

# TRAUMA RESUSCITATION UNIT REPORT SHEET

*Not Part of the Medical Record*

<b>Facility:</b>	<b>Date of Admission:</b>	
<b>Phone # / Sending RN:</b>	<b>Pick Up Time:</b>	
<b>Mech of Injury:</b>	<b>Age:</b>	<b>Isolation:</b>
<b>Diagnosis:</b>	<b>Ht/Wt:</b>	<b>MOLST in record? Y/N</b>
<b>Accepting Service/MD:</b>	<b>Allergies:</b>	<b>Images Copied/Uploaded? Y/N</b>
<b>Past Medical/Surgical Hx:</b>		
<b>Studies/Treatments:</b>		
<b>Vitals: Time</b> <b>am/pm</b> HR BP Temp SPO2 RR	<b>Access (size/location):</b>  <i>Send CL insertion checklist</i>	
<b>Medications (dose/time):</b>  Tetanus: Y/N Antibiotics:	<b>Fluids/Products:</b> IVF: PRBC: FFP: Platelets:	
<b>Neuro:</b> GCS:		
<b>Resp:</b>		
<b>Cardiac:</b>		
<b>GI/GU:</b>		
<b>Abd:</b>		
<b>Skin:</b>		
<b>Next of Kin/Phone #:</b>		
Fax this form to 410-328-8858 --- Please call 410-328-8869 when the patient leaves your facility		