



Immediately after primary & secondary surveys:

IS FURTHER AIRWAY INTERVENTION NEEDED? May be needed if: <ul style="list-style-type: none"> Abnormal level of consciousness (AVPU scale) Stridor Respiratory Distress Hypoxaemia or hypercarbia 	<input type="checkbox"/> YES, DONE <input type="checkbox"/> NO
IS THERE A SEVERE ALLERGIC REACTION? (ADRENALINE NEEDED)	<input type="checkbox"/> YES <input type="checkbox"/> NO
IS THERE A <i>TENSION</i> PNEUMOTHORAX? (NEEDLE/DRAIN NEEDED)	<input type="checkbox"/> YES <input type="checkbox"/> NO
DOES THE PATIENT NEED OXYGEN?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IS THE PULSE OXIMETER PLACED AND FUNCTIONING?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DOES THE PATIENT NEED BRONCHODILATORS? (e.g. salbutamol)	<input type="checkbox"/> YES <input type="checkbox"/> NO
DOES THE PATIENT NEED IV FLUIDS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
ASSESSED FOR ONGOING BLEEDING (including gastrointestinal, vaginal, and other internal):	<input type="checkbox"/> BY EXAM <input type="checkbox"/> NGT <input type="checkbox"/> ULTRASOUND <input type="checkbox"/> CT <input type="checkbox"/> DIAGNOSTIC PERITONEAL LAVAGE
IS TREATMENT FOR HYPOGLYCAEMIA NEEDED?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IS TREATMENT FOR OPIOID OVERDOSE NEEDED?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IS THE PATIENT HYPOTHERMIC/HYPERTHERMIC?	<input type="checkbox"/> YES <input type="checkbox"/> NO

When initial resuscitation is complete:

HAVE VITAL SIGNS BEEN RECHECKED?	<input type="checkbox"/> YES
HAS THE PATIENT BEEN GIVEN:	<input type="checkbox"/> ASPIRIN <input type="checkbox"/> ANALGESIC <input type="checkbox"/> TRANSFUSION <input type="checkbox"/> ANTIBIOTICS <input type="checkbox"/> NONE INDICATED
DOES THE PATIENT NEED AN ECG?	<input type="checkbox"/> YES <input type="checkbox"/> NO
PREGNANCY TEST DONE?	<input type="checkbox"/> YES <input type="checkbox"/> NOT INDICATED
HAVE ALL TESTS AND IMAGING BEEN REVIEWED?	<input type="checkbox"/> YES <input type="checkbox"/> NO, PLAN IN PLACE
WHICH SERIAL EXAMS ARE NEEDED?	<input type="checkbox"/> NEUROLOGICAL <input type="checkbox"/> ABDOMINAL <input type="checkbox"/> VASCULAR <input type="checkbox"/> RESPIRATORY <input type="checkbox"/> NONE
PLAN OF CARE DISCUSSED WITH:	<input type="checkbox"/> PATIENT/FAMILY <input type="checkbox"/> RECEIVING UNIT <input type="checkbox"/> PRIMARY TEAM <input type="checkbox"/> OTHER SPECIALISTS
RELEVANT EMERGENCY UNIT CHART COMPLETED?	<input type="checkbox"/> YES

*if intervention is needed but unavailable, respond YES and note missing item, date & time on stockout log sheet.