

# EMERGENCY DEPARTMENT TRAUMA DOCUMENTATION

The scribe needs to complete pages 1 - 9

The Team Leader is responsible for checking the entire document

Patient (Alias) Name					(Patient sticker here)
Patient (Real) Name					
NHS Number					
Hospital Number					
Date & Time of Arrival					@
ED Consultant					PRESENT: Y/N
Team Leader & Grade					
Nurse One					
Specialty	Name	Grade	Time	Consultant	
ED				SpR Dect: 6456	
Orthopaedics				SpR Dect: 6176	
Neurosurgery				SpR Dect: 6177	
Anaesthetics				SpR Dect: 6042	
General Surgery				SpR Dect: 6366	
ODP					
Radiographer				X-ray Dect: 6232	
Transfusion					
Nurse					
Paeds				SpR Dect: 6816	
OBGYN				SpR Dect: 6703	

# PRE-HOSPITAL INFORMATION

NAME:  
 HOSPITAL NUMBER:  
 NHS NUMBER:  
 DATE:

TIME OF INCIDENT:		TIME OF ARRIVAL:	
AMBULANCE CAD NUMBER:		POST CODE OF INCIDENT:	
AGE		AMBULANCE PRF - ORIGINAL PHOTOCOPIED:	Y / N
SEX			
HEMS LAS EoE PRU BASICS Other		CODE RED:	Y / N TIME:
MECHANISM OF INJURY			ACTIVATED: <ul style="list-style-type: none"> <li>• PRE HOSPITAL</li> <li>• ED</li> <li>• THEATRE</li> </ul>
PRE-HOSPITAL OBSERVATIONS	RR	SaO <sub>2</sub>	PR/HR
PRE-HOSPITAL INTERVENTIONS			
INTUBATED	Y/N	TIME OF ANAESTHESIA	THORACOSTOMY Y/N R/L
DRUGS AND DOSES	ETOMIDATE		ONDANSETRON
	PROPOFOL		CYCLIZINE
	KETAMINE		PARACETAMOL
	MORPHINE		TXA
	MIDAZOLAM		OTHER
	PANCURONIUM		
	SUXAMETHONIUM		
PRE-HOSPITAL FLUIDS	CRYSTALLOID mls	COLLOID mls	DEXTROSE mls
	STARCH mls	ALBUMIN mls	HARTMANS mls
			POLYGELATINE mls
			OTHER mls
			BLOOD mls
			HYPERTONIC SALINE mls
ALLERGIES			
MEDICATION			
PMH			
LAST EATEN			
TETANUS COVERED?	YES / NO / UNKNOWN		

# PRIMARY SURVEY

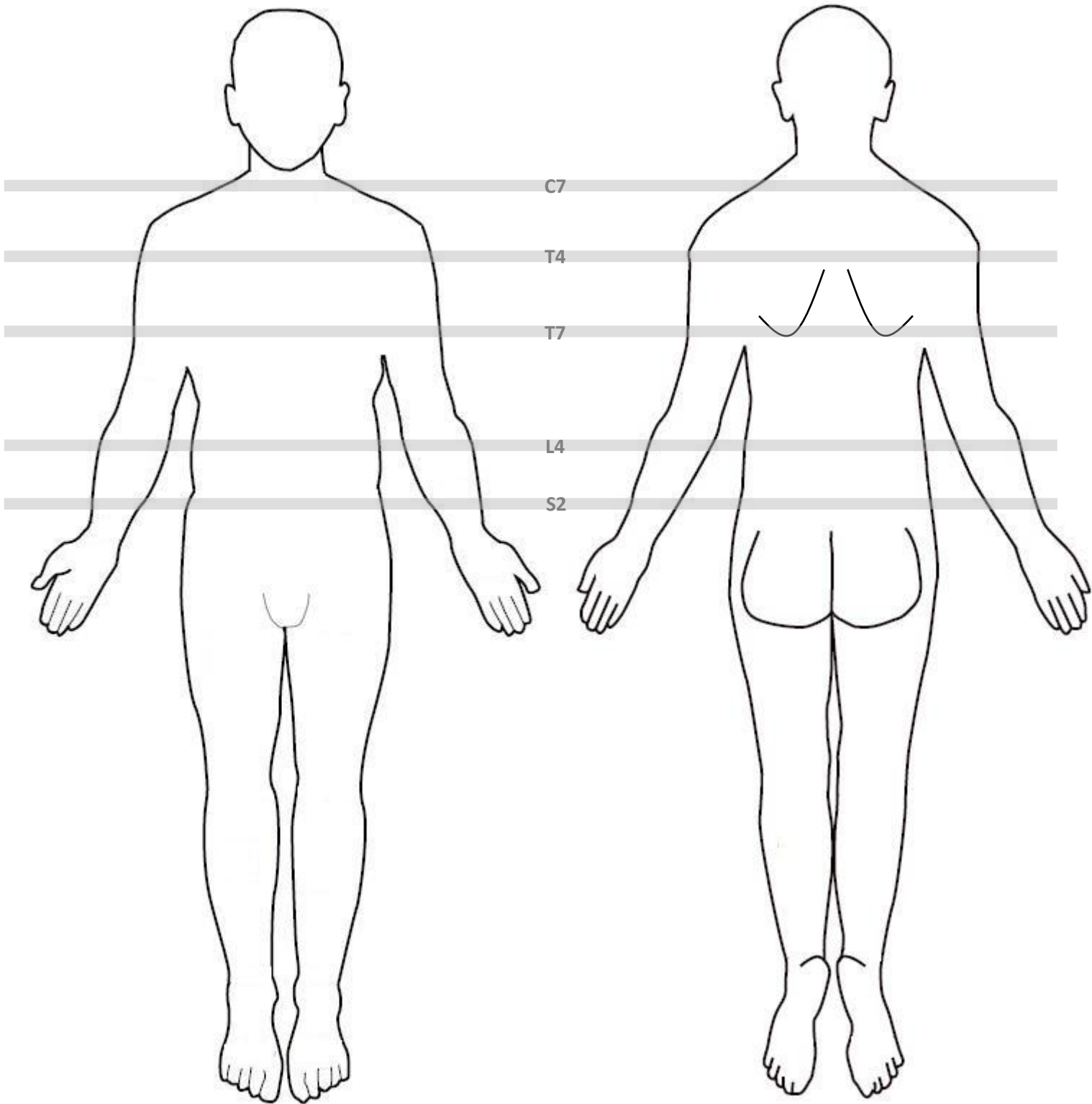
NAME:  
 HOSPITAL NUMBER:  
 NHS NUMBER:  
 DATE:

