

3 - PHYSICAL EXAM / TREATMENT (Cont'd)

<b>LEVEL OF CONSCIOUSNESS:</b> ORIENTED TO: <input type="checkbox"/> PERSONAL PLACE <input type="checkbox"/> TIME <input type="checkbox"/> EVENT  <input type="checkbox"/> A - AWAKE & ALERT <input type="checkbox"/> V - VERBAL STIMULI <input type="checkbox"/> P - PAINFUL STIMULI <input type="checkbox"/> U - UNRESPONSIVE	<b>PUPILLARY RESPONSE:</b> L    R <input type="checkbox"/> NORMAL <input type="checkbox"/> CONSTRICTED <input type="checkbox"/> DILATED <input type="checkbox"/> PINPOINT <input type="checkbox"/> REACTIVE TO LIGHT <input type="checkbox"/> NON-REACTIVE	<b>RESPIRATIONS &amp; LUNG SOUNDS:</b> L    R <input type="checkbox"/> ABSENT <input type="checkbox"/> CLEAR <input type="checkbox"/> LABORED <input type="checkbox"/> FATIGUED <input type="checkbox"/> IRREGULAR <input type="checkbox"/> STRIDOR <input type="checkbox"/> RHONCHI <input type="checkbox"/> RALES <input type="checkbox"/> WHEEZES	<b>SKIN COLOR / MOIST / TEMP:</b> <input type="checkbox"/> NORMAL (Pink Mucosa) <input type="checkbox"/> ASHEN <input type="checkbox"/> CYANOTIC <input type="checkbox"/> JAUNDICED <input type="checkbox"/> PALE <input type="checkbox"/> DRY <input type="checkbox"/> SWEATY <input type="checkbox"/> FLUSHED <input type="checkbox"/> COOL <input type="checkbox"/> WARM <input type="checkbox"/> HOT	<b>ABDOMEN:</b> <input type="checkbox"/> NORMAL <input type="checkbox"/> SOFT / TENDER <input type="checkbox"/> GUARDED <input type="checkbox"/> RIGID <input type="checkbox"/> DISTENDED <input type="checkbox"/> TENDER <input type="checkbox"/> OBESE  IN WHICH QUADRANT?
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<b>GLASCOW COMA SCALE (GCS) VALUES</b>  <table style="width:100%;"> <tr> <td style="width:33%;"> <b>EYE</b>                      4-Spontaneous                      3-To Pain                      2-To Pain                      1-None                 </td> <td style="width:33%;"> <b>VERBAL</b>                      5-Oriented                      4-Confused                      3-Inappropriate                      2-Incomprehensible                      1-None                 </td> <td style="width:33%;"> <b>MOTOR</b>                      6-Obeys Command                      5-Localizes (Pain)                      4-Withdraw (Pain)                      3-Flexion (Pain)                      2-Extension (Pain)                      1-None                 </td> </tr> </table> TOTAL:	<b>EYE</b> 4-Spontaneous 3-To Pain 2-To Pain 1-None	<b>VERBAL</b> 5-Oriented 4-Confused 3-Inappropriate 2-Incomprehensible 1-None	<b>MOTOR</b> 6-Obeys Command 5-Localizes (Pain) 4-Withdraw (Pain) 3-Flexion (Pain) 2-Extension (Pain) 1-None	<b>REVISED TRAUMA SCORE (RTS) VALUES</b>  <table style="width:100%;"> <tr> <td style="width:33%;"> <b>RESP RATE</b>                      4= 10-29                      3= &gt;29                      2= 6-9                      1= 1-5                      0= None                 </td> <td style="width:33%;"> <b>SYSTOLIC BP</b>                      4= &gt;89                      3= 76-89                      2= 50-75                      1= 01-49                      0= None                 </td> <td style="width:33%;"> <b>GCS TOTAL</b>                      4= 13-15                      3= 09-12                      2= 06-08                      1= 04-05                      0= None                 </td> </tr> </table> TOTAL:	<b>RESP RATE</b> 4= 10-29 3= >29 2= 6-9 1= 1-5 0= None	<b>SYSTOLIC BP</b> 4= >89 3= 76-89 2= 50-75 1= 01-49 0= None	<b>GCS TOTAL</b> 4= 13-15 3= 09-12 2= 06-08 1= 04-05 0= None	<b>PEDIATRIC TRAUMA SCORE (PTS)</b>  <table style="width:100%;"> <tr> <td style="width:10%;">PT</td> <td style="width:10%;">SIZE</td> <td style="width:10%;">AIRWAY</td> <td style="width:10%;">SYS BP</td> <td style="width:10%;">CNS</td> <td style="width:10%;">SKELETAL</td> <td style="width:10%;">TISSUE</td> </tr> <tr> <td>+2</td> <td>&gt;20 kg</td> <td>Normal</td> <td>&gt;90 mmHg</td> <td>Awake</td> <td>No Injury</td> <td>No Injury</td> </tr> <tr> <td>+1</td> <td>10-20 kg</td> <td>Maintainable</td> <td>50-90 mmHg</td> <td>Obtunded</td> <td>Single FX</td> <td>Laceration</td> </tr> <tr> <td>-1</td> <td>&lt;10kg</td> <td>Unmaintainable</td> <td>&lt;50mmHg</td> <td>Coma</td> <td>Open/multi FX</td> <td>Major</td> </tr> </table> TOTAL:	PT	SIZE	AIRWAY	SYS BP	CNS	SKELETAL	TISSUE	+2	>20 kg	Normal	>90 mmHg	Awake	No Injury	No Injury	+1	10-20 kg	Maintainable	50-90 mmHg	Obtunded	Single FX	Laceration	-1	<10kg	Unmaintainable	<50mmHg	Coma	Open/multi FX	Major
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AIRWAY:	TIME:	ECG RHYTHM & RATE:	DEFIB / SYNC:	TCP:	IV / MEDS / INFUSION:	DOSE / RATE:	ROUTE:	INITIAL:

