

Example of a proforma for routine documentation of head injury in children under five years of age

Head Injury History : Children under 5 years of age

Affix Patient Label Here

DOB / /
 YO
 Sex Male Female

Person responsible at home:

Injury Date / / Injury Time :
 Exam Date / / Exam Time :
 History from: Patient Parent Other: _____

Drug Therapy Yes No Other Drugs: Drug Allergies Known Allergies:
 None On warfarin None
 Unknown On aspirin Unknown

History (if NAI suspected, see ED Dept Child Protection protocol ~ Head Injury)

Incident Description: Safety Equipment:
 F/S Passenger Pedal Cyclist School Accident Sport / Play Yes No
 B/S Passenger Pedestrian Home Accident Other Seatbelt
 Motor Cycle / Pillion Fall Assault or NAI Helmet

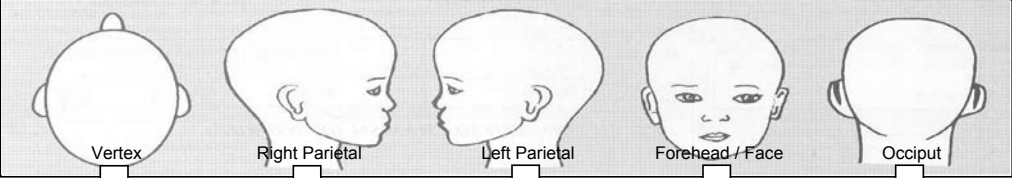
| | Yes | No | Unable To Assess | |
|-----------------------------|--------------------------|--------------------------|--------------------------|-----------------------------------|
| Loss of consciousness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | How long? <input type="text"/> |
| Post-traumatic amnesia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | How long? <input type="text"/> |
| Seizure since injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Describe: <input type="text"/> |
| Headache | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Describe: <input type="text"/> |
| Nausea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | No of times: <input type="text"/> |
| Drowsy / unusually tired | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Comment: <input type="text"/> |
| Visual disturbance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Comment: <input type="text"/> |
| Rhinorrhoea / Otorrhoea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Comment: <input type="text"/> |
| Limb weakness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Comment: <input type="text"/> |
| Other neurological symptoms | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Details: <input type="text"/> |

Pre-existing disorders Give details of known pre-existing disorders eg epilepsy, diabetes, cardiac arrhythmias, bleeding disorders, mental disorders, other medical.
 None Unknown

Tetanus State Covered Needs Booster Needs Course Not Known

Head Injury Examination : Children under 5 years of age

Tick the boxes corresponding to the injured areas, and illustrate with appropriate measurements of lacerations and bruises in cms:



Head Examination

| | Yes | No |
|--|--|--|
| Boggy haematoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Laceration(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| Bruising | <input type="checkbox"/> | <input type="checkbox"/> |
| Suspicion of compound skull fracture or penetrating injury | <input type="checkbox"/> | <input type="checkbox"/> |
| Sign of base of skull fracture | <input type="checkbox"/> | <input type="checkbox"/> |
| CSF/Blood leak from right ear | <input type="checkbox"/> | <input type="checkbox"/> |
| CSF/Blood leak from left ear | <input type="checkbox"/> | <input type="checkbox"/> |
| CSF/Blood leak from nose | <input type="checkbox"/> | <input type="checkbox"/> |
| Evidence of injury to neck | <input type="checkbox"/> | <input type="checkbox"/> |
| Fontanelle / Sutures | <input type="checkbox"/> Normal | <input type="checkbox"/> Bulging / tense |
| Head circumference | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> cm | |
| C Spine movements | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| | <input type="checkbox"/> | <input type="checkbox"/> Immobilised |

Neurological Examination : Score from Glasgow Coma Scale

| | GCS | Eyes | Cranial N |
|---|--|--|---|
| E | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | Left <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> Right <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> | Normal <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> Abnormal <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> |
| M | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | Pupil reacting <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> Movements <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> | Left <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> Right <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> |
| V | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | Left <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> Right <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> | Normal <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> Abnormal <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> |
| | | Tone <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> Power <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> | Normal <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> Abnormal <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> |
| | | Cerebellar signs <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> No | <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> Yes |
| | | Gait <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> Normal | <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> Abnormal |

If <1 year old

| | Observed | Not seen | |
|--------|--|--|--|
| Sits | <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> | <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> | Developmental milestone consistent with history |
| Rolls | <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> | <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> | |
| Crawls | <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> | <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> | Yes <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> No <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> |
| Walks | <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> | <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> | |

Comments on injuries, neuro-examination and treatment:

Investigations and Results

| | | | | | |
|----------------------|--|---------------|--------------------------|--------------------------|---|
| BM | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | Brain CT | Yes | No | Findings on Imaging: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| Temp | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | C Spine CT | <input type="checkbox"/> | <input type="checkbox"/> | |
| BM/Temp not relevant | <input type="checkbox"/> | C Spine X-ray | <input type="checkbox"/> | <input type="checkbox"/> | |

Management

Discharge home written advice verbal advice
 Request opinion of:
 Refer to surgeons time :
 Admit to ward specify:
 Transfer to SGU

ED Diagnosis

Head injury Nose injury
 Skull fracture Facial injury
 Other diagnosis give details in box below:

Signature: _____

Additional notes on ED card Yes No