

For office use only:   H I

## Centre for Maternal and Child Enquiries

Improving the health of mothers, babies and children



# HEAD INJURY IN CHILDREN

## TRANSFER INFORMATION FORM (B)

Please complete this form for a child or young person up to 15 years old (*14 yrs + 365 days*) who as a result of a head injury\* or a head injury as part of a pattern of injuries was transferred\* to your hospital within the first 72 hours post injury for secondary or tertiary care between 1<sup>st</sup> SEPTEMBER 2009 and 28<sup>th</sup> FEBRUARY 2010 inclusive:

Please tick type of case: (*Select one option only*)

- Child arrives in your Emergency Department following transfer\* from another hospital and admitted\* for secondary or tertiary care in the same hospital **OR**
- Child admitted directly to a unit in your hospital for secondary or tertiary care following transfer or retrieval from another hospital (e.g. direct to PICU)

### Instructions for completing and returning the notification form

1. This form should be completed by the hospital receiving the child.
2. Certain sections may not be applicable to all children. Please read the guidance manual before completing.
3. One form should be completed per child, per transfer.
4. Please complete the form using the information available in the child's notes. Complete all dates in the format DD/MM/YY and times using the 24hr clock e.g. 18:50.
5. Please keep a copy of this form for your records. Return hardcopies of completed forms to your local CMACE regional office. See back of form for local contact details.
6. If you have any queries about completing or returning this form please contact your CMACE regional office.

Date form completed:

Date form returned:

### DETAILS OF PERSON COMPLETING FORM

Name:	Trust:
Job title/Role:	Telephone:
Unit:	Email:
Hospital:	

\* **Head injury:** Examples of head injuries to include or exclude can be found on the back of this form.

\* **Admission:** Hospital admission is defined as occurring when the patient is in receipt of treatment or observation in an inpatient area. This includes short term assessment units associated with wards or emergency departments, short stay units, general or specialist wards, PICUs, Neurosurgical unit, or other inpatient unit. This may only be for a matter of hours beyond the first four hours from arrival at hospital.

\* **Transfer:** Refers to the transport of a patient by ambulance (land or air) from one hospital to another hospital facility. Also referred to as an 'inter-hospital transfer' between two hospitals either within or out of the same trust.

**SECTION 1: DETAILS OF CHILD***(Affix patient label if preferred)*

- 1.1 Hospital Number
- 1.2 NHS Number/Healthcare Number    /    /
- 1.3 Surname/family name \_\_\_\_\_
- 1.4 First name \_\_\_\_\_
- 1.5 Sex  Male  Female  Not known
- 1.6 Date of birth and/or estimated age   /   /    
*If no full date of birth is known enter month and year. If no full or short DOB, enter their estimated age.*  Not known
- years   months
- 1.7 Postcode of patient's normal residence     /      Not known

**SECTION 2: DETAILS OF TRANSFER TO SECONDARY/TERTIARY CARE**

- 2.1 Was this a transfer or retrieval?  Transfer  Retrieval  Not known
- 2.2 Name of hospital and trust child transferred FROM  
 (Hospital) \_\_\_\_\_  
 (Trust) \_\_\_\_\_
- 2.3 Name of hospital and trust child transferred TO  
 (Hospital) \_\_\_\_\_  
 (Trust) \_\_\_\_\_
- 2.4 Date and time first referral made for transfer   /   /     :    Not recorded  
 (24 hr clock)
- 2.5 First referral request for transfer accepted  Yes  No  Not recorded
- 2.6 Date and time departure for transfer   /   /     :    Not recorded  
 (24 hr clock)
- 2.7 Date and time arrival at secondary/tertiary care   /   /     :    Not recorded  
 (24 hr clock)
- 2.8 Reason for transfer *(please tick all that apply)*
- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> No paediatric facilities                 | <input type="checkbox"/> Access to paediatric neuroscience facilities | <input type="checkbox"/> Not recorded |
| <input type="checkbox"/> No ICU facilities in hospital            | <input type="checkbox"/> Paediatric surgery                           | <input type="checkbox"/> Not known    |
| <input type="checkbox"/> No PICU bed available in hospital        | <input type="checkbox"/> Receiving hospital close to child's home     |                                       |
| <input type="checkbox"/> No general ICU bed available in hospital | <input type="checkbox"/> Other, <i>please specify</i> _____           |                                       |
- 2.9 Means of transfer
- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Specialist PICU transport team | <input type="checkbox"/> Private/public transport                    | <input type="checkbox"/> Not recorded |
| <input type="checkbox"/> Local team                     | <input type="checkbox"/> Other land, <i>please specify</i> _____     | <input type="checkbox"/> Not known    |
| <input type="checkbox"/> Paramedic Ambulance            | <input type="checkbox"/> Helicopter (Paramedic/medic)                |                                       |
| <input type="checkbox"/> Ambulance (Non paramedic)      | <input type="checkbox"/> Other airborne, <i>please specify</i> _____ |                                       |
- 2.10 Additional transfer information *(e.g. reason for delay)*

