Affix barcode label here	
Surname: First Name: DOB	

Age>65 years of ages?

	NHS
Sherwood	Forest Hospitals
	NHS Foundation Trust

Silver Trauma Clerking Form

Pain Score:

Silver trauma is defined as trauma sustained by patients >65 years of age following a low mechanism of injury, e.g., a fall from standing.

Clinical Frailty Score

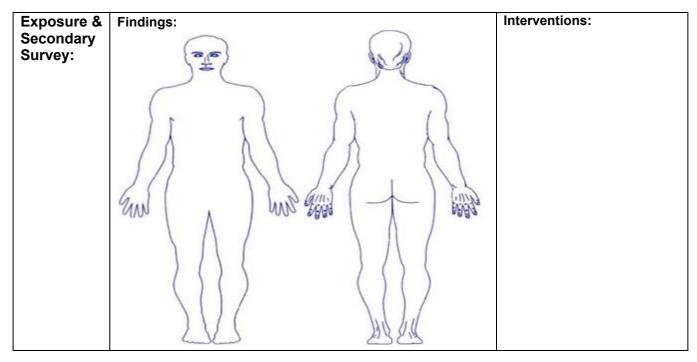
Please note that silver trauma clerking should not be used in patients who meet the criteria for Major Trauma, as stated in the guidelines.

Date/Time of Injury:

Mechanism of	iniurv:	Sats:		Is the patient on anticoagulation?
	, ,	R/R:		Yes/No/Unsure?
		Heart Rate:		-
		BP:		1
		GCS:		1
		Temperature:		-
		<u> </u>		
The primary s	survey is to be	completed within 15 min	utes of th	ne identification of silver trauma.
Airway	Findings:		Airway	Interventions:
assessment				
with				
C-spine:			C-spin	e Interventions:
			_	equired □
			Blocks	s/tape □ Hard collar □ Improvised □
			Othor	
			Other	
Breathing:	Findings:		Interve	entions:
Circulation:	Findings:		Interve	entions:
Disability:	Findings:		Interve	entions:
			1	

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Once the primary survey is completed, note down your findings. Discuss the modality of imaging with the senior decision maker.

Does the patient need urgent treatment? Yes / No Has analgesia been prescribed? Yes / No

Has analgesia been prescribed	d? Yes / No	
Any other concerns regarding presentation:		
e.g., sepsis, infection, long lie, cardiac event, new oxygen requirement, or low/fluctuating GCS.		
Urgent treatment - IV fluids.		
Actions taken to address other concerns: e.g., chest x-ray, antibiotics, ECG, ABG.		
Injuries identified during the prima	ry survey:	Imaging requested after discussion with senior decision maker: Y/N

Injuries identified during the primary survey:	Imaging requested after discussion with senior decision maker: Y/N
Discussed with:	

Name:	Signature:	
Date:	Time:	

Imaging results:				Date and Time:
Final Diagnosis:				Date and Time:
Plan:				Date and Time:
Admitted Locally:	Discharged back to the usual		Transfer to another health	
	place of residence:		facility:	
Name:		Signature:		
Date:		Time:		