TRAUMA TERTIARY SURVEY

Admission Date (YYYY/MON/DD): _____ Time: _____

Asesssment Date (YYYY/MON/DD): _____ Time: _____

Referral Hospital: ❑ N/A _____ Referring Physician: _____ ❑ Unknown

Admitting Service: _____ Location: _____

History of Injury: ❑ Blunt ❑ Penetrating ❑ Burn ❑ Other

Details: _____

Past Medical History: _____

Past Surgical History: _____

Medication: _____ Allergies: ❑ NKDA: _____

Social History: _____ Family History: _____

Physical Examinations

Current Vital Signs	BP	HR	RR	Temp	SpO2 %
					O2:

Glasgow Coma Score	Eyes	Verbal	Motor	Total
				/ 15

Head and Neck: _____

Face: _____

Resp / Chest: _____

Abdomen: _____

GU / Pelvis: _____

Extremities: _____

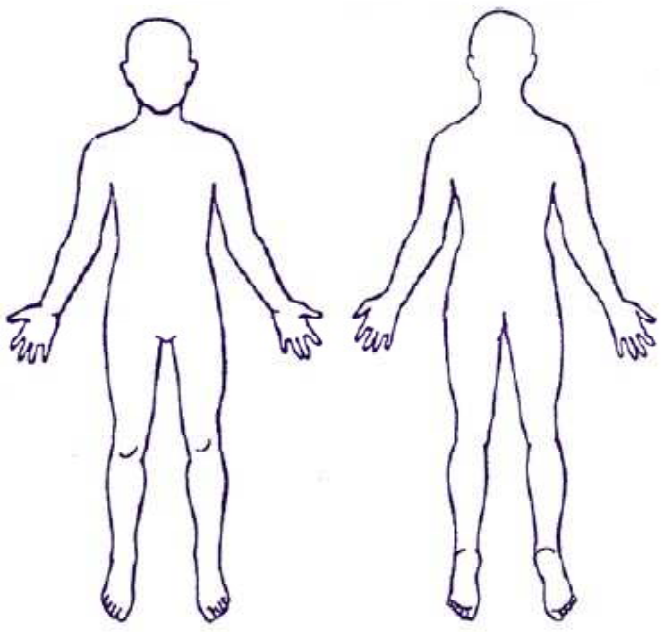
Spine: _____

_____ ASIA Scale Score: _____ Date: _____ ❑ N / A
YYYY/MON/DD

TRAUMA TERTIARY SURVEY

Laceration / Abrasion / Burn / Scar

A = Abrasion
L = Laceration
C = Contusion
B = Burn
CF = Closed Fracture
OF = Open Ffracture
SP = Splinted
CA = Casted
S = Sutured



Radiology Investigations

❑ Reviewed by Radiologist: Date (YYYY/MON/DD): _____ Time: _____ ❑ N / A

Key Findings

X−rays: ❑ None

❑ Chest: _____
❑ C− Spine _____
❑ T / L Spine: _____
❑ Pelvis: _____
❑ Extremities: _____
❑ Other: _____

CT: ❑ None

❑ Head: _____
❑ Chest: _____
❑ Abdo / Pelvis: _____
❑ C−Spine: _____

Other: ❑ None

Ultrasound: _____ MRI: _____

_____ _____

Known Injuries:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7 _____
4. _____ 8. _____

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New Findings: ❑ None

1. _____ ❑ See Trauma Consult Note
2. _____ ❑ See Trauma Consult Note
3. _____ ❑ See Trauma Consult Note
4. _____ ❑ See Trauma Consult Note

Consults:

Service: _____ Physician: _____ Date: _____ YYYY/MON/DD

Service: _____ Physician: _____ Date: _____ YYYY/MON/DD

Service: _____ Physician: _____ Date: _____ YYYY/MON/DD

Service: _____ Physician: _____ Date: _____ YYYY/MON/DD

Incidential Findings: ❑ None

1. _____ Plan: _____
2. _____ Plan: _____
3. _____ Plan: _____

Allied Health Consults:

❑ Physiotherapy Date (YYYY/MON/DD): _____ ❑ Social Work Date (YYYY/MON/DD): _____

❑ OT Date (YYYY/MON/DD): _____ ❑ Dietician Date (YYYY/MON/DD): _____

❑ Pharmacy Date (YYYY/MON/DD): _____ ❑ Other: _____

Verified:

❑ Lab work reviewed

❑ DVT Prophylaxis Started Type: _____ Date (YYYY/MON/DD): _____ Time: _____ ❑ N / A

Alcohol Screening:

AUDIT−C Questions	**Scoring**					**Your Score**
	0	1	2	3	4	
How often did you have a drink containing alcohol in the past year?	Never	Monthly or less	2−4 times per month	2−3 times per week	4 or more per week	
How many drinks did you have on a typical day when you were drinking in the past year?	0 −2	3 − 4	5 − 6	7 − 9	10 or more	
How often did you have six or more drinks on one occassion in the past year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Score: A total of 5 or more refer to SW					**Total**	

Medically Fit to Operate Motor Vehicle: ❑ Yes ❑ No Letter to Ministry of Transportation Sent: ❑ Yes ❑ No ❑ N / A

Physician Name (print): _____

Signature: _____