



# Trauma Service

Hospital Tuanku Ja'afar Seremban

HOSPITAL TUANKU JA'AFAR

EXTERNAL TRAUMA REFERRALS  
& INTERHOSPITAL TRANSFER  
PROTOCOL

Updated DEC 2024

---

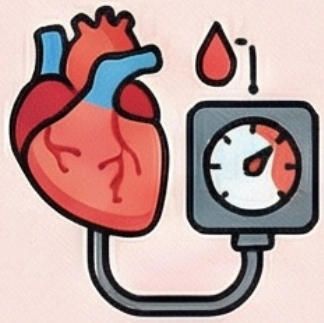
Version 1.0



# Protocol for External Trauma Referrals: Hospital Tuanku Ja'afar (HTJ) Seremban



## Immediate Transfer Criteria



### Hemodynamic Instability

**SBP  $\leq$  90**  
mmHg at any  
time

**HR  $>$  120/min**  
after 1L crystalloid  
infusion



### High-Risk Injuries

Penetrating torso/neck wounds,  
positive FAST scans, peritonitis,  
or obvious vascular injury.



### Critical Polytrauma

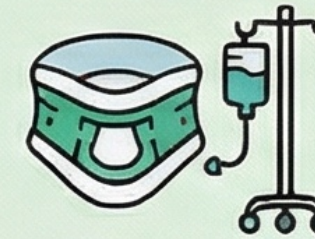
Unstable patients requiring  
intubation or those with low GCS  
scores.

## Pre-Transfer & Journey Requirements



### Eliminate Diagnostic Delays

No hematology/biochemistry needed; only perform  
CXR or Pelvic X-rays if they don't delay transfer.



### Stabilization Standards


Secure airway, apply cervical collar/spinal  
board, and insert two large-bore IV lines.



### Destination: ED Red Zone

All trauma transfers must pass through the  
Emergency Department; ward transfers are prohibited.

## Contact Hierarchy for Informing HTJ

Timing	Primary Contact (Sequence)	Secondary Contact
Office Hours	 Trauma Surgery MO	 ED Red Zone MO / Trauma Surgeon
After Hours	 On-call Surgical MO	 ED Red Zone MO / On-call Surgeon





# External Trauma Referral

During regular work hours, external referrals from other hospitals can be initiated through a dedicated phone line. This direct line connects to a member of the Trauma Service capable of promptly making informed decisions. While all Trauma Service members, with the exception of House officers, have the authority to decide whether to accept or divert external referrals, the Medical Officer (MO) receiving the referral is required to consult with the Trauma surgeon/Fellow before deciding on diversion.

For cases originating from district hospitals lacking specialists that necessitate urgent transfer, immediate transfer is facilitated without any unnecessary delays, contingent upon the patient meeting the criteria for urgent transfer (refer to **Appendix D**).

Regardless of urgency, all trauma transfers are routed through the Emergency Department (ED). Stable patients may undergo triage by the ED team and be assessed by the Trauma Surgeon/Fellow/Registrar/MO.

After normal working hours, referrals and transfers are channeled to the respective on-call team. It is crucial to note that regardless of the timing, all patients in transit must pass through the ED.





**TRAUMA SURGERY**

# External Trauma Referral

**WORKING HOURS** - To call Trauma Surgeon / Oncall Surgeon / Oncall Surgical MO (ED)

**AFTER HOURS** - To call Oncall Surgeon / Oncall Surgical MO (ED)

Ideally Surgeon to Surgeon referral.

All trauma transfers **MUST** go through the ED. No ward transfer.

**Immediate transfer (unstable patient)** from the District Hospital without a specialist as per protocol (**Appendix D**).



APPENDIX D

# Inter-Hospital Transfer Protocol





# INTER-HOSPITAL TRANSFER PROTOCOL

## TRANSFER PROTOCOL

This is the transfer protocol between Hospital Tuanku Ja'afar, Seremban, and a non-specialist district hospital. Eg. Hosp ...

