MISSOURI DEPARTMENT OF HEALTH
DIVISION OF HEALTH RESOURCES

**HEAD & SPINAL CORD INJURY/TRAUMA REGISTRY**

RETURN TO:
P.O. BOX 570
J.C., MO 65102
(314) 751-6356

**PATIENT INFORMATION**

1. STATE REGISTRY NUMBER
2. HOSPITAL ID NUMBER
3. MEDICAL RECORD NUMBER
4. SOCIAL SECURITY NUMBER ___ - ___ - ___
5. NAME OF INJURED PATIENT (LAST, FIRST, MIDDLE INITIAL)
6. DATE OF BIRTH ___/___/___
7. IF MINOR, NAME OF PARENT OR GUARDIAN (LAST, FIRST)
8. SEX: 1 = MALE 2 = FEMALE
9. PATIENT RESIDENT ADDRESS (STREET, CITY, COUNTY, STATE, ZIP CODE)
10. RACE: 1 = WHITE 2 = BLACK 3 = HISPANIC 4 = INDIAN 5 = ASIAN 6 = OTHER
11. PATIENT TELEPHONE NUMBER ( ) -
12. BILLED HOSP. CHARGES
13. MAIN SOURCE OF PAYMENT: 0 = UNKNOWN 1 = MEDICARE 2 = MEDICAID 3 = HMO 4 = BLUE CROSS 5 = WORKER'S COMP 6 = OTHER INS. 7 = SELF PAY 8 = NONE

**PREHOSPITAL INFORMATION**

14. DATE OF INJURY ___/___/___
15. TIME OF INJURY
16. SCENE OF INJURY (CITY, COUNTY, STATE)
17. PLACE OF INJURY: 0 = HOME 1 = FARM 2 = MINE 3 = INDUSTRY 4 = RECREATION 5 = STREET 6 = PUBLIC BLDG. 7 = RESIDENTIAL INST. 8 = OTHER 9 = UNSPEC.
18. PROTECTIVE EQUIPMENT USED: 1 = NONE 2 = UNKNOWN 3 = SEATBELT 4 = CHILD SEAT 5 = AIR BAG 6 = BELT & BAG 7 = HELMET 8 = OTHER
19. INJURED WHILE WORKING: 1 = YES 2 = NO 3 = UNK
20. MODE OF ARRIVAL: 1 = GROUND AMBULANCE 2 = AIR AMBULANCE 3 = PRIVATE VEHICLE 4 = POLICE VEHICLE 5 = OTHER
21. AMBULANCE SERVICE NUMBER
22. AMBULANCE REPORT NUMBER
23. AMBULANCE RESPONSE TIMES ▶ a. VEHICLE DISPATCHED b. ARRIVED LOCATION c. DEPARTED LOCATION
24. R.T.S. AT SCENE

25. IF TRANSFER FROM ACUTE CARE HOSPITAL (INFORMATION RELATED TO HOSPITAL SENDING PATIENT)

a. NAME OF HOSPITAL
b. CITY HOSPITAL LOCATED
c. DATE PATIENT ARRIVED ___/___/___
d. TIME PATIENT ARRIVED

**EMERGENCY DEPARTMENT INFORMATION**

26. DATE OF ARRIVAL IN E.D. ___/___/___
27. TIME OF ARRIVAL
28. TIME TRAUMA SURG. CALL.
29. TIME TRAUMA SURG. ARR.
30. TIME NEURO. CALLED
31. TIME NEURO. ARRIVED
32. S.B.P. ON ARRIVAL
33. RESP. RATE/MIN. ON ARR.
34. G. C. SCORE ON ARR.
35. P.T.S. ON ARRIVAL
36. TIME SENT TO CT SCAN
37. TIME OF DISCHARGE
38. BLOOD ALCOHOL CONCENTRATION (mg/dL)
39. DRUGS DETECTED AS RESULT OF TOXICOLOGY TEST: 1 = NONE 2 = COCAINE 3 = PCP 4 = BENZODIAZEPINE 5 = BARBITURATE 6 = NARCOTIC 7 = AMPHETAMINE 8 = MARIJUANA 9 = NOT TESTED
40. EMERGENCY DEPARTMENT DISPOSITION: 1 = OPERATING ROOM 2 = INTENSIVE CARE UNIT 3 = ADMIT TO FLOOR 4 = TRANSFER TO ACUTE CARE HOSPITAL 5 = EXPIRED
41. ADMITTING SERVICE: 0 = N/A 1 = TRAUMA 2 = NEUROSURG. 3 = BURN 4 = GEN. SURG. 5 = ORTHOPEDICS 6 = THORACIC SURG. 7 = OTHER SURG. 8 = NON-SURGICAL

42. IF TRANSFER TO ACUTE CARE HOSPITAL (ITEM # 40 CHOICE # 4 OR ITEM # 57 CHOICE # 7 IS CIRCLED)

a. NAME OF HOSPITAL
b. CITY HOSPITAL LOCATED

**OPERATING ROOM INFORMATION**

43. DATE OF FIRST OPERATION ___/___/___
44. START TIME FIRST OPERATION
45. PROCEDURES PERFORMED FIRST OPERATION ▶ a. b. c.
46. DATE OF SECOND OPERATION ___/___/___
47. START TIME SECOND OPERATION
48. PROCEDURES PERFORMED SEC. OPERATION ▶ a. b. c.

**DISCHARGE INFORMATION**

49. DATE OF ADMISSION ___/___/___
50. TIME OF ADMISSION
51. DATE OF DISCHARGE ___/___/___
52. TIME OF DISCHARGE

53. FINAL INJURY DIAGNOSES (ICD-9-CM ANATOMIC INJURY CODES)

a. b. c. d. e. f. g. h.

54. CAUSE OF INJURY (E-CODE) E
55. TOTAL I.C.U. DAYS
56. I.S.S.
57. DISPOSITION AT DISCHARGE: 1 = HOME 2 = HOME HEALTH CARE 3 = HOME/OUTPT. REHAB. 4 = SNF 5 = ICF 6 = INPATIENT REHAB. 7 = ACUTE CARE HOSP. 8 = EXPIRED 9 = OTHER

58. DISABILITY AT DISCHARGE (REFER TO INSTRUCTIONS FOR DEFINITIONS OF 4, 3, 2, AND 1)

a. FEEDING
b. LOCOMOTION
c. EXPRESSION

4 = INDEPENDENT; 3 = INDEPENDENT WITH DEVICE
2 = DEPENDENT - PARTIAL HELP; 1 = DEPENDENT - TOTAL HELP

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**DESCRIPTION OF INJURY EVENT**

Enter a concise statement describing how the injury occurred, including:

The specific activity or task of the patient when the injury occurred, including occupational or sports/recreational activity.

Exactly how the injury was caused (e.g., landed on concrete, caught hand in the lathe, struck windshield).

The intentionality of the injury.

The reported relationship of offender to victim in an assault or homocide (e.g., type of family member, aquaintance, stranger, etc.).

If motor vehicle related: mode of transport, location in the vehicle, and the object with which the vehicle collided.

If work related: industry, name of employer, specific occupation of patient.

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