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

Brighton and Sussex University Hospitals



Clinician's Details		Patient's Details			
Name/stamp:					
Date:		Date of Birth:			
		Trust ID & NHS number:			
Date of injury: .		Time of in	jury:		
Who's providing	g the history?		Who witnessed the injur	y?	
Describe what h	nappened:				
Head injury re			ist of injuries:		
Symptoms L.O.C	Y N				
Seizure		2			
		3			
Irritability		4			
Vomiting		5			
Other sympton	ns / injuries:				
РМН:		C	Current developmental milestones:		
Allergies:		D	rug history:		
Immunisations	: UTD / N	ot UTD			

Yes / No

Smokers:

Brighton and Sussex University Hospitals

Patient's Details



Examination

Observ	ations
Pulse	
RR	
BP	
Temp	

GC	s
E (4)	
V (5)	
M (6)	
Total	

	Genera
cm	Trust ID &
	Date of Bi
OFC:	Name:

Alert

Name:					
Date of Birth:					
Trust ID & NHS number:					
General condition (circle)					
Нарру	Crying	Irritable			

Head injury screening examination

Normal gait	Υ	/	N	Normal Co-ordination	Υ	/	N
Normal tone & posture	Υ	/	N	Signs of basal skull fracture*	Υ	/	N
Pupils equal & reactive	Υ	/	N	Neck tenderness	Υ	/	N
Normal eye movements	Υ	/	N	Full range of neck movements	Υ	/	N
Normal facial symmetry Y / N							
*haemotympanum, "panda" eyes, cerebrospinal fluid leakage from the ear or nose, Battle's sign							

Fontanelle: Ears:

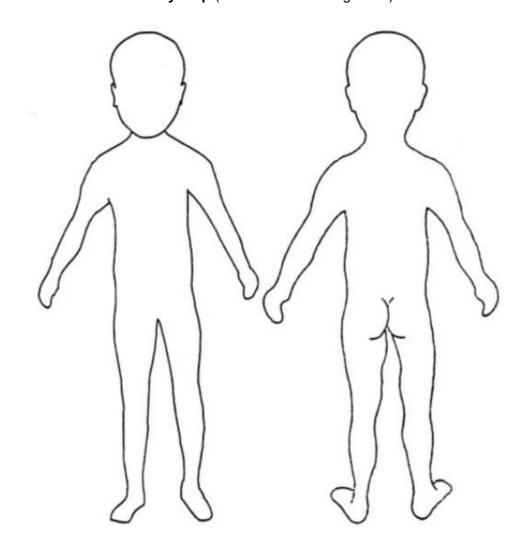
L

R

Mouth:

Frenum

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



Brighton and Sussex	NHS
University Hospitals	
NHS Trust	



Neuro or focussed area examination (if required)

Patient's Details
Name:
Date of Birth:
Trust ID & NHS number:

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:

 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)	

Brighton and Sussex University Hospitals

Patient's Details



Additional notes:

Additional notes:	Name:
	Date of Birth:
	Trust ID & NHS number:
	Signature / Name / Grade / Bleep:

Head injury management pathway

Any of the following present?		No? More than one of the following present?
Suspicion of non- accidental injury**	GCS <15 in CED	Abnormal drowsiness
Post-traumatic seizure with no history of epilepsy	Signs of basal skull fracture* (see page 1)	3 or more discrete episodes of vomiting
		Dangerous mechanism of injury***
Bruise, swelling or laceration >5cm on head	Suspicion of open or depressed skull fracture or tense fontanelle	LOC lasting > 5 minutes
		***high-speed RTA, fall from >3m, high speed injury from a projectile or an object.
Focal neurological deficit	**suspected abusive head injury, refer to guideline available on Microguide	Only 1 of above present then observe for a minimum of four hours after HI
	ES? Obably requires CT head	Consider CT head if symptoms ongoing