- 2.11 Was the child 'admitted' to receiving hospital for secondary or tertiary care *(see cover for definition of admission)*  Yes → *Go to 3.1*  No → *Go to 2.11.1*

**2.11.1 If no, where did child go:**

- Transferred to another hospital → *Go to 4.2*
- Deceased → *Go to 4.4*
- Other, *please specify* \_\_\_\_\_ → *Go to 4.1*

## SECTION 3: ADMISSION AT SECONDARY/TERTIARY CARE

**3.1 Date admitted to area**   Not recorded

**3.2 Time admitted to area**  (24 hr clock)  Not recorded

**3.3 Area child first admitted to:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> General children's ward                   | <input type="checkbox"/> General/Adult ICU                | <input type="checkbox"/> Theatre          |
| <input type="checkbox"/> Paediatric Intensive Care Unit (PICU)     | <input type="checkbox"/> Adult Neurosurgical unit         | <input type="checkbox"/> Short stay Unit  |
| <input type="checkbox"/> Paediatric Neurosurgical unit             | <input type="checkbox"/> Adult High Dependency Unit (HDU) | <input type="checkbox"/> Observation unit |
| <input type="checkbox"/> Paediatric High Dependency Unit (PHDU)    | <input type="checkbox"/> Other, specify _____             | <input type="checkbox"/> Not known        |
| <input type="checkbox"/> Specialist children's ward, specify _____ |   |   |

**3.4 Designated lead team for this admission** *(If joint care tick all that apply)*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> General Paediatrics           | <input type="checkbox"/> General/Adult Emergency Medicine | <input type="checkbox"/> Not known            |
| <input type="checkbox"/> Paediatric Emergency Medicine | <input type="checkbox"/> General/Adult Intensive Care     | <input type="checkbox"/> Other, specify _____ |
| <input type="checkbox"/> Paediatric Intensive Care     | <input type="checkbox"/> Adult Neurosurgery               |   |
| <input type="checkbox"/> Paediatric Neurosurgery       | <input type="checkbox"/> General/Adult Surgery            |   |
| <input type="checkbox"/> Paediatric Surgery            | <input type="checkbox"/> Orthopaedic Surgery              |   |

**3.5 Indication for admission** *(Please tick all that apply)*

- |   |   |
|---|---|
| <input type="checkbox"/> Severity of the head injury                          | <input type="checkbox"/> Recovery from GA or sedation used for CT scan  |
| <input type="checkbox"/> Severity of other injuries                           | <input type="checkbox"/> Child fulfils criteria for CT scanning but this cannot be done within the appropriate period |
| <input type="checkbox"/> Severity of mechanism of injury                      | <input type="checkbox"/> Not sufficiently cooperative to allow scanning   |
| <input type="checkbox"/> Continuing worrying signs in relation to head injury | <input type="checkbox"/> Admitted for GA to have a CT scan  |
| <input type="checkbox"/> Abnormality identified on CT scan                    | <input type="checkbox"/> Shock  |
| <input type="checkbox"/> Base of skull fracture                               | <input type="checkbox"/> Suspected Non Accidental Injury (NAI)  |
| <input type="checkbox"/> Meningism  | <input type="checkbox"/> Other, please specify (e.g. not related to head injury, gastroenteritis)                     |
| <input type="checkbox"/> CSF leak   | _____   |
| <input type="checkbox"/> Drug or Alcohol intoxication                         |   |

**3.6 Child's neurological status at admission to secondary/tertiary care**

*Document the worst score before intubation/intervention on arrival. If no intubation/intervention occurred, document the worst score.*

**3.6.1 Glasgow Coma Scale Score**  Not recorded

Eye opening	
Verbal response	
Motor response	
TOTAL (out of 15)	

**Time GCS recorded:**

(24 hr clock)  Not recorded

**3.6.2 AVPU Score**  Not recorded

Alert	
Respond to Voice	
Respond to Pain	
Unresponsive	

**Time AVPU recorded:**

(24 hr clock)  Not recorded

**3.7 Child intubated following arrival at centre**  Yes  No  Not known

**3.8 Consultant paediatrician involved in care of child**  Yes  No  Not known  
*(i.e. Discussed with at time of care delivered)*

