

HILLSBOROUGH COUNTY TRAUMA AGENCY



GUIDELINES FOR TRANSFER OF A TRAUMA PATIENT TO A TRAUMA CENTER Revised August 2007

PURPOSE

These guidelines are offered to assist in the appropriate transfer of trauma patients between non-trauma centers and trauma centers. It is expected that these conditions or diagnoses should be discovered within a timely manner and efforts to transfer be initiated immediately upon discovery.

GENERAL

- I. If a patient persistently meets trauma alert criteria or one of the following injury conditions, the patient should be transferred to a Trauma Center.
- II. Within 30 minutes of the patient's arrival at the hospital:
 - A. The sending Emergency Physician will initiate definitive care required by the trauma alert patient; or
 - B. The sending Emergency Physician will initiate procedures to transfer the trauma alert patient to a Trauma Center.
- III. The sending Emergency Physician will consult the appropriate specialist(s) on call upon request of the receiving Trauma Center Surgeon.
- IV. An unstable patient with abdominal injuries should be operated upon for hemostasis prior to transfer. If no surgeon is available, such a patient would be transferred.
- V. The sending Emergency Physician should not perform in-depth work-ups, imaging and consultations if this will delay the patient from receiving the medical benefits reasonably expected from the provision of appropriate medical treatment at the Trauma Center.
- VI. Prior to transfer, the sending Emergency Physician and/or surgeon should ensure stability of the patient's airway, breathing, and circulation.
- VII. If the patient is 65 years or older and meets one or more of the ELDER GRAY-AREA conditions, consider transferring that patient to a trauma center.

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HEAD AND SPINE INJURIES

- Sustained GCS of 12 or less, or a decrease of 2 or more points from the time of injury
- Open or depressed skull fracture
- Basilar skull fracture
- Brain hemorrhage
- Meningeal hemorrhage
- Presentation of new neurological deficits
- Spinal cord injury, or major/unstable vertebral injury
- Subluxations
- Open spinal wounds
- Neurogenic shock

CHEST INJURIES

- Pneumothorax, tension pneumothorax, or hemothorax with persistent respiratory insufficiency, or with persistent hemorrhage, after appropriate thoracostomy tube placement
- Flail chest.
- Pulmonary contusion with respiratory insufficiency
- Cardiac tamponade, or other cardiac injury
- Aortic disruption
- Diaphragmatic hernia
- Tracheobronchial tree injuries
- Esophageal trauma
- Wide mediastinum on upright CXR, or other signs suggesting great vessel injury

ABDOMINAL INJURIES

- Hemodynamically unstable patients with physical evidence of abdominal trauma, without surgeon evaluation within 30 minutes and/or without capability for surgical intervention within 60 minutes
- Solid organ injury without immediate surgical capability
- Ruptured hollow viscus

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ORTHOPEDIC INJURIES

- Open pelvic injury
- Pelvic fracture with evidence of continuing hemorrhage
- Unstable pelvic ring disruption with concomitant abdominal, chest or head injury
- One or more open long bone fractures with concomitant abdominal, chest or head injury
- One or more open long bone fractures, with no orthopedic surgeon available, or after fracture site(s) has (have) been appropriately cleaned/irrigated by an orthopedic surgeon
- Fracture/dislocation with loss of distal pulses after realignment, with either concomitant abdominal, chest or head injury, or no vascular or orthopedic surgeon available
- Pediatric fractures, with either concomitant abdominal, chest or head injury, with no vascular or orthopedic surgeon available

VASCULAR INJURIES

- Major vascular injuries documented by arteriogram, or loss of distal pulses with signs of ischemia after re-alignment of extremity, with either concomitant abdominal, chest or head injury, or no vascular surgeon available

BURN INJURIES

Burns injuries, including flash/flame, chemical, scalding, contact, electrical or lightning, are to be transferred to a burn center as follows:

- Second degree burns over 10% total body surface area in children under 15 years old; or over 15% total body surface area in adults
- Second or third-degree burns involving the face, eyes, ears, hands, feet, genitalia, perineum, and major joints
- Third-degree burns greater than 5% of the total body surface area in any age group
- Electrical burns, including lightning injury
- Burns associated with inhalation or other significant major injury or pre-existing disease
- Circumferential extremity burns

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If the patient is 65 years or older and meets one or more of the following ELDER GRAY-AREA conditions, consider transferring that patient to a trauma center.

ELDER GRAY-AREA CRITERIA

Mechanism of injury:

Burns

Motor vehicle collision associated with:

- Rapid deceleration of automobile (> 35 mph)
- Pedestrian/bicycle/golf cart
- Motorcyclist
- Vehicle occupant with lack of restraints
- Significant passenger space invasion
- Prolonged extrication greater than 20 minutes
- Significant vehicular damage
- Rollover
- Fatality of other occupant

Other events associated with high-energy dissipation:

- Fall greater than ground level
- Blast

Injuries associated with an above mechanism:

- Significant chest or pelvic trauma

Traumatic injury and currently taking:

- Anticoagulants and blood thinners
- Cardiac medications such as beta blockers and antiarrhythmics
- Diabetic medications

Traumatic injury and medical history of:

- Cardiac
- CHF
- COPD
- Paralysis
- Dementia
- Surgical: recent surgery, transplant recipient
- Diabetes