

Riverside County Community Health Agency / Emergency Medical Services Agency
PARAMEDIC RECEIVING HOSPITAL TRAUMA PATIENT REGISTRY FORM

1. IDENTIFICATION

Hospital Name _____
 Hospital Log # _____
 PCR Incident # _____
 Incident Location _____
 Patient Age _____ Patient Sex M F

2. EMERGENCY DEPT ADMISSION DATA

Date of Arrival _____
 Time of Arrival _____
 Transport Duration _____

Method of Arrival

Base Hospital Directed Yes No N/A
 Paramedics Walk-In
 BLS Ambulance Other: _____

Incident Type (choose one only)

Auto Accident Gun Shot Wound
 Fall Shot Gun Wound
 Assault Stab Wound
 Motorcycle Injury Other: _____
 Pedestrian Injury
 Bicycle Injury
 Sports Injury
 Thermal

Presenting Vital Signs Time _____

HR _____ RR _____ BP _____

GCS Eyes _____
 Verbal _____
 Motor _____
 GCS Total _____

CT Done Time _____
 Intubated Time _____
 Blood Products Time _____

EMERGENCY DEPT ADMISSION DATA *continued*

The Revised Trauma Score

Glasgow Coma Scale (GCS)	Systolic Blood Pressure (SBP)	Respiratory Rate (RR)	RTS Value
13 - 15	> 89	10 - 29	4
9 - 12	76 - 89	> 29	3
6 - 8	50 - 75	6 - 9	2
4 - 5	1 - 49	1 - 5	1
3	0	0	0

+ + = _____
Revised Trauma Score

Projected Estimate of Survival

The table below gives survival probabilities for values of the sum of the coded RTS variables.

Trauma Score	Percentage Survival	Trauma Score	Percentage Survival
12	99.5	5	45.5
11	96.9	4	33.3
10	87.9	3	33.3
9	76.6	2	28.6
8	66.7	1	25.0
7	63.6	0	3.7
6	63.0		

3. EMERGENCY DEPT DISPOSITION

Admitted Time _____

(specify to where) _____

Expired Time _____

Discharged Time _____

To OR Time _____

(procedures if known)

Transferred Time _____

To: _____ How: Air Ground

(Any difficulties with transfer ie. How many hospitals were called and refused transfer, any patient concerns)

3. Comments