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Introduction

The purpose of this plan is to develop a systematic response to an event that generates a surge of burn patients requiring initial care in a hospital setting. A Burn Mass Casualty Disaster is defined as any catastrophic event in which the number of burn victims exceeds the capacity of the local burn center to provide care. Capacity includes the availability of burn beds, burn surgeons, burn nurses, support staff, operating rooms, equipment, supplies and related resources.

The American Burn Association (ABA) defines burn center surge capacity as the capacity to handle up to 50% more than normal maximum number of burn patients when there is a disaster. The Oregon Burn Center at Legacy Emanuel Medical Center is the only burn center in the state and has a capacity of 16 beds, which can be used for critical care or acute care of the burn injured. This places our current burn surge capacity at 24 patients.

The Oregon Burn Center is part of the American Burn Association Western Region Burn Mass Casualty Consortium, which serves as a communication and coordination center for burn bed census and/or patient triage and transfer.

The Burn Surge Mass Casualty Plan includes:

- Utilizing existing incident command systems within EMS (including use of Medical Resource Hospital, MRH) and hospital emergency management plans
- Likelihood of local and regional hospitals needing to care for burn patients for an extended period of time until transfer arrangements are made
- Burn unit placement may require transport outside of Oregon, depending on the size of the event; the Western Region Burn Disaster Consortium (WRBDC) will assist with the coordination of patient triage and transfer in this case.
- The Oregon Burn Center will assist hospitals with the secondary triage

*** The list of burn centers part of the Western Region Burn Disaster Consortium is in the appendix ***
Triage and Prioritization for Patient Placement

In the event of a burn mass casualty event, there may be deviation from the normal standards for referral and transfer to a burn center. It is our goal, as well as the Western Region Burn Disaster Consortium, to place patients requiring definitive inpatient burn care in a burn center within 96 hours of the injury.

Field Triage

Triage of large incidents is an objective sorting process that considers the available resources to do the greatest good for the greatest number of people. The rapid categorization of patients combines acuity and survivability with the number of resources available. EMS will perform this function according to acceptable standards, e.g. START and color coding of patients for transport to the nearest facility or trauma center.

Burn Specific Considerations for the Field or Scene Initial First Aid

- Universal precautions
- Stop the burning process
- Remove clothing and jewelry
- If chemical agent suspected, rinse with water according to protocols
- Apply clean, dry dressing
- KEEP the patient warm

Determine the Size and Severity of the Burn

The severity of a burn is determined by the extent of body surface area involved, the depth of skin damaged, age of patient and presence of comorbidities and/or complications.

The extent of burn injury is expressed as the percentage of total body surface area (TBSA) burned. In addition to the severity of the injury, the estimated TBSA guides fluid rates during resuscitation.

It is extremely important to note that first degree or superficial burns are NOT included when estimating TBSA.

The most common and easiest guide to use during a mass casualty event is the “Rule of Nines”. When a burn injury is small or irregularly shaped, the size of the patient’s hand, including the fingers, can be used to represent 1% of the body surface area.

Initial Fluid Rate for burn that is suspected to be >20% TBSA

≤ 5 yr old: LR @125 ml/hr

6-13 yr old: LR @ 250 ml/hr

>14 yr old: LR @ 500 ml/hr
Worksheets that help with determining the size of the burn are in the appendix.
**Burn Depth**

Burn injuries can change in appearance over the first several days after the injury. In a mass casualty event, it will be important to assess the size of the burn roughly every 24 hours.

Please note that first degree or superficial burn injury is not included in the calculation of total body surface area.

<table>
<thead>
<tr>
<th>Burn Type</th>
<th>Characteristics</th>
<th>TBSA</th>
<th>Example</th>
</tr>
</thead>
</table>
| **First Degree or Superficial** | **Red**  
**Painful**  
**Blanches**  
**Moist or dry**  
**May have blisters**  
**May become edematous** | **DO NOT INCLUDE in the calculation of TBSA.** | ![First Degree Example] |
| **Second Degree or Partial Thickness** | **Can be red or white**  
**Dryer or blisters**  
**May be moist or dry**  
**Blanches**  
**Not as painful** | **Include in calculation of TBSA** | ![Second Degree Example] |
| **Third Degree or Full Thickness** | **White, cherry red, brown or black**  
**Hard and leathery**  
**Painless**  
**Does not blanch** | **Include in calculation of TBSA** | ![Third Degree Example] |
Hospital Triage

The following table can help receiving hospital with resource allocation and initial management treatment decisions.

Please remember that only partial and full thickness (2nd and 3rd degree) burns are calculated in the percent of Total Body Surface Area (%TBSA).

