

Vital Signs Data in Trauma Patients (VSDR)
Ambulance Run Sheet
UMMS IRB H-26300

Field Information *AACO:*

Station #: _____ Unit #: _____ CC #: _____
(From SYSCOM)

Shock Trauma Information

STC DOE #: _____ Date / time STC admission: _____ TRU bay #: _____

Patient Information

PDA patient #: _____ *(Please copy from PDA when displayed)*

Check a single box in each column representing the patient's values during your care:

<u>GCS (Lowest)</u>	<u>Systolic BP (Lowest)</u>	<u>Respiratory Rate (Lowest)</u>
<input type="checkbox"/> 13 – 15	<input type="checkbox"/> > 89	<input type="checkbox"/> 10 – 29
<input type="checkbox"/> 9 – 12	<input type="checkbox"/> 76 – 89	<input type="checkbox"/> > 29
<input type="checkbox"/> 6 – 8	<input type="checkbox"/> 50 – 75	<input type="checkbox"/> 6 – 9
<input type="checkbox"/> 4 – 5	<input type="checkbox"/> 1 – 49	<input type="checkbox"/> 1 – 5
<input type="checkbox"/> 3	<input type="checkbox"/> 0	<input type="checkbox"/> 0

Do you believe this patient has *intra-abdominal* injury requiring surgery?

Highly Unlikely	Unlikely	Likely or Unlikely	Probable	Highly Probable
1	2	3	4	5

Event Markers Used:

- Total Pre-Hospital Fluids : Crystalloid _____ ml Colloids _____ ml
- Rapid Fluid bolus _____ ml
 - Drugs given, Specify: _____
 - BVM assisted ventilation
 - Intubation
 - CPR
 - Other, Specify: _____

Comments:

Leave completed form at the 2nd Floor Shock Trauma Center or
Fax completed forms to 410-328-7175

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