



= YES = NO

(PLACE PATIENT LABEL HERE)

SURNAME: _____ NHI: _____

FIRST NAMES: _____

Date of Birth: ____ / ____ / ____ SEX: _____

TRAUMATIC HIP PAIN - ADULTS
(Suspected # neck of femur)

Date: / / 20 Time: Clinician: NP CNS HS Reg SMO

HISTORY AND PRESENTING COMPLAINT

Traumatic hip pain : Right Left

Circumstances of the injury: Mechanical fall Collapse

Witnessed Unwitnessed

Systems review

Gen: Fever

CVS: Chest pain

Resp: SOB (new)

GU: Urinary Sx

CNS: Confusion (new)

Abnormal neurology (new)

RELEVANT PREVIOUS MEDICAL HISTORY Nil relevant

CVS: AF / PAF → Anti-coagulated: Yes No

IHD:

Resp: COPD

Dementia

Endo: T1DM T2DM

RELEVANT MEDICATIONS / ALLERGIES Nil regular medicines

Aspirin Warfarin Dabigatran Clopidogrel Other anticoagulants *e.g. Rivaroxaban*

Nil known allergies **ALLERGIES:**

EMERGENCY MEDICINE NOTES



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FUNCTIONAL AND SOCIAL HX

Living situation: <input type="checkbox"/> alone	Mobility <input type="checkbox"/> independent	Activities of daily living: <input type="checkbox"/> independent
<input type="checkbox"/> with family	<input type="checkbox"/> walking stick	<input type="checkbox"/> needs some help e.g. cleaning
<input type="checkbox"/> rest home	<input type="checkbox"/> walking frame	<input type="checkbox"/> significant help e.g. dressing
<input type="checkbox"/> private hospital	<input type="checkbox"/> wheelchair	<input type="checkbox"/> needs help eating
<input type="checkbox"/> other:	<input type="checkbox"/> immobile	<input type="checkbox"/> completely dependent
Smoking Hx: <input type="checkbox"/> Never	<input type="checkbox"/> Ex-smoker: ____ pack years	
	<input type="checkbox"/> Current smoker ____ pack years	
Supports: _____		

VITAL SIGNS

Within normal limits

BP _____ mmHg

Resp Rate _____ min

Pain score ____ /10

Pulse _____ bpm

SPO2 _____ %

Temp _____ °C

Air NP Hudson: ____ l/min

General NOT distressed

Pain None Mild 1-3 Moderate 4-7 Severe 8-10

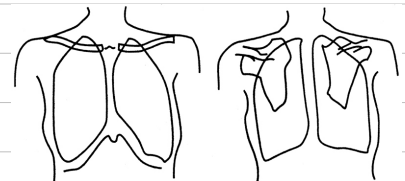
EXAMINATION

CVS Warm and well perfused

Cap refill Normal

Pulses Normal

Heart sounds Normal



Respiratory

Breathing work Normal

Breath sounds Vesicular

Added sounds No Yes:

ABDOMEN

Palpation Soft

Tender No Yes:

NEUROLOGY

Look for new weakness / focal neurology

GCS /15 E: ____ V: ____ M: ____

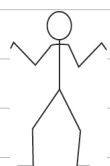
Cranial nerves II - XII normal PEARL FROEM

Power Normal in all myotomes

Sensation Normal in all dermatomes

Coordination Normal

Reflexes Normal



Plantar reflex ↓ ↑ ↓ ↑

Clonus - + - +



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DEMENTIA / DELIRIUM 4AT score:

Known dementia No Yes: *Details:*

Agitation None Mild Moderate Severe *Formulary p4 Best Care Bundle: agitation Rx*

Alert Fully alert Mildly drowsy Very drowsy / clearly abnormal

Orientation Current place Current year Own age Date of birth

Attention *Say months of the year backwards* ≥ 7 correct < 7 correct Not testable *too drowsy*

Acute change *Δ in alertness, cognition or mental function* No change Acute change noted < 2 weeks

4AT score: *Data collected for ERAS & STRIDE studies. Calculate & document in Éclair. 4AT = 0 may be eligible for STRIDE study. See info sheets in handover room & EM CeDDS. Call 0204 154 0774*

MUSCULOSKELETAL / OTHER *Palpate the whole spine to look for other fractures / injuries*

Neurovascular status Normal
 Compromised *describe:*

Other injuries None

D - Dislocation # - Fracture C - Contusion A - Abrasion L - Laceration P - Pain S - Skin tear

RESULTS

HAEMATOLOGY	BIOCHEMISTRY	COAGS	URINE MSU / CSU
Hb	Na ⁺	INR	Nitrates
WCC	K ⁺	APTT	Leuc est
PL	Gluc		WCC
Fe	Creat		RCC
Ferritin	CRP		Epi's
	Trop		Bacteria

ECG *Describe:*

NSR

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RADIOLOGY

Pelvis X-Ray: # NOF Left # NOF Right Intra-capsular Extra-capsular

Chest X-Ray: Normal

Films reviewed by: Dr: _____

DIAGNOSIS / PLAN / NURSING INSTRUCTIONS

Diagnosis: # NOF confirmed → *Please complete the checklist & FIB procedure note page 2 & 3 of pathway document. This is an important standardisation, quality improvement and communication tool. Data collected for nationwide ERAS study.*

No NOF on plain films? → *Decision aid page 3 of BCB pathway regarding further imaging*

Other problems:

Plan:

Referral note Inpatient referral: Discussed with Dr: _____ Time: _____

Admit Ortho AT&R Gen Med

Clinician Name: _____ Designation: _____ Sign: _____ Contact details: _____

For junior staff: Discussed with Reviewed by SMO Dr : _____ Sign: _____