Case Report Forms

Document Version Date: 03.17.2015

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General Instructions:

- Enter all dates in **DD/MMM/YY** format. Enter all times in **HH:MM** using 24hr clock format.
- Print additional form pages if needed. Label additional form pages using a decimal point followed by sequential numbers. (Example: Page 5.01, 5.02)
- Use the following codes in data fields with unknown values:

NA = Not Applicable (e-CRF Code **–995**)	**ND** = Not Detectable (e-CRF Code **–996**)	**NK** = Unknown (e-CRF Code **–997**)
NP = Not Palpable (e-CRF Code **–998**)	**NR** = Not Recorded/Not Done (e-CRF Code **–999**)	

Form 1: Verification of Eligibility/Screening

1. ED Arrival: Date: __ __ /__ __ __ /__ __ Time: __ __:__ __ ***(TIME ZERO)***
(dd/mmm/yy) *(24hr Clock in hh:mm)*

Inclusion Criteria: *(To be eligible, all questions must be answered "**YES**")*

1. Age (Est. ≥ 15 yr. or ≥ 50 kg if age unknown) ☐ Yes ☐ No
2. Received directly from the injury scene via helicopter service ☐ Yes ☐ No

Exclusion Criteria: *(To be eligible, all questions must be answered **"NO"**)*

1. Prisoners, defined as those who have been directly admitted from a correctional facility ☐ Yes ☐ No

Direct Observation Inclusion Criteria:

A. Meet at least 1 of the following during helicopter transport: ☐ Yes ☐ No

Heart Rate > 120 bpm	☐ Yes	☐ No
SBP ≤ 90 mmHg	☐ Yes	☐ No
Penetrating Truncal Injury	☐ Yes	☐ No
Tourniquet applied	☐ Yes	☐ No
Pelvic Binder applied	☐ Yes	☐ No
Intubated	☐ Yes	☐ No

AND: Are blood products available on your helicopter? ☐ Yes ☐ No (*go to Form 2*)

B. Received blood products during transport ☐ Yes ☐ No

If no blood products were given, what was the reason?

a. ☐ Did not meet the Direct Observation Inclusion Criteria

b. ☐ Did not meet the specific site criteria

c. ☐ Other (please explain)

Form 2: EMS / Pre-Hospital Care

1. Estimated Injury date: __ __/__ __ __/__ _
   (dd/mmm/yy)
2. Estimated Injury time: ____:____
   (24hr Clock in hh:mm)
3. Air team call date: __ __/__ __ __/__ _
   (dd/mmm/yy)
4. Air team call time: ____:____ ☐ Not Noted/Unknown
   (24hr Clock in hh:mm)
5. Air team dispatch date: __ __/__ __ __/__ _
6. Air team dispatch time: _ _: _ _ *Not noted/unknown*
7. Air team arrival date: __ __/__ __ __/__ _
   (dd/mmm/yy)
8. Air team arrival at scene: ____:____ ☐ Not Noted/Unknown
   (24hr Clock in hh:mm)
9. Air team depart from scene date: __ __/__ __ __/__ _
10. Air team depart from scene time: _ _: _ _ *Not noted/unknown*
11. First available vital signs & GCS obtained by air team at the scene:

Blood Pressure *(mmHg)*		Pulse *(beats/min)*	Respiratory Rate (breaths/min)
Systolic	Diastolic		
___ ___ ___	___ ___ ___	___ ___ ___	___ ___
	Palpable	Palpable	
	Yes / No	Yes / No	

GCS	
Record Component Scores **OR** GCS Total Score	
E: ___ V: ___ M: ___	GCS Total Score:___
☐ Not Recorded	

Form 2: EMS / Pre-Hospital Care *(cont.)*

12. Point of Care Lab available Yes ☐ No ☐

If yes, enter lab results

13. Mechanism of Injury: (*As ascertained by EMS*)

a. ☐ **Blunt Injury** *(Select all that apply)*

□ Fall	□ MVC – Motorcycle	□ MVC – Unknown
□ Machinery	□ MVC – Bicycle	□ Struck by/against (assault)
□ MVC – Occupant	□ MVC – Pedestrian	□ Bicycle
□ Motorcycle	□ Other, *(Describe)*:_____	

b. ☐ **Penetrating Injury** *(Select all that apply)*

□ Gunshot Wound	□ Shotgun Wound	□ Impalement
□ Stabbing (knife)	□ Other, (*Describe*): _____	

14. Source of bleeding from prehospital care team: (*Select all that apply)*

☐ Abdomen ☐ Chest ☐ Intracranial ☐ Limb/Extremity ☐ Neck

☐ Pelvis ☐ Scalp/Face ☐ No Source Identified

15. Did the subject receive any pre-hospital lifesaving interventions?

☐ Yes, (*Select all that apply*) ☐ No

□ Cardioversion	□ Chest/Needle Decompression	□ CPR
□ Intubation	□ Trach/Cricothyrotomy	□ Tourniquet
□ Other, (*Describe*): _____		

Form 2: EMS / Pre-Hospital Care*(cont.)*

15a. IV fluids given before ED arrival:

Record total volume infused, **or check here** ☐ if no IV fluids were given.

Fluid	Amount Infused
Normal Saline	___ ___ ___ ___ ml.
Lactated Ringers	___ ___ ___ ___ ml.
Hypertonic Solution 3%	___ ___ ___ ___ ml.
Hypertonic Solution 5%	___ ___ ___ ___ ml.
Hypertonic Solution, other %, *(Specify)*:_____	___ ___ ___ ___ ml.
Plasma-Lyte	___ ___ ___ ___ ml.
Other Crystalloids, *(Specify)*:_____	___ ___ ___ ___ ml.
Albumin (5%)	___ ___ ___ ___ ml.
Albumin (25%)	___ ___ ___ ___ ml.
Hextend	___ ___ ___ ___ ml.
Hespan	___ ___ ___ ___ ml.
Other Colloids, *(Specify)*:_____	___ ___ ___ ___ ml.

15b. Blood Products given before ED arrival:

Record total units infused, **or check here** ☐ if no blood products were given.

Blood Product		Amount Infused
RBCs		___ ___ Units
Plasma	☐ A ☐ AB	___ ___ Units
	☐ liquid ☐ thawed	
Platelets		___ ___ Units
Whole Blood		___ ___ Units
Other_____		___ ___ Units

Form 2: EMS / Pre-Hospital Care*(cont.)*

16. Procoagulants/antifibrolitic given before ED arrival? Yes ☐ No ☐

If yes, please check name. If other, please add name.

Aminocaproic Acid *(Amicar) (g/hr.)*	
Tranexamic Acid *(Cyclokapron) (mg/kg/hr.)*	
Fibrinogen Concentrate *(Riastap) (mg/kg/hr.)*	
Octaplex / Ocplex *(in ml.s)*	
Prothrombin Complex Concentrate *(PCC)*	
Recombinant Factor VIIa *(rFVIIa) (mics/kg)*	
Factor VIII	
Vitamin K	
OTHER Procoagulant *(Specify with unit of measure)* _____ _____	

17. Reason Initial Resuscitation Stopped:

☐ Further transfusions were deemed futile.

☐ Subject expired. *(Document death on CRF #11)*

☐ Patient Improved

☐ Other, (specify): _____

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Form 3: Initial 24hr Vital Signs & Glasgow Coma Scale (GCS)

(Record initial vital signs & GCS at ED Admission and NU Admission.)

Location (LOCAT) Codes	
1	Emergency Department
2	ICU
3	Intermediate Level Care
4	Nursing Unit
5	Other *(Specify)*

GCS Scoring Key

Eye Movement (E)		
1	No Response	
2	To Pain	
3	To Verbal Command	
4	Spontaneous	

Verbal (V)		
1	No Response / Intubated	
2	Incomprehensible Sounds	
3	Inappropriate Words	
4	Disoriented, Converses	
5	Oriented, Converses	

Motor (M)	
1	No Response
2	Extension *(Decerebrate)*
3	Flexion – *(Decorticate)*
4	Flexion – Withdrawals From Pain
5	Localizes Pain
6	Obeys Commands Appropriately

LOCAT Code	Date *(dd/mmm/yy)*	Time *(hh:mm)*	Height	Weight	Blood Pressure *(mmHg)*		Pulse *(beats/min)*	Temperature	Advanced Airway?	Chemically Paralyzed?	Respiratory Rate	GCS
					Systolic	Diastolic						Record EVM Scores OR GCS Total Score
	/ /	:	□ cm □ in	□ kg □lbs.		Palpable □ Yes □ No	___ ___ ___ Palpable □ Yes □ No	___ ___ ___ .___ □ F □ C	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	___ ___	E: ___ V: ___ M: ___ or GCS Total:____

LOCAT Code	Date *(dd/mmm/yy)*	Time *(hh:mm)*	Height	Weight	Blood Pressure *(mmHg)*		Pulse *(beats/min)*	Temperature	Advanced Airway?	Chemically Paralyzed?	Respiratory Rate	GCS
					Systolic	Diastolic						Record EVM Scores OR GCS Total Score
	/ /	:	□ cm □ in	□ kg □lbs.		Palpable □ Yes □ No	___ ___ ___ Palpable □ Yes □ No	___ ___ ___ .___ □ F □ C	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	___ ___	E: ___ V: ___ M: ___ or GCS Total:____

