

## Nevada Trauma Registry Data Collection Form

Reporting Hospital:

Person Reporting:

Complete the following information if the patient meets trauma criteria. Please be specific, and fill out each section as completely as possible. Circle or fill in the following information.

### Demographics

Last:  First:  MI:

SSN:  Date of Birth (M/D/YY):  Gender:  Male  Female  ND

Race: **NOT AVAILABLE**

Address:

City:  ST:  Zip Code:  NV County: **CARSON CITY** OR Out of State County:

Is injury work related?  Yes  No  ND

If yes, document occupation: **NOT AVAILABLE**

### Injury

Date of Injury (M/D/YY):  Time of Injury:  City of Injury:

Zip Code of Injury:  County of Injury: **CARSON CITY** OR Out of State County:

Mechanism of Injury:  Blunt  Penetrating  Burn

Site of Injury: **FARM**

External Cause of Injury/E-Code:

Safety: **NOT AVAILABLE**

Accidents:

MVC  MCC  Driver  Passenger  Front  Back

Single Vehicle OR Number of Vehicles:  Collided With:   Rollover  Ejected

Major Damage  Minor Damage  Not Available

GSW:

Assault  Self Other:

Burn:

Chemical  Electrical  Fire Other:

Other Event:

Other Important Information:

### Prehospital Information (From Transport Service)

EMS Company:   ND  Pending Run Number:

Scene Report:  Complete  Incomplete  Missing

Condition: **NA**

Dispatch Date (M/D/YY):  Time:  Arrive Scene:  Depart Scene:  Arrive Hospital:

Vital Signs At Scene: Pulse:  Resp:  Sys. BP:

GCS: Eye:  Verbal:  Motor:  Manual GCS:

Qualifier: **L Legitimate**

CPR: **NA** IV Fluids: **NA**

Airway: **NA**

ED Admission	
Hospital Transfer: <input type="checkbox"/> No <input type="checkbox"/> Yes	Direct Admit to Floor: <input type="checkbox"/> No <input type="checkbox"/> Yes
ED Arrival Date: <input type="text"/> Time: <input type="text"/>	ED Discharge Date: <input type="text"/> Time: <input type="text"/>
Arrived From: <input checked="" type="checkbox"/> ND or <input type="checkbox"/> Referring Hospital: <input type="text"/>	
Transport By: <input type="checkbox"/> Private Vehicle/Walk-in <input type="checkbox"/> Police <input type="checkbox"/> Other <input type="checkbox"/> Not Available	
Ambulance: <input type="checkbox"/> ALS <input type="checkbox"/> ILS <input type="checkbox"/> BLS <input type="checkbox"/> Helicopter <input type="checkbox"/> Fixed Wing	
Ambulance Rendezvous: <input type="checkbox"/> Amb/Amb <input type="checkbox"/> Amb/Heli <input type="checkbox"/> Amb/Fixed Wing	
Complaint: Mechanism Of Injury, I.E.,: ATV, MCC, MVC, Assault, Burn GSW, Snowboard, Sports, Fall, Pedestrian, etc.	
List/Document: <input type="text"/>	
Condition: <b>ALERT</b>	

ED Assessment	
Time Surgeon/Trauma Team Requested: <input type="text"/>	Time Surgeon Arrived: <input type="text"/>
Vital Signs: Temp (F): <input type="text"/> Pulse: <input type="text"/> Resp: <input type="text"/> Sys. BP: <input type="text"/>	
GCS: Eye: <input type="text"/> Verbal: <input type="text"/> Motor: <input type="text"/> Manual GCS: <input type="text"/>	
Qualifier: <input checked="" type="checkbox"/> LEGITIMATE	
Airway: <input checked="" type="checkbox"/> NA	
CPR: <input checked="" type="checkbox"/> NOT APPLICABLE	
Units Of Blood: <input type="text"/>	
Alcohol Related: <input type="checkbox"/> No <input type="checkbox"/> Yes	ETOH: <input type="text"/> Drug Related: <input type="checkbox"/> No <input type="checkbox"/> Yes Drug: <input type="text"/>
Head CT: <input checked="" type="checkbox"/> NOT APPLICABLE	Date: <input type="text"/> Time: <input type="text"/>
Abd. CT: <input checked="" type="checkbox"/> NOT APPLICABLE	Date: <input type="text"/> Time: <input type="text"/>
Abd. <input checked="" type="checkbox"/> NOT APPLICABLE	Date: <input type="text"/> Time: <input type="text"/>
Chest CT: <input checked="" type="checkbox"/> NOT APPLICABLE	Date: <input type="text"/> Time: <input type="text"/>
Perit. Lavage: <input checked="" type="checkbox"/> NOT APPLICABLE	Date: <input type="text"/> Time: <input type="text"/>
Aortogram: <input checked="" type="checkbox"/> NOT APPLICABLE	Date: <input type="text"/> Time: <input type="text"/>
Arterio/Angiogram: <input checked="" type="checkbox"/> NOT APPLICABLE	Date: <input type="text"/> Time: <input type="text"/>
Admit Service: <input checked="" type="checkbox"/> NOT AVAILABLE	Other: <input type="text"/>
ED Disposition: <input checked="" type="checkbox"/> ND	
Name Of Receiving Hospital (If Applicable): <input type="text"/>	

Hospital Diagnosis	
List complete ICD-9 code(s) or describe injuries in detail.	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	

Complications	
Identify any complications:	
<input type="text"/>	
<input type="text"/>	

Operations/ Procedures							
Date:	<input type="text"/>	Time:	<input type="text"/>	ICD-9 Code:	<input type="text"/>	Description:	<input type="text"/>
Date:	<input type="text"/>	Time:	<input type="text"/>	ICD-9 Code:	<input type="text"/>	Description:	<input type="text"/>
Date:	<input type="text"/>	Time:	<input type="text"/>	ICD-9 Code:	<input type="text"/>	Description:	<input type="text"/>

Hospital Outcome	
Hospital Discharge Date:	<input type="text"/> <b>Time:</b> <input type="text"/>
Discharge Service:	<input checked="" type="checkbox"/> <b>NA</b> Other: <input type="text"/>
Disposition:	<input checked="" type="checkbox"/> <b>ND</b> Other: <input type="text"/>
Organ Donation:	<input type="checkbox"/> Yes <input type="checkbox"/> No Days In ICU: <input type="text"/>
Nevada County or State of the Scene of the Injury:	<input type="text"/> <b>CARSON CITY</b> OR Out of State County: <input type="text"/>
Nevada County or State of the Patient's Home:	<input type="text"/> <b>CARSON CITY</b> OR Out of State County: <input type="text"/>
Nevada County or State of the Patient's Disposition (Discharge To):	<input type="text"/> <b>CARSON CITY</b> OR Out of State County: <input type="text"/>
Primary Payor Source:	<input checked="" type="checkbox"/> <b>ND</b>