**Inpatient Trauma PI Review Form**

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| **Demographics**Last Name: Medical record #:Date of report:  | **Source of Information**[ ]  Floor RN[ ]  Inpatient RN Supervisor[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Location** [ ] MS[ ] ICU[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_ |
| Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_Disposition: * Discharge to home
* Discharge to SNF
* Discharge to rehab
* Transfer (Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
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Admission diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Trauma Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Admission Plan: [ ]  Surgery Consult - [ ] Remote/[ ] Onsite – Time of consult: \_\_\_\_\_\_\_[ ]  Surgery Surgeon Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Admit for trauma care [ ]  Pain control only [ ]  PT/OT [ ]  Placement [ ]  Palliative Care [ ]  Care for Medical Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Co-Morbidities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Was the patient admission appropriate in accordance with our admission policy? [ ]  Yes [ ]  No - Identify conflict: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Did the patient experience decompensation during their stay? [ ]  Yes [ ]  No Time of Decompensation: \_\_\_\_\_\_\_\_\_Which decompensation indicator was identified?[ ]  Hypotension or decreasing blood pressure [ ]  Fluctuating or increasing heart rate [ ]  diaphoresis or pallor [ ]  Increasing agitation or anxiety [ ]  fluctuating or worsening level of consciousness or mental status [ ]  Increased work of breathing, shortness of breath or tachypnea, respiratory compromise/Intubation [ ] Compartment syndrome [ ]  Neurologic decline [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If hospital admits under 10.2, Was the surgeon called? [ ] Yes/[ ] No Did the surgeon respond to the hospital? [ ] Yes/[ ] No/[ ] N/A Time arrived to evaluate patient? \_\_\_\_\_\_\_\_\_\_\_Was the patient transferred? [ ] Yes/[ ] No; If yes, Time EMS called: \_\_\_\_\_\_\_\_\_ time transfer occurred: \_\_\_\_\_\_\_\_\_ Name of transfer facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Did patient arrive at definitive care within 120 minutes of decompensation, if transferred: [ ] Yes/[ ] No/[ ] UnknownAre there any patient care opportunities regarding the inpatient care? What follow up is needed or was completed? (Include dates and details) |
| Signature: | Date: |