Tertiary Trauma Survey (TTS)

**** Perform TTS < 24 hours for Trauma Admissions to ICU &*
*Repeat (or perform for Ward Admissions) prior to discharge*****

Date of TTS: _____ Time: _____
Admission Date: _____ Trauma Activation Type:
Admission GCS: E: V: M: Admit Injury Severity Score (ISS): _____
HPI:

PMHx
PSHx:
Social Hx:

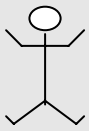
Patient Name:
DOB:
MR#:

Patient Location:

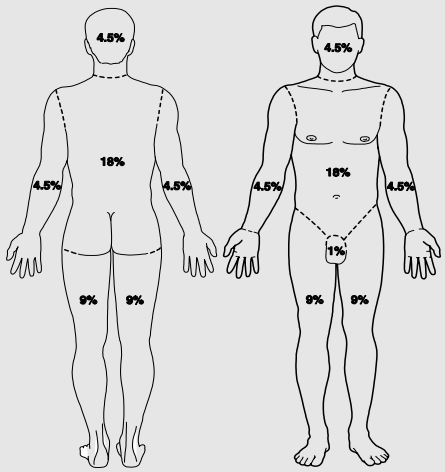
Addressograph

PHYSICAL ASSESSMENT: Hgt: Wgt:
General:
VS: BP : ___/___, PR: ___, RR: ___, Temp: ____
GCS: E: V: M:
HEENT:
NECK:
Heart:
Chest/Lungs:
Abdomen:
Back:
Rectal:
Extremities:

Neurologic:



**** Only Document New/Confirm Findings on Physical Assessment****



Consults (Date):
_____ Neurosurgery _____ _____
_____ Orthopedics _____ _____
_____ Plastics _____ _____
_____ Urology _____ _____

List Injuries Identified to Date:

LIST OPERATIVE & Interventional RADIOLOGICAL Procedures:

(over)

Evaluating Provider MD/NP:

Date Completed:

Tertiary Trauma Survey (TTS)

RADIOLOGICAL FINDINGS REVIEW:	Date/Time Completed:	Date/Time if Repeated:
CXR:		
Pelvis:		
C-Spine: T/L/S Spine:		
Extremity:		
HEAD CT:		
NECK CT:		
CHEST CT:		
ABD/PELVIS CT:		
OTHER:		
Lab Trends:		

Interpretation of Findings:

Evaluating Provider MD/NP:

Date Completed: