REFERENCE CARD FOR WHO EMERGENCY UNIT FORM: TRAUMA

DATES/TIMES: Do not leave dates/times blank. Where unknown, write UNK. If more than one calendar is used in your setting, all dates must be converted to Gregorian calendar and times converted to 24-hour format by data clerk before it is entered into registry.

MASS CASUALTY: Check box if patient part of a mass casualty event.

AGE: If age unknown, circle category: IN (infant) if appears <1 year of age, CH (child) if 1-18 years, or AD (adult)

SEX: Biological sex, differs from patient defined Gender category.

OCCUPATION: Be as specific as possible (eg. farm laborer or farm manager instead of farming).

PATIENT RESIDENCE: Note if homeless, migrant worker, other.	**INJURY LOCATION:** Address or area where injury occurred.
RACIAL/ETHNIC IDENTITY: In the patient's own words.	**INTERPRETER:** Ask whether required.

DISABILITY: Any developmental, physical or intellectual problem that impacts the patient's ability to perform activities independently.

SAFE AT HOME: Ask about violence in the home.	**CONTACT:** Ask who the patient would like to designate.
VACCINATIONS: Ask if up to date. Review card if available.	**SUBSTANCE USE:** Ask about current or prior substance use.

PREGNANT: Ask if patient knows if she is pregnant, designate whether formal testing has been done.

G: Gravida – number of pregnancies.	**P**: Para – number of live births.
CHIEF COMPLAINT: Always in the patient's own words	**ALLERGIES:** Ask about any medication, drug, or food allergies.

DEAD ON ARRIVAL: Use ONLY if NO signs of life on arrival

NORMAL VITAL SIGNS FOR ALL: SpO_2 >92% on RA, Temp 36˚C - 38˚C

Adult: Pulse 60-100 bpm, RR 10-20, SBP >90

Pain Score: Ask the patient to rate their pain 0 (none) to 10 (severe or worst).

Paediatric:

AGE	RESPIRATORY RATE
<2 months	40-60 breaths per minutes
2-11 months	25-50 breaths per minute
1-5 years	20-40 breaths per minute

AGE	PULSE RATE RANGE
0-1	100-160
1-3	90-150
3-6	80-140

*Record O_2 saturation and amount/route of O_2, eg. 94% on 2L by NC

HIGH RISK RED SIGNS: Check box if patient meets any criteria.	**HIGH RISK TRAUMA:** Check box if patient meets any criteria.
TRIAGE CATEGORY: Record color designation using standard tool.	**TRIAGED FOR:** Record reason for triage category (color).

TREATING PROVIDER ASSESSMENT Date and time of first assessment of patient by medical provider at current facility

