EMERGENCY DEPARTMENT INTERFACILITY TRANSFER CHECKLIST FOR TRAUMA RE-TRIAGE

9-1-1 Trauma Re-Triage Checklist

Yes No

❐ ❐ Patient meets Trauma Re-Triage Criteria, circle criteria(s) met:

Perfusion:
- ➢ Persistent signs of poor perfusion
- ➢ Need for immediate blood replacement

Respiratory
- ➢ Intubation required

GCS/Neurologic
- ➢ GCS < 9
- ➢ GCS deteriorating by 2 or more during observation

Anatomic
- ➢ Penetrating injuries to head, neck, chest, or abdomen
- ➢ Neurovascular compromise or loss of pulses to extremities

Provider Judgment
- ➢ Patients with high likelihood of needing emergent life or limb saving interventions within 2 hours, as determined by the emergency physician

❐ ❐ Patient is in the emergency department and not admitted to the hospital.

If no to either, do not utilize 9-1-1, contact a private ambulance to transport patient. If meets **both** criteria, follow procedure below:

- ❐ ED physician: Calls designated Trauma Center for a "9-1-1 Trauma Re-Triage" and speaks to Trauma Surgeon or ED Physician.
- ❐ Verify transfer is accepted by the Trauma Center.
  - ❐ Physician accepted patient.
  - ❐ Facility has capacity.
- ❐ Immediately prepare patient for transport: Copy ED records initial EMS Report Form when applicable, labs, relevant diagnostic imaging, etc.
- ❐ Ensure hospital-specific transfer paperwork completed.
- ❐ Verify patient is not receiving medication outside of paramedic scope of practice (IV drips except NS; monitoring of blood products is allowed) then call 9-1-1 for transport (after patient and paperwork is prepared). If patient needs level of care beyond paramedic scope of practice, contact private ambulance service for appropriate level of transport – RN Specialty Care or ALS or BLS with hospital RN to accompany.
- ❐ Call 9-1-1 for transportation when patient is ready for transport. If patient **does not meet** the above trauma re-triage criteria, ***do not call 9-1-1***, arrange for private ambulance transport.
- ❐ ED RN: Calls Trauma Center and provides report to accepting RN or house supervisor.

Patient Name

Medical Record # | Sending Hospital

Receiving Hospital | Accepting MD

Report given to

PROVIDE COPY TO TRANSPORTING AGENCY

Completed by (print): ________________________ Signature: __________________________

Date: ____________