<input type="checkbox"/> NASOPHARYNGEAL <input type="checkbox"/> OROPHARYNGEAL <input type="checkbox"/> HEAD TILT - CHIN LIFT <input type="checkbox"/> MODIFIED JAW THRUST <input type="checkbox"/> ASSIST VENTS - BVM <input type="checkbox"/> NEBULIZER	<input type="checkbox"/> NASAL CANNULA <input type="checkbox"/> SIMPLE MASK <input type="checkbox"/> NON-REBREATHER <input type="checkbox"/> OXYGEN @ _____ LPM <input type="checkbox"/> PULSE OXIMETRY <input type="checkbox"/> GASTRIC TUBE NASAL                      ORAL <input type="checkbox"/> SUCTIONING	<input type="checkbox"/> DRESSING / BANDAGING <input type="checkbox"/> BURN SHEETS <input type="checkbox"/> BLEEDING CONTROL <input type="checkbox"/> CPR <input type="checkbox"/> OTHER	<input type="checkbox"/> EPI-PEN AUTO-INJECTOR  ADULT    PEDI TIME 1 <sup>ST</sup> DOSE: _____ TIME 2 <sup>ND</sup> DOSE: _____ GIVEN BY: _____	<b>MAST / PASG:</b> <input type="checkbox"/> LEGS    TIME: _____ <input type="checkbox"/> ABD      TIME: _____ <input type="checkbox"/> BOTH    TIME: _____  INFLATED BY: _____
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<b>AED / SAED</b>	TIME 1 <sup>ST</sup> SHOCK:	TOTAL # DELIVERED SHOCKS:	SUCCESSFUL DEFIB? <input type="checkbox"/> YES <input type="checkbox"/> NO	WITNESSED ARREST? <input type="checkbox"/> YES <input type="checkbox"/> NO	WITNESSED BY:	BYSTANDER CPR?: <input type="checkbox"/> YES <input type="checkbox"/> NO
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<b>VEHICULAR TRAUMA:</b> <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> NON-VEHICULAR TRAUMA <input type="checkbox"/> OTHER	<b>IMPACTING:</b> <input type="checkbox"/> AUTO <input type="checkbox"/> TRUCK <input type="checkbox"/> TREE / POLE <input type="checkbox"/> OTHER	<b>OCCUPANT OF:</b> <input type="checkbox"/> AUTO <input type="checkbox"/> TRUCK <input type="checkbox"/> BUS <input type="checkbox"/> MOTORCYCLE <input type="checkbox"/> BICYCLE <input type="checkbox"/> OTHER	<b>EXTRICATION FROM:</b> <input type="checkbox"/> NO EXTRICATION REQUIRED <input type="checkbox"/> VEHICLE <input type="checkbox"/> BUILDING <input type="checkbox"/> REMOTE PLACE <input type="checkbox"/> OTHER	<b>PT PROTECTIVE DEVICES:</b> <input type="checkbox"/> NONE <input type="checkbox"/> SEAT BELT <input type="checkbox"/> AIRBAG - FRONT <input type="checkbox"/> AIRBAG - SIDES <input type="checkbox"/> CHILD SEAT <input type="checkbox"/> OTHER	<b>EXTRICATING AGENCY:</b>  _____  <b>MEANS OF EXTRICATION:</b>  _____  <b>TOTAL EXTRICATION TIME:</b>  _____
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<b>NON-VEHICULAR TRAUMA TYPE:</b> <input type="checkbox"/> FALL >6 FT <input type="checkbox"/> FALL < 6 FT <input type="checkbox"/> GUNSHOT <input type="checkbox"/> KNIFE <input type="checkbox"/> ATHLETICS <input type="checkbox"/> DOMESTIC VIOLENCE <input type="checkbox"/> ELECTRICITY <input type="checkbox"/> INDUSTRIAL / MACHINERY <input type="checkbox"/> OTHER	<b>DNR COMFORT CARE</b>
PATIENT NAME: _____	
PHYSICIAN NAME: _____	
COMFORT CARE ID #: _____	
<b>NOTE: IF POSSIBLE, A PHOTOCOPY OF THE COMFORT CARE CERTIFICATE SHOULD BE ATTACHED TO THIS PCR FOR MEDICO-LEGAL PURPOSES.</b>	