Administrative Policy		5303
	Effective April 1, 2018	**Expires** March 31, 2019
Policy: **Prehospital Receiving Center Trauma Pati . . .**	Approval: Medical Director **Reza Vaezazizi, MD**	Signed
Applies To: **PRC, Trauma System, EMS System**	Approval: REMSA Director **Bruce Barton**	Signed

PURPOSE

This policy defines the process for completing the Prehospital Receiving Center Trauma Patient Registry Form when a Critical Trauma Patient (CTP) presents to a *non-trauma* Prehospital Receiving Center (PRC) or Base Hospital (BH).

AUTHORITY

California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services

Prehospital Receiving Center Trauma Patient Registry

1. The data listed in this policy is to be sent to the EMS Agency via standard mail, fax, or e-mail.
   a. Data is to be sent to the EMS Agency within 30 days of patient discharge, transfer or death.
   b. Data will be used to generate a quarterly EMS Trauma Report for the Trauma Audit Committee and for periodic Riverside trauma patient studies and research.
   c. Specific patient data remains confidential.

2. For trauma patients meeting any of the Trauma Triage Criteria (see the REMSA Policy for Trauma Triage Indicators and Destination), and/or with final disposition to a trauma center, a Prehospital Receiving Center Trauma Patient Registry Form is to be completed by designated personnel from the PRC or BH. This is to include all traumatic full arrests, trauma-related deaths in the ED or after hospital admission, submersions, and hangings. To exclude isolated hip fractures due to mechanical and/or ground level falls.

Instructions and form are included in the next pages:

Instructions

Instructions for completing the Prehospital Receiving Center Trauma Patient Registry Form:

1. Section I – IDENTIFICATION
   a. Incident Location: Enter the original location of the incident.
   b. Hospital: Enter name of the PRC or BH completing the form.
   c. Patient: Enter the name of the patient.
   d. Age: Enter the patient's age.
   e. Sexes: Check male or female.

2. Section II – EMERGENCY DEPARTMENT ADMISSION DATA
      i. Date of Arrival: Enter month, day, year admitted to the ED.
      ii. Time of Arrival: Enter time of arrival to the ED.
   b. Method of Arrival: Check applicable; if "Other", describe.
   c. Mechanism of Injury: Check one; if "Other", describe.
   d. Vital Signs upon Arrival: Enter initial vital signs taken in the ED.
      i. Glasgow Coma Score (GCS): Enter initial GCS taken in the ED.
      ii. Enter heart rate (HR).
      iii. Enter respiratory rate (RR).
      iv. Enter blood pressure (BP).
   e. Procedures: Check applicable and enter time; if "Other", describe.
      i. Blood products: Enter time of first unit if any products were given.
   f. Revised Trauma Score Upon Arrival: Enter variables and calculate the Revised Trauma Score.

3. Section III – EMERGENCY DEPARTMENT DISPOSITION
   a. Admitted: Check if applicable, enter time, and specify hospital unit under comments.
   b. OR: Check if applicable, enter time, and specify procedure(s) if known under comments.
   c. Admitted Post-op: Check if applicable, enter time, and specify hospital unit under comments.
   d. Discharged: Check if applicable, and enter time.
   e. Continuation of Trauma Care: Check if applicable, enter time, and specify destination under comments.
   f. Interfacility Transfer: Check if applicable, enter time, and specify destination under comments.
   g. Ground Transport: Check if applicable, and enter time.
   h. Air Transport: Check if applicable, and enter time.
   i. Other: Check if applicable, enter time, and include explanation under comments.
   j. Comments:
      Include anything pertinent, explanatory, or interesting.

PREHOSPITAL RECEIVING CENTER TRAUMA PATIENT REGISTRY FORM

1. IDENTIFICATION

Incident location ___________________________

Receiving hospital __________________________

Pre-hospital PCR # _________________________

Age ______ Male ☐ Female ☐

2. EMERGENCY DEPT. ADMISSION DATA

Date of Arrival ______________

Time of Arrival ______________

Method of Arrival

Walk-in ☐

BLS Ambulance Provider _____________________

ALS Ambulance Provider _________ Unit # ______

Other ☐, if other please describe _______________

Base Hospital directed ☐

BH Name __________________________________

Mechanism of Injury

Auto accident ☐ Gun shot ☐

Motorcycle ☐ Thermal ☐

Bicycle ☐ Fall ☐

Pedestrian ☐ Sports Injury ☐

Assault ☐ Stabbing ☐

Other ☐ If other, please describe _________________

Vital signs upon arrival

BP: ________ Eyes:_______

HR: ________ Verbal: _____

RR: ________ Motor: ______

Temp: ______ Total GCS:___

Procedures

	Time
Blood Products	_______
Intubation	_______
CT	_______
TXA	_______

Other ☐ If other, please describe

____

Revised Trauma Score (RTS) upon arrival

Glasgow Coma Scale		Systolic BP		Respiratory Rate	
GCS	RTS Points	SBP	RTS Points	RR	RTS Points
13-15	4	>89	4	10-29	4
9-12	3	76-89	3	>29	3
6-8	2	50-75	2	6-9	2
4-5	1	1-49	1	1-5	1
3	0	0	0	0	0
Points:		Points:		Points:	

3. EMERGENCY DEPARTMENT DISPOSITION

	Time
Admit ☐	______
OR ☐	______
Admit post-op ☐	______
Continutation of trauma care ☐	______
Destination ________________________	
Discharged ☐	______
Discharge date/ time	______
Deceased ☐	______
Inter-facility transfer ☐	______
Air transport ☐	______
Ground transport ☐	______
Destination ☐	______
Hospital LOS	______

Discharge Dx ___________________________

4. COMMENTS

Within 30 days of patient arrival, send completed form to address below
Attention: Trauma Systems Coordinator, or Email- shkissel@rivco.org.

Mailing Address: 4210 Riverwalk Parkway • Suite 300 • Riverside, CA 92505
Phone: (951) 358-5029 • Fax: (951) 358-5160 • TDD: (951) 358-5124 • www.rivcoems.org