**3.9 Neurosurgeon involved in care of child**  Yes  No  Not known  
*(This includes liaison over telephone, or other means)*

**3.10 Specialist in Child Protection with level 3 training or above involved**  Yes  No  Not known  
*(i.e. Discussed with at time of care delivered)*

**3.11 Child Protection referral made to external body**  Yes  No  Not known  
*(e.g. Social Services or Police)*

**3.12 Skeletal survey undertaken**  Yes  No  Not known  
*(i.e. as part of a child protection assessment)*

**3.13 Review by ophthalmology undertaken**  Yes  No  Not known  
*(i.e. as part of a child protection assessment)*

## SECTION 3: ADMISSION AT SECONDARY/TERTIARY CARE *continued*

**3.14** IN ADDITION to the first area of admission was the child *at any time during the first 72 hours post injury* admitted to any of the following areas?

Area	Yes	No	Date admitted	Time admitted (24 hr clock)	Date discharged	Time discharged (24 hr clock)
a. PICU	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
b. PHDU	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
c. General ICU	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
d. General HDU	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
e. Neurosurgical unit	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
f. Ward	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
g. Theatre	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
h. Other, <i>specify</i>	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM

## IMAGING (At any time following transfer)

**3.15** Head CT scan performed  Yes → *Go to 3.15.1*  No → *Go to 3.15.4*  Not known → *Go to 3.16*

**3.15.1** Date first head CT scan performed DD/MM/YY  Not recorded

**3.15.2** Time first head CT scan performed HH:MM (24 hr clock)  Not recorded

**3.15.3** Was the first head CT scan reported as normal on provisional report?  Yes → *Go to 3.16*  No → *Specify abnormality:*  Not known → *Go to 3.16*

**3.15.4** If no head CT performed, please indicate reason/reasons why: *(tick all that apply)*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> CT scan already done at first hospital    | <input type="checkbox"/> Child not stable | <input type="checkbox"/> Other, please specify _____ |
| <input type="checkbox"/> Not considered to be clinically indicated | <input type="checkbox"/> No CT available  | <input type="checkbox"/> Not known                   |

**3.16** Complete cervical spine CT performed  Yes → *Go to 3.16.1*  No → *Go to 3.16.2*  Not known → *Go to 3.17*

**3.16.1** Was the first spine CT scan reported as normal on provisional report?  Yes → *Go to 3.17*  No → *Specify abnormality:*  Not known → *Go to 3.17*

**3.16.2** If no spine CT scan performed please indicate reason/reasons why: *(tick all that apply)*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> CT scan already done at first hospital    | <input type="checkbox"/> Child not stable | <input type="checkbox"/> Other, please specify _____ |
| <input type="checkbox"/> Not considered to be clinically indicated | <input type="checkbox"/> No CT available  | <input type="checkbox"/> Not known                   |

**3.17** Additional CT information *(e.g. reason for delay)*

## SECTION 4: CHILD'S OUTCOME - Complete at *whichever occurs first*: at transfer, at death in hospital, or at the end of the first 72 hours post injury.

**4.1** Please indicate the status or location of the child at whichever occurs first *(i.e. at transfer, at death in hospital, or at the end of the first 72 hours post injury)*

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Transferred → <i>Go to 4.2</i>                   | <input type="checkbox"/> Paediatric Intensive Care Unit (PICU)  | <input type="checkbox"/> Adult/General HDU    |
| <input type="checkbox"/> Discharged → <i>Go to 4.3</i>                    | <input type="checkbox"/> Paediatric High Dependency Unit (PHDU) | <input type="checkbox"/> Not known            |
| <input type="checkbox"/> Deceased → <i>Go to 4.4</i>                      | <input type="checkbox"/> Paediatric Neurosurgical unit          | <input type="checkbox"/> Other, specify _____ |
| <input type="checkbox"/> General children's ward                          | <input type="checkbox"/> General/Adult ICU                      |   |
| <input type="checkbox"/> Specialist children's ward, <i>specify</i> _____ | <input type="checkbox"/> Adult Neurosurgical unit               |   |

