

Name

ID Number

Date of Birth

Date patient arrived

**ORTHOPAEDICS & SPINAL**

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| **INCIDENT: mechanism and circumstances** | | | |
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| **INCIDENTAL information: past history and personal circumstances** | | | |
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| **INJURIES: precise anatomical descriptions** | | | |
| **SPINE** | **Consultant:** | |  |
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| **LIMBS including shoulder & pelvic girdles** | | **Consultant(s):** |  |
|  |  | | |
| **OTHER INJURIES in brief** (*these will be described in detail by other specialties*) **& relevant negative findings** | | | |
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| **INTERVENTIONS** |
| **COMPLETED OPERATIONS** (*with surgeon’s name and grade*) **& other physical interventions** (*e.g. manipulation or cast*) |
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| **PLANNED OPERATIONS & other physical interventions** (*with time scale and surgeon responsible*) |
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| **ADJUNCT TREATMENT** (*e.g. instructions for anticoagulants, antibiotics, positioning and mobilising*) |
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| **Comments and issues** |
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| **Appendix: CQUIN – BOAST 4 data for open lower limb fractures** |
| **Is the open fracture heavily contaminated?** YES / NO / NOT KNOWN  **If yes: Contamination Type**: MARINE / AGRICULTURAL / SEWAGE MATTER / AQUATIC  **Combined orthopaedic & plastic surgery management plan?** YES / NO  **Systematic assessment of vascular and neurological status?** YES / NO  **Is there vascular impairment?** YES / NO  **Antibiotics given?** YES / NO **Date & time of antibiotics:** \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_ \_\_\_ : \_\_\_  **Antibiotic type:** NON IV / IV COAMOXICLAV 1.2g 8 hrly / IV CEFUROXIME 1.5g 8 hrly / IV CLINDAMYCIN 600mg 6 hourly / OTHER IV  **Wound dressing (post-operative)?** YES / NO **Date & time of dressing:** \_\_\_\_ / \_\_\_\_ /\_\_\_\_\_ \_\_\_ : \_\_\_  **If yes: Wound dressing type:** SIMPLE DRESSING / VACUUM FOAM DRESSING / ANTIBIOTIC BEAD POUCH / SALINE SOAKED GAUZE  **Limb splint?** YES / NO **Date & time of splint:** \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_ \_\_\_ : \_\_\_  **Ankle and knee splint:** YES / NO  **Has the fracture been surgically stabilised?** YES / NO **Was definitive soft tissue cover achieved?** YES / NO  (*Describe the surgical stabilization/soft tissue cover procedures in the ‘COMPLETED OPERATIONS’ section above*) |
|  |

Grade

Surgeon completing sheet

/ / :

Signature

Date & time