Shriners Hospitals for Children
Galveston Burn Hospital
815 Market Street
Galveston, Texas 77550
Referral Calls: 409-770-6773

Date: _____ _____ _____
Time: _____ _____ _____
Resource: _____ _____ _____
Contact: _____ _____ _____

Fax #: 409-770-6539

Patient Name: _____ Sex: _____

Home Address: _____ Age: _____

City, State, Zip: _____ Race: _____

County or Parish: _____

Telephone: _____ Birthdate/Birthplace: _____

Father's Name: _____ Mother's Name: _____

Accompanying Guardian: _____ Relationship: _____

Guardian's birthdate/birthplace? _____

Citizenship of Patient: _____ Visas?: Yes No N/A **Date of Burn**: ___/___/___ **Time**: _____

☐ Ask for a faxed copy of birth certificate or for one to be sent

Referral Hospital/Physician Information

_____ _____ _____
Referring Physician's Name | Telephone Contact #'s

_____ _____ _____ _____
Referring Physician Address | City | State | Country

_____ _____ _____
Referring Hospital Name | Telephone/Fax # | Patient Location (ER, Room # or Unit)

Circumstances of Injury:

Cause of burn _____ %Burn_____ Smoke Inhalation: ___ Yes ___ No

How accident happened: _____

_____

Was child's clothing involved? _____ (ASK STAFF TO FORWARD SAMPLE WITH PATIENT).

Were others involved (if yes indicate relationship): _____

If injury suspicious, has Child Protective Services been notified? ___ Yes ___ No [Notify Care Coordinator & Psych if Yes]

If so, please indicate name of Case Worker and phone number: _____

_____

Significant past medical history : _____

When was initial IV/fluid resuscitation started? _____

Associated injuries: _____ Accept blood products? ____ Yes ____No

☐ Ask for a faxed copy of H & P and Immunization Record

Clinical Data (Please note most recent parameters or test results):

B.P. _____ Pulse: _____ Resp.: _____ Temp: _____

Oxygen: _____L/min Breath Sounds: _____ CXR: Y/N_____

Artificial Airway: _____ Type/Size Placement: _____

SaO_2_____ Carboxyhemoglobin: _____ Date/Time: _____

Ventilator Settings
Mode:_____ FiO2: _____
Tidal Volume: _____Rate: _____
PEEP: _____ PIP: _____

☐ **Has the patient had a cardiac/resp. arrest ____ yes ____ no**

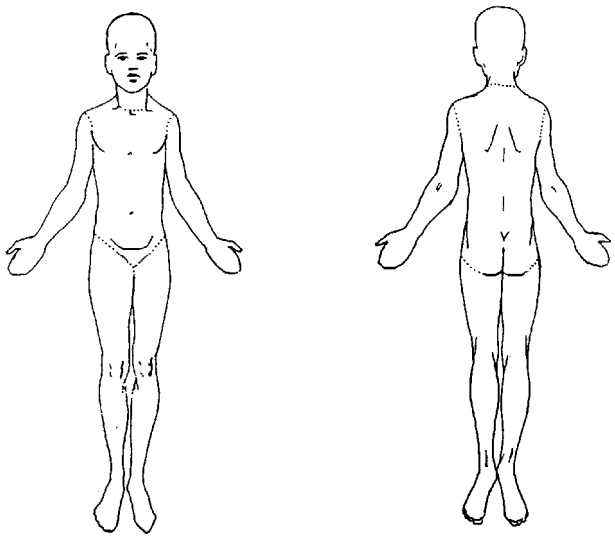
Date/Time pH pCO2 pO2 HCO3 B.E. HgB HCT

Date/Time WBC PT/PTT NA+ K+ Cl- BUN Creat Gluc T.P.

(See updates on last page)

Patient Name: _____ **Date:** _____

Please complete Burn Diagram:



Please note circumferential burns of extremities or chest wall: _____

_____

Note Escharotomies/Fasciotomies Performed:_____

_____

Peripheral pulses absent in any extremity (please circle):
RUE LUE RLE LLE

Neurological Status: (please circle)

Alert	Yes	No
Oriented x3	Yes	No
Moving all extremities	Yes	No

Glascow Coma Scale: _____

If neurologically depressed, have any neurological Tests been done?

