Trauma Chronology	Name:	MRN:	Date:	
Time (24h clock)	Time (from arrival)	Name band: Yes / No	Nurse	Signature
:	00 : 00	Patient arrival		
:	:	Scoop / board removed *(target from time of arrival 5 minutes)*		
:	:	IV access obtained *(target from time of arrival 5 minutes)*		
:	:	Primary survey x-ray performed *(target from time of arrival 10 minutes)*		
:	:	Patient on CT table *(target from time of arrival 30 minutes)*		
:	:			
:	:			
:	:			
:	:			
:	:			
:	:			
:	:			
:	:			
:	:			
:	:			
:	:			
:	:			
:	:			
:	:			

Ongoing care notes

Name: MRN: Date:

Time (24h clock)		Nurse	Signature
:			
:			
:			
:			
:			
:			
:			
:			
:			
:			
:			
:			
:			
:			
:			
:			
:			
:			
:			

Valuables

Valuables retained by patient:

Clothes:

☐ Spectacles ☐ Hearing aid

☐ Dentures ☐ Watch

☐ Rings _____

Keys _____

Mobile phone

Valuables retained for safekeeping

Property book receipt number_____

Signature nurse 1 _____

Print name_____

Signature nurse 2 _____

Print name _____

Property disposal

Given to relatives ☐

Signature of relative _____

Print name _____

Given to police ☐

Reference number_____

Prescription chart (1)- Fluids and Drugs

Name: MRN: Date:

Date	Time	Fluid / Drug	Dose	Route	Rate	Prescriber's signature	Given by / Checked by	Time
		Morphine		iv			/	
		Paracetamol	1g	iv	20 mins		/	
		Tetanus toxoid	1	im	stat		/	
		0.9% Saline _____ml + Tranexamic acid	1g	iv	10min		/	
		0.9% Saline _____ml + Tranexamic acid	1g	iv	8h		/	
							/	
							/	
							/	
							/	
							/	
							/	
							/	
							/	
							/	
							/	
							/	
							/	

Prescription chart (2) - Blood and Blood components

Name: MRN: Date:

Pre-transfusion checklist: 1. Verbal ID 2. ID wristband 3. Prescription 4. Compatibility label 5. Blood group 6. Expiry date 7. Product details

Date	Time	Blood / Blood component	Dose	Rate	Prescriber's signature	Given by / Checked by	Transfusion label	Time

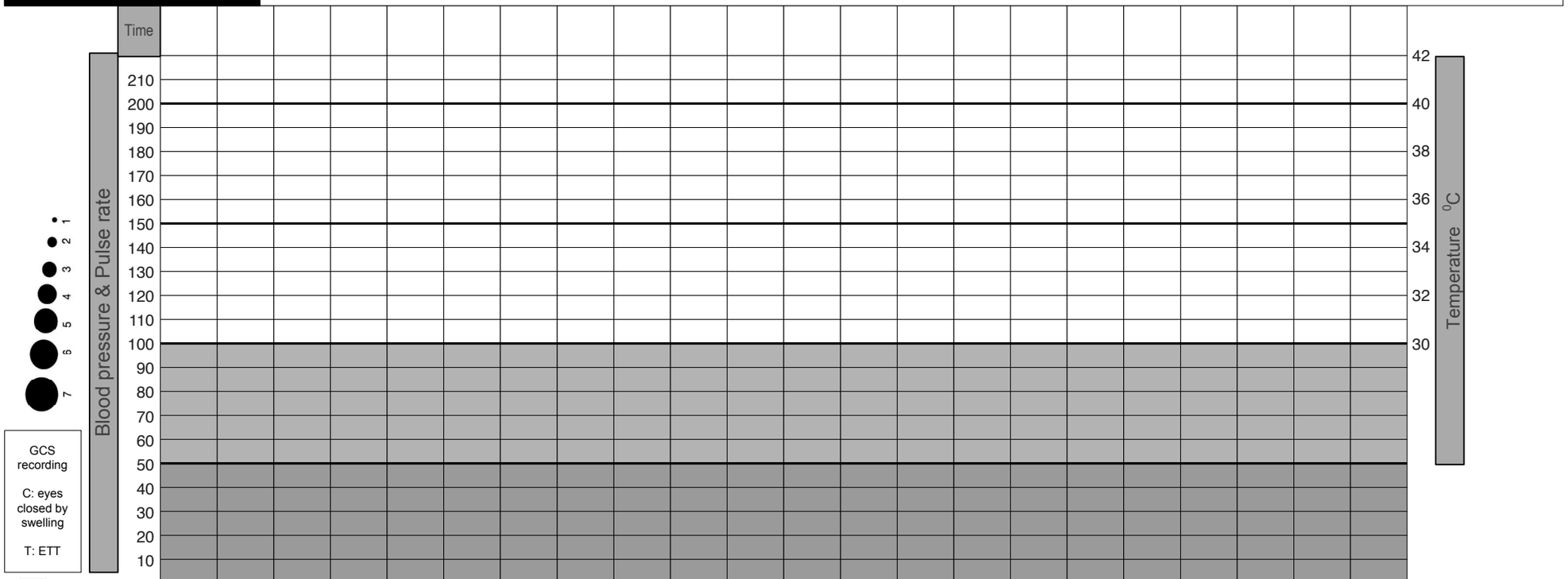
Prescription chart (3) - Blood and Blood components