INITIAL OBSERVATIONS	RR	SaO <sub>2</sub>	PR/HR	BP	TEMP	GCS			Total
						E	V	M	
<b>AIRWAY</b>									
CLEAR	YES / NO	COMPROMISED	YES / NO	COLLAR/ BLOCKS	YES / NO	CLEARED	YES / NO		
INTUBATED	YES / NO	SURGICAL AIRWAY	YES / NO	SPINAL BOARD	YES / NO	RADIOLOGICAL / CLINICAL			
COMMENTS				CLEARED BY					
<b>BREATHING</b>									
EQUAL AIR ENTRY	YES NO		DECREASED AIR ENTRY			RIGHT   LEFT			
NEEDLE DECOMP	RIGHT / LEFT		CHEST DRAIN			RIGHT	LEFT		
CREPITUS	YES		NO			AIR   BLOOD	AIR   BLOOD		
COMMENTS									
<b>CIRCULATION</b>									
SKIN TO TOUCH	WARM		COLD		CAP REFILL	Secs			
EXTERNAL HAEMORRHAGE	YES		NO		PELVIS	STABLE	UNSTABLE		
ABDOMEN	SOFT	DISTENDED	RIGID		FAST	NIL	FREE FLUID		
COMMENTS									
<b>DISABILITY</b>									
RIGHT PUPIL (SIZE/REACTION)	mm YES NO		LEFT PUPIL (SIZE/REACTION)			mm YES NO			
LIMB MOVEMENT	RA	LA	PRIAPISM			YES	NO		
	RL	LL							
BM		TEMPERATURE				PAIN SCORE 1 - 10			
COMMENTS									

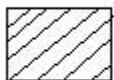
# SECONDARY SURVEY

NAME:  
HOSPITAL NUMBER:  
NHS NUMBER:  
DATE:

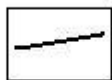
PLEASE INDICATE LOCATION OF ALL INJURIES & INTERVENTIONS



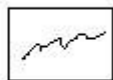
Key:



Abrasion



Incised Wound



Laceration



Swelling



Bruise



Tenderness

PLEASE ENSURE EACH PAGE IS COMPLETED IN FULL

# SECONDARY SURVEY

*Under remit of Orthopaedics*

NAME:  
HOSPITAL NUMBER:  
NHS NUMBER:  
DATE:

## BODY REGION FINDINGS

HEAD	NONE	
FACE	NONE	
NECK	NONE	
CHEST	NONE	
ABDO	NONE	
PELVIS	NONE	
UPPER LIMBS	NONE	
LOWER LIMBS	NONE	
LOG ROLL/BACK	NONE	
RECTAL	NONE	
ECG	NONE	MANDATORY IN PATIENTS OVER 40
OTHER		

