"Agency name" TXA QA Form

Date: _____ PCR #: _____ DR #: _____

Patient Complaint: ☐ Traumatic Injury, Uncontrolled Bleeding ☐ Post-Partum Hemmorhage

Patient Age: _____ Weight: _____ Time of Injury: _____

Initial Vital Signs

Blood Pressure: _____/_____ Heart Rate: _____ SpO2: _____ Resp: _____ Skin Condition: _____

Medical Command Contacted: ☐ Yes ☐ No Medical Command Physician: _____

Contact Made: ☐ Pre Administration ☐ Post Administration Time of Contact: _____

*****Medical Command Must Be Notified of TXA Administration*****

Patient Status: ☐ Improved ☐ Deteriorated ☐ Unchanged

******Below Required for all TXA Administration******

Vitals Every 5 Minutes (Including GCS) ☐ Yes ☐ No

Oxygen Administration: ☐ Yes ☐ No Route: ☐ Nasal Cannula ☐ Non-Rebreather LPM: _____

Nasal Capnography: ☐ Yes ☐ No ETCO2: _____ mmHg RR: _____

Fluid Administration: ☐ Yes ☐ No ML Given: _____

Allergies Documented: ☐ Yes ☐ No

Time of Injury > 3 hrs: ☐ Yes ☐ No Trauma Use? ☐ Yes ☐ No

Under 15 years old: ☐ Yes ☐ No Pregnancy Use? ☐ Yes ☐ No

Isolated Head Injury: ☐ Yes ☐ No If yes > 24 weeks? ☐ Yes ☐ No

Administered By: _____ Signature: _____

QA/QI Review: _____ Date: _____

Medical Director: _____ Date: _____

Appropriate application of inclusion/exclusion criteria? ☐ Yes ☐ No

Appropriate Patient management prior to TXA admin? ☐ Yes ☐ No

Comments: _____
_____
_____
_____