Burns & Scalds Assessment Template.  
(BASAT)

Please complete for ALL children 0-16th birthday presenting with a BURN or SCALD injury.  
Please complete ALL sections, ticking ALL answers that apply.

Patient Details (or addressograph)

Name:                                                                       Hosp. No.                                                                                     DOB:  

Section 1: History of Injury

1.1 Type of Injury

☐ Scalp         ☐ Seaburn
☐ Contact Burn        ☐ Home
☐ Electrical        ☐ Other:

1.2 Location

☐ Home        ☐ Café/Restaurant
☐ School        ☐ Other:

1.3 Details of Incident

Was anyone in the room/vicinity at the time?  
☐ Yes        ☐ No

If yes, who?

☐ Parent        ☐ Grandparent       ☐ Other:
☐ Sibling        ☐ Other:

Did they see what happened?  
☐ Yes        ☐ No

What is the explanation for the injury?

☐ None            ☐ Other (specify)

Section 2: Details of child

2.1. Is there any developmental impairment?

(please complete all that apply)  
☐ Mental        ☐ Neurological        ☐ Hearing        ☐ Vision        ☐ Behavioural        ☐ Learning        ☐ Other:

2.2. Current 'best' stage of development.

(please complete for children < 3 years & if yes to Q 2.1)  
☐ N/A

☐ Non mobile Baby        ☐ Baby able to roll over
☐ Sitting        ☐ Crawling        ☐ Cruising        ☐ Walking

Section 3: Characteristics of injury on examination.

3.1 Body map—please shade distribution of injury.  
☐ N/A — no visible injury

3.2 Pattern of injury

☐ Symmetrical (both sides of the body)
☐ Asymmetric/stocking distribution
☐ Clearly defined margins
☐ Skin fold sparing
☐ Margin in shape of an implement
☐ Multiple contact burns (more than one)

3.3 Depth of Injury

☐ N/A

☐ Erythema/redness            ☐ Blisters, not burst
☐ Wet, pink            ☐ Dry, white or charred

Section 4: Screening, Referrals & Outcomes

☐ Has the child/parent/carer been referred to a child protection team?

☐ Yes        ☐ No

Did the child/parent/carer see a SW or any other professional in the last 24 hours?

☐ Yes        ☐ No

Section 5: Causative factor

☐ Agent

☐ Hot Drink     ☐ Oven Hob     ☐ Radiation     ☐ BBQ
☐ Hot Food     ☐ Oven Door     ☐ Hair Tongs/ straighteners
☐ Water       ☐ Fry/Oil       ☐ Sun       ☐ N/K
☐ Other:

☐ Source if scald

☐ Mag/Toilet     ☐ Bowl       ☐ Sink       ☐ Shower
☐ Kettle      ☐ Pan       ☐ N/K       ☐ Other:

☐ Location of hot item

☐ Kitchen surface       ☐ Low table       ☐ Floor       ☐ On cooler hob
☐ Dining table       ☐ Oven       ☐ Garden/outside
☐ N/K       ☐ Other:

3.6 Have there been any previous ED attendance for:

☐ N/A

☐ Syrhythmia/nudness
☐ Blisters, not burst
☐ Wet, pink
☐ Dry, white or charred

Section 6: Assessment undertaken:

Assessment undertaken:      Date:          /          /

Clinician completing form:      Name:      Scr No:

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