## TERMS OF REFERENCE

1

This transfer protocol is between Hospital X (Level IV) and the Department of Surgery Hospital Tuanku Ja'afar, Seremban.

2

The duration of use of this protocol is from the date of issue (as stated in the covering letter) until further review.

3

This protocol pertains to only trauma patients who fulfill the immediate transfer criteria.

## IMMEDIATE TRANSFER CRITERIA

The criteria listed below will be used to determine immediate transfer from X (Level IV) Hospital ED to Hospital Tuanku Ja'afar, Seremban

Criteria apply only to **TRAUMA** patients :

1. **SBP of 90 mmHg or less at any time**
2. **HR of >120/min after 1L of crystalloids rapid infusion for adult patients**
3. **Peritonitis**
4. **Positive FAST**
5. **Any penetrating wound to the torso (abdomen/chest) or neck (gunshot wounds, stab wounds, impalement injuries)**
6. **Unstable polytrauma patient and requires intubation**
7. **Obvious signs of vascular injury (i.e massive external haemorrhage)**

The criteria listed stand independent of each other (i.e. do not require correlation with another existing entity).

All other patients not satisfying the criteria above are to be referred through the usual existing channels of communication.



# INTER-HOSPITAL TRANSFER PROTOCOL

## PRE-TRANSFER WORKUP

## LABORATORY

1

**NO** haematological/biochemistry tests need to be done.

2

**Group-specific blood** (whole blood or PRC) should be typed and available for use during transport of the patient (any amount available), group specific implies **emergency typing** only and NOT a complete cross-match. If blood is not available at all, this should NOT delay transfer.

## RADIOLOGY

1

**NO** radiologic investigations are required unless they are readily available. The basic trauma series (**AP supine chest x-ray and supine AP pelvic x-ray**) may be obtained provided these do not delay rapid transfer of the patient.

2

**NO** other imaging is required other than CXR and Pelvic X-ray if the patient is haemodynamically unstable.

3

**DO NOT** perform Skull and Cervical X-ray for a patient with low GCS and suspected to have Traumatic Brain Injury as a CT scan is mandatory for this patient.

## TRANSFER REQUIREMENTS

1

Secure airway. Patients will require endotracheal intubation if the upper airway is not secured or in imminent threat of control being lost en route or where consciousness is impaired sufficiently to endanger the airway. **DO NOT** transfer the patient unless airway control is ensured.

2

Supplemental oxygen will be administered to all patients (the modality to be decided by the attending doctor based on the clinical condition of the patient).

3

A hard collar and spinal board should be used for all patients to be transferred.



## INTER-HOSPITAL TRANSFER PROTOCOL

4	Ensure adequate breathing during transport (i.e. bag or portable ventilation during transfer, if required).	10	The patient's BP need <b>NOT</b> be normal for transfer and this should NOT delay transfer (i.e. do not wait for the BP to be "stable"), resuscitation should continue during the journey. Aim of a SBP of 80-90mmhg and MAP of 50-60mmhg before transfer provided there is no Head Injury. Fluids and infusions should NOT be stopped en route.
5	Tension pneumothorax is a <b>CLINICAL</b> diagnosis, a chest drain should be inserted before transfer in the presence of a combination of; unilateral decreased air entry of a hemithorax, distended neck veins, and hypotension. A confirmatory CXR is <b>NOT</b> required if a transfer is imminent, however, the receiving team should be informed that a confirmatory CXR has not been done.	11	An indwelling urinary catheter and a nasogastric tube should be in place before transfer.
6	Chest tubes should <b>NOT</b> be clamped at any time during transfer.	12	Patients shall have an accompanying doctor who is competent to secure the airway (ie. able to perform endotracheal intubation) if the need arises en route or if the tube dislodges.
7	All patients shall have 2 large bores (16G or 18G) IV lines in situ at any convenient site.	13	The Trauma Team (*refer to contact list) shall be informed prior to transfer (once initially and once more just as the patient leaves Hospital X (Level IV) ED) during working hours of the weekdays and the On Call Surgical MO or On Call Surgeon of the day during after hours and weekends.
8	One liter of crystalloid should be infused in ED and en route. Subsequently, blood should be transfused. <b>DO NOT</b> give more than one liter of crystalloid.	14	The <b>receiving team's (Trauma/General Surgery)</b> medical officer will notify the ED red zone of the impending transfer or vice versa if the ED is notified, the ED team will notify the Trauma Team of the impending arrival of the patient. One party (either Trauma/General Surgery or ED red zone team) notification is sufficient (i.e. the transferring hospital need not make multiple phone calls to multiple units.
9	Control all external haemorrhage with dressings and apply pressure/compression where and when necessary.		