Study ID # ___ ___ ___ ___ ___ ___ ___ ___

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Form 4: IV Fluids & Blood Products Transfusion Record

*(Record blood products in **units** and all other fluids in **mL.s** using the **codes** below for the 1st 24 hours only. Print additional pages if needed.)*

Check here ☐ Did not receive Blood Products in 1st 3 Hours after ED Admission

Location (LOCAT) Codes	
1	Emergency Department
2	Operating Room
3	Interventional Radiology
4	ICU
5	Intermediate Level Care
6	Nursing Unit
7	Other: *(Specify)*

Blood Products Codes			
1	Red Blood Cells **(RBC)**	7	Platelets - Pooled **(Plt-P)**
2	Plasma – Fresh Frozen **(FFP)**	8	Cryoprecipitate - **(Cryo)**
3	Plasma – Liquid **(LP)**	9	Autologous Blood **(Auto)**
4	Plasma - Thawed **(TP)**	10	Cell Saver - **(Cell)**
5	Plasma – FP24 **(FP24)**	11	Other Blood Product **(OBL)**
6	Platelets - Apheresis **(Plt -A)**		

Colloids Codes		Crystalloids Codes	
1	Albumin **(Alb)**	6	Hypertonic Solution **(Ht)**
2	Hextend **(Hex)**	7	Lactated Ringers **(LR)**
3	Hespan **(Hes)**	8	Manitol **(MN)**
4	THAM Solution (THAM)	9	Normal Saline **(NS)**
5	Voluven **(Vol)**	10	Normosol **(Norm)**
		11	Plasma-Lyte **(PL)**
12	**Other** Colloid **(OCL)** or Crystalloid **(OCY)**		

MR: Data Collected from Medical Record Review | **DO:** Direct Observation

Complete for All Blood Products & IV Fluids							**Complete for ONLY Blood Products**
LOCAT Code	**Blood / Fluid Code**	**Start Date** *(dd/mmm/yy)*	**Start Time** *(hh:mm)*	Amount/Units		**DO MR**	**Unit or Accession #**
		/ /	:			☐DO ☐MR	 Exp. Date: / /
		/ /	:			☐DO ☐MR	 Exp. Date: / /
		/ /	:			☐DO ☐MR	 Exp. Date: / /
		/ /	:			☐DO ☐MR	 Exp. Date: / /
		/ /				☐DO ☐MR	 Exp. Date: / /
		/ /	:			☐DO ☐MR	 Exp. Date: / /

Form 5: End of Resuscitation

1a. Source of bleeding requiring the transfusion from surgeon: *(Select all that apply)*

☐ Abdomen ☐ Chest ☐ Intracranial ☐ Limb/Extremity ☐ Neck

☐ Pelvis ☐ Scalp/Face ☐ No Source Identified

1b. What is the primary source of bleeding:(select one)

☐ Abdomen ☐ Chest ☐ Intracranial ☐ Limb/Extremity ☐ Neck

☐ Pelvis ☐ Scalp/Face

2a. Reason Initial Resuscitation Stopped:

☐ Trauma Attending and/or Anesthesiologist determined subject achieved hemorrhage control.

a. Anatomic Hemostasis Date: __ __/__ __ __/__ _ *(dd/mmm/yy)* Time: **_____:_____** *(24hr Clock in hh:mm)*

b. Active Resuscitation with Blood Products Stop Date: __ __/__ __ __/__ _ *(dd/mmm/yy)* Time: **_____:_____** *(24hr Clock in hh:mm)*

☐ Further transfusions were deemed futile.

a. Date: __ __/__ __ __/__ _ *(dd/mmm/yy)*

b. Time: **_____:_____** *(24hr Clock in hh:mm,)*

c. Reasons for Futile:

☐non-survivable head injury ☐exsanguination ☐pre-injury DNR noted

☐blood products not available ☐other_____

☐ Subject expired.
(Document death on CRF #11)

☐ Other, (specify): _____

a. Other Date: __ __/__ __ __/__ _ *(dd/mmm/yy)*

b. Other Time: **_____:_____** *(24hr Clock in hh:mm,)*

2b. Location of subject when initial resuscitation stopped: *(Select one)*

☐ ED ☐ OR ☐ IR ☐ ICU ☐ Intermediate Level Care

☐ Nursing Unit ☐ Other, specify: _____

3. Is the patient clinically coagulopathic? Yes ☐ No ☐

Form 6: Non OR/IR Lifesaving Interventions *(1st 24 hours only.)*

Check here ☐ if no lifesaving interventions were performed.