## SECTION 4: CHILD'S OUTCOME *continued*

### 4.2 Transferred

- 4.2.1 Was this a transfer or retrieval?  Transfer  Retrieval  Not known
- 4.2.2 Name of hospital and trust child transferred to (Hospital) \_\_\_\_\_  
(Trust) \_\_\_\_\_
- 4.2.3 Date and time first referral made for transfer DD/MM/YY HH:MM  Not recorded  
(24 hr clock)
- 4.2.4 First referral request for transfer accepted  Yes  No
- 4.2.5 Date and time departure for transfer DD/MM/YY HH:MM  Not recorded  
(24 hr clock)
- 4.2.6 Reason for transfer *(please tick all that apply)*
- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> No paediatric facilities                 | <input type="checkbox"/> Access to paediatric neuroscience facilities | <input type="checkbox"/> Not recorded |
| <input type="checkbox"/> No ICU facilities in hospital            | <input type="checkbox"/> Paediatric surgery                           | <input type="checkbox"/> Not known    |
| <input type="checkbox"/> No PICU bed available in hospital        | <input type="checkbox"/> Receiving hospital close to child's home     |                                       |
| <input type="checkbox"/> No general ICU bed available in hospital | <input type="checkbox"/> Other, <i>please specify</i> _____           |                                       |
- 4.2.7 Means of transfer
- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Specialist PICU transport team | <input type="checkbox"/> Private/public transport                    | <input type="checkbox"/> Not recorded |
| <input type="checkbox"/> Local team                     | <input type="checkbox"/> Other land, <i>please specify</i> _____     | <input type="checkbox"/> Not known    |
| <input type="checkbox"/> Paramedic Ambulance            | <input type="checkbox"/> Helicopter (Paramedic/medic)                |                                       |
| <input type="checkbox"/> Ambulance (Non paramedic)      | <input type="checkbox"/> Other airborne, <i>please specify</i> _____ |                                       |
- 4.2.8 Additional transfer information *(e.g. reason for delay)*

### 4.3 Discharged

- 4.3.1 Place child discharged to  Home  Rehab centre  
 Other, *specify* \_\_\_\_\_  Not known
- 4.3.2 Date of discharge DD/MM/YY  Not recorded
- 4.3.3 Time of discharge HH:MM (24 hr clock)  Not recorded
- 4.3.4 Diagnosis on discharge \_\_\_\_\_

### 4.4 Death *(if a diagnosis of brain stem death is made then the date and time of this diagnosis equals the date and time of death)*

- 4.4.1 Date of death DD/MM/YY  Not recorded
- 4.4.2 Time of death HH:MM (24 hr clock)  Not recorded
- 4.4.3 Place of death
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> General children's ward                          | <input type="checkbox"/> General/Adult ICU                | <input type="checkbox"/> Theatre          |
| <input type="checkbox"/> Paediatric Intensive Care Unit (PICU)            | <input type="checkbox"/> Adult Neurosurgical unit         | <input type="checkbox"/> Short stay Unit  |
| <input type="checkbox"/> Paediatric Neurosurgical unit                    | <input type="checkbox"/> Adult High Dependency Unit (HDU) | <input type="checkbox"/> Observation unit |
| <input type="checkbox"/> Paediatric High Dependency Unit (PHDU)           | <input type="checkbox"/> Emergency Department             | <input type="checkbox"/> Home             |
| <input type="checkbox"/> Specialist children's ward, <i>specify</i> _____ | <input type="checkbox"/> Other, <i>specify</i> _____      | <input type="checkbox"/> Not known        |
- 4.4.4 Death certificate issued  Yes  No  Not known
- 4.4.5 Coroner's referral made  Yes  No  Not known
- 4.4.6 Cause of death *(as stated on death certificate. If no certificate issued state cause of death as in notes)*

**For children who died <28 days old**

1. \_\_\_\_\_
- 2a. \_\_\_\_\_
- 2b. \_\_\_\_\_
- 2c. \_\_\_\_\_
- 2d. \_\_\_\_\_

**For deaths of a child (> 28 days old)**

- 1a. \_\_\_\_\_
- 1b. \_\_\_\_\_
- 1c. \_\_\_\_\_
2. \_\_\_\_\_

## Inclusion & exclusion criteria

### Please include:

- Children up to 15 years old (14 years and 364 days) who between 00:00 on the 1<sup>st</sup> September 09 and 23:59 on the 28<sup>th</sup> February 2010 have a brain or skull injury (trauma to the head) as a result of blunt or penetrating trauma or acceleration or deceleration force (e.g. road traffic accident, fall, shaking) **OR** who have experienced a head injury as part of a pattern of injuries or multi trauma **AND** fulfill the following length of stay criteria:

- ⇒ Admitted to an area of inpatient care (regardless of length of stay) **OR**
  - ⇒ Died in the hospital, including the Emergency Department **OR**
  - ⇒ Transferred to other hospital for specialist care or for an ICU/HDU bed **OR**
  - ⇒ Died at the scene or en route to the receiving hospital **OR**
  - ⇒ Transferred in to your hospital (regardless of length of stay)
- Definition of 'admission' can be found on the front of this form

### Please exclude:

- Children who have experienced primarily superficial or facial injuries which are *unlikely to be associated with a brain injury* (e.g. isolated or trivial facial (nose, ear, lip etc), scalp or auricular injuries)
- Children who do not meet the above inclusion criteria (i.e. children who do not die that are not admitted; children who have reached their 15<sup>th</sup> birthday at the time of injury).

