**Burn Patient Transfer Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Date: | Time: | | Contact: |
| Referring Hospital: | | Physician: | |
| Telephone: | | Burn Physician: | |

**PATIENT INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | | | | | | | | Age: | | Sex: M / F | | | |
| Incident Date: | | | Time: | | | Pre-Burn Weight: Kg | | | | | | | |
| Allergies: | | | | | | | | | | | | | |
| Family Contact: | | | | | | | | | | | | Notified: Yes No | |
| **Burn Type:** | **Source:** | | | | | | **Total TBSA:** | | | | | | |
| Flame | Clothes sent with patient | | | | | | Send Wound Document Flowsheet | | | | | | |
| Inhalation | Enclosed space/Open air | | | | | |  | | | | | | |
| Scald | Type of Fluid | | | | | |  | | | | | | |
| Chemical | Type | | | | | |  | | | | | | |
| Electrical | Contact wounds? | | | | | |  | | | | | | |
| Radiation |  | | | | | |  | | | | | | |
| **Respiratory Status:** | | Oxygen: | | | Intubated: Yes / No | | | | | | Trach: | | |
| Tube Size: | | | Secured @ cm @ teeth/gums | | | | | | Secured with: | | | | |
| Vent Settings: | | | | | | | | | | | | | |
| ABGs: | | | | | | | | | | | | | |
| Respiratory Treatments: | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Other Injuries: | | | | | | | | | | | | | |
| Complications: | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Medical History:** | | | **Vital Signs** | | | | | | **Immunizations:** | | | | |
|  | | | Pulse | | | | | | Up to date: | | | | Yes No |
|  | | | Resp | | | | | | Tetanus/Dip | | | | Yes No |
|  | | | B/P | | | | | | Cyanokit | | | | Yes No |
|  | | | Temp | | | | | |  | | | |  |
|  | | | SaO2 | | | | | |  | | | |  |
| **Lines** | | **IV fluids** | | | **Medications** | | | | | | **Tests** | | |
|  | |  | | |  | | | | | |  | | |
|  | |  | | |  | | | | | |  | | |
|  | |  | | |  | | | | | |  | | |
|  | |  | | |  | | | | | |  | | |
|  | |  | | |  | | | | | |  | | |
| **Dressing:** | | | | | | | | | | | | | |
| **TRANSPORT** | | | | | | | | | | | | | |
| **To Referring Hospital** | | | | **Burn Center** | | | | | **Final Disposition** | | | | |
| Basic Life Support | | | | Time Notified | | | | | Transfer Accepted | | | | |
| Critical Care | | | | Time Departed | | | | | Referred to Outpatient Clinic | | | | |
| Helicopter | | | | SBCC Notified | | | | |  | | | | |
| Comments: (Use back if needed) | | | | | | | | | | | | | |
|  | | | | | Signature: | | | | | | | | |