



Call Center TRAUMA INFORMATION

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|-------------------------|-------|
| Date: | Time: |
| Transferring facility: | |
| Transferring physician: | |

| | |
|------------------------------|------|
| Patient name: | Age: |
| History/Mechanism of Injury: | |
| Known/suspected Injuries: | |

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|-------------------|
| Procedures done: |
| Treatments/tests: |

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|---|
| Expected departure time from transferring facility: _____ AM PM |
| Transport Type: <input type="checkbox"/> Ground <input type="checkbox"/> Air |