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| **Incident Name:** Click here to enter text. |  |
| **NAME of PERSON TAKING CALL** Click here to enter text.**HEALTH CARE FACILITY/AGENCY** Click here to enter text. | **DATE of CALL** Click here to enter a date.**TIME of CALL** Click here to enter text. |
| **CALLER INFORMATION:****NAME AND TITLE** Click here to enter text.**HEALTH CARE FACILITY/AGENCY** Click here to enter text.**PHONE** Click here to enter text. **E-MAIL** Click here to enter text. |
| **PATIENT INFORMATION:****NAME** Click here to enter text. **DOB** Click here to enter a date.**TRACKING NUMBER (assigned by initial health care facility)** Click here to enter text.**% TBSA** Click here to enter text. **TIME OF BURN INJURY** Click here to enter text.**BURN INJURY** Click here to enter text.**INTUBATED** Choose an item. **VENTILATOR CAPABILITIES AT CALLER FACILITY** Choose an item.**OTHER INJURIES/CO-MORBIDITIES** Click here to enter text.**FAMILY /SOCIAL ISSUES** Click here to enter text.**FAMILY CONTACT INFORMATION** Click here to enter text. |
| **PURPOSE OF CALL:**[ ]   **BURN CONSULTATION** Click here to enter text. [ ]  **TRANSFER COORDINATION** Click here to enter text. **RESOURCE NEEDS** Choose an item.[ ]  Other Click here to enter text.[ ]  **TRIAGE REQUEST****TRIAGE CATEGORY/TYPE OF HEALTHCARE FACILITY NEEDED**Choose an item.[ ]  **OTHER**Click here to enter text. |
| **RESPONSE/INFORMATION PROVIDED**Click here to enter text. | **TRANSFER INFORMATION****RECEIVING HEALTH CARE FACILITY**  Click here to enter text.**LOCATION (CITY)** Click here to enter text.**DATE/TIME of TRANSPORT** Click here to enter a date.Click here to enter text.**METHOD OF TRANSPORT** Choose an item. Other: Click here to enter text. |

**ADDITIONAL NOTES**

Click here to enter text.