

Injury in the under 1s proforma

Clinician's Details

Name/stamp:

Date: Time:

Age: Male / Female

Presenting injury:

Patient's Details

Name:

Date of Birth:

Trust ID & NHS number:

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Date of injury: Time of injury:

Who's providing the history? Who witnessed the injury?

Describe what happened:

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Head injury related symptoms

Symptoms	Y	N	U
L.O.C			
Seizure			
Irritability			
Vomiting			

List of injuries:

1.
2.
3.
4.
5.

Other symptoms / injuries:

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PMH:

Current developmental milestones:

Allergies:

Drug history:

Immunisations: UTD / Not UTD

FH / SH (who lives at home? Social worker involvement?):

Smokers: Yes / No

Examination

Observations	
Pulse	
RR	
BP	
Temp	

GCS	
E (4)	
V (5)	
M (6)	
Total	

OFC:
..... cm

Patient's Details

Name:

Date of Birth:

Trust ID & NHS number:
.....

General condition (circle)

Alert Happy Crying Irritable

Head injury screening examination

Normal gait	Y / N	Normal Co-ordination	Y / N
Normal tone & posture	Y / N	Signs of basal skull fracture*	Y / N
Pupils equal & reactive	Y / N	Neck tenderness	Y / N
Normal eye movements	Y / N	Full range of neck movements	Y / N
Normal facial symmetry	Y / N		

*haemotympanum, "panda" eyes, cerebrospinal fluid leakage from the ear or nose, Battle's sign

Fontanelle:

Ears:

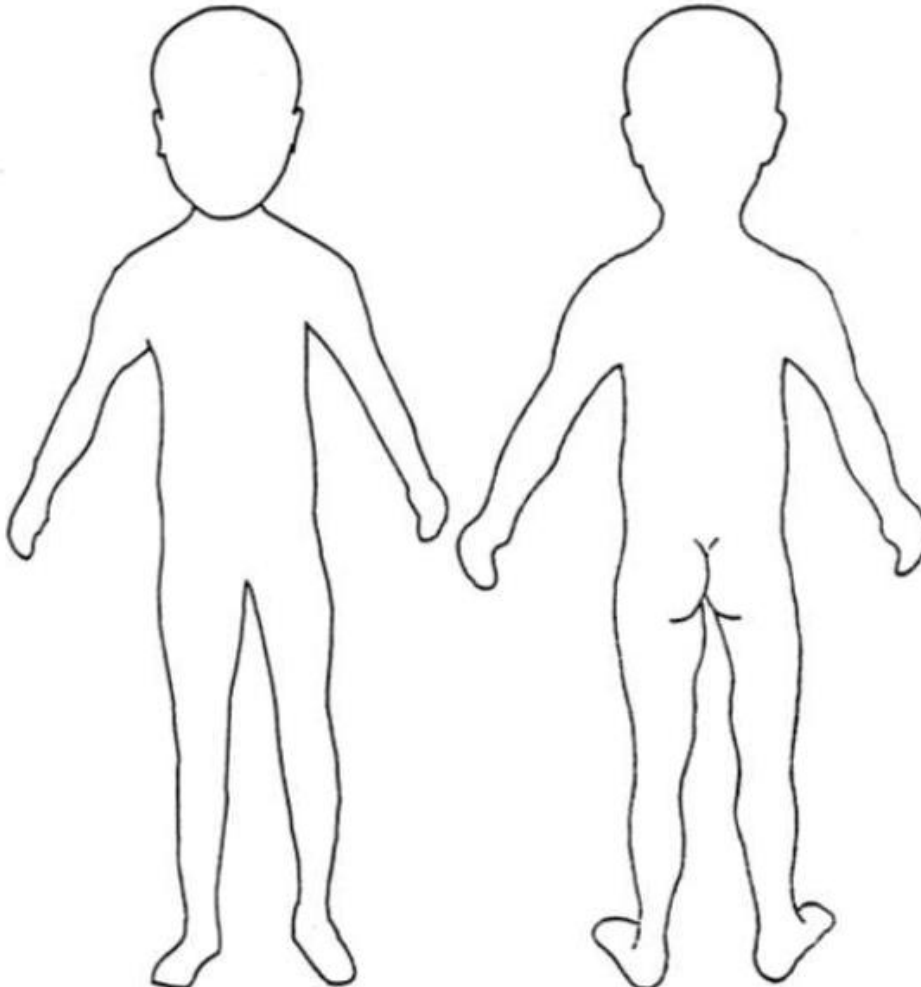
L

R

Mouth:

Frenum

Injuries – draw and describe on body map (include relevant negatives)



Neuro or focussed area examination (if required)

Patient's Details

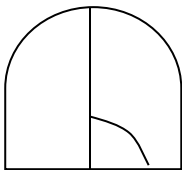
Name:

Date of Birth:

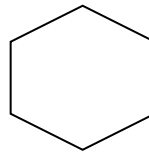
Trust ID & NHS number:
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CVS:

Respiratory:



Abdomen:



Genitalia

Management (See next page for head injury management pathway)

	Yes	No
Is injury consistent with described mechanism?		
Is described mechanism consistent with developmental assessment?		
Was there any unexplained delay in presentation?		
Are there any concerns re: supervision? e.g. unwitnessed, poor home safety		
Do you have any other concerns regarding this child / family?		

Flag up any grey areas with a Consultant or Paediatric Middle Grade immediately.
Consider referral to social care or HV liaison.

Differential diagnosis and treatment plan:

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Discharge criteria (tick)	
GCS >15	
No vomiting	
No neurological symptoms & no focal neurology	
No suspicion of non-accidental injury	
All injuries considered and treated	
Senior review (CED middle grade / Cons / ENP)	
Discussion only	
Face to face review (essential for non-mobile infants)	

Signature / Name / Grade / Bleep:

