

#20 Head / Face / Neck - Injury
 check box or circle word(s) if affirmative, -strike- word(s) if negative, note additional findings

Date: _____ Time: _____ Room: _____

Patient's PMD or Specialists: _____ Vital Signs Reviewed

P: _____ **BP:** _____ **RR:** _____ **T:** _____ oral lb
 tympanic Wght: _____ kg
 rectal

Allergies: NKDA see RN notes

Arrived by: EMS walk-in wheelchair
 Historian: patient family / friend EMS

Chief Complaint: Injury Fall Assault

History of Present Illness Levels 1, 2, 3: 1-3 elements Levels 4, 5: 4 or more elements

Onset: <input type="checkbox"/> unknown <input type="checkbox"/> today _____ <input type="checkbox"/> am <input type="checkbox"/> pm _____ <input type="checkbox"/> min. <input type="checkbox"/> hours <input type="checkbox"/> days P.T.A. Locale: <input type="checkbox"/> home <input type="checkbox"/> street <input type="checkbox"/> work <input type="checkbox"/> school	Description of Injury (Quality): <input type="checkbox"/> contusion / bruise <input type="checkbox"/> puncture / penetrating injury <input type="checkbox"/> laceration <input type="checkbox"/> cervical strain / injury <input type="checkbox"/> abrasion <input type="checkbox"/> burn (thermal)	Associated Symptoms: <input type="checkbox"/> none <input type="checkbox"/> briefly confused / "dazed" <input type="checkbox"/> loss of consciousness: witnessed <input type="checkbox"/> yes <input type="checkbox"/> no duration: _____ <input type="checkbox"/> headache <input type="checkbox"/> neck pain <input type="checkbox"/> nausea / vomiting <input type="checkbox"/> numbness / tingling <input type="checkbox"/> weakness Severity: At worst (0-10): ____ <input type="checkbox"/> mild <input type="checkbox"/> mod. <input type="checkbox"/> severe At present (0-10): ____ <input type="checkbox"/> mild <input type="checkbox"/> mod. <input type="checkbox"/> severe
Mechanism of Injury: <input type="checkbox"/> unknown <input type="checkbox"/> struck by blunt object <input type="checkbox"/> cut with sharp object <input type="checkbox"/> alleged assault / altercation <input type="checkbox"/> sports injury <input type="checkbox"/> MVC <input type="checkbox"/> fall from: <input type="checkbox"/> standing position <input type="checkbox"/> chair / bed <input type="checkbox"/> _____ feet (height)	Location of Injury: <input type="checkbox"/> head (scalp) <input type="checkbox"/> jaw <input type="checkbox"/> forehead <input type="checkbox"/> chin <input type="checkbox"/> cheek <input type="checkbox"/> neck <input type="checkbox"/> nose <input type="checkbox"/> upper back <input type="checkbox"/> lip <input type="checkbox"/> shoulder <input type="checkbox"/> mouth	

Context: _____

Review of Systems Levels 1, 2, 3: 1 system Level 4: 2-9 systems Level 5: 10 or more systems

All systems reviewed: negative negative except as marked below History limited or unobtainable due to: altered LOC patient acuity

Constit: fatigue fever chills **GU:** incontinence LMP: _____

Eyes: visual change pain redness **Musc:** myalgias arthralgias painful extremity

ENT: sore throat ear pain hearing loss **Neuro:** syncope vertigo / dizziness seizures focal weakness

CV: chest pain palpitations **Skin:** rash swelling adenopathy

Resp: shortness of breath cough hemoptysis **Psych:** anxiety depression hallucinations

GI: abdominal pain black / bloody stools **Immun / Allerg:** HIV / AIDS

Past, Family, and Social History Levels 1, 2, 3: no history areas Level 4: 1 history area Level 5: 2-3 history areas