Location Codes (LOCAT)	
1	Emergency Department
2	ICU
3	Intermediate Level Care
4	Nursing Unit
5	Other: *(Specify)*

Life Saving Interventions Codes	
1	Cardioversion
2	CPR
3	Emergency Laparotomy
4	Emergency Intubation
5	Chest Tube Insertion
6	Trach/Cricothyrotomy
7	Emergency Thoracotomy
8	Pericardiocentesis
9	REBOA
10	Other

LOCAT Code	**Start Date** *(dd/mmm/yy)*	**Start Time** *(hh:mm)*	**Intervention Code**
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	

Form 7: Procoagulants *(1st 24 hours only.)*

Check here ☐ if no Procoagulant medications were given.

LOCATION CODE (LOCAT)	
1	Emergency Department
2	Operating Room
3	Interventional Radiology
4	ICU
5	Intermediate Level Care
6	Nursing Unit
7	Other *(Specify)*

Document Administration of the Following Medications Using the Codes Below	
1	Aminocaproic Acid *(Amicar) (g/hr.)*
2	Tranexamic Acid *(Cyclokapron) (mg/kg/hr.)*
3	Fibrinogen Concentrate *(Riastap) (mg/kg/hr.)*
4	Octaplex / Ocplex *(in ml.s)*
5	Prothrombin Complex Concentrate *(PCC)*
6	Recombinant Factor VIIa *(rFVIIa) (mics/kg)*
7	Factor VIII
8	Vitamin K
9	OTHER Procoagulant *(Specify with unit of measure)*

LOCAT	Administration Start Date *(dd/mmm/yy)*	Administration Start Time *(24hr clock in hh:mm)*	Medication Code *(If other, Specify)*
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	
	/ /	:	

Form 8: Operating Room (OR) and Interventional Radiology Visits

Check here ☐ if there were no OR/IR visits

(Document OR\IR visits from admission through Day 30, using the codes below. Print additional pages as needed.)

	Head:	21	Splenectomy		**Upper Extremity:**	63	Irrigation/Debridement (include wash outs)
1	Craniotomy	22	Cholecystectomy	43	Amputation through Forearm (includes revisions/secondary procedures)	64	Skin Grafts
2	Craniectomy	23	Liver operative procedures	44	Amputation through Humerus (includes revisions/secondary procedures)	65	Wound Vac Operative Procedures (includes insertion, exchanges, removal)
3	Ventriculostomy	24	Pancreas procedures	45	External Fixation of Humerus	66	Wound Closures (fascial, abdominal, other wounds)
4	Craniocervical IR (diagnostic)	25	Nephrectomy	46	External Fixation of Forearm	67	Abscess Drainage in OR Location of abscess:
5	Craniocervical IR (therapeutic)	26	Other kidney operative procedures	47	Open Reduction/Internal Fixation	68	Abscess Drainage in IR Location of abscess:
	Neck:	27	Bladder Repairs	48	Closed Reduction/Internal Fixation	69	Antibiotic Bead Exchange
6	Neck Exploration	28	Lysis of Adhesions	49	Removal of External Fixators	70	Muscle Flap Reconstuction
7	Tracheostomy	29	Abdominal IR (diagnostic)	50	Fasciotomy for Compartment Syndrome	71	Major Artery Repair Name of Artery:
	Chest:	30	Abdominal IR (therapeutic)	51	Upper Extremity IR (diagnostic)	72	Major Vein Repair Name of Vein:
8	Chest Tube Placement	31	Splenic IR (diagnostic)	52	Upper Extremity IR (therapeutic)	73	Angiographic control of hemorrhage (embolization)
9	Thoracotomy	32	Splenic IR (therapeutic)		**Lower Extremity:**	74	Angiographic inferior vena cava filter (IVC filter)
10	Aortic stent placement	33	Hepatic IR (diagnostic)	53	Below Knee Amputation (includes revisions/secondary procedures)	75	**Other:_____**
11	Diaphragm Repairs	34	Hepatic IR (therapeutic)	54	Above Knee Amputation (includes revisions/secondary procedures)		
12	Pericardial Windows	35	Renal IR (diagnostic)	55	Closed Reduction/Internal Fixation		
13	Thoracic Packing (damage control procedure)	36	Renal IR (therapeutic)	56	Open Reduction/Internal Fixation		
14	Thoracic IR (diagnostic)		**Pelvis:**	57	External Fixation of Tibia		
15	Thoracic IR (therapeutic)	37	Closed Reduction	58	External Fixation of Femur		
	Abdomen:	38	Open Reduction/Internal Fixation	59	Removal of External Fixators		
16	Exploratory Laparotomy (add details)	39	External Fixation	60	Fasciotomy for Compartment Syndrome		
17	PEGs/Feeding Tube/Dobb Hoff/Gastric Tube Placement	40	Removal of External Fixators	61	Lower Extremity IR (diagnostic)		
18	Abdominal Packing (damage control procedure)	41	IR (diagnostic)	62	Lower Extremity IR (therapeutic)		
19	Temporary Abdominal Closure	42	IR (therapeutic)		**Other Procedures (OR and IR):**		
20	Vascular shunt						