# OBS/ANAESTHETIC CHART

NAME:  
 HOSPITAL NUMBER:  
 NHS NUMBER:  
 DATE:

TIME																				
GCS SCORE	EYES (1-4)																			
	VERBAL (1-5)																			
	MOTOR (1-6)																			
	GCS TOTAL (3-15)																			
PUPILS	RIGHT	SIZE																		
		REACTION																		
	LEFT	SIZE																		
		REACTION																		
ANAESTHETIC & ANALGESIC DRUGS																				
VENTILATION PARAMETERS	FiO <sub>2</sub>																			
	ETCO <sub>2</sub>																			
	PEAK AIRWAY																			
	SaO <sub>2</sub>																			
	RESPIRATORY RATE																			
1 . 2 ● 3 ● 4 ● 5 ● 6 ● 7 ● 8 ● Pupil Size	BLOOD PRESSURE AND PULSE RATE ↑ X ↓	190																		
		180																		
		170																		
		160																		
		150																		
		140																		
		130																		
		120																		
		110																		
		100																		
		90																		
		80																		
		70																		
		60																		
50																				
40																				
30																				
20																				
FLUIDS OUT	CENTRAL VENOUS																			
	URINE OUTPUT																			
	CHEST DRAINAGE																			
FLUIDS IN	CRYSTALLOID																			
	COLLOID																			
	BLOOD																			
	FFP																			
	PLATELETS																			
	TEMPERATURE																			
	COT SIDE UP																			







# ED Injury Summary

NAME:  
 HOSPITAL NUMBER:  
 NHS NUMBER:  
 DATE:

	Injuries	Investigations Completed	Outstanding Tasks
Head			
Face			
C Spine			
T/L Spine			
Chest			
Abdomen			
Pelvis			
Upper Limbs			
Lower Limbs			
Skin			
Other			

Time of Death		Admitting Consultant	
Disposal		Signature of Team Leader	

# Team Leader's Notes

NAME:  
HOSPITAL NUMBER:  
NHS NUMBER:  
DATE:

DATE		TIME		CONSULTANT	
PRINT NAME					

<b>I BELIEVE THE PRECEDING PAGES TO BE A TRUE RECORD OF EVENTS</b>	<b>SIGNATURE</b>	
--	------------------	--



# NURSING Notes

NAME:  
HOSPITAL NUMBER:  
NHS NUMBER:  
DATE:

PRIMARY NURSE 1

TIME:

PRIMARY NURSE 2

TIME:

# NURSING Notes

NAME:  
 HOSPITAL NUMBER:  
 NHS NUMBER:  
 DATE:

PRIMARY NURSE 1		TIME:	
PRIMARY NURSE 2		TIME:	

ACCOMODATION	SOCIAL	PROPERTY
ALONE	DISTRICT NURSE	NOT CHECKED
SPOUSE	HOME HELP	ON FORM
FAMILY	M.O.W.	DAMAGED
OPH	SOCIAL WORKER	RELATIVES
WARDEN	KEYS	IN SAFE
	SCHOOL	FORENSICS

Police Station and CAD Number	
-------------------------------	--

NEXT OF KIN	PRESENT:	Yes	No
-------------	----------	-----	----

NAME	
RELATIONSHIP:	
TEL NUMBER:	HOME: MOBILE:
ADDRESS:	

# GENERAL SURGERY

## Notes

NAME:  
HOSPITAL NUMBER:  
NHS NUMBER:  
DATE:

DATE		TIME		CONSULTANT	
PRINT NAME					

Signature







# PAEDIATRIC Notes

NAME:  
HOSPITAL NUMBER:  
NHS NUMBER:  
DATE:

DATE		TIME		CONSULTANT	
PRINT NAME					
AGE		WEIGHT		Immunisations	
Accompanying Adult	Name			Relationship	

Are there any General Paediatric issues? If so, please list and describe management plan to resolve them.  
 Is there a requirement for CATS involvement? Y | N      Has there been senior involvement? Y | N  
 If so, please name those involved. Time called:                      Time attended:


## FAMILY AND SOCIAL HISTORY


Is the reported history consistent with the injuries?	Yes	No
Was the injury independently witnessed (e.g., public place)?	Yes	No
Does the child already have a Child Protection Plan?	Yes	No
Is there any concern of neglect or physical assault by an adult?	Yes	No

CHILD PROTECTION PROCEDURES COMMENCED: Y | N      Consultant informed Y | N

	SIGNATURE	
--	-----------	--

# MISCELLANEOUS Notes

NAME:  
HOSPITAL NUMBER:  
NHS NUMBER:  
DATE:

DATE		TIME		CONSULTANT	
PRINT NAME					

SIGNATURE

# RESULTS PAGE

NAME:  
HOSPITAL NUMBER:  
NHS NUMBER:  
DATE:

