

# Tertiary Survey

## UNIVERSITY OF MICHIGAN HEALTH SYSTEMS TRAUMA TERTIARY SURVEY

*To be completed within 24 hours of admission*

*If the patient is unconscious, intoxicated, or sedated, the tertiary survey will be repeated once the patient regains consciousness*

**Substance Abuse Screening:**  **Negative** (No Further Intervention Needed)  
 **Positive** - Social Work Substance Abuse Consult Ordered:  **YES**  **NO**

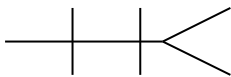
**Blood Alcohol Level:** \_\_\_\_\_ **UTOX performed:**  **YES**  **NO**

**Subjective:** \_\_\_\_\_

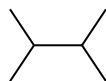
**VS:** T \_\_\_\_\_ **HR:** \_\_\_\_\_ **RR:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **O2Sat:** \_\_\_\_\_

	YES	NO		YES	NO
<b>GENERAL</b>			<b>ABDOMEN</b>		
Alert	<input type="checkbox"/>	<input type="checkbox"/>	Lacerations/Abrasions	<input type="checkbox"/>	<input type="checkbox"/>
Oriented	<input type="checkbox"/>	<input type="checkbox"/>	Swelling/Ecchymosis	<input type="checkbox"/>	<input type="checkbox"/>
GCS 15	<input type="checkbox"/>	<input type="checkbox"/>	Absent Bowel sounds	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEENT</b>			Pain/Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Pain/Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	Rigidity/Guarding	<input type="checkbox"/>	<input type="checkbox"/>
Lacerations/Abrasions	<input type="checkbox"/>	<input type="checkbox"/>	Distended	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/Ecchymosis	<input type="checkbox"/>	<input type="checkbox"/>	Unstable Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Drains	<input type="checkbox"/>	<input type="checkbox"/>
Malocclusion	<input type="checkbox"/>	<input type="checkbox"/>	<b>BACK</b>		
Abnormal visual acuity	<input type="checkbox"/>	<input type="checkbox"/>	Lacerations/Abrasions	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses / Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Swelling/Ecchymosis	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Pain/Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal hearing	<input type="checkbox"/>	<input type="checkbox"/>	Step-offs	<input type="checkbox"/>	<input type="checkbox"/>
<b>NECK</b>			<b>EXTREMITIES (UPPER)</b>		
Cleared C-Spine	<input type="checkbox"/>	<input type="checkbox"/>	Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Pain/Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	Lacerations/Abrasions	<input type="checkbox"/>	<input type="checkbox"/>
<b>CHEST</b>			Swelling/Ecchymosis	<input type="checkbox"/>	<input type="checkbox"/>
Asymmetrical	<input type="checkbox"/>	<input type="checkbox"/>	Pain/Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Pain/Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	Absent Pulses	<input type="checkbox"/>	<input type="checkbox"/>
Lacerations/Abrasions	<input type="checkbox"/>	<input type="checkbox"/>	Extremity involved	<input type="checkbox"/> Rt	<input type="checkbox"/> Lt
Swelling/Ecchymosis	<input type="checkbox"/>	<input type="checkbox"/>	<b>EXTREMITIES (LOWER)</b>		
Air/Bony Crepitus	<input type="checkbox"/>	<input type="checkbox"/>	Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Heart sound	<input type="checkbox"/>	<input type="checkbox"/>	Lacerations/Abrasions	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Swelling/Ecchymosis	<input type="checkbox"/>	<input type="checkbox"/>
Unclear Breath sounds	<input type="checkbox"/>	<input type="checkbox"/>	Pain/Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Chest Tubes	<input type="checkbox"/>	<input type="checkbox"/>	Pulses	<input type="checkbox"/>	<input type="checkbox"/>
<b>OTHER:</b>			Extremity involved	<input type="checkbox"/> Rt	<input type="checkbox"/> Lt

**Labs:**



**Ca**  
**Mg**  
**PO<sub>4</sub>**



**PT**  
**INR**  
**PTT**

**Other pertinent labs:**

**Operative, interventional Procedures:** \_\_\_\_\_

**Radiology:** ("D" if study done, "F": final report, "P" if study pending)

**CT scan:** **Head:** \_\_\_\_\_ **C-Spine:** \_\_\_\_\_ **Face:** \_\_\_\_\_ **Chest:** \_\_\_\_\_ **A/P:** \_\_\_\_\_ **other:** \_\_\_\_\_

**X-ray:** **Chest:** \_\_\_\_\_ **Pelvis:** \_\_\_\_\_ **other:** \_\_\_\_\_