PMH: <input type="checkbox"/> none <input type="checkbox"/> unknown <input type="checkbox"/> see RN notes <input type="checkbox"/> HTN <input type="checkbox"/> CAD <input type="checkbox"/> MI <input type="checkbox"/> arrhythmia <input type="checkbox"/> IDDM <input type="checkbox"/> NIDDM <input type="checkbox"/> CHF <input type="checkbox"/> COPD <input type="checkbox"/> PE <input type="checkbox"/> CVA <input type="checkbox"/> seizure <input type="checkbox"/> dementia <input type="checkbox"/> prior head / neck injury <input type="checkbox"/> prior head / neck pain <input type="checkbox"/> disc disease	Meds: <input type="checkbox"/> none <input type="checkbox"/> see RN notes <input type="checkbox"/> ASA <input type="checkbox"/> warfarin Tetanus current: <input type="checkbox"/> yes <input type="checkbox"/> no	Surgical Hx: <input type="checkbox"/> none <input type="checkbox"/> brain surgery <input type="checkbox"/> laminectomy <input type="checkbox"/> discectomy <input type="checkbox"/> fusion Family Hx: <input type="checkbox"/> none <input type="checkbox"/> CAD at < 55 y/o <input type="checkbox"/> aneurysm	Social Hx: <input type="checkbox"/> unknown Tobacco <input type="checkbox"/> yes <input type="checkbox"/> no ETOH <input type="checkbox"/> yes <input type="checkbox"/> no last drink _____ Drugs _____ Occupation _____ Home circumstances <input type="checkbox"/> lives alone <input type="checkbox"/> with family or friend <input type="checkbox"/> nursing home
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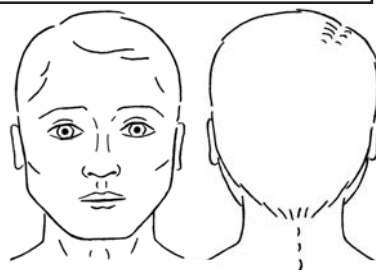
Physical Exam Level 1: 1 organ system Levels 2, 3: 2-5 organ systems Level 4: 6-7 organ systems Level 5: 8 or more organ systems

Gen: distress: none mild moderate severe hydration: nl
 nutrition: nl malnourished obese dehydrated

Head: no evidence of trauma no Raccoon Eyes no Battle's sign

Eyes: PERRL EOMI lids, sclera nl
 disc margins sharp, no evidence of retinal detachment

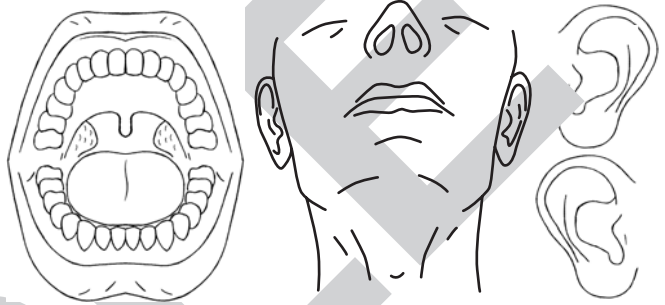
Neck: nontender painless ROM trachea midline



IMPORTANT PRINTING INSTRUCTIONS:
 For best results, print this sample BartCharts ED Template at 100%. In other words, when printing, do not "pagescale" or "shrink to fit".

Physical Exam (continued)	<input type="checkbox"/> Exam limited by patient condition or acuity
ENT: <input type="checkbox"/> external facial exam nl <input type="checkbox"/> oropharynx nl <input type="checkbox"/> no malocclusion <input type="checkbox"/> nasal exam nl <input type="checkbox"/> no injury to lips, <input type="checkbox"/> no hemotympanum <input type="checkbox"/> no septal hematoma teeth, or gums	
CV: <input type="checkbox"/> regular rate, rhythm <input type="checkbox"/> heart sounds nl, no murmur	
Resp: <input type="checkbox"/> no resp. distress <input type="checkbox"/> breath sounds clear and equal <input type="checkbox"/> chest nontender	
Abd: <input type="checkbox"/> soft, nontender <input type="checkbox"/> no organomegaly <input type="checkbox"/> rectal nl, heme negative	
Musculoskeletal: <input type="checkbox"/> ROM nl, painless <input type="checkbox"/> back and extremities nontender	
Skin: <input type="checkbox"/> warm, dry <input type="checkbox"/> no cyanosis	
Neuro: <input type="checkbox"/> alert and oriented x 3 <input type="checkbox"/> cranial nerves 2-12 intact <input type="checkbox"/> gait nl <input type="checkbox"/> motor grossly nl <input type="checkbox"/> sensation intact to light touch <input type="checkbox"/> speech nl	
Psych: <input type="checkbox"/> affect, mood nl <input type="checkbox"/> judgment nl	

