# Childrens Burns and Plastic Surgery

## Referral Pathway Out-of-Hours

**SHO on-call receives a referral for patient from NUH ED or a referring service**

### Does the patient need to come to NUH ED?

**>2% Burn, FT Burn, safeguarding concern,**
**Special Anatomical Areas, Chemical/Electrical**

**Yes**

- Take patient details and demographics
- Tell referrer that patient must come to QMC paeds ED for plastics review.
- Inform QMC paeds ED patient is expected
- Tell plastics registrar that patient is expected.
- Email CNS: nuhnt.childrensburnsandplastics@nhs.net
- EMAIL MUST INCLUDE ALL DETAILS (BELOW) AND PHOTOS, IF AVAILABLE.

**No**

- Take Pt details and demographics
- Monday–Friday: tell referrer to tell the family that a CNS will phone the next working day to book a review.
- On weekends: tell referrer to tell the family that a CNS will phone on Monday morning to book a review.
- Always give safety netting advice to attend local ED if any concerns.
- Email CNS: nuhnt.childrensburnsandplastics@nhs.net
- EMAIL MUST INCLUDE ALL DETAILS (BELOW) AND PHOTOS, IF AVAILABLE

### Required Details

1. Referring Emergency Department
2. Date & Time of Referral
3. Name
4. Date of Birth
5. K Number
6. NHS Number:
7. GP Surgery
8. Families First Language
9. Interpreter Required?
10. Date and Time of Injury
11. Cause of Injury
12. TBSA of Injury
13. Area of body burnt/Injured
14. Treatment Plan
15. Photos of Injury
16. Safeguarding Concerns
17. Social Care Referral
18. Name of referrer:

### Epiprotect

Epiprotect for 2%TBSA and above.

ALL children with burns 2%TBSA or greater MUST come to ED for speciality review

### Email

Email ALL photos and patient details:
nuhnt.childrensburnsandplastics@nhs.net

### Out of Hours Advice

Please call D35 on 0115 9249924 ext 89035

## Referral Details

Referring ED: QMC / Derby / Lincoln / Leic. / KMH

Other ED / MIU / WIC / G.P. (*must* specify): _____

Date & Time of Referral: ____ / ____ / _____ ____ : ____

## Patient Details

Patient Label (Paeds Burns Unit will do this)

Name: _____

Date of Birth: _____ / _____ / _____

K Number (QMC only): **K**_____

NHS Number (if known): _____ _____ _____

G.P., Surgery & Telephone Number: _____

Contact Number for Patient: _____

Families First Language: _____ Interpreter Needed: Yes ☐ No ☐

## Injury Details

Type / Cause of Injury: _____

%TBSA: _____

Position of Injury: _____

Treatment Plan inc. Antibiotics: _____

Safeguarding: _____

_____

Social Care: _____

_____

Date & Time of Injury: ____ / ____ / _____ ____ : ____

First Dressing Clinic Appointment: _____ / _____ / _____ ____ : ____

## Staff Member Completing Form (*you are signing to say you have completed all points*)

Name & Title of Person Completing Form: _____

Are Photos Available and Sent? _____