Spinal Clearance Checklist

Patient's Name	
Date of birth	
St G. Hosp. No.	

The purpose of this form is to clearly document the current status of the patient to ALL members of the multidisciplinary team. It should be completed by the Trauma Team Leader before the patient leaves the ED and amended as soon as further information becomes available.

1. Given the mechanism of injury is there a risk of spinal injury? If uncertain, then the answer is YES. Are symptoms or signs of spinal injury reported or evident (from history, medical notes, secondary or tertiary survey)?

	Risk			Symptoms & / or signs of injury (bony & / or neurological)	Date	By whom
	No	Yes	No	Yes. Symptoms / signs were		(PRINT)
C- spine						
T & L spine						

2. CT scans with planar reconstruction. Are these necessary? Have they been performed? Have they been reported by a radiologist OR consultant? Is the spine radiologically cleared or are there injuries noted? If there are injuries are they stable or unstable?

	Necessary		Performed		RADIOLOGICAL CLEARANCE			D
	No	Yes	No	Yes	Yes	No. The injuries are The spine is stable / unstable	Date	By whom (PRINT)
C- spine								
T & L spine								

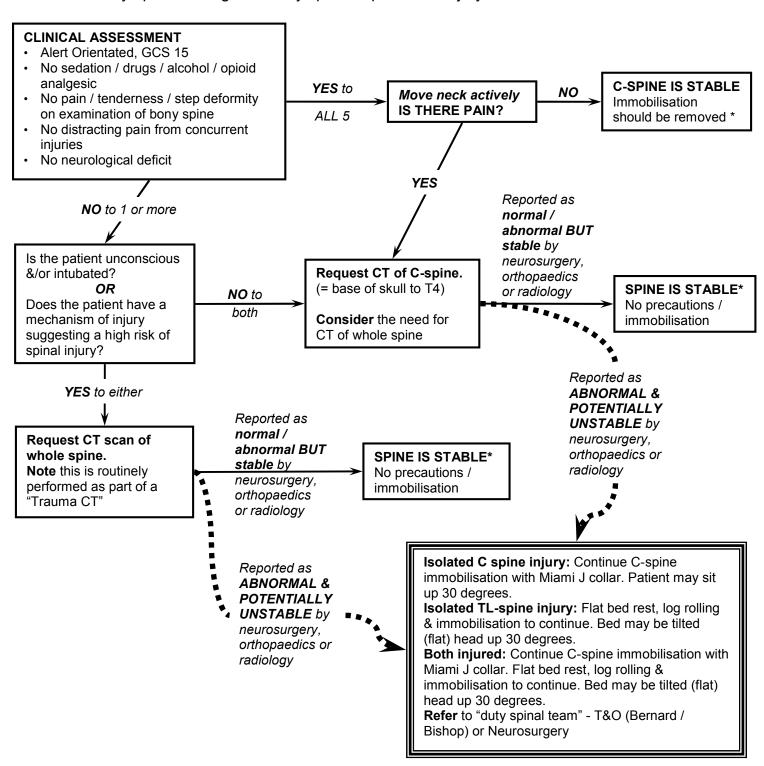
3. Management plan. It is intended that the plan will progress to no precautions over time.

Precautions (circle)	Details	Time & Date	Sign	Name (PRINT)
Full	Miami J collar / spinal mattress / log roll / scoop stretcher / supine			
Limited / special instructions				
Updates / changes				
None				

SPINAL CLEARANCE FLOW DIAGRAM

Use this flow chart IF:

- from the mechanism of injury there is a risk of spinal injury AND / OR
- there are symptoms or signs of bony spinal / spinal cord injury



^{*}Close observation is required during mobilisation (removal of immobilisation). Development of weakness, paraesthesia or pain may indicate a missed injury.

Neurological deficit referable to spinal injury requires CONSIDERATION of urgent MRI and ICU review regarding risk and management of ascending injury and spinal perfusion pressure / spinal shock.

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