## RESULTS

TIME					
Hb					
WCC					
Plts					
INR					
PPT					
APPT					
Na <sup>+</sup>					
K <sup>+</sup>					
UREA					
CREAT					
GLU					
ALC					

AFFIX  
ARTERIAL BLOOD GAS / Urine dip  
HERE

**RADIOLOGY RESULTS**

**PLEASE AFFIX  
RADIOLOGY / FAST SCAN  
REPORT  
HERE**

# Secondary Transfer

NAME:  
HOSPITAL NUMBER:  
NHS NUMBER:  
DATE:

**TRANSFER FROM**

**TRANSFER TO (please circle)**

**ROYAL LONDON HOSPITAL  
(020 3416 5000 BLEEP 1115 or DECT 45722  
EMERGENCY DEPT)**

**ACCEPTING TEAM LEADER OR  
SPECIALTY CONSULTANT**

**TIME OF ACCEPTANCE**

**TIME OF DEPARTURE**

**CATEGORY OF SECONDARY  
TRANSFER (please circle)**

**LEVEL 1: Haemodynamically Stable**

**LEVEL 2: Haemodynamically Unstable**

**LEVEL 3: Stable pathology requiring specialist  
intervention at MTC or STU**

**LEVEL 4: Time critical pathology requiring specialist  
intervention at MTC or STU**

**LEVEL 5: Stable patient with multisystem injuries &  
requires transfer to MTC**

**LEVEL 6: Unstable multisystem trauma or penetrating  
thoracic trauma requiring immediate transfer to MTC**

**ESCORTING STAFF NAME**

**LAS CLINICAL COORDINATION DESK  
INFORMED  
(02073436212)**

**(NB THEY MUST BE INFORMED OF ANY  
TRANSFERS)**

**TIME CCD INFORMED:**

**SIGNATURE:**

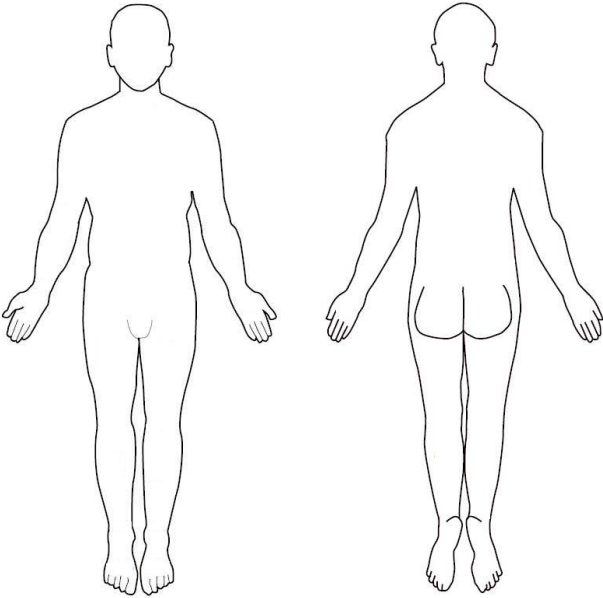


















**TIME:**

# Tertiary Survey

(once admitted)

*Under remit of Neurosurgery*

NAME:  
 HOSPITAL NUMBER:  
 NHS NUMBER:  
 DATE:

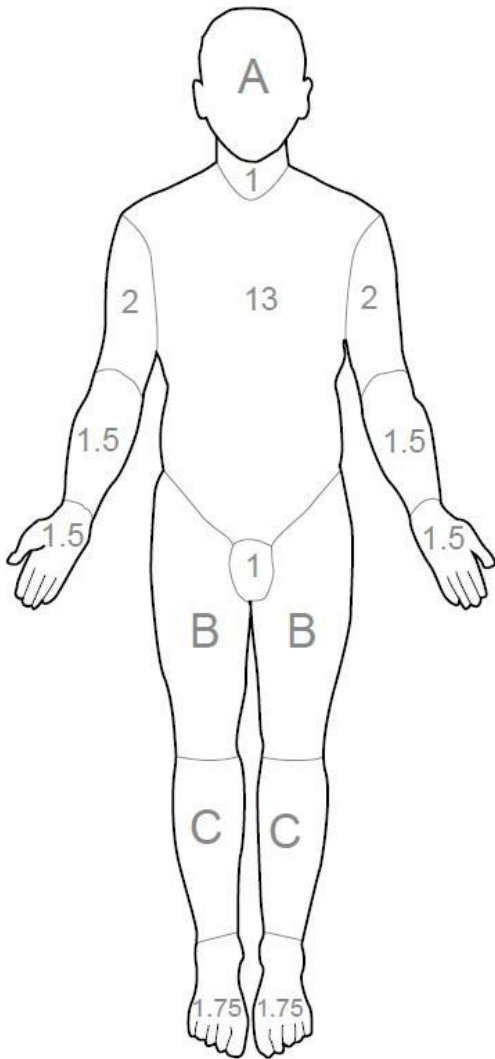
<p><b>Patient Name:</b></p> <p><b>DOB:</b></p> <p><b>Hosp No: NHS No:</b></p> <p><b>Ward:</b></p>	<p><b>HEAD/FACE:</b></p>												
<div style="text-align: center;">  </div> <p><b>Key:</b></p> <table style="width: 100%; text-align: center;"> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Abrasion</td> <td>Incised Wound</td> <td>Laceration</td> <td>Swelling</td> <td>Bruise</td> <td>Tender</td> </tr> </table>							Abrasion	Incised Wound	Laceration	Swelling	Bruise	Tender	<p><b>NECK:</b></p>
													