<table>
<thead>
<tr>
<th>Age</th>
<th>Burn Size Group</th>
<th>% TBSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-9%</td>
<td>Minor</td>
</tr>
<tr>
<td></td>
<td>10-19%</td>
<td>Minor</td>
</tr>
<tr>
<td></td>
<td>20-29%</td>
<td>Delayed</td>
</tr>
<tr>
<td></td>
<td>30-39%</td>
<td>Delayed</td>
</tr>
<tr>
<td></td>
<td>40-49%</td>
<td>Delayed</td>
</tr>
<tr>
<td></td>
<td>50-59%</td>
<td>Urgent</td>
</tr>
<tr>
<td></td>
<td>60-69%</td>
<td>Urgent</td>
</tr>
<tr>
<td></td>
<td>&gt;70%</td>
<td>Urgent</td>
</tr>
</tbody>
</table>

To better assist with resource allocation during a disaster, the following information can be helpful:

<table>
<thead>
<tr>
<th>Mortality</th>
<th>Estimated Length of Stay</th>
<th>Surgical Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>&lt; 10%</td>
<td>None</td>
</tr>
<tr>
<td>Minor</td>
<td>&lt; 10%</td>
<td>Up to 21 days</td>
</tr>
<tr>
<td>Delayed</td>
<td>&lt; 10%</td>
<td>Up to 21 days</td>
</tr>
<tr>
<td>Urgent</td>
<td>50 – 90 %</td>
<td>&gt; 21 days</td>
</tr>
<tr>
<td>Expectant</td>
<td>&gt; 90%</td>
<td></td>
</tr>
</tbody>
</table>

Oregon Burn Center 503-413-4232 or 1-888-598-4232
**Burn Specific Destination Prioritization**

In order to facilitate patient distribution to regional hospitals and available burn centers, multiple factors will be considered.

- All adult and pediatric patients with a burn injury greater than 90% will receive comfort and palliative care in a local or regional hospital.
- Minor burns that can be cared for on an outpatient basis, should be instructed to follow up with primary care.

In the event of a burn mass casualty incident occurring outside the Portland Metro Area, all injured patients should be immediately transported to local and regional hospitals as determined by the incident Patient Destination Coordinator and local or regional dispatch services.

Hospitals who have received burn injured patients should call the burn center after the initial evaluation. Calls from hospitals will be directed to the Burn Clinical Information Nurse who will take incoming information and coordinate communication for ongoing care and final receiving burn facility.

After evaluation at an initial hospital, receiving facility and timing of transfer will be determined based on location and available resources. **Local and regional facilities may be required to care for the burn injured patient for up to 96 hours.** Burn injured patients may be transported to burn centers throughout or beyond the western region, and will be determined with the help of the Western Region Burn Disaster Consortium.

<table>
<thead>
<tr>
<th>Within the Portland Metro Area</th>
<th><strong>Outside of Metro Area OR if Significant Disruption to Transportation Infrastructure</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult + Peds 40-90% TBSA</strong></td>
<td><strong>Destination</strong> Legacy Emanuel</td>
</tr>
<tr>
<td><strong>Adult + Peds Intubated and &gt;20% TBSA</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Adults &lt;40% or &gt;90% TBSA</strong></td>
<td><strong>Destination</strong> As assigned by MRH - preferably local Trauma Centers</td>
</tr>
<tr>
<td><strong>Peds &lt;20% or &gt;90% TBSA</strong></td>
<td><strong>Destination</strong> Hospitals able to provide qualified personnel and equipment for care of children – As assigned by MRH</td>
</tr>
<tr>
<td></td>
<td><strong>Definitive Facility</strong> Hospitals able to provide qualified personnel and equipment for care of children</td>
</tr>
</tbody>
</table>
Decision Matrix for Intubation for Burn Injury

- Altered mental status
  - GCS ≤ 8 or
- Signs and symptoms of direct upper airway injury
  - edema
  - stridor

  YES

  NO

- Evidence of smoke inhalation injury
  - soot
  - carbonaceous sputum with hypoxemia (O2 sat < 92)
  - Tachypnea

  YES

  NO

- Total burn size >30% with early evidence of large volume resuscitation
  - low urine output
  - hypotension

  YES

  NO

- Need for large dose of analgesics or sedatives for wound care or procedures in the absence of appropriate expertise.