% Burn	% 3rd	BSA m^2	BSABm^2

CT scan Yes No MRI Yes No

Blood Flow Yes No

Patient's Height: _____ Weight: _____

(Accurate height and weight is necessary to calculate BSA m²)

Calculations for Fluid:

BSA _____m^2 BSAB: _____m^2

Fluid Calculations

First 24 hours

2000ml x _____BSAm^2 = ____ml

5000ml x _____BSABm^2 = ____ml

Total for first 24 hours = _____ml

First 8 hours = _____ml/hr

Next 16 hours = _____ml/hr

IV Lines/Site	**Fluids/Rate**	**Sutured?**
_____	_____	_____
_____	_____	_____

Foley Catheter: _____ Urine Output: _____

NGT: _____ Gastric pH: _____

Total Fluids	
In	Out
____	_____
x _____ hours	

P.O. Intake: _____

Other: _____

_____

_____

Please call Burn Unit staff to assist with calculations and recommended resuscitation fluids.

Medications (please list with doses):

Antibiotics:_____

Sedation/Pain: _____

Immunizations: _____ Tetanus Toxoid: Yes No

Allergies: _____

MD to MD referral done (Date and Time)**:** _____

Preparation for Transports:

Please:

- Send copies of medical records and/or x-rays.
- Try to keep patients temperature between 38^{0}C and 39^{0}C rectally.
- Have two (2) large bore IV lines sutured in place if burns are greater than 20%.
- Administer only lactated ringers unless instructed to do otherwise by the receiving physician.
- Limit sedation and narcotics (only give **IV** medications in small, titrated doses).
- Place Foley Catheter if burn is greater than 20%.
- Place Salem Sump NG tube if burn greater than 20%.

Resource Nurse: _____ **Date**: _____

Acute Patients
Supplement to Referral Form

Name: _____ Date/Time: _____
Initial Referral Date: _____ SBH Physician _____ Resource Nurse: _____
Referring Physician: _____ Phone Number: _____
Referring Hospital and Phone Number:_____
SBH Attending Physician: _____ Date/Time of Attending Acceptance: _____
Burn Date:_____ %Burn:_____ Name of Temple/Sponsor: _____
Approval/Guarantor:_____
Will Referring Hospital be responsible for Transportation Costs? [ ]Yes [ ]No
Will Referring Hospital charge Patient for Transportation Costs? [ ]Yes [ ]No
Mode of Transportation: [ ] Jet [ ] TurboProp [ ] Helicopter [ ] Commercial Airline
[ ] Ground Ambulance [ ] Shriner Van [ ] UTMB [ ] Private Auto [ ] Walk-in [ ] Other_____
_____
_

Transport Company:
Company:_____ Company: _____ Company: _____
Contact: _____ Contact: _____ Contact: _____
Quote: _____ Quote: _____ Quote: _____

Company selected:_____ Reason:_____
_____
Mileage: _____ ETA/FBO: _____ FAA Certification: _____
Flight/Tail Number: _____ Takeoff time _____
Flight Times – To Destination: _____ Return to Galveston:_____
Airport to Referring Hospital transfer contact: _____
_____

Other Transportation Information:
_____

_____

SBH Staff Accompanying Team from Local Airport: _____

ETA to SBH: _____ Date and Time of Admission_____

(See transport sheet for other info)

SBH Flight Team:
RN: _____
RT: _____
RN/MD: _____

Letters sent to VerMaas: _____
Armstrong: _____

Acceptance letter faxed to: _____
_____

Copies of original referral form made ____

Final Disposition: _____
_____

Notification: (Name/time/date)
Transport RN: _____
Transport RT: _____
Transport MD: _____
Security: _____
Van Driver: _____
Nurse Admin. On Call: _____
Photography: _____
Research:
_____
Administrator:
_____
Care Coordinator:
_____
Psychology Services:
_____
OR Pager:
_____
Outpt./Housing:
_____
Inspector Alcazar 409-766-3581
_____

NOTES:

UPDATES:

Date/Time: _____ SHC Staff: _____

Date/Time: _____ SHC Staff: _____

Date/Time: _____ SHC Staff: _____

Date/Time: _____ SHC Staff: _____

Date/Time: _____ SHC Staff: _____

NOTES: