Annex 6
Example of a proforma for routine documentation of head injury in children over five years of age

<table>
<thead>
<tr>
<th>Head Injury History : Children of 5 years and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affix Patient Label Here</td>
</tr>
<tr>
<td>Inj Date</td>
</tr>
<tr>
<td>Drug Therapy</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Hand Dominance</td>
</tr>
<tr>
<td>Incident Description:</td>
</tr>
<tr>
<td>F/S Passenger</td>
</tr>
<tr>
<td>B/S Passenger</td>
</tr>
<tr>
<td>Motor Cyclist / Pillion</td>
</tr>
<tr>
<td>Loss of consciousness</td>
</tr>
<tr>
<td>Post-traumatic amnesia</td>
</tr>
<tr>
<td>Seizure since injury</td>
</tr>
<tr>
<td>Headache</td>
</tr>
<tr>
<td>Nausea</td>
</tr>
<tr>
<td>Vomiting</td>
</tr>
<tr>
<td>Drowsy / unusually tired</td>
</tr>
<tr>
<td>Visual disturbance</td>
</tr>
<tr>
<td>Evidence of alcohol/drug consumption</td>
</tr>
<tr>
<td>Rhinorrhoea / Otorrhoea</td>
</tr>
<tr>
<td>Limb weakness</td>
</tr>
<tr>
<td>Other neurological symptoms</td>
</tr>
<tr>
<td>Pre-existing disorders</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Tetanus State</td>
</tr>
</tbody>
</table>

annEXEs
### Head Injury Examination: Adults and children of 5 years and older

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

- Vertex
- Right Parietal
- Left Parietal
- Forehead/Face
- Occiput

<table>
<thead>
<tr>
<th>Injuries</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boggy haematoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laceration(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bruising</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suspicion of compound skull fracture or penetrating injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sign of base of skull fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSF/Blood leak from right ear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSF/Blood leak from left ear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSF/Blood leak from nose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of injury to neck</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C Spine Examination</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Immobilised</th>
</tr>
</thead>
</table>

### Neurological Examination: Score from Glasgow Coma Scale

<table>
<thead>
<tr>
<th>GCS</th>
<th>E (Pupil reacting)</th>
<th>M (Movements)</th>
<th>V (Cranial N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Left</td>
<td>Right</td>
<td>Left</td>
</tr>
</tbody>
</table>

- Tone |
- Power |
- Cerebellar signs: No ☐ Yes ☐
- Gait (Normal, Abnormal)

### Commentary

- Left Right
- Pupil reacting: Normal, Abnormal
- Movements: Normal, Abnormal
- Cranial N: Normal, Abnormal

### Investigations and Results

<table>
<thead>
<tr>
<th>Tests</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>BM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temp</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BM/Temp not relevant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain CT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Spine CT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Spine X-ray</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Findings on Imaging:

- Normal, Abnormal

### Management

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

### Diagnosis from ED

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

### Additional notes on ED card

- Yes ☐ No ☐