**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) * Died   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/Unknown  Are there any patient care opportunities regarding the inpatient care?  What follow up is needed or was completed? (Include dates and details) | | | |
| Signature: | | Date: | |