

Trauma Chronology

Name:

Hosp. No:

Date:

Plain films

Time:

CXR / PXR / C-spine

CT

Time:

Head /C-spine/ Chest/ Abdo/ Pelvis/ other

Time

Events

TRAUMA
CHART
Part 2

Observation Chart

Name: _____ Hosp. No: _____ Date: _____

Time	Blood pressure & Pulse rate		Temperature °C	
210				
200				
190				
180				
170				
160				
150				
140				
130				
120				
110				
100				
90				
80				
70				
60				
50				
40				
30				
20				
10				

Eyes	Open spontaneously	4
	Opens to speech	3
Verbal	Opens to pain	2
	None	1
	Orientated	5
	Confused	4
	Inappropriate words	3
Motor	Incomprehens. sounds	2
	None	1
	Obeys commands	6
	Localises to pain	5
	Normal flexion to pain	4
	Abnormal flexion to pain	3
	Extension to pain	2
None	1	
Pupils	Total GCS	
	Right pupil size	
	Right pupil reaction	
	Left pupil size	
	Left pupil reaction	

Name:

Hosp. No:

Date:

Time

Type of rep.

Rate of resp.

FiO₂

ETCO₂

SaO₂

Peak airway pressures

CVP

Drug / Infusions

Crystalloid

Colloid

Blood

FFP

Input

Urine

Rt chest drain

Lt chest drain

Output

Balance

Other

Fluids and Drug Charts

Name:

Hosp. No:

Date:

Date	Time	Drug / Fluid	Dose	Rate	Prescriber's sign.	Given by	Time

Blood and Blood Products

Date	Time	Blood / Blood Product	Pack No	Rate	Prescriber's sign.	Transfused by	Time

Nursing Notes	Name: _____	Hosp. No: _____	Date: _____
	Nurse 1: _____		
	Nurse 2: _____		
	Nurse 3: _____		
Time	_____		

Valuables		
Valuables retained by patient: Clothes	Valuable retained by patient: Other	Valuables retained for safeweeping
	<input type="checkbox"/> Spectacles	Property book receipt number _____
	<input type="checkbox"/> Hearing aid	Signature nurse 1 _____
	<input type="checkbox"/> Dentures	Print name _____
	<input type="checkbox"/> Watch	Signature nurse 1 _____
	<input type="checkbox"/> Rings _____	Print name _____
	<input type="checkbox"/> Keys _____	Property disposal
	<input type="checkbox"/> Mobile phone	Given to relatives <input type="checkbox"/>
		Signature of relative _____
		Print name _____
		Given to police <input type="checkbox"/>
		Reference number _____

Tertiary Survey (once admitted)

Name:

Hosp. No:

Date:

Ward:

Consultant

Airway		Summary of Injuries	
		Head /Face:	
Breathing		Neck:	
		Chest:	
Circulation		Abdomen:	
		Pelvis:	
Disability		Back:	
		Neurological:	
		Limbs:	
Missed injuries identified to date:		Comments:	
Print Name		Signature	