Additional Findings:



Medical Decision Making Level 1: straightforward Levels 2-3: low complexity Level 4: moderate complexity Level 5: high complexity

Differential Diagnosis	<input type="checkbox"/> subarachnoid hemorrhage	<input type="checkbox"/> concussion	<input type="checkbox"/> laceration	<input type="checkbox"/> facial fracture	<input type="checkbox"/> eye / orbit injury
<input type="checkbox"/> epidural hematoma	<input type="checkbox"/> intracerebral hemorrhage	<input type="checkbox"/> cervical strain	<input type="checkbox"/> contusion	<input type="checkbox"/> mandible fracture	<input type="checkbox"/> nasal fracture / injury
<input type="checkbox"/> subdural hematoma	<input type="checkbox"/> skull fracture	<input type="checkbox"/> cervical fracture	<input type="checkbox"/> hematoma	<input type="checkbox"/> blowout fracture	<input type="checkbox"/>

Labs <input type="checkbox"/> CBC: <input type="checkbox"/> nl <input type="checkbox"/> nl except values noted below: WBC _____ Hb _____ Hct _____ Plt _____ neut _____ lymphs _____ other _____	<input type="checkbox"/> INR	<input type="checkbox"/> Pulse Ox: _____ % on <input type="checkbox"/> RA or <input type="checkbox"/> O ₂ : _____ Saturation is: <input type="checkbox"/> normal <input type="checkbox"/> hypoxic
<input type="checkbox"/> Chem: <input type="checkbox"/> nl <input type="checkbox"/> nl except values noted below: Na _____ K _____ Cl _____ CO ₂ _____ BUN _____ Cr _____ Glu _____	<input type="checkbox"/> ETOH	<input type="checkbox"/> EKG: rate: _____ rhythm: _____ intervals: _____ ST / T-waves: _____ comments: _____

X-rays / Imaging interpreted by: me radiologist
(NAD - no acute disease) discussed w/ radiologist

1. _____ NAD
2. _____ NAD 3. _____ NAD 4. _____ NAD

Treatment / Management / Course medication / treatment: _____ response: _____ <input type="checkbox"/> IV fluids <input type="checkbox"/> tetanus <input type="checkbox"/> antibiotics <input type="checkbox"/> pain meds	Procedure: _____ <input type="checkbox"/> see addendum Critical Care: _____ min. <input type="checkbox"/> see addendum Reviewed: <input type="checkbox"/> nurses notes <input type="checkbox"/> EMS notes <input type="checkbox"/> old records Consultation: Dr. _____ (time) _____ Notes: _____
Course: <input type="checkbox"/> same <input type="checkbox"/> better <input type="checkbox"/> worse <input type="checkbox"/> signed out to _____ (time) _____	

Wound Repair: sutures staples adhesive
Location: _____ Length: _____ cm
Depth: superficial subcut. intramuscular
Shape: linear irregular flap stellate
Contaminated: minimal moderate severe
 Neurovascular intact adjacent and distal to wound
Anesthesia: _____ cc of _____
(with: epi bicarb)
Explored: no tendon or nerve injury
 no F.B. F.B. found F.B. removed
 thoroughly cleansed and / or irrigated
Repair: _____ # of _____ -O _____ sutures
_____ # of _____ -O _____ sutures
 Multi-layer repair (skin subcut fascia)

Diagnosis 1. _____ 2. _____ 3. _____

Disposition Home Admit (medical surgical ICU) Admit Physician: _____ Transfer to: _____
 Case and instructions discussed with, understood by, and agreed upon by: patient family caretaker
Follow up: PMD and/or other clinician _____ in _____ days or prn Written instructions provided

Condition: <input type="checkbox"/> unchanged <input type="checkbox"/> improved <input type="checkbox"/> stable	signature _____ title _____ date _____ time _____
Discharge Prescriptions / Instructions:	signature _____ title _____ date _____ time _____