Abrasion	Incised Wound	Laceration	Swelling	Bruise	Tender								
<p><b>LIMBS:</b></p>	<p><b>CHEST:</b></p>												
<p><b>Missed Injuries Identified to Date:</b></p>	<p><b>ABDOMEN:</b></p>												
<p><b>PRINT NAME</b></p>	<p><b>PELVIS:</b></p>												
	<p><b>PR EXAMINATION PERFORMED: Y / N</b></p> <p><b>PV EXAMINATION PERFORMED: Y / N</b></p>												
	<p><b>BACK:</b></p>												
	<p><b>NEUROLOGICAL:</b></p>												
	<p><b>Suggestions:</b></p>												
	<p><b>SIGNATURE</b></p>												



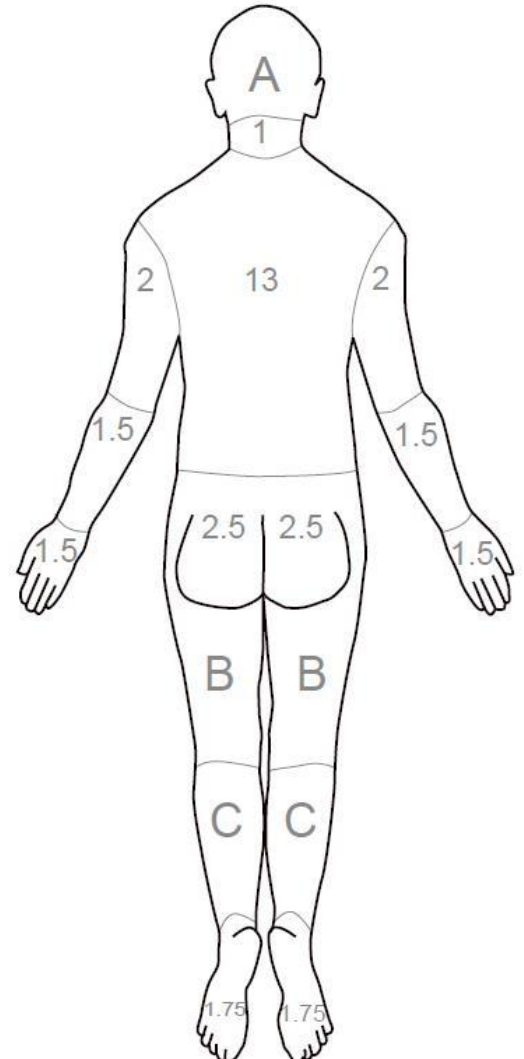
# BURNS Chart

NAME:  
HOSPITAL NUMBER:  
NHS NUMBER:

**% Total body surface area burn**  
Be clear and accurate, and **DO NOT** include Erythema.



Region	%	
	PLT	FTL
Head		
Neck		
Ant. Trunk		
Post. Trunk		
Right arm		
Left arm		
Buttocks		
Genitalia		
Right leg		
Left leg		
Total burn		



Area	Age 0	1	5	10	15	Adult
A = ½ of head	9 ½	9 ½	6 ½	5 ½	4 ½	3 ½
B = ½ of 1 thigh	3 ¾	3 ¾	4	4 ½	4 ½	4 ¾
C = ½ of 1 Lower leg	2 ½	2 ½	2 ¾	3	3 ½	3 ½

## PARKLAND FORMULA

Burns (second or third degree) over 10% in children and 20% in adults need hospital admission and fluid resuscitation.