## INTER-HOSPITAL TRANSFER PROTOCOL

15

If the patient has other concurrent injuries that may involve other disciplines, the appropriate referrals will be made by the Trauma Team in HTJ. The referring hospital need not refer separately.

### TRANSFER DESTINATION

All patients shall be admitted via **HTJ Emergency and Trauma Department**. No ward transfers are allowed. Upon arrival, the Surgical MO/Trauma MO will attend to the patient in ETD.

### CONTACT LIST

1. Trauma Surgery Unit HTJ (via HTJ switchboard)
2. General Surgery - Medical Officer on call (ward), via HTJ switchboard
3. General Surgeon - Fellow/Trauma Surgeon or Gen Surgeon on-call via HTJ switchboard.
4. Emergency RED ZONE, medical officer/specialist, via HTJ switchboard.

Sequence of contact in descending order (one phone call only to any personnel below in the order listed):

During normal work hours on weekdays:

1. Trauma Surgery Medical officer, if unavailable-
2. ED RED ZONE Medical officer-in-charge, if unavailable-
3. Trauma Surgery Fellow/Surgeon in the Trauma Surgery Unit, if unavailable-
4. ED RED ZONE Specialist in charge, if unavailable
5. On-call Medical Officer, General Surgery, if unavailable-
6. On-call Surgeon of the day, if unavailable -
7. Director of Trauma Surgery / Consultant Trauma Surgeon if unavailable
8. ED Head of Department

During off hours, weekends, and public holidays

1. On-call Medical Officer, General Surgery, if unavailable-
2. ED RED ZONE Medical officer-in-charge, if unavailable-
3. On-call Surgeon of the day, if unavailable -
4. Trauma Fellow/Trauma Surgeon

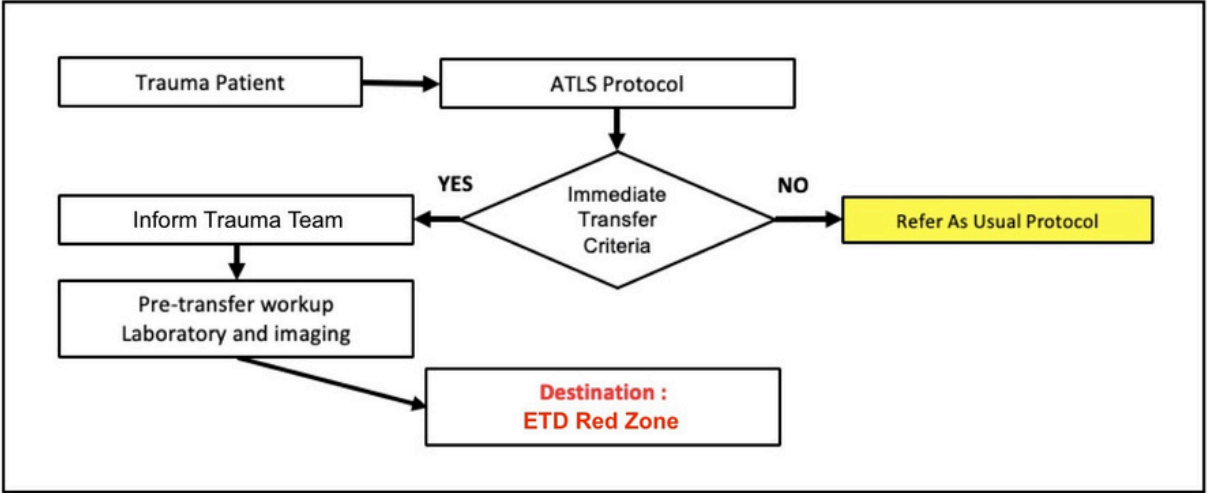
### QUALITY INDICATORS

1. Time lapsed between the decision of criteria met and transfer decided by the attending doctor in Hospital X (Level IV) Hospital and the ambulance leaving Hospital X (Level IV) Hospital ED with the patient on board shall not be more than 50 minutes.
2. Fulfills all necessary transfer requirements.
3. No unnecessary investigations were done by the attending team in Hospital X (Level IV) Hospital or requested by the receiving team in HTJ.



# INTER-HOSPITAL TRANSFER PROTOCOL

## INTERHOSPITAL TRANSFER PROTOCOL FOR TRAUMA CASES



**IMMEDIATE TRANSFER CRITERIA**

- SBP  $\leq$  90 mmHg
- HR of  $>$  120 bpm after 1L of crystalloids
- Peritonitis
- Any penetrating wound to torso or neck, impalement injuries
- Obvious signs of vascular injuries
- Positive FAST
- Low GCS with polytrauma  
(The listed criteria stand independent of each other)

**PRE-TRANSFER WORKUP**

**LABORATORY**

- Haematological / biochemistry test are not required
- Group Specific Blood should be done and available for use (provided it does not delay transfer)

**RADIOLOGY**

- CXR and Pelvic X-ray may be obtained provided it does not delay transfer
- Omit Cervical and Skull x-ray if CT Brain is indicated
- X-ray of other extremities are not required for unstable patient.

**TRANSFER REQUIREMENT**

- CBD and RT should be in place
- All intubated patient must be accompanied by a trained medical officer.

**INFORMATIONS NEEDED BY TRAUMA TEAM**

**M** : Mechanism of injury  
**I** : Injuries observed  
**S** : Vital Signs  
**T** : Treatment given

**INFORM TRAUMA TEAM**

(IT IS SUFFICIENT TO CALL ONLY ONE PERSONAL BELOW IN ORDER AS LISTED):

**OFFICE HOURS:**

1. Trauma Surgery MO
2. ED Red Zone MO/Specialist
3. Trauma Surgeon
4. On call MO or Surgeon
5. Consultant Trauma Surgeon
6. Consultant EP

**OFF HOURS / WEEKEND / PUBLIC HOLIDAYS**

1. On Call Surgical MO
2. ED Red Zone MO/Specialist
3. On call Surgeon

**AIRWAY**

- Secure the airway
- Provide supplemental oxygen
- Apply cervical collar/spinal board

**BREATHING**

- Ensure adequate breathing and ventilation
- Chest tube : DO NOT CLAMP Chest tube during transfer
- Confirmatory CXR post CT insertion is not required if transfer is imminent

**CIRCULATION**

- Secure external active bleeding
- 2 large bore IV access with concurrent infusion of 500mls of IVF
- SBP 80-90 mmhg/MAP 50-60 mmhg is acceptable
- SBP need not be normal prior to transfer
- SBP  $>$  110 mmhg for patient with TBI
- Resuscitation need to be continued en-route

**DISABILITY**

- Secure the airway if GCS  $<$  11

**EXPOSURE**

- Quick secondary survey and secure any external bleeding
- Apply splint accordingly



# TRAUMA SURGERY SERVICE

HOSPITAL TUANKU JA'AFAR SEREMBAN

E-mail: [htjstraumasurgery@gmail.com](mailto:htjstraumasurgery@gmail.com)

Phone: 06-768 5101/5102

Prepared by:

Dr Izwan Ismail

Consultant General & Trauma Surgeon

MB BCH BAO, DrGenSurg, Trauma Surgery Fellowship, CMIA, AM

[izwanismail@moh.gov.my](mailto:izwanismail@moh.gov.my)