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Form 8: Operating Room (OR) and Interventional Radiology Visits

Visit	Date of Visit	Arrival Time	Type of Visit?	Procedure Type	Surgical Procedure Code
1	/ /	:	☐ OR ☐ IR ☐ Hybrid	☐ Primary ☐ Additional	__ __
	/ /	:	☐ OR ☐ IR ☐ Hybrid	☐ Primary ☐ Additional	__ __
	/ /	:	☐ OR ☐ IR ☐ Hybrid	☐ Primary ☐ Additional	__ __
	/ /	:	☐ OR ☐ IR ☐ Hybrid	☐ Primary ☐ Additional	__ __
	/ /	:	☐ OR ☐ IR ☐ Hybrid	☐ Primary ☐ Additional	__ __
	/ /	:	☐ OR ☐ IR ☐ Hybrid	☐ Primary ☐ Additional	__ __
	/ /	:	☐ OR ☐ IR ☐ Hybrid	☐ Primary ☐ Additional	__ __
	/ /	:	☐ OR ☐ IR ☐ Hybrid	☐ Primary ☐ Additional	__ __
	/ /	:	☐ OR ☐ IR ☐ Hybrid	☐ Primary ☐ Additional	__ __
	/ /	:	☐ OR ☐ IR ☐ Hybrid	☐ Primary ☐ Additional	__ __

Form9: Admission Lab Results

Section A: Blood Count & Coagulation Tests

*Indicate unit of measure, then enter value in the table below:			
Hgb? □ mmol/L □ g/dL □ g/L □ Other *(Specify)*:	**Fibrinogen?** □ mg/dL □ g/L □ Other *(Specify)*:	**Platelets?** □ x 10^3/µL □ x 10^9/L □ x 10^3/ ml^3 □ Other *(Specify)*:	**WBC?** □ x 10^3/µL □ x 10^9/L □ x 10^3/ mm^3 □ Other *(Specify)*:

Location	Date *(dd/mmm/yy)*	Time *(hh:mm)*	*Hgb	Hct %	*Platelets	*WBC	PT *(sec)*	PTT *(sec)*	INR	*Fibrinogen
ED	/ /	:	.	.	.	.	.	.	.	.
NU	/ /	:	.	.	.	.	.	.	.	.

Section B: Blood Gases

*Indicate unit of measure, then enter value in the table below:
HCO_3? □ mmol/L □ mg/L □ Other *(Specify)*:

Location	Date *(dd/mmm/yy)*	Time *(hh:mm)*	Type of Blood Sample	FiO_2 %	pH	PaO_2 (mmHg)	$PaCO_2$ (mmHg)	*HCO_3	SaO_2 %	Base (mmol/L)	
ED	/ /	:	□ Arterial □ Venous								
NU	/ /	:	□ Arterial □ Venous								

Form 9: Admission Lab Results *(cont.)*

Section C: Chemistry & Metabolic Panels

* Indicate unit of measure, then enter value in the table below:		
Lactate? □ mg/dL □ mEq/L □ mmol/L □ Other *(Specify):*	**Creatinine?** □ mg/dL □ µmol/L □ Other *(Specify):*	**Glucose?** □ mg/dL □ mmol/L □ Other *(Specify):*
Albumin? □ g/L □ U/L □ µmol/L □ g/dL □ Other *(Specify):*	**Total Bilirubin?** □ mg/dL □ µmol/L □ Other *(Specify):*	

Location	Date *(dd/mmm/yy)*	Time *(hh:mm)*	Sodium *(mEq/L)*	Potassium *(mEq/L)*	Chloride *(mEq/L)*	*Lactate	BUN *(mg/dL)*	*Creatinine	*Glucose	*Albumin	*Total Bilirubin	Bilirubin Direct, *(mg/dL)*	Bilirubin Indirect *(mg/dL)*	Calcium *(mg/dL)*
ED	/ /	:	.	.	.	□ Arterial □ Venous	.	.	.		.	.	.	.
NU	/ /	:	.	.	.	□ Arterial □ Venous	.	.	.		.	.	.	.

