

Online Research @ Cardiff

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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)

Hospital or NHS number: _____

Name: _____ Date of Birth: _____

Gender: _____ Post code: _____

Ethnicity:

White	Asian	Other
British	Indian	Arab
Irish	Pakistani	Any other back ground
Gypsy or Irish Traveller	Bangladeshi	
Any other white back ground	Chinese	
Mixed	Any other Asian back ground	
White & Black Caribbean	Black	
White & Black African	African	
White & Asian	Caribbean	
Any other mixed back ground	Any other Black back ground	

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Name:	
Hospital No.	Centre
DOB:	ID. No.
Clinician completing form:	
Person completing this form: <input type="checkbox"/> Research Nurse <input type="checkbox"/> Nurse <input type="checkbox"/> SHO <input type="checkbox"/> REG <input type="checkbox"/> ENP <input type="checkbox"/> CONS <input type="checkbox"/> ANP	
Who is accompanying the child? <input type="checkbox"/> Mum <input type="checkbox"/> Dad <input type="checkbox"/> Grandparent <input type="checkbox"/> Unaccompanied <input type="checkbox"/> Other:	
Assessment undertaken: Date: / / (dd/mm/yy) Time: : (24hr)	
Injury Occurred: Date: / / (dd/mm/yy) Time: : (24hr)	
Details of child: Gender: *Age (record in mths if child < 2)	

Section 1: History of Injury

1.1 Type of Injury

Scald Sunburn
 Contact Burn Flame
 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 Peer
 Sibling Other:

Did they see what happened? Yes No

What is the explanation for the injury?

1.4 What was the child doing just before the incident?

Running/Walking Being Carried/ held
 Lying Down Sitting Standing
 N/K Other:

1.5 Agent/Mechanism (please complete all applicable)

***Agent**

Hot Drink Oven Hob Radiator BBQ Iron
 Hot Food Oven Door Hair Tongs/ Straighteners
 Water Fat/Oil Sun N/K
 Other:

Source if scald
 Mug/cup Bowl Tap Bath Shower
 Kettle Pan N/K Other:

Location of hot item
 Kitchen surface Low table Floor On cooker hob
 Dining table Oven Garden/outside
 N/K Other:

Mechanism
 Touch Pull down Immersion Spill
 Fell/ran into Splash Exposure to sun
 N/K Other:

1.6 First Aid (including inappropriate first aid)

Was First Aid given by Parent/carer? Yes No

If yes was it? (tick all that apply)

Cold Water Sudocrem Butter
 Wet compress Talcum Powder Honey
 Ice Toothpaste Tumeric
 Other "cooling" agent Other cream/gel/ointment Egg
 (e.g frozen peas) (specify) Other (specify)

If cold water how was it applied?
 Tap/shower (running water) Put into water (immersion)

How long was water applied for? (mins)
 Was the burn covered? Yes No

If yes, what with?
 Was Analgesia administered by the parent/carer prior to arrival at ED?
 None Paracetamol Ibuprofen Other (specify)

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Name: _____ Hosp. No. _____ DOB: _____

Section 2: Details of child

2.1. Is there any developmental impairment?

(Please tick all that apply) N/A

Motor Neurological Hearing Behavioural Learning Vision Other:

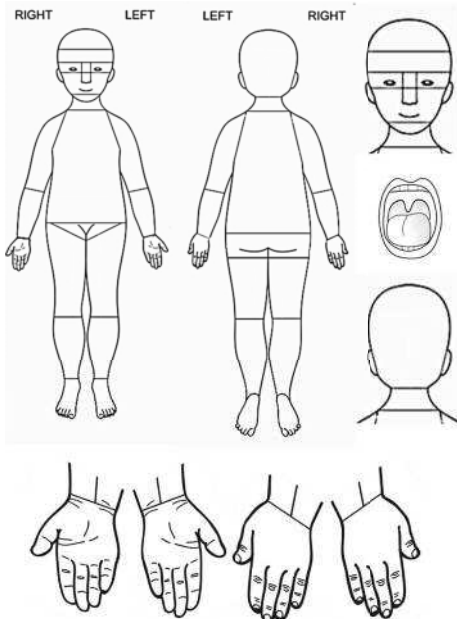
2.2. Current 'best' stage of development.

(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



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Name: _____ Hosp. No. _____ DOB: _____

*3.2 Pattern of injury (tick all that apply)

N/A

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

Percentage of body injured:

≤ 1% 2-9% 10-14% ≥ 15%

3.5 Any other injuries on examination?

Yes No

Details if yes:

*3.3 Depth of Injury (tick all that apply) N/A

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

3.6 Have there been any previous ED attendance for:

Burn Injury Other Injury

Details if yes

Section 4: Screening, Referrals & Outcomes

* 4.1 Social Service (SS) Involvement

Does the Child/Family have a Social worker (SW) Now? Yes No

Did the Child/Family have a SW or any SS involvement in the past? Yes No

Is there any Domestic Violence in the Home Yes No

(A proposed way to ask this question is "Do you feel safe at home?" - only ask this question if you can talk to the parent on their own)

* 4.4 Referrals & Outcomes (tick as many as apply)

Was a Child Protection referral made?	Were any other referrals made?	Outcome?
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> Discharged Home
<input type="checkbox"/> Social Services	<input type="checkbox"/> Health Visitor	<input type="checkbox"/> ED review
<input type="checkbox"/> Hospital Safeguarding Team	<input type="checkbox"/> School Nurse	<input type="checkbox"/> GP/Practice Nurse
	<input type="checkbox"/> Other	<input type="checkbox"/> Specialist Burns Unit
		<input type="checkbox"/> Transfer to Acute ward
		<input type="checkbox"/> Other

Overall Additional comments:

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