  YES

  NO

  Continue close monitoring with use of adjuncts

  SECURE DEFINITIVE AIRWAY
# Burn Specific Considerations added to the Primary Assessment

<table>
<thead>
<tr>
<th>Airway</th>
<th>• If concern for inhalation injury or prolonged exposure to smoke, check Carboxyhemoglobin • Consider associated trauma related to C-Spine needs</th>
<th>• Please see decision matrix for intubation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing</td>
<td>• Adequate and equal chest expansion • High flow O2 for patients with altered level of consciousness</td>
<td>• Burn involving large areas of upper torso may require Escharotomies for adequate chest expansion</td>
</tr>
<tr>
<td>Circulation</td>
<td>• Burn injuries require large amounts of PO and/or IV fluid replacement • Alert patients with &lt;20% TBSA, can use oral fluid for resuscitation • FREE WATER IS TOXIC – causes hyponatremia, cerebral edema and death</td>
<td><strong>Initial Fluid Rates for &gt;20% TBSA</strong>&lt;br&gt;≤ 5 yr old: LR @125 ml/hr&lt;br&gt;6-13 yr old: LR @ 250 ml/hr&lt;br&gt;≥14 yr old: LR @ 500 ml/hr&lt;br&gt;LR or Plasmalyte for IV Fluid&lt;br&gt;NS can cause acidosis when used in large volumes</td>
</tr>
<tr>
<td>Disability</td>
<td>• For ALOC – consider associate trauma, Carbon Monoxide toxicity or Cyanide toxicity Carbon Monoxide Toxicity • Mild=headache, lethargy, dizziness • Moderate=sedation, vomiting, syncope, chest pain • Severe=coma, seizures, focal neurologic deficits, acidosis Cyanide Toxicity • Mild=dizziness, headache, vomiting • Moderate or Severe = lactic acidosis, tachycardia, depressed mental status progressing to coma, apnea, hypotension, seizures, cardiac arrest</td>
<td><strong>Carbon Monoxide Toxicity</strong> • Mild = Room air or low flow O2 for up to 5 hours • Moderate and Severe = high flow O2 for 6 hours post normalization <strong>Cyanide Toxicity</strong> • Mild = Oxygen • Moderate and Severe = Oxygen plus hydroxocobalamin</td>
</tr>
<tr>
<td>Exposure</td>
<td>Keeping patients warm is CRITICALLY important</td>
<td>Remove clothing and jewelry Cover with clean, dry dressing or sheet</td>
</tr>
</tbody>
</table>
### Burn Specific Considerations added to the Secondary Assessment

| Airway | Burns >30% may need intubation secondary to how the fluid resuscitation is going or the degree of oral and facial edema | Be mindful of supplemental oxygen and ventilator resources.  
  - If able, raise head to 30° to reduce facial and oral edema |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing</td>
<td>Assess need for chest or abdominal compartment syndrome effecting adequate chest expansion</td>
<td>May need to reduce acceptable pulse oximeter thresholds to 90 or 92% based on available resources</td>
</tr>
</tbody>
</table>
| Circulation | Calculate adjusted IV fluid rates when weight and TBSA have been estimated  
  - The adjusted rates are estimates  
  - Ideally, fluid is titrated based on Urine output | **Adjusted Resuscitation Fluid Rates**  
  - Give ½ of total in first 8 hours  
  - Give the other half over next 16 hours  
  **Flame or Scald**  
  - <14 yr old = 3 ml LR x kg x %TBSA  
  - >14 yr old = 2 ml LR x kg x %TBSA  
  **Electrical Injury**  
  - All ages = 4 ml LR x kg x %TBSA |
| | **Maint Goal Urine Output of:**  
  - Adult = 30-50 ml/hr  
  - Child = 1 ml/kg/hr  
  - Infant = 2 ml/kg/hr | **Pediatrics ≤30 kg ADD Maintenance using 4-2-1 Formula**  
  - Maintenance fluid does NOT get titrated – stays constant  
  - Use D5LR  
  - 4 ml/hr for each kg up to 10 kg  
  - 2 ml/hr for each kg from 11-20 kg  
  - 1 ml/hr for each kg from 20-30 kg |
| | With ability to monitor Urine Output:  
  - If urine output is OVER goal – decrease resuscitation fluid rate by 10-20%  
  - If urine output is UNDER goal – increase resuscitation fluid rate by 10-20% | **Oral Hydration MUST contain glucose and electrolytes (pg 13)** – free water is **TOXIC** in quantities required for burn resuscitation  
  - <2 yr old – 1 teaspoon q 1-2 mins  
  - >2 yr old – 8-10 ounces q 10-15 mins  
  - Adjust based on urine output  
  - Occasional nausea and vomiting is inevitable, but not a reason to discontinue oral resuscitation  
  **Elevate injured extremities above the heart to help with edema** |
| Disability | Assess for new or continuing ALOC and possible causes | When resources are available consider:  
  - Head CT and associated Trauma  
  - Blood Gas  
  - Carboxyhemoglobin  
  - Chemistries  
  - Hematocrit  
  - Chest Xray |
| Exposure | Every effort should be made to keep patients warm and dry | Cool the burned area with clean water for not more than 10 mins  
  - Application of a petroleum-based ointment can greatly reduce pain  
  - Bacitracin  
  - Petroleum jelly  
  - Burn creams |
## Special Care Topics for Burn Patients

