|  |  |  |
| --- | --- | --- |
| **Incident name** Click here to enter text. | **Date**  Click here to enter a date. | **Time** Click here to enter time |
| **Form completed by** Click here to enter text. | **Title** Click here to enter text. |
| **Patient Name (Last, First)** Click here to enter text. | **DOB** Click here to enter a date. | **Gender**Choose an item. |
| **Tracking Number** (assigned by initial health care facility)Click here to enter text. | **Age**  Years Months [ ]  Estimated |
|  **Family/Guardian** Click here to enter text. **Contact #** Click here to enter text. **Notified:** Choose an item. |
| **Transferring health care facility** Click here to enter text.**Unit at hospital** Click here to enter text.**Full address** Click here to enter text. | **Transferring physician** Click here to enter text. |
| **Transferring health care facility telephone** Click here to enter text. |
| **Receiving physician** Click here to enter text. |
| **Receiving health care facility** Click here to enter text.**Room #** Click here to enter text. |
| **Acuity Level** Choose an item. |
| **PATIENT HISTORY** |
| **Pre-burn weight (kg)** Click here to enter text. [ ]  actual [ ] estimated | **Allergies** Choose an item.**List:** Click here to enter text. | **Home medications** Choose an item.**List** Click here to enter text.[ ]  See attached medication reconciliation form |
| **Relevant medical/surgical history (list)** Click here to enter text.[ ]  See attached |
| **BURN INJURY HISTORY** |
| **Burn Injury Date** Click here to enter a date. | **Time of Injury** Click here to enter time | **% Total Burn Surface Area (Complete burn diagram below to identify specific areas of injury)**% partial thickness Click here to enter text.% full thickness Click here to enter text.Circumferential truncal burn Choose an item.Circumferential extremity burn Choose an item. |
| **Mechanism of Injury** Click here to enter text. |
| **Burn Type** | **Source** |
| Flame |  | Click here to enter text. |
| Inhalation |  | Enclosed space [ ]  | Open Air [ ]  |
| Scald |  | Click here to enter text. |
| Chemical |  | Click here to enter text. | **Non-burn injuries** Click here to enter text. |
| Electrical |  | Click here to enter text. |
| Contact |  | Click here to enter text. | **Non-burn wounds** Click here to enter text. |
| Radiation |  | Click here to enter text. |
| **Burn Diagram** |
| **FORM CONTINUES ON PAGE 2** |
| **MEDICAL MANAGMENT** |
| **Respiratory Status**Current FiO2 Click here to enter text. Current SpO2 Click here to enter text.Intubated Choose an item. ETT/Trach tube size Click here to enter text.Location at the teeth Click here to enter text.Ventilator settings Click here to enter text.Latest ABG Click here to enter text.Respiratory treatments Click here to enter text. | **Vital Signs**Time Click here to enter text.HR Click here to enter text.RR Click here to enter text.BP Click here to enter text.Temp Click here to enter text. | **Intake**

|  |  |  |
| --- | --- | --- |
| **IV Site** | **IVF Type** | **Rate (mL/hr)** |
|   |   |   |
|   |   |   |

Other Click here to enter text.Total IVF since injury Click here to enter text. mLTotal IVF in last 24 hrs Click here to enter text.mLTotal IVF since admission Click here to enter text. mL |
| **Procedures**Current burn wound dressing Click here to enter text. Date/time last burn wound evaluationClick here to enter a date. Click here to enter text.Date/time last burn dressing change Click here to enter a date. Click here to enter text.Escharotomies: Choose an item.  If yes: Date/Time Click here to enter a date. Click here to enter text. Site(s) Click here to enter text. | **Output**Urinary catheter Choose an item. Urine (last 24 hours) Click here to enter text.mLUrine (last 4 hours) Click here to enter text. mLNGT Click here to enter text.mLOther Click here to enter text. |
| **Current Medications**Tetanus vaccination given Choose an item.Antibiotics (name, date and time given) Click here to enter text.Other Click here to enter text. | **Pain Management** Click here to enter text. |
| **TRANSPORT NEEDS** |
| **Type of transport service needed** Choose an item. [ ] Other Click here to enter text. | Name of transport provider used to transport patient: Click here to enter text.Phone number of transport provider: Click here to enter text. |
| **Equipment needed for transport** Choose an item. [ ]  Other (list) Click here to enter text. |
| **Notification (times)** Family: Click here to enter text. SBCC: Click here to enter text. Receiving hospital: Click here to enter text. |
| **OTHER NOTES** |
|  |