Section D: TEG Results

Location	TEG Type	Date / Start Time	R-Time *(min.)*	ACT (sec)	K-Time *(min.)*	Alpha Angle (%)	Max. Amp. *(mm)*	G-Value *(d/sc)*	Ly30 (%)
ED	□Kaolin	/ /	.	.	.	.	.	.	.
	□Rapid	:							
NU	□Kaolin	/ /	.	.	.	.	.	.	.
	□Rapid	:							

Form10: 24 Hour to 30 Day Follow-Up Assessments

(*Complete daily while subject remains in the ICU until ICU discharge or at Day 30 of hospitalization. Collect all data elements from the previous 24 hours. If a" highest" and "lowest" value is needed and only one value is available, enter the value in* ***both*** *data fields. Print a new form for each assessment.)*

Check here ☐ if the subject died before reaching the ICU and proceed to the next form.

1. Assessment Date: ___ ___ / ___ ___ ___ / ___ ___
(dd/mmm/yy)

2. Vital Signs:

Systolic Blood Pressure *(mmHg)*	Highest Reading:	Lowest Reading:
Diastolic Blood Pressure *(mmHg)*	Highest Reading:	Lowest Reading:
Heart Rate *(bpm)*	Highest Reading:	Lowest Reading:
Respiratory Rate	Highest Reading:	Lowest Reading:
Temperature ☐ F. ☐ C.	Highest Reading:	Lowest Reading:
CVP *(mmHg)*	Highest Reading:	Lowest Reading:
Mean Arterial Pressure *(MAP) (mmHg)*	Highest Reading:	Lowest Reading:

3. GCS Scores:

Glasgow Coma Scale *(Record individual assessment scores or the GCS total)*		*Highest Score*	*Lowest Score*
	Eye Movement:		
	Verbal:		
	Motor:		
	GCS Total:		

4. Lab Assessments:
Enter the ABG values associated with the **lowest PaO2** value for each day.

Arterial Blood Gases	pH	
	PaO2	
	FiO2	
	$PaCO_2$	
	CO_2 ☐ mmol/L ☐ mg/L ☐ mEq/L	
	SaO_2 %	
	HCO_3 ☐ mmol/L ☐ mg/L	
	Base *(mmol/L)*	

Form 10: 24 Hour to 30 Day Follow-Up Assessments *(cont.)*

5. Lab Assessments: *(cont.)*
Enter the first recorded values for each day.

Coagulation	PT *(seconds)*	
	PTT *(seconds)*	
	INR *(seconds)*	
	Fibrinogen ☐ mg/dL ☐ g/L	

Enter the first recorded values for each day.

Blood Count	Hgb *(Select measure)* ☐ mmol/L ☐ g/dL ☐ g/L	
	Hematocrit *(Hct %)*	
	WBC Count *(Select measure)* ☐ x 10^3/µL ☐ x 10^9/L ☐ x 10^3/ mm^3	
	Platelets *(Select measure)* ☐ x 10^3/µL ☐ x 10^9/L ☐ x 10^3/ml^3	

Enter the first recorded values for each day.

Chemistry & Metabolic Values	BUN *(mg/dL)*	
	Creatinine *(Select measure)* ☐ mg/dL ☐ µmol/L	
	Albumin *(Select measure)* ☐ g/L ☐ g/dL ☐ U/L ☐ µmol/L	
	Lactate *(Select measure)* ☐mg/dL ☐mEq/L ☐mmol/L	
	Glucose *(Select measure)* ☐ mg/dL ☐ mmol/L	
	Total Bilirubin *(Select measure)* ☐ mg/dL ☐ µmol/L	

6. Was the subject thought to have any of the following?

Pulmonary edema/respiratory failure from cardiac origin?	☐ Yes ☐ No
Pulmonary Contusions?	☐ Yes ☐ No
If intubated and displaying mild or moderate hypoxia *, does today's CXR/CT demonstrate bilateral infiltrates?	☐ Yes ☐ No ☐ NA

Form 10: 24 Hour to 30 Day Follow-Up Assessments *(cont.)*

7. Did the subject require any of the following?

Mechanically Ventilated?	☐ Yes ↓ ☐ No ***(Enter ventilator settings below associated with the lowest PaO2 value for the day)***
Mode: ☐ Volume Assist Control ☐ Pressure Assist Control ☐ Pressure Support ☐ Volume-targeted pressure regulated (PRVC, CMV+ auto flow, VC+PCV-VG) ☐ Other _____ Tidal Volume: ml Rate: FiO_2: PIP: PEEP:	
Chemical Paralysis?	☐ Yes ☐ No
Vasopressors?	☐ Yes ☐ No
Dialysis?	☐ Yes ☐ No

8. Urine Output for the last 24 hours: ___ ___ ___ ___ *(ml.s)*

Form11: Discharge/Death *(Initial Hospitalization through discharge or Day 30.)*

1. Total (cumulative) number of ICU days: ___ ___

2. Total (cumulative) number of ventilator days: ___ ___

3. 1st recorded Hgb after 24 hours from ED admission ___ ___
   Hgb units (□ mmol/L □ g/dL □ g/L □ Other (Specify):_____)

