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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.