- 4mls/kg x % of Total body surface area burned over 24 hours
- half this volume given in the first 8hours, the remainder given over the next 16hours



# Trauma Debrief

NAME:  
HOSPITAL NUMBER:  
NHS NUMBER:  
DATE:

Trauma Team Leader		Date:	
ED Consultant		Time	

## Patient Disposal

Admitted	
Theatre	
Transferred to MTC	
NHS Number	
Hospital Number	

## Outside Agencies Notified

Police (Include CAD Number)	
Coroner	
Social Services	
Other	

## Feedback from Debrief

Positive	
Areas for Concern	
Learning Points	
Team Leader Signature	



# Radiology Request

**INCOMPLETE / ILLEGIBLE FORMS WILL BE RETURNED** in line with IRMER 2000 regulations

Version: 04-07-1

Please answer the following for **ALL** requests:-

<b>Consultant (print name):</b> Dr Mir Ahmad <b>Emergency Department</b> <b>Practice details:</b>  <b>Drop Number:</b>	<b>Hospital No</b> <b>Surname</b> <b>Forenames</b> <b>Address</b>  <b>Postcode</b> <b>Telephone</b> <b>Mobile</b> <b>Email</b>	<b>NHS No</b>  <b>Date of Birth</b> <input type="checkbox"/> <b>Male</b> <input type="checkbox"/> <b>Female</b>  <input type="checkbox"/> <b>NHS</b> <input type="checkbox"/> <b>PP</b>
<b>Clinical details/Relevant history</b> (Include reason for urgency if applicable)		
<b>Clinical question: to identify trauma related injuries</b>		
Examination Requested: <i>tick all that apply</i> <input type="checkbox"/> CT Head (no contrast) <input type="checkbox"/> CT Chest (with contrast) <input type="checkbox"/> CT C-spine (no contrast) <input type="checkbox"/> CT Abdomen (with contrast) <input type="checkbox"/> CT Whole spine (no contrast) <input type="checkbox"/> CT Pelvis (with contrast)		
<b>Referrer Status:</b> <input type="checkbox"/> Consultant <input type="checkbox"/> ST <input type="checkbox"/> SpR <input type="checkbox"/> F1/2 <input type="checkbox"/> GP   GMC Code: ..... <input type="checkbox"/> Other (specify)		
<b>Signature</b>	<b>Date</b>	<b>Referrer</b> (print name)
		<b>Contact number:</b> bleep/ dect/ phone:
Tick all that apply: <input type="checkbox"/> <b>Walking</b> <input type="checkbox"/> <b>Chair</b> <input type="checkbox"/> <b>Trolley</b> <input type="checkbox"/> <b>Bed</b> <input type="checkbox"/> <b>Portable</b> <input type="checkbox"/> <b>Oxygen</b>		<b>Ambulance required?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Pregnancy status</b> if applicable <input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant   Gestation weeks:		<b>LMP:</b>
<b>Patient alerts:</b> MRSA, Blind, Deaf etc.		
<b>Diabetic Status</b> ( <i>please tick</i> ) <input type="checkbox"/> Not diabetic <input type="checkbox"/> Diet controlled <input type="checkbox"/> Oral hypoglycaemic <input type="checkbox"/> Insulin dependent		
State any known <b>allergies</b> , especially to Radiographic contrast media (including the type of reaction if known)		
Please answer the following <b>ONLY</b> for examinations which may require the administration of IV contrast agents		
<b>Renal impairment or failure</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                      If yes, specify the eGFR ..... or                      Serum Creatinine ..... If only the Cr level is provided, specify if patient is <input type="checkbox"/> Black <input type="checkbox"/> Other   Date of result .....		
On <b>Metformin</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Asthmatic</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Hypertension</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
On <b>nephrotoxic drugs</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Cardiac failure</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                      Severity:	
Please answer the following <b>ONLY</b> for MRI examinations		
<b>Cardiac pacemaker</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Programmable hydrocephalus shunt?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any operations involving the use of <b>metal clips, pins, stent</b> or <b>implants?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If known, <b>specify date</b> and <b>relevant details</b> including <b>type</b> of clip, implant etc. ....		
Please answer the following <b>ONLY</b> for procedures requiring a Bowel Cleansing Solution*		
1. Patient has been assessed for suitability of Citrafleet / Picolax 2. Procedure and use of Bowel Cleansing Solution has been explained to patient		*A Bowel Cleansing Solution will not be issued to the patient unless this section is completed and signed.
Signed.....                      Date.....		
<b>For Departmental Use only</b>		
Justifier / authoriser  Signature  Date  Date last CT scan checked • tick	Vetting stamp/protocol here	Attach patient attendance label here
I confirm that there is no possibility that I am pregnant.                      Patient to sign:                      Date:		