<table>
<thead>
<tr>
<th>Special Care Topic</th>
<th>Details</th>
</tr>
</thead>
</table>
| **Blast Injury** | • Lungs are very susceptible to injury  
• Must balance between over resuscitation, which will worsen pulmonary contusions and under resuscitation.  
• Lung and GI tract injuries may have delayed presentation  
• Trauma trumps burn  
  - Priority should be damage control resuscitation and surgery as needed  
  - CT scans are invaluable |
| **Radiation Injury** | • Radiation Burns can have a delayed onset  
• Treat radiation burns as thermal burns  
• Patients with signs and symptoms of radiation exposure in the first 4 hours, check CBC with Diff every 6-8 hours for first 24-48 hours; supportive care  
• Oregon Radiation Treatment Injury Network (RITN) Hospital is located at OHSU 503-494-8311  
Follow Decontamination Protocols  
After decontamination, it is safe to care for patients with standard PPE  
• Vomiting <1 hour post exposure  
  - Severe Exposure, likely > 4 Gy  
  - Watch for hypotension, hyperthermia, CNS symptoms  
• Vomiting 1-4 hours post exposure  
  - Exposure likely 1-4 Gy  
  - Watch for Acute Radiation Syndrome |
| **Hypermetabolic State** | The hypermetabolic state of burn patients  
• Elevated heart rate  
• Elevated temperature  
  - In the first week post injury mildly elevated temperatures 38-39 are expected and NOT a sign of infection  
  - DO NOT give prophylactic antibiotics  
Tachycardia is >130 in Adult  
• During the first 24 hours of fluid resuscitation, if the urine output is adequate – consider pain or sedation as cause  
• Post fluid resuscitation (usually >48 hours) consider Propranolol for sustained heart rate >125  
• Treat arrhythmias as indicated  
• Monitor electrolytes  
• Temperature  
• For the first week after injury - do not consider febrile unless >38.9 |
| **Pain Management** | • Resources regarding pain management will be limited.  
• Consider using inhaled Nitrous Oxide during procedures and/or dressing changes (contraindicated with some traumatic injuries)  
• Protecting wounds from exposure to the air and environment helps to reduce pain and risk of infection.  
• Elevating burned extremities decreases swelling and pain.  
• Application of a petroleum-based ointment (polysporin) with an occlusive dressing can reduce pain in first and second degree burns.  
• Antianxiolytics should be used liberally in the burn injured patient.  
• Medications appropriate for pain management of burn injured patients:  
  - Acute/Procedural: Ketamine IV, IM, Infusion  
  - Other Long Acting: Methadone PO, Enteral |

<table>
<thead>
<tr>
<th>Acute/Procedural</th>
<th>Other Long Acting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ketamine IV, IM, Infusion</td>
<td>Methadone PO, Enteral</td>
</tr>
<tr>
<td><strong>Wound Care</strong></td>
<td><strong>Nutrition</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| • Identify and train a wound-care team  
  • Prepare a venue for wound care  
    - Even in austere environments, basic infection control concepts can and must be pursued  
    - Dedicated wound care area would ideally allow patient bathing, privacy, and hand-washing  
    - Dressing Supply Cart  
• Establish a process for daily wound care and inspection  
  - “Durable” dressings, such as silver impregnated dressings, do not need to be changed daily  
• Determine availability of topical antimicrobials and plan their rational use  
• Provide adequate analgesia and anxiolysis  
• Decrease inpatient workload by doing early surgery and outpatient follow-up | • Start feeding as soon as possible  
  Pediatric and Obese patients will require special considerations  
    - For obese patient use ideal body weight | • Socks or washcloth, rolled in hand to avoid fisting  
• Elbows extended  
• Wrist neutral  
• Knees straight  
• Ankles at a right angle |
| **Less Potential for Respiratory Depression:**  
• Butorphanol IV, IM, Intranasal  
• Nalbuphine IV, IM  
• Buprenorphine SL, TD, IV | **Neuropathic Pain**  
• Gabapentin PO, Enteral  
  - Decