


Standardized EMS Radio Report for STRAC, Trauma Service Area - P

	Trauma Service Area - P
STRAC Standardized Patient Radio Report	
1 Agency and Unit Number: _____	
2 Pt. Category/Severity: _____	
3 Pt. Age & Sex: _____ year old <u>Male / Female</u>	
4 Chief Complaint: _____	
5 Mechanism of Injury: _____	
6 Vital Signs: BP: _____ / _____ ; P: _____ ; R: _____ ; GCS: _____	
Monitor: _____ Neuro: _____	
SPO2: _____ ; ETCO2: _____ ; Glucose: _____	
7 Pertinent Assessment Findings: _____	

8 Interventions: _____	

9 E.T.A.: _____	

1. Provide your Agency Name and Unit Number. Depending on jurisdiction and preference of your local hospital, the reporting medic may also provide their name as well.
2. The patient category / severity is what is used to describe the criticality of your patient. The current nomenclature is Code 1 (BLS/non-life threatening) Code 2 (BLS or ALS but not critical) and Code 3 (ALS, Critical life threatening). Other nomenclature includes Category 1, 2, and 3 (as Austin/Travis County uses) or Red, Yellow, Green common on MCI/Disaster tags.
3. The patient's age and sex.
4. The patient's Chief Complaint as simply and accurately as possible.
5. Mechanism of Injury: For trauma patients (MVC, Fall, Altercation, etc)
6. Vital Signs: Multiple vital signs are provided but only those pertinent to the chief complaint and condition of your patient need to be reported.
7. When relaying the assessment, you need to include only the abnormal findings that are pertinent to the patient's ABCD's. Examples are obvious deformity fractures, 12-lead abnormalities (ST elevation, etc), and aphasia. In addition you only need to report **pertinent findings** of your assessment, not a complete assessment. The goal is to provide baseline information so that proper room assignment and care provisions can be made. A complete report including assessments and all interventions can be provided at the patient's bedside once you arrive at the facility.
8. Only Interventions related to the ABCD assessment of your patient need to be reported. Examples include Intubation and Cardioversion/Defibrillation. A complete report of all interventions can be provided at the patient's bedside once you arrive at the facility.
9. ETA needs to be provided as the last item.