4. Demographic Information:

   a. Gender: ☐ Male
   ☐ Female
   ☐ Unknown

   b. Year of Birth: ___ ___ ___ ___ □ Unknown
   ↓
   If age is unknown, select the age group that best describes the subjects.
   ☐ Less than 15 years of age
   ☐ 15 to 19
   ☐ 20 to 34
   ☐ 35 to 49
   ☐ 50 to 65
   ☐ > 65 years of age

   c. Ethnicity:

   ☐ Not Hispanic or Latino
   ☐ Hispanic or Latino
   ☐ Unknown

   d. Race: *(Check all that apply)*
   ☐ White
   ☐ American Indian/Alaskan Native/Aboriginal
   ☐ Asian
   ☐ Black/African American
   ☐ Native Hawaiian/other Pacific Islander
   ☐ Other *(Specify)*: _____
   ☐ Not Noted/Unknown

Form11: Discharge/Death *(Initial Hospitalization through discharge or Day 30.)*

5. Insurance status at discharge, death, or Day 30 of protocol if still hospitalized: *(Select one)*

□ Self Pay/None □ Private Insurance □ Medicare/Medicaid
□ Not Noted/Unknown □ Military Provider

6. Was there a reported history of anti-coagulant use prior to the injury?

□ Yes ↓ □ No □ Not Noted/Unknown

□ Warfarin □ Plavix □ Aspirin □ Thrombin Inhibitors □ Other, specify: _____

7. ***Prior to trauma***, was there a reported history of any of the following? *(Check all that apply)*

□ Alcohol Use
□ Acquired Immune Deficiency Syndrome *(AIDS)*
□ Cardiovascular Disease
□ Cirrhosis
□ COPD
□ Diabetes
□ Hepatic Failure
□ Hypertension
□ Immunosuppression
□ Leukemia/Multiple Myeloma
□ Lymphoma
□ Metastatic Cancer
□ Renal Disease
□ Tobacco Use *(smoking)*

8. Was a DNR ordered at any point during the hospitalization? □ Yes ↓ □ No
Time: ___:___ □ Unknown
(24hr Clock in hh:mm)
Date: ___ / _____ / ___
(dd/mmm/yy)

9. Was care withdrawn at any point during the hospitalization? □ Yes ↓ □ No
Time: ___:___ □ Unknown
(24hr Clock in hh:mm)
Date: ___ / _____ / ___
(dd/mmm/yy)

10. Did the subject die before day 30 of the initial hospitalization? □ Yes *(Go to question # 15)*
□ No *(Go to next question)*

11. Date of hospital discharge: ___ / _____ / ___ □ Remains Hospitalized on Day 30.
(dd/mmm/yy)

Form 11: Discharge/Death *(Initial Hospitalization through hospital discharge or Day 30 cont.)*

12. Record the ***first*** 15 discharge diagnostic below.

Discharge Diagnostic Codes *(xxx.xx format)*	
(1) __ __ __ . __ __	(8) __ __ __ . __ __
(2) __ __ __ . __ __	(10) __ __ __ . __ __
(3) __ __ __ . __ __	(11) __ __ __ . __ __
(4) __ __ __ . __ __	(12) __ __ __ . __ __
(5) __ __ __ . __ __	(13) __ __ __ . __ __
(6) __ __ __ . __ __	(14) __ __ __ . __ __
(7) __ __ __ . __ __	(15) __ __ __ . __ __
(8) __ __ __ . __ __	

13. Did the subject leave AMA? □ Yes □ No

14. Subject discharged to?: *(Select one)*

□ Home □ Long Term Care Facility □ Skilled Nursing Facility
□ Rehabilitation Facility □ Hospice □ Acute Care Hospital
□ Other, specify: _____

15. Was a Discharge Glasgow Coma Score (GCS) obtained?

GCS	
Record Component Scores **OR** GCS Total Score	
E: ___ V: ___ M: ___	GCS Total Score:___
☐ Not Recorded	

GCS Scoring Key								
Eye Movement	**1**	**No Response**	**Verbal**	**1**	**No Response / Intubated**	**Motor**	**1**	**No Response**
	2	**To Pain**		**2**	**Incomprehensible Sounds**		**2**	**Extension (Decerebrate)**
	3	**To Verbal Command**		**3**	**Inappropriate Words**		**3**	**Flexion – (Decorticate)**
	4	**Spontaneous**		**4**	**Disoriented, Converses**		**4**	**Flexion – Withdrawals From Pain**
				5	**Oriented, Converses**		**5**	**Localizes Pain**
							6	**Obeys Commands Appropriately**