**LEAVE BLANK**

# Radiology Request

Version: 04-07-1

**INCOMPLETE / ILLEGIBLE FORMS WILL BE RETURNED** in line with IRMER 2000 regulations

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<b>Consultant (print name):</b> Dr Mir Ahmad <b>Emergency Department</b> <b>Practice details:</b>  <b>Drop Number:</b>		<b>Hospital No</b> <b>Surname</b> <b>Forenames</b> <b>Address</b>  <b>Postcode</b> <b>Telephone</b> <b>Mobile</b> <b>Email</b>	<b>NHS No</b>  <b>Date of Birth</b> <input type="checkbox"/> <b>Male</b> <input type="checkbox"/> <b>Female</b>  <input type="checkbox"/> <b>NHS</b> <input type="checkbox"/> <b>PP</b>
<b>Clinical details/Relevant history</b> (Include reason for urgency if applicable)		<b>Clinical question:</b> <i>presence of haemothorax, pneumothorax, widened mediastinum or pelvic bony injury</i> <b>Examination Requested:</b> <i>tick all that apply</i>  <p style="text-align: center;"><b>X ray Trauma Series</b></p>	
<b>Referrer Status:</b> <input type="checkbox"/> Consultant <input type="checkbox"/> ST <input type="checkbox"/> SpR <input type="checkbox"/> F1/2 <input type="checkbox"/> GP GMC Code: ..... <input type="checkbox"/> Other (specify)			
<b>Signature</b>	<b>Date</b>	<b>Referrer</b> (print name)	<b>Contact number:</b> bleen/ dect/ phone:
Tick all that apply: <input type="checkbox"/> <b>Walking</b> <input type="checkbox"/> <b>Chair</b> <input type="checkbox"/> <b>Trolley</b> <input type="checkbox"/> <b>Bed</b> <input type="checkbox"/> <b>Portable</b> <input type="checkbox"/> <b>Oxygen</b>			<b>Ambulance required?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Pregnancy status</b> if applicable <input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant Gestation weeks:			<b>LMP:</b>
<b>Patient alerts:</b> MRSA, Blind, Deaf etc.			
<b>Diabetic Status</b> (please tick) <input type="checkbox"/> Not diabetic <input type="checkbox"/> Diet controlled <input type="checkbox"/> Oral hypoglycaemic <input type="checkbox"/> Insulin dependent			
State any known <b>allergies</b> , especially to Radiographic contrast media (including the type of reaction if known)			
Please answer the following <b>ONLY</b> for examinations which may require the administration of IV contrast agents			
<b>Renal impairment or failure</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify the eGFR ..... or Serum Creatinine ..... If only the Cr level is provided, specify if patient is <input type="checkbox"/> Black <input type="checkbox"/> Other Date of result .....			
On <b>Metformin</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Asthmatic</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
On <b>nephrotoxic drugs</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Cardiac failure</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Severity:	
Please answer the following <b>ONLY</b> for MRI examinations			
<b>Cardiac pacemaker</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Programmable hydrocephalus shunt?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any operations involving the use of <b>metal clips, pins, stent</b> or <b>implants?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If known, <b>specify date</b> and <b>relevant details</b> including <b>type</b> of clip, implant etc. ....			
Please answer the following <b>ONLY</b> for procedures requiring a Bowel Cleansing Solution*			
3. Patient has been assessed for suitability of Citrafleet / Picolax 4. Procedure and use of Bowel Cleansing Solution has been explained to patient Signed..... Date.....			*A Bowel Cleansing Solution will not be issued to the patient unless this section is completed and signed.
<b>For Departmental Use only</b>			
<b>Justifier / authoriser</b>  Signature  Date  Date last CT scan checked <input type="checkbox"/> tick		<b>Vetting stamp/protocol here</b>          <p style="text-align: center;"><b>Attach patient attendance label here</b></p>	
I confirm that there is no possibility that I am pregnant.		Patient to sign: _____ Date: _____	

**LEAVE BLANK**

## Frequently Asked Questions

---

### What is Major Trauma?

- Any injury that has the potential to cause prolonged disability or death; there are many causes of Major Trauma, blunt and penetrating injury, falls, road traffic collisions (RTC) and gunshot wounds.

### What is a Major Trauma Centre?

- A major trauma centre (MTC) is part of a major trauma network. It is a specialist hospital responsible for the care of the most severely injured patients involved in major trauma. It provides 24/7 emergency access to consultant-delivered care for a wide range of specialist clinical services and expertise.

### What is a Trauma Unit?

- A Trauma unit is a hospital that is part of the major trauma network providing care for all except the most severe major trauma patients. When it is not possible to get to the major trauma centre within 45 minutes, or where the patient needs to be stabilised quickly, the patient is taken to the nearest hospital with a local trauma unit for immediate treatment and stabilisation before being transferred on to the major trauma centre. Once discharged from a major trauma centre, local trauma units also provide on-going treatment and rehabilitation for patients.