Name: MRN: Date:

Date	Time	Blood / Blood component	Dose	Rate	Prescriber's signature	Given by / Checked by	Transfusion label	Time

Observation Chart

Name: MRN: Date:



Eyes	Open spontaneously 4																						4	Open Spontaneously
	Open to speech 3																						3	Opens to speech
	Opens to pain 2																						2	Opens to pain
	None 1																						1	None
Verbal	Orientated 5																						5	Smiles /interacts
	Confused 4																						4	Consolable
	Inappropriate words 3																						3	Inconsistently consolable
	Incomprehen.sounds 2																						2	Inconsolable/Irritable
	None 1																						1	None
Motor	Obeys commands 6																						6	Moves spontaneously
	Localises to pain 5																						5	Localises to pain
	Normal flexion to pain 4																						4	Withdraws to pain
	Abnorm. flexion to pain 3																						3	Abnormal flexion to pain
	Extension to pain 2																						2	Extension
	None 1																						1	None
	Total GCS																							Paediatric GCS
Pupils	Right pupil size																							
	Right pupil reaction																							
	Left pupil size																							
	Left pupil reaction																							

	Time																					
Ventilation parameters	Resp. rate																					
	SpO_2																					
	O_2 device / Air																					
	O_2 flow rate																					
	Mode of ventilation																					
	$ETCO_2$																					
	Tidal volume																					
	Peak press.																					
	PEEP																					
CVS	CVP																					
	MAP																					
	Pain score																					
Drugs / Infusions																						
Input	Crystalloid																					
	Colloid																					
	Blood																					
	FFP																					
Output	Urine																					
	Rt chest drain																					
	Lt chest drain																					
	Balance																					
Other																						

O_2 device	Code
Air	A
Nasal canulae	N
Venturi 24%	V24
Humidified 24%	H24
Simple mask	SM
Resevoir mask	RM

Mode of ventilation	Code
Spontaneous Vent.	S
NIV	NIV
Ventilated	V

Name:

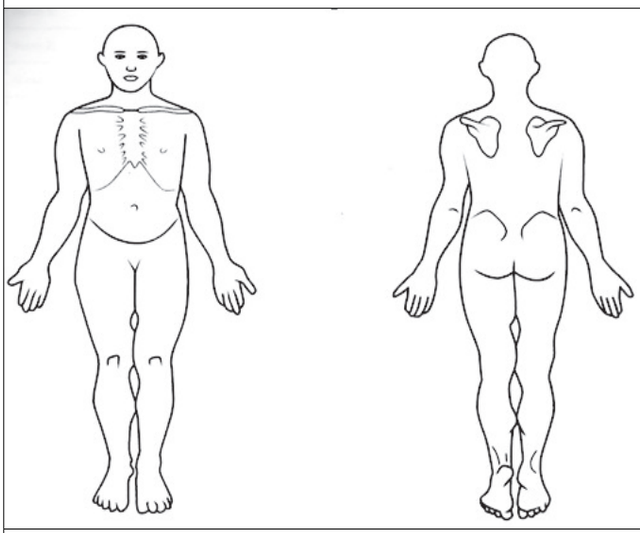
Hosp. No:

Date:

Tertiary Survey (once awake)	Name:	MRN:	Date:
Ward:	Consultant:		

Summary of Examination

ABCD issues:



Missed injuries to date:

Head / face:

Neck:

Chest:

Abdomen:

Pelvis:

Back:

Neurological:

Limbs:

Pending investigations:

Plan:

Clinical team transfer

Name of transferring Consultant: **Specialty:**

Name of receiving Consultant: **Specialty:**

Reason for transfer of care: **Date:**