Form11: Discharge/Death *(Initial Hospitalization through discharge or Day 30.)*

16. Was an extended Glasgow outcome scale (GOSE) obtained?

□ Yes, GOSE Score: _____ □ No

The Extended Glasgow Outcome Scale (GOSE) Scoring Key	
SCORE	Performance Level
1	Dead
2	Vegetative State
3	Lower severe disability; completely dependent on others
4	Upper severe disability; dependent on others for some activities
5	Lower moderate disability; unable to return to work or participate in social activities
6	Upper moderate disability; return to work at reduced capacity, reduced participation in social activity
7	Lower good recovery; good recovery with minor social or mental deficits
8	Upper good recovery

17. Date of Death: ____/_____/____
(dd/mmm/yy)

18. Time of Death: ___:___
(24hr Clock in hh:mm)

19. Cause of Death: *(Check ALL that apply)*

□ Exsanguination / Hemorrhagic Shock
□ Traumatic Brain Injury (TBI)
□ Respiratory/Pulmonary Contusion/Tension Pneumothorax
□ Sepsis
□ Multiple Organ Failure (MOF)
□ Cardiovascular Event *(Select event(s) from below)*
○ Stroke ○ MI ○ Both Stroke & MI
□ Pulmonary Embolism
□ Transfusion Related Fatality
□ Other, *(Specify)*: _____
□ Unknown

20. Of the causes checked above, what is the primary cause of death?

□ Exsanguination / Hemorrhagic Shock
□ Traumatic Brain Injury (TBI)
□ Respiratory/Pulmonary Contusion/Tension Pneumothorax
□ Sepsis
□ Multiple Organ Failure (MOF)
□ Cardiovascular Event *(Select event(s) from below)*
○ Stroke ○ MI ○ Both Stroke & MI
□ Pulmonary Embolism
□ Transfusion Related Fatality
□ Other, *(Specify)*: _____

Form 12: Complications **Check here** ☐ if there are NO Complications to report.

(Record any of the following complications that occurred during the subject's hospitalization. Print additional pages as needed.)

CODE	Complication	CODE	Complication	CODE	Complication
1	Abdominal Compartment Syndrome (ACS)	13	Multiple Organ Failure (MOF)	25	Transfusion-Related Acute Lung Injury (TRALI)
2	Abdominal Complications (Open or Closed) after Exploratory Laparotomy	14	Pneumonia (PNUI)	26	Ventilator Associated Pneumonia (VAP)
3	Acute Kidney Injury (AKI) / Acute Renal Failure	15	Sepsis	27	Other
4	Acute Respiratory Distress Syndrome (ARDS)-	16	Severe Sepsis		
5	Cardiac Arrest	17	Septic Shock		
6	Empyema (EMP)	18	Thromboembolic complications		
7	Bacteremia	19	Myocardial Infarction (MI)		
8	Catheter-Related Bloodstream Infections (CRBSI)	20	Stroke or Cerebral Infarction		
9	Skin Infection (SI)	21	Deep Vein Thrombosis (DVT)		
10	Soft Tissue Infection (STI)	22	Pulmonary Embolus (PE)		
11	Surgical Site Infections (SSI)	23	Mesenteric Thrombosis		
12	Urinary Tract Infection (UTI)	24	Transfusion-Associated Circulatory Overload (TACO)		

↓

Code	Start Date *(dd/mmm/yy)*	Stop Date *(dd/mmm/yy)*	
	/ /	/ /	☐ Ongoing ☐Not Noted/Unknown
	/ /	/ /	☐ Ongoing ☐Not Noted/Unknown
	/ /	/ /	☐ Ongoing ☐Not Noted/Unknown
	/ /	/ /	☐ Ongoing ☐Not Noted/Unknown
	/ /	/ /	☐ Ongoing ☐Not Noted/Unknown
	/ /	/ /	☐ Ongoing ☐Not Noted/Unknown
	/ /	/ /	☐ Ongoing ☐Not Noted/Unknown

Refer to "Definitions of Complications Reported in PROHS" reference for more information.

Site P.I. Name: Signature:

Form 13: Trauma Registry Data Form

1. Was subject data entered into the trauma registry? ☐ Yes ☐ No

2. Abbreviated Injury Scale (AIS) Score: **Check here** □ if the AIS Score was not noted/unknown.

ANATOMIC REGION	Head/ Neck	Face	Chest	Abdomen	Extremity	External
INJURY# 1 Score						

3. Injury Severity Score (ISS): __ __ __ __ **Check here** □ if the ISS Score was not noted/unknown.

Form 14: Additional Information

Check here ☐ if there are no additional comments.

Form #	Question #	Comments

(Print additional pages if needed)