PRIMARY SURVEY

Normal Airway: (Check box if) •Patent (speaking normally) •NO signs of obstruction, stridor or angioedema		•OPA = oropharyngeal airway •NPA = nasopharyngeal airway •LMA = laryngeal mask airway •BVM=bag valve mask •ETT = endotracheal tube •Spine Stabilized: cervical immon	
Normal Breathing: • Effort normal • Sounds clear	**Abnormal Breathing:** •RR <10 or >20 (enter N/A for spontaneous RR if sedated, paralyzed, or on ventilator) • Breath sounds: note presence with check and quality on lung fields (such as distant, wheezing, rhonchi, crackle, crepitation) • Cyanosis if present	•Record flow rate and route: Nasal = nasal cannula • Facemask = simple facemask •NRB = non-rebreather mask •BVM = bag valve mask •CPAP/BiPAP = continuous or bi-level positive airway pressure •Ventilator = mechanical ventilation •Chest tube: note location, size, and depth if inserted	
Normal Circulation: •Warm & dry •Pulse strong & symmetric in all extremities	**Abnormal Circulation:** •Cool, moist, pale skin •Prolonged capillary refill > 3 seconds •Asymmetric pulses (note which is abnormal) •JVD (jugular venous distention)	•Bleeding: note type of control used •Access: Document location and size •IV = peripheral intravenous •Central = central venous line •IO = intraosseous line •IVF = intravenous fluids, types include: NS = normal saline, LR = Lactated Ringer's, Other (write name) •Note if pelvis stabilized or not indicated	
Normal Disability: •Alert (A) •Moves all extremities •Oriented to person, place, time •Pupils symmetric, reactive, mid-range	**Abnormal Disability:** • Responds to V = Verbal or P = Painful Stimulus or is U = Unconscious • Motor or sensory deficit: note location • Pupils: indicate size and reactivity •Blood Glucose: document level, abnormal if <65 mg/dL or <3.5 mmol/L •Interventions: note if glucose (any form), antidote (such as naloxone or atropine or other), antiepileptic, antibiotic, or other medication is administered	**GCS Eye Opening** 4 – Spontaneously 3 – To verbal command 2 – To pain 1 – No response **GCS Verbal** 5 – Talking and oriented 4 – Confused 3 – Inappropriate words 2 – Incomprehensible sounds 1 – No response	**GCS Motor** 6 – Obeys commands 5 – Localizes pain 4 – Withdraws to pain 3 – Flexes to pain 2 – Extends to pain 1— No response ***Qualified GCS**: Check box if patient sedated, intubated, or vision obstructed
Exposure: Note that patient was fully exposed for examination. Detail all injuries in space provided for physical exam.		**FAST:** Note if an ultrasound FAST exam was performed, not indicated, or not available. If performed, check boxes to indicate results and circle R or L to designate side.	

HISTORY OF PRESENT ILLNESS

Place of injury: Note type of location where injury occurred, eg. home, school, highway, restaurant, farm, factory, sports field
Activity at time of injury: Note activity time of injury, eg. sports, leisure, working, attending school, in transit, sleeping
Mechanism of injury (may use multiple mechanisms)
If road traffic incident: **Vehicle**: •Cycles (bicycle, etc) •Motorised 2- or 3-wheeler •Other non-motorised vehicles •Car •Minibus (<10 seater), pick-up truck, van •Bus (≥10 seater) •Heavy transport vehicle (eg. truck, lorry) •Other
Impacted with*:* •Pedestrian •Animal •Cycles •Motorised 2- or 3-wheeler •Other non-motorised vehicle •Car •Train or railway vehicle •Minibus, pick-up truck, van •Bus, heavy cargo truck or lorry •Fixed or stationary object •Non-collision transport incident •Other
When relevant, note: fall height, drowning with or without intent of being in the water, cause of burn (eg. electric, thermal, chemical), route of toxic exposure (ingestion, inhalation, cutaneous). "Other" mechanisms include: transport incident without road traffic (eg. boat, railway, air), animal bite/scratch, snake bite, electric/lightning injury, radiation exposure, explosive blast, exposure to nature, etc.
First care sought: First source of care for this injury/illness, eg. clinic, traditional healer, etc.
Prehospital care: Mark if and what type of care was provided at the scene of injury or prior to arrival at current facility
Assaulted by (relationship between patient and assaulter): •Spouse or partner •Parent •Other relative •Unrelated caregiver • Friend or acquaintance(s) •Stranger(s) •Other

PAST HISTORIES

Past Medical History: •HTN = Hypertension •DM = Diabetes •COPD = Chronic Obstructive Pulmonary Disease •Other: list conditions not noted, eg. heart disease, stroke, asthma, cancer, and HIV/AIDS) **Past Surgeries:** include type and date	**Medications:** include anticoagulants, prescription medications, traditional medicines, herbs, and supplements **Family History**: include early death, known heart disease, cancer, epilepsy, or others

