

HEAD TRAUMA

Subjective Data:

Allergies: _____

Chief complaint: _____

Date of injury: _____ Time of injury: _____ Activity at time of injury: _____

Associated symptoms:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Generalized weakness | <input type="checkbox"/> Disturbance of speech | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Agitated/ irritable |
| <input type="checkbox"/> Neckache | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Loss of consciousness | | | |

Objective Data: (clinically indicated VS)

BP _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____ O2 Sats. _____

Character of wound if present:

- Clean Dirty Dry Weeping Crusted Redness/ Swelling Imbedded or foreign material present

Respiration	Lung Sounds	Skin	LOC	Neurologic	Drainage
<input type="checkbox"/> Even	<input type="checkbox"/> Clear	<input type="checkbox"/> Warm	<input type="checkbox"/> Awake	<input type="checkbox"/> Gait steady	<input type="checkbox"/> No drainage
<input type="checkbox"/> Uneven	<input type="checkbox"/> Rhonchi	<input type="checkbox"/> Pink	<input type="checkbox"/> Alert	<input type="checkbox"/> Gait unsteady	<input type="checkbox"/> Drainage from nose
<input type="checkbox"/> Labored	<input type="checkbox"/> Wheezes	<input type="checkbox"/> Cool	<input type="checkbox"/> Oriented X_____	<input type="checkbox"/> Grips equal	<input type="checkbox"/> Drainage from ear
<input type="checkbox"/> Unlabored	<input type="checkbox"/> Diminished	<input type="checkbox"/> Pale	<input type="checkbox"/> Confused	<input type="checkbox"/> Grips unequal	<input type="checkbox"/> Drainage bloody
<input type="checkbox"/> Shallow	<input type="checkbox"/> Rales	<input type="checkbox"/> Cyanotic	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Speech normal	<input type="checkbox"/> Drainage clear
<input type="checkbox"/> Deep		<input type="checkbox"/> Mottled	<input type="checkbox"/> Comatose	<input type="checkbox"/> Speech slurred	
<input type="checkbox"/> Rapid		<input type="checkbox"/> Diaphoretic	<input type="checkbox"/> Follows commands	<input type="checkbox"/> Pupils equal	
		<input type="checkbox"/> Raccoon eyes	<input type="checkbox"/> Unable to follow commands	<input type="checkbox"/> Pupils unequal	

NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY IN ALL CASES OF HEAD TRAUMA:

Emergency department notification time: _____ Transport time: _____

Medical Provider/RN Notified: Date: _____ **Time:** _____ **Orders Received for Treatment:** Yes No

Assessment:

- Alteration in comfort and neurological status related to head trauma

Plan:

Nursing Intervention Emergency:

- Call 911 for altered state of consciousness, abnormal VS or bleeding
- Maintain head in a neutral position (do not adjust by flexion, hyperextension, or elevation onto support)
- Immobilize neck with cervical collar, notify medical provider
- Maintain flat, without pillow, shoulders back and hips kept in alignment at all times
- Administer O₂ (this will require an order from the medical provider)
- Pressure / sterile dressing to control bleeding
- ABC's frequent assessed

Progress Note: _____

Offender Education:

- Instructed on treatment provided, follow-up sick call with medical provider after ER / hospitalization. Offender verbalizes understanding of instructions.

LPN Signature/credentials: _____ **Date:** _____ **Time:** _____

RN/Provider Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

DOC #