Examples of types of head injuries to be INCLUDED	Examples of types of head injuries to be EXCLUDED
<b>S02 Fracture of skull and facial bones, e.g.</b>	<b>S00 Superficial Injuries, e.g.</b>
Fracture of vault of skull	Superficial injury of scalp
Fracture of base of skull	Contusion of eyelid and periorcular area
Multiple fractures involving skull and facial bones	Other superficial injuries of eyelid and periorcular area
Fractures of other skull and facial bones	Superficial injury of nose, ear, lip, or oral cavity
<b>S04 Injury of cranial nerves, e.g.</b>	<b>S01 Open wound of head, e.g.</b>
Injury of optic nerve and pathways	Scalp, eyelid and periorcular area, nose, ear, cheek & temporomandibular area, lip & oral cavity.
Injury of oculomotor nerve	
<b>S06 Intracranial injury, e.g.</b>	<b>S02 Fracture of skull and facial bones, e.g.</b>
Concussion	Fracture of tooth, mandible, nasal bones, orbital floor, malar & maxillary bones.
Traumatic cerebral oedema	
Diffuse brain injury	<b>S03 Dislocation, sprain &amp; strain of joints &amp; ligaments of head,</b>
Focal brain injury	Dislocation of jaw, septal cartilage of nose, septal cartilage of nose, or tooth. Sprain and strain of jaw.
EDH (Extra Dural Haematoma)	<b>S04 Injury of cranial nerves, e.g.</b>
Traumatic subdural/subarachnoid haemorrhage	Injury of trochlear nerve, trigeminal nerve, abducent nerve, facial nerve
Intracranial injury with prolonged coma	<b>S05 Injury of eye and orbit, e.g.</b>
Other intracranial injuries	Injury of conjunctiva and corneal abrasion
Intracranial injuries - unspecified	Contusion of eyeball and orbital tissues
<b>S07 Crushing injury of head, e.g.</b>	Ocular laceration and rupture with prolapse
Crushing injury of the face	Penetrating wound of orbit, or eyeball
Crushing injury of the skull	Avulsion of eye
<b>S08 Traumatic amputation of part of head, e.g.</b>	<b>S08 Traumatic amputation of part of head, e.g.</b>
Traumatic amputations	Avulsion of scalp
Multiple injuries of head	Traumatic amputation of ear

**If you have any queries regarding the inclusion/exclusion criteria, please contact your CMACE regional office.**

#### CMACE East of England Office

Carol Hay, Regional Manager  
Box 111, Room 414, Clinical School  
Addenbrooke's Hospital, Hills Road  
Cambridge, CB2 0SP

T: 01223 330 356 or 351      E: [carol.hay@cmace.org.uk](mailto:carol.hay@cmace.org.uk)

#### CMACE East Midlands and Yorkshire and The Humber Office

Daniel Beever, Administrative Assistant  
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John Street, Sheffield  
S2 4SW

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#### CMACE London and South East Office

Dave Kimani, Administrative Assistant  
Lower ground floor, Chiltern Court  
188 Baker Street, London  
NW1 5SD

T: 020 7467 3224      E: [dave.kimani@cmace.org.uk](mailto:dave.kimani@cmace.org.uk)

#### CMACE North East Office (FAO Marjorie Renwick)

C/O CMACE Central Office  
Lower ground floor, Chiltern Court  
188 Baker Street, London  
NW1 5SD

T: 020 7467 3224      E: [headinjury@cmace.org.uk](mailto:headinjury@cmace.org.uk)

#### CMACE Northern Ireland Office

Terry Falconer, Project Manager  
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BT2 8HS

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#### CMACE North West, West Midlands & Wales Office

Pamela Norris, Project Midwife  
Research Floor (5th Floor), St Mary's Hospital  
Oxford Road, Manchester  
M13 9WL

T: 0161 7016915      E: [pamela.norris@cmace.org.uk](mailto:pamela.norris@cmace.org.uk)

#### CMACE South West and Wessex Office

Jo Coffee, Regional CMACE Assistant  
Institute of Child Life & Health, Level D  
St Michaels Hospital, Southwell Street  
Bristol, BS2 8EG

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