PHYSICAL EXAM

Normal:	**Abnormal** (specify right/left when needed, draw arrow from injury on diagram to description)
General: Well-developed, well-nourished, awake, alert	**General:** Distressed, malnourished, diaphoretic, uncooperative, sedated, lethargic
Neuro/Psychiatric: Oriented x3, cranial nerves (CN) intact, no focal weakness or sensory deficits	**Neuro/Psychiatric:** Disoriented, cranial nerve deficit, sensory or motor deficit (RUE, LUE, RLE, LLE), abnormal gait or coordination, hypo/hyper-reflexic, saddle anesthesia, no rectal tone
HEENT: Normocephalic, atraumatic, pupils equal and reactive, ocular movements intact, conjunctivae normal	**HEENT**: Unequal pupils, eye injury, bleeding from ears, skull fracture (open or closed), penetrating head/face injury, scalp haematoma, scalp/face laceration, signs of basilar skull fracture (Raccoon eyes/Battle's sign, cerebrospinal fluid leak)
Neck/C-spine: Trachea midline, neck supple, range of motion (ROM) normal	**Neck/C-spine:** C-spine tenderness, palpable deformity/step off, haematoma, limited ROM, neck crepitation, active bleeding, penetrating injury, superficial injury
Respiratory: Normal effort, normal breath sounds, normal expansion, atraumatic	**Respiratory:** Respiratory rate low or high, absent breath sounds, decreased breath sounds, crackles, wheezes, crepitation, transmitted upper airway sounds, paradoxical chest wall movement, sucking chest wound, penetrating injury, palpable rib fracture, superficial injury
Cardiac: Normal rate and rhythm, strong pulses, normal sounds	**Cardiac:** Distant heart sounds, systolic or diastolic murmur, abnormal pulse, S3 or S4 gallop, irregular heartbeat, bradycardia, tachycardia, asymmetric pulses
Abdominal: Soft and non-tender, bowel sounds normal	**Abdominal**: Distension, tenderness, rebound, tense/guarding, evisceration, mass, penetrating abdominal injury, abnormal bowel sounds, superficial injury *If pregnant* - no fetal heart rate
Pelvis: Stable, no pain to palpation	**Pelvis:** Unstable, pain with palpation, superficial injury, penetrating injury
GU/Rectal: External genitalia normal, no blood at meatus, normal urine color, atraumatic, rectal tone, no rectal bleeding	**GU/Rectal:** Vaginal laceration, vaginal bleeding, penile laceration, priapism, blood at urethral meatus, high riding prostate, rectal bleeding, superficial injury, penetrating injury
MSK: Range of motion normal, no deformities	**MSK:** Joint swelling, joint dislocation, sprain or muscle/tendon injury, decreased ROM or strength, extremity deformity/closed fracture, open fracture, crush injury, compartment syndrome, amputation
Skin: Warm, capillary refill < 3 sec, atraumatic	**Skin:** Superficial laceration, deep laceration, ecchymosis, abrasion, burn, foreign body, overlying infection if presentation delayed

ASSESSMENT AND PLAN: include summary and differential diagnosis AND plan for diagnostics, intervention, consults

DIAGNOSTICS & PROCEDURES: check if ordered and note results •**Hgb:** haemoglobin •**Other:** include items such as lactate, amylase, lipase, PT/INR, PTT, CK, and cultures [blood, CSF or urine]) with result •**Imaging**: Specify radiograph type (XR, CT, U/S), location and results. If study needed but not available, write this in other.

Medications: list Blood product (eg. PRBC, platelets) and number of units, write medication name/dose and time given/initials of person administering (eg. Opioid Analgesia: Morphine 4 mg)	**Procedure:** include type, location, outcome, and time •Other: Diagnostic peritoneal lavage, regional block, central line placement, suprapubic catheterization, cricothyroidotomy, foreign body removal, etc.

REASSEMENT: include time, vital signs, and condition (mark condition same or changed, if changed include description)

DISPOSITION: include whether WHO medical emergency checklist was completed, date and time of ED departure, updated vital signs (VS)

Diagnoses: List ALL injuries (sprains, fractures, lacerations, burns, contusions, etc). Include shock, respiratory failure, AMS if relevant.
Number of serious injuries as judged by provider: *Circle* number (0, 1, ≥2)

DISPOSITION: Check box for destination. . Include the accepting provider if applicable once handover performed. Confirm that the plan of care, including follow-up was discussed with all discharged patients. Specify cause of death, but do not write cardiac or respiratory failure/arrest. Instead, use precise terms such as "pneumonia", "organophosphate poisoning", or "suicide".

Document all providers engaged in the patient's care including through shift handovers.