixed Wing Ambulance Public Vehicle/ Private Vehicle/Walk-in Police other: _____ N/A Not known

SBP: ___ Pulse Rate: ___ Respiration Rate: ___

GCS EYE: ___ VERBAL: ___ MOTOR: ___ Total: ___

Assessment Qualifiers: Patient intubated Obstruction to patient's eye Patient chemically sedated NA Not known

Referring Facility Procedures: _____

SECTION 5: ED Information

Arrived from: Scene Doctor's office Clinic Stand-alone ambulatory surgery center Acute care hospital Home
 Other: _____ N/A Not known

Mode: Ambulance Helicopter Police Public Vehicle Private Vehicle Walk-in Fixed wing ambulance
 Other: _____ N/A Not known

Direct admit: Yes No **Readmission:** Yes No

Admitting Services: Trauma Neurosurgery Orthopedic surgery ENT/Plastic surgery Thoracic surgery Pediatric surgery
 Pediatrics Other surgical service Other non-surgical service N/A Not known

ED Arrival Date: ___/___/___ @ ___:___ **ED Discharge Date:** ___/___/___ @ ___:___

Trauma Team Activation:

Level 1: Yes No N/A Not known Date/Time: ___/___/___ @ ___:___
 Level 2: Yes No N/A Not known Date/Time: ___/___/___ @ ___:___
 Level 3: Yes No N/A Not known Date/Time: ___/___/___ @ ___:___

Physician call time: ___:___ **Physician arrival time:** ___:___

ED Discharge Disposition: Floor bed Observation unit Telemetry/Step down unit Home with services Died ICU
 OR ICU Home without services Left without medical advice Transferred to another hospital Other: _____

Signs Of Life: Arrived with no signs of life Arrived with signs of life N/A Not Known

ED Death: Dead on arrival Death after failed resuscitation attempt < 15 minutes Death after failed resuscitation attempt > 15 minutes
 Died in ED

Discharge Destination Hospital: _____

SBP: ___ **Pulse Rate:** ___ **Respiration Rate:** ___ **Respiratory Assistance:** ___ **Oxygen Saturation:** ___
Supplemental Oxygen: ___

GCS: EYE: ___ VERBAL: ___ MOTOR: ___ Total: ___

Assessment Qualifiers: Patient intubated Obstruction to patient's eye Patient chemically sedated

Alcohol Use Indicator: No – not suspected No - confirmed by test Yes – confirmed by test – trace levels
 Yes – confirmed by test – beyond legal limits N/A Not known

Drug Use Indicator: No – not suspected No - confirmed by test Yes – confirmed by test – prescription drugs
 Yes – confirmed by test – illegal drugs N/A Not known

ED Care Issues: (up to 5)

Transport to appropriate facility ER physician availability Trauma team activation Trauma team arrival General surgeon availability General surgeon arrival Specialist call Specialist arrival Transfer out to appropriate facility Delay in transfer out Met transfer criteria and not transferred out Blood availability MRI availability Diagnostic test results availability Equipment not readily available Indicated procedure not performed Indicated diagnostic test not ordered or not performed Delay of pain medication Ward bed not available Missed injury Unrecognized or untreated hypothermia Unrecognized or untreated hypovolemia Aspiration due to c-spine restraints Cardiac arrest outside of ED Chest tube displacement Intubation-Esophageal Intubation-Mainstem Intubation – tube displacement Medication not available Neurovascular changes after splinting Other No ED care identified Patient refused lab/x-ray CT scan availability OR Acceptance Critical care bed not available

SECTION 6: HOSPITAL PROCEDURES

Procedures:

ICD-9 Code/ICD-10 Code	Start Date	Start Time

OR Disposition:

- Ward/floor
 ICU/CCU
 Short stay/ discharged
 Expired
 Other in-house
 Other
 Other acute care facility
 Peds
 Peds-CU
 Progressive care unit
 Jail
 N/A
 Not known

SECTION 7: DIAGNOSES

Injury Narrative, AIS, and ISS Info Injury Narrative:

Anatomical Diagnoses

ICD9/10 Code	Predot	AIS Severity	ISS Body Region

SECTION 8: QA

Comorbidities:

- Attention Deficit Disorder /Attention Deficit Hyperactivity Disorder
 Alcoholism
 Bleeding disorder
 Chemotherapy for cancer within 30 days
 Chronic Obstructive Pulmonary Disease (COPD)
 Cirrhosis
 Congenital Anomalies
 Congestive heart failure
 Current smoker
 Currently Requiring or on dialysis
 Cerebrovascular Accident (SVA)
 Dementia
 Diabetes
 Disseminated cancer
 Drug Use Disorder
 Do Not Resuscitate (DNR) status
 Functionally dependent health status
 History of angina within past 1 month
 History of myocardial infarction within past 6 months
 History of revascularization / amputation for PVD
 Hypertension requiring medication
 Major psychiatric illness
 Prematurity
 Steroid use
 Other
 N/A
 Not Known/Not Recorded

Complications:

- Acute renal failure
 Acute Respiratory Distress Syndrome (ARDS)
 Cardiac arrest with CPR
 Catheter-related blood stream infection
 Decubitus ulcer
 Deep surgical site infection
 Deep vein thrombosis (DVT)/ thrombophelbitis
 Drug or alcohol withdrawal syndrome
 Extremity compartment syndrome
 Graft/prosthesis/flap failure
 Myocardial infarction
 Organ/space surgical site infection
 Osteomyelitis
 Pneumonia
 Pulmonary embolism
 Severe sepsis
 Stroke/CVA
 Superficial surgical site infection
 Unplanned admission to ICU
 Unplanned intubation
 Unplanned return to the OR
 Urinary tract infection
 Other
 N/A
 Unknown

SECTION 9: OUTCOME

Hospital Discharge date/time: ___/___/___ @ ___:___ Total hospital days:___ Total ICU days:___
 Total Ventilator days:___

Hospital Disposition:

- Discharged/Transferred to a short term general hospital for inpatient care
- Discharged/ Transferred to an intermediate care facility (ICF)
- Discharged/Transferred to home under organized home health services
- Left against medical advice or discontinued care
- Expired
- Home or self-care (routine discharge)
- Discharged/Transferred to a skilled nursing facility
- Discharged/Transferred to hospice care
- Discharged/Transferred to another type of rehabilitation or long term care facility
- Discharged/Transferred to court/law enforcement
- Discharged/Transferred to inpatient rehab or designated unit
- Discharged/Transferred to Long Term Care Hospital (LTCH)
- Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

Discharge to alternate caregiver: Yes No N/A Not known

Initial rehab referral facility: _____ N/A Unknown

Receiving rehabilitation facility: _____ N/A Unknown

Days from referral to discharge: _____ Days N/A Unknown

Delays to rehab facility: Patient medical condition Bed availability Payment issues Other facility delays N/A Unknown

GOS-E: Extended Glasgow Outcome Scale: Dead Vegetative state Lower severely disabled Upper severely disabled
 Lower moderately disabled Upper moderately disabled Lower good recovery Upper good recovery N/A Unknown

Consults: Social Work Physical Therapy Mental Health Rehabilitation Family Practice ER Physician Hospitalist
 Psychiatrist Other: _____ N/A Unknown

Life support withdrawn: Yes – life support was withdrawn No- life support was not withdrawn N/A Not known

Organ donation: Yes No N/A Not known

Organs donated: Heart Lungs Liver Kidneys Cornea Pancreas Intestine Skin Other tissue Other organ
 N/A Not known

Autopsy done: Yes – autopsy done No - autopsy not done N/A Unknown

Autopsy results requested: Yes – autopsy requested No – autopsy not requested N/A Unknown

Autopsy results received: Yes – autopsy received No – autopsy not received N/A Unknown

SECTION 10: FINANCIAL INFORMATION

Primary Payment Method:

- Medicaid Not billed (for any reason) Self-pay Private/commercial insurance No fault automobile Medicare
- Other government Workers compensation Other: _____

Secondary Payment Method:

- Medicaid Not billed (for any reason) Self-pay Private/commercial insurance No fault automobile Medicare
- Other government Workers compensation Other: _____

Financial Information Available: Yes - available at this time No – not available at this time

Charges: \$ _____ **Actual Reimbursement:** \$ _____