Mass Trauma Data Instrument - Explanatory Notes

Collect as much of the following information as is feasible to record and compile in a timely manner. After a mass trauma event, it is expected that there will be missing data.

Demographics

Facility: Name of entity providing treatment. May be a hospital, clinic, or improvised treatment area.

Date: Date when care was given at the facility. Use MM / DD / YYYY format.

Time: Time when care was initiated at the facility. Use military 24-hour clock.

Last Name: Family name/surname of patient. Include fully hyphenated last names

DOB: Date of Birth. Use MM / DD / YYYY format.

Age: Not necessary if DOB recorded Circle "yrs" (years) or "months".

First Name: Given name.

Sex: Circle "M" if Male; "F" if Female; "No Data" if sex not known.

Medical Record #: Identification number assigned by treating entity.

Other: Optional field that may be used to categorize the patient (e.g. firefighter), record contact information, or record other information.

Circumstances of Injury

Reason for Visit: Transcribe the patient's reason for seeking medical care. Reason for visit may be recorded in the chief compliant section of a medical chart or may be recorded on a disaster logbook or Emergency Department logbook. Reason for visit may be in the patient's own words or may be implied or summarized.

How did the injury happen? Transcribe as much detail as possible about *how* the injury happened. Often this information may be recorded in the history of present illness (HPI) section of the medical chart or on an ambulance or triage form. (e.g. "glass window shattered on patient", "tripped while running")

What was he/she doing? Transcribe as much detail as possible about the activity that the patient was doing when injured (e.g. "sitting at work desk", "walking to school", "searching for other survivors")

Where did it happen? Transcribe the most specific information available about the *place* where the injury occurred (e.g. building name, street name, vehicle description) and the *location of the patient* (e.g. floor, room, seat)

Was the injury caused by the event? The "event" is an occurrence or string of occurrences that caused a large number of traumatic injuries. Based on information available, check the box preceding:

Direct Effect:	If the forces of the immediate event caused a problem that brought a patient to medical care. (e.g. "cut by flying glass", "difficulty breathing from smoke")
Indirect Effect:	If the patient's problem is related to the event but not a result of the immediate event forces (e.g. "tripped and fell while fleeing", "heart attack while fighting fires", "agitation/nervousness after the event").
Not Event Caused:	If injury is clearly not related to the event.
No Data:	If it cannot be determined if the injury was caused by the event.

How Patient Arrived: Check the box next to the appropriate category. How a patient arrived is often found in the triage notes or Emergency Department logbook. If no information is available check "No Data".

Summary Information

Injury Conditions: Check all injuries that are reported. The most accurate information on the *nature* of the injury is usually found in the medical chart, specifically in the section where the attending physician records the final diagnoses. If a doctor's diagnosis is not available, look in the nursing notes, ambulance notes, triage notes, or logbooks. If appropriate and the information is available, record % of body burned, the degree of the burn (2nd or 3rd), or substance that caused a poisoning. If unsure of appropriate category, choose "Other" and describe. If no information is available check "No Data".

Other Conditions: Check all conditions that are reported. To determine the presence of other conditions, use the same sources of information as for determining injury conditions. "Altered mental status" does not include psychological problems. If unsure of the appropriate category, choose "Other". (The abbreviation "N/V" stands for nausea/vomiting.) If unsure of appropriate category, choose "Other" and describe. If no information is available check "No Data".

Disposition – Check the box preceding the description of where the patient went after assessment and emergency treatment. Check "Hospitalized" if the patient was admitted to the hospital or observed in the hospital for >24 hours. Check "Discharged Home" if the patient was released from the facility and not hospitalized or transferred. Check "Left/AMA" if the patient left against medical advice or left before being discharged. If unsure of the appropriate category, check "Other" and describe. If no information is available choose "No Data".

Details

Conditions #1 – #4: Transcribe details of patient's injuries or other conditions. Usually, the most accurate source of details is to transcribe the doctor's diagnoses directly from the medical chart. If final diagnoses are not available or do not provide details, look for information from the physical examination section of the chart, the results of tests or x-rays, nurses notes, ambulance notes, or logbooks.

Body Part: Next to each Condition #1 – #4, record the part of the body that is affected. To determine the body part, transcribe information from the same sources as listed for the details of conditions. A simplified categorization of body part which may be used is: head/face/neck, chest, back, abdomen, buttocks/pelvis, arm, or leg.