### Why might I need transfer?

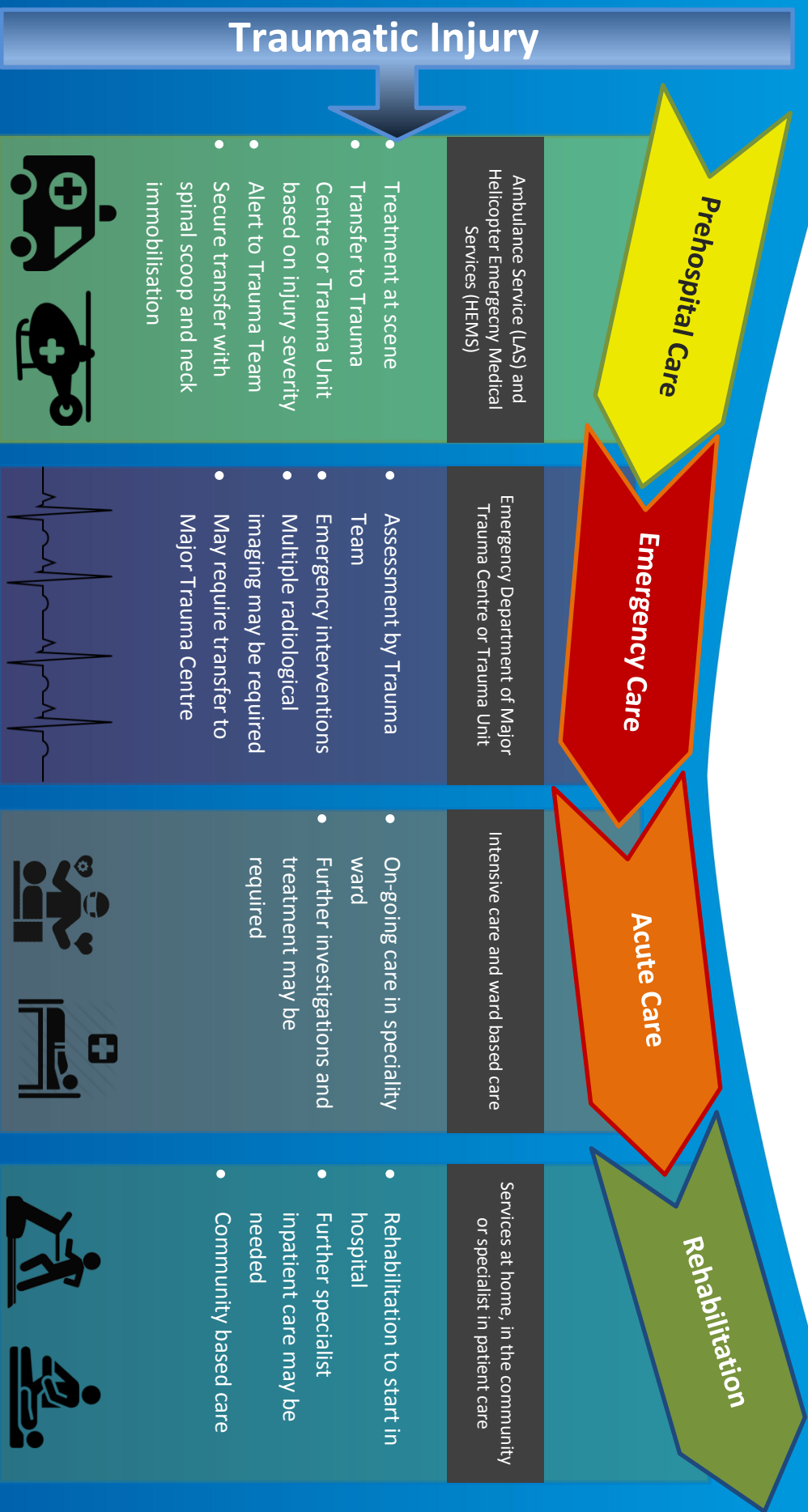
- Trauma units transfer patient to Major Trauma Centre for further specialty care, this is a very common process and the severity of the patient's condition will determine this.

### What support can I get in the community?

- Please ask a member of staff for this information as there all Trauma patients are different and we can direct you in the best direction suiting your needs.

### What is rehabilitation?

- Describes specialized healthcare dedicated to improving, maintaining or restoring physical strength, cognition and mobility with maximized results. Typically, rehabilitation helps people gain greater independence after illness, injury or surgery.



The Trauma Patient journey through BHRUT and North East London and Essex Trauma Network

Queen's Hospital, Romford, functions as a Major Trauma Centre for isolated head injuries and as a Trauma Unit for all other injuries