

TO BE COMPLETED BY BURN UNIT AT INITIAL CONTACT

Age _____ yrs _____ mnths Postcode: _____ Ethnic background: _____
First language: _____ Interpreter required? **Yes / No**

PATIENT INITIALLY PRESENTED TO:

PED (WCH) GP Other hospital Where: _____

WHERE DID THE INJURY OCCUR?

Home Workplace School Road Traffic Way Waterway Campsite
Farm Shop Park Other Specify: _____

IN WHAT LOCATION?

Bathroom Bedroom Dining Kitchen Laundry Living Shed
Vehicle Outdoors Unknown Other Specify: _____

TYPE OF BURN

Chemical Contact Electrical Flame Friction Inhalation Sun Cold
Radiation Scald Specify fluid: _____ Unknown Other _____

CAUSE OF BURN

Bath Bucket Cup/Mug Bowl Kettle Microwave
Stove Frypan Saucepan BBQ Heater Flammable liquid
Fireplace Housefire Campfire MVA Exhaust pipe Hair straightener
Iron Powerpoint Treadmill Flash Ingestion Cleaning products
Explosion Aerosol Unknown Other Specify: _____

WERE FLAMES PUT OUT?

Yes / No Unknown Not a flame burn
Blanket Drop and roll Hands Water Other Specify: _____

WHAT FIRST AID WAS ADMINISTERED?

Running water For how long?: _____ mins
Wet cloth Ice Creams None Unknown
Other Specify: _____

WAS THERE CLOTHING ON THE AFFECTED AREA?

Yes / No Was this removed immediately? Yes / No
Cotton Synthetic Wool Other

Other initial management considerations:
 Swab for MRSA screening for all admissions (NOT day cases)
 Baseline bloods (CBP/EUC) for any child with co-existing medical condition or infected burn
 Ophthalmology review (for burns involving eye/eyelid), (refer to Burn Management Guidelines pg 11)
 Social Work referral (refer to Burn Management Guidelines pg 38-39)
 Dietician review (if requiring NG feeds or dietary supplementation) (refer to Burn Management Guidelines pg 35-37)
 Aboriginal Liaison Referral
 Case manager: _____

Completed By: _____ **Date** ____ / ____ / ____
(print clearly)

PATIENT SUMMARY: (to be completed by Burns M.O. at time of discharge)

Admission date: ____ / ____ / ____ Discharge date: ____ / ____ / ____ Consultant: _____
Final estimated % TBSA: _____ Burn distribution / depth: _____

MANAGEMENT:

Debridement in theatre: Yes / No Date(s): _____

Skin graft: Yes / No

Split skin graft: Area: _____ %TBSA: _____ meshed Yes / No Dated: ____ / ____ / ____
Area: _____ %TBSA: _____ meshed Yes / No Dated: ____ / ____ / ____
Area: _____ %TBSA: _____ meshed Yes / No Dated: ____ / ____ / ____
Area: _____ %TBSA: _____ meshed Yes / No Dated: ____ / ____ / ____

Donor sites: _____

Other: Integra / Biobrane / CEA site: _____ Dated: ____ / ____ / ____
Integra / Biobrane / CEA site: _____ Dated: ____ / ____ / ____

Positive swabs / cultures Date: ____ / ____ / ____ Organism: _____ Site: _____
Date: ____ / ____ / ____ Organism: _____ Site: _____

Antibiotics: Yes / No: IV / po / topical: _____ Duration: _____

Other injuries / comorbidities: _____

Complications: _____

Child protection / FAYS involvement: Yes / No Outcome: _____

NURSING DISCHARGE CHECKLIST

Current dressings: _____

- Follow - up: OPD / Day case Date ____ / ____ / ____ Time: ____ : ____
- Parent/carer education (eg dressing care/signs of infection)
- Parent information brochure given
- Discharge medication

Discharge date: ____ / ____ / ____ Discharge to care of: _____

Completed by: _____
(print clearly)

Women's & Children's Hospital
PAEDIATRIC BURNS ASSESSMENT
PATIENT LABEL
UR Number:
Surname:
Given Names:
D.O.B.: Sex:

Date: ____ / ____ / ____ Arrival time at WCH: ____ : ____ Admission time at WCH: ____ : ____ Inpatient Outpatient

PREHOSPITAL / FIRST AID

- Cool running water applied for 20 minutes prior to arrival (*one hour for chemical burns*)
- Dressing applied by: Caregiver SAAS _____
- Analgesia given (Time ____ : ____) Details: _____

HISTORY

History obtained from: _____

When did the injury occur? Date: ____ / ____ / ____ Time ____ : ____

Time from injury at presentation? Days: _____ Hours: _____ Minutes: _____

What occurred / caused the injury? _____

Was the incident actually witnessed? (*Circle*): Yes / No By whom _____

On review of the medical record or history, has the child had any previous injuries? Yes / No

Details: _____

What is the developmental level of the child? (*Circle those applicable*):

Sitting / Crawling / Walking / Running / Climbing

Was the child being adequately supervised at the time of injury? Yes / No / Unclear

Conclusion about injury: Clearly accidental / Neglectful / Inflicted / Unclear

The following situations *must* be discussed with the ED Consultant / Fellow / Senior Burns Staff: any child < 18 months, any child with unclear, neglectful, or inflicted injuries, any child where there is a supervision issue or whether the developmental capabilities of the child do not fit the injury explanation.

PAST MEDICAL HISTORY: _____

ALLERGIES: _____ **MEDICATIONS:** _____

FASTING STATUS: **IMMUNISATIONS:**
Last ate ____ : ____ Last drank ____ : ____ Last tetanus < 5 yr 5 - 10 yr NUTD Unknown
Given in ED: DTPa ADT TIG

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PAEDIATRIC BURNS ASSESSMENT-MR-*

