

RHCG >2yrs Head Injury ED assessment Part A

Date / Time:	Accompanied by:	History from:	Name: _____
Seen by:	Specialty:	Grade:	Address: _____

			CHI No. _____
			<i>Affix patient data label</i>

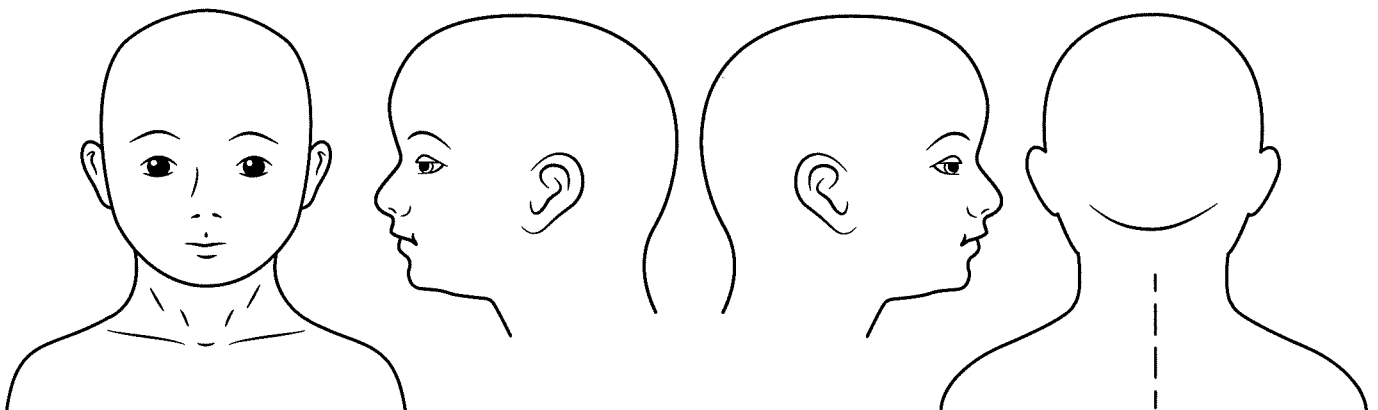
History

First hand witness? Yes No Time of injury: _____

Features during event:		PMH: Immunisations: <input type="checkbox"/> Up to date Allergies: <input type="checkbox"/> No Known Medications: <input type="checkbox"/> None Anticoagulant <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, CT scan is indicated up to 8 hours from injury.</i>
Loss of consciousness	<input type="checkbox"/> <5mins <input type="checkbox"/> > 5mins <input type="checkbox"/> No LOC	
Amnesia (ante/retro grade)	<input type="checkbox"/> <5mins <input type="checkbox"/> > 5mins <input type="checkbox"/> Nil	
Seizure since injury	<input type="checkbox"/> Yes <input type="checkbox"/> Unsure <input type="checkbox"/> No	
Vomiting	<input type="checkbox"/> <2 vomits <input type="checkbox"/> >2 vomits <input type="checkbox"/> No vomit	
Rhinorrhoea / Otorrhoea	<input type="checkbox"/> Yes <input type="checkbox"/> Unsure <input type="checkbox"/> No	
Abnormal limb weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Describe:	
Drowsy/unusually tired	<input type="checkbox"/> Yes <input type="checkbox"/> Unsure <input type="checkbox"/> No	Evidence of Alcohol/Drug consumption? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Neurology	<input type="checkbox"/> Yes <input type="checkbox"/> detail in Hx <input type="checkbox"/> No	Is a Notification of Concern required? <input type="checkbox"/> Yes <input type="checkbox"/> No

PEWS Score: _____ GCS: E_M_V_ / A V P U BP: _____ Pulse: _____ Resps: _____ SpO2: _____

Examination: (Please use illustration to identify injuries) Boggy Haematoma Yes No – Size



Name: _____
 Address: _____

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Examination continued (see illustration)

Pupil Size: Left: _____ Right: _____ Equal Reaction Y / N

Ears: Haemotympanum or CSF No Yes:

Nose: Septal Haematoma No Yes:

Throat: Uvula deviated No Yes:

Mouth: Dental trauma No Yes:

C/N 1-12: Normal Abnormal:

Cerebellar signs/Coordination Normal Abnormal:

Neck/Spine (C4-T1): N/A Normal Abnormal:

Wounds (describe):

Do any of the following apply? BOX 2

Witnessed loss of consciousness >5 minutes
 Yes No

Abnormal drowsiness
 Yes No

3 or more discrete episodes of vomiting
 Yes No

Dangerous mechanism of injury
 Yes No

(high-speed road traffic accident either as a pedestrian, cyclist or vehicle occupant, fall from height of >3 metres, high speed injury from an object)

Amnesia (antegrade or retrograde) lasting >5 minutes Yes No

If yes to more than 1 question in BOX 2, CT head scan within 1 hour is indicated. Please discuss with senior member of medical staff.

If yes to 1 question in BOX 2, please observe for 4 hours post injury and also commence "Part B" HI proforma.

Do any of the following apply? BOX 1

Suspicion of non-accidental injury.
 Yes No

Post-traumatic seizure but no history of epilepsy.
 Yes No

On initial emergency department assessment, GCS less than 14
 Yes No

At 2 hours after the injury, GCS less than 15.
 Yes No

Suspected open or depressed skull fracture or tense fontanelle.
 Yes No

Any sign of basal skull fracture
(haemotympanum, 'panda' eyes, cerebrospinal fluid leakage from the ear or nose, Battle's sign).
 Yes No

Focal neurological deficit.
 Yes No

If yes to any questions in BOX 1, CT head scan within 1 hour is indicated.

Please discuss with most senior member of medical staff.

Management:

CT scan head: Yes No

Observe for 4 hours? Yes No

Requires admission? Yes No

Referral to:
 General Surgeon / Neurosurgeon / CP

Referral Time: _____

Accepted by: _____

Admission ward: _____

Admission or discharge plan/treatments:

Discharge Home with written and verbal advice
 Yes No

(If age 5 and over, give and discuss ACoRN concussion advice)

Signature: _____

Additional notes / Part B? Yes No