PRINT BLANK FORM | PRINT COMPLETED FORM AND RESET | RESET FORM

MUSC Health

PRGRECRD

Trauma Tertiary Survey Form

Form Origination Date: 4/11
Version: 1 Version Date: 4/11

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

Date: Time:
Admission Date: Time:
Patient Location:

Referral Hospital: Primary Physician:

History of present illness:

Past Medical History: Past Surgical History:

Social History: Family History:

Allergies: ☐ NKDA Home medications: ☐ None

☐ No additional information

Physical Examination

Vitals: Temp _____°C P _____ BPM BP _____ mmHg RR _____ breaths/min
GCS:
Eyes: Verbal: Motor:

HEENT:

Neck:

CV:

Resp/Chest:

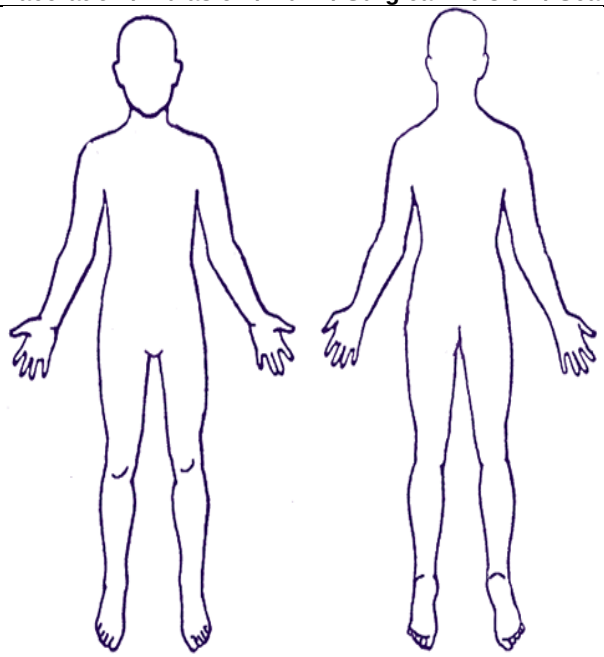
Abdomen:

GU:

Extremities:

Neuro:

Laceration / Abrasion / Burn / Surgical Incision / Scar



☐ ED lines removed
☐ DVT prophylaxis
☐ IVC filter
☐ Restart home medications
☐ Diet
☐ Activity
☐ PT
☐ OT
☐ Speech

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Diagnostic Data (**Provide final reads**):

Plain films ☐ None

CXR:	☐ Final report reviewed, no significant change
C/T/L Spine:	☐ Final report reviewed, no significant change
Pelvis:	☐ Final report reviewed, no significant change
Extremities:	☐ Final report reviewed, no significant change
Other:	

CT/MRI/MRA ☐ None

Chest:	☐ Final report reviewed, no significant change
Abdomen/Pelvis:	☐ Final report reviewed, no significant change
Head:	☐ Final report reviewed, no significant change
C-spine:	☐ Final report reviewed, no significant change
Other:	

Consultations (include dates): ☐ None

1. _____
2. _____
3. _____
4. _____
5. _____

New Findings:	**Date / Time MD Notified:**	**Action Taken:**
1.		
2.		
3.		
4.		
5.		

Updated Problem List:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Physician/PA Signature _____ Pager ID _____ Date/Time _____