Midland Burn
Operational Delivery Network

NHS

PATIENT REPATRIATION DOCUMENT

Pt Details: (or apply sticky label) Name: Hospital No: NHS No:		Address:
Admission Date and Time:		Admitting Hospital:
Mechanism of injury:	______________	If other injury please specify:
First Aid given?	Yes ☐ No ☐	
Past Medical History:		
TBSA: %	Resuscitated? Yes ☐ No ☐	
If resuscitated – which formula used?	PARKLAND ☐	MUIR-BARCLAY ☐

AREA	AGE 0	1	5	10	15	ADUL
A - ½ OF HEAD	9½	8½	6½	5½	4½	3½
B - ½ OF ONE THIGH	2¾	3¼	4	4½	4½	4¾
C - ½ OF ONE LEG	2½	2½	2¾	3	3¼	3½

REGION	**SPT%**	**FT %**
HEAD	0.0	0.0
NECK	0.0	0.0
ANT. TRUNK	0.0	0.0
POST. TRUNK	0.0	0.0
RIGHT ARM	0.0	0.0
LEFT ARM	0.0	0.0
BUTTOCKS	0.0	0.0
GENITALIA	0.0	0.0
RIGHT LEG	0.0	0.0
LEFT LEG	0.0	0.0
INITIAL BURN AREA TOTAL	0.0	0.0

Version 3 Reviewed 02.2015
Review date 10.2015 MBODN CAG

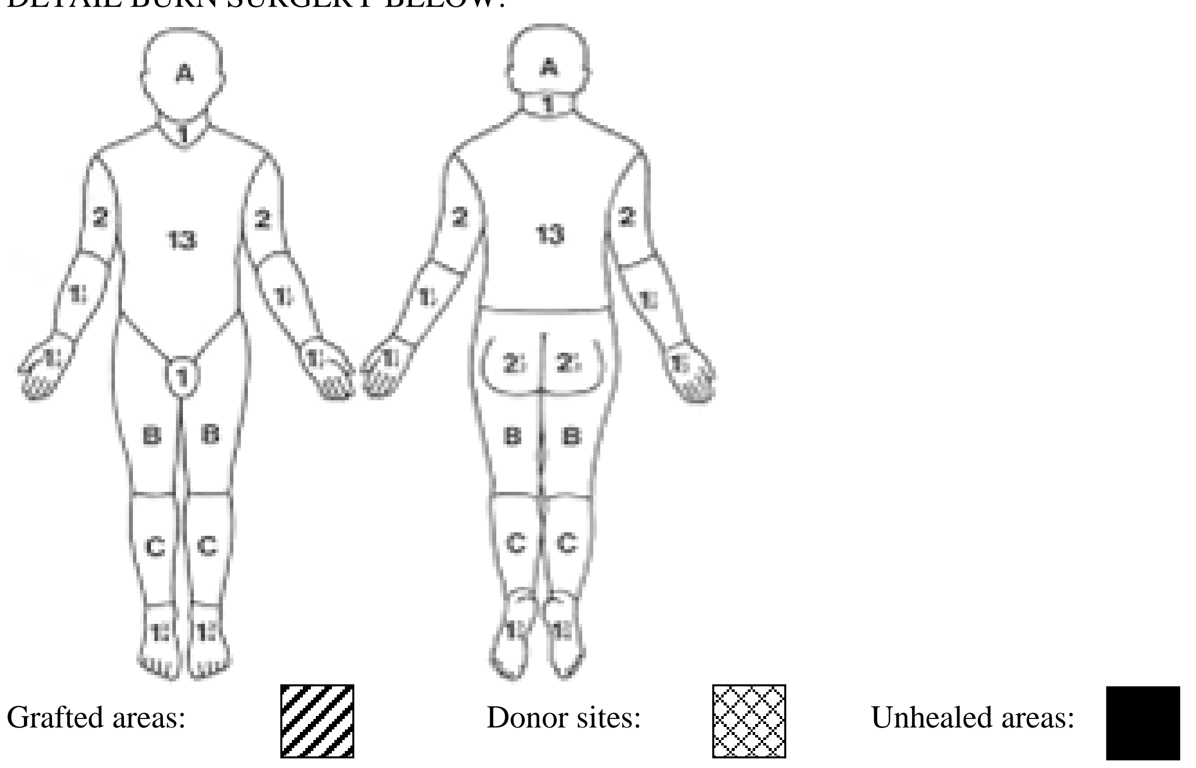
THEATRE:

Has the patient required theatre? Yes ☐ No ☐
Please detail below:
Escharotomies required? Yes ☐ No ☐
Locations: Neck ☐ Chest ☐ Left Arm ☐ Right Arm ☐ Left Leg ☐ Right Leg ☐
Tracheostomy? Yes ☐ No ☐
Grafting required? Yes ☐ No ☐

DRESSINGS: (A copy of the last wound chart to accompany this form)

LOCATION	DRESSING	OTHER INFORMATION
________________		
________________		
________________		
________________		
________________		
________________		
________________		
________________		
Any further information regarding dressings including the time taken for the last dressing and the analgesia management:		

DETAIL BURN SURGERY BELOW:



Grafted areas: ▨ Donor sites: ▩ Unhealed areas: ■

INTENSIVE CARE.

Required ITU care? Yes ☐ No ☐
If yes – reason for admission: ____________________
If other, or more details required please specify:

MICROBIOLOGY:

Significant positive microbiology? Yes ☐ No ☐	
Organism: ____________________	If other please specify:
Location: ______________________	If other please specify:
Sensitivities:	
Current Antibiotic Course:	
Further microbiology/infection control information including any barrier nursing precautions required:	

BLOOD RESULTS:

Have you included a flow chart of blood results? Yes ☐ No ☐

If no, please complete chart below:

TEST	DATE					
Hb						
WCC						
Platelets						
HCT						
Na						
K						
Urea						
Creat						
INR						
CRP						
Alb						

DRUG HISTORY:

DRUG	DOSE	ROUTE	FREQUENCY	OTHER INFO
		____	________	
		____	________	
		____	________	
		____	________	
		____	________	
		____	________	
		____	________	
		____	________	
		____	________	
		____	________	

ALLERGIES:

Does the patient have any allergies? Yes ☐ No ☐ (If Yes, please detail below)
Details:

PHYSIO / OCCUPATIONAL THERAPY:

OTHER PATIENT/FAMILY NEEDS (e.g. mental capacity/learning disability/other):

ALLIED PROFESSIONALS:

Are other allied professionals involved? Yes ☐ No ☐
Dietician ☐ Safeguarding ☐ Social Services ☐ Psychology ☐ Interpreter ☐ Health Visitor ☐ Mental Health ☐
Please give details:

WHERE POSSIBLE PLEASE INCLUDE THE PATIENT'S OBSERVATION CHART, DRUG CHART AND ANY RELEVANT OPERATION NOTES OR ANAESTHETIC CHARTS.

SIGNED: DATE:

NAME: JOB TITLE:

CONTACT DETAILS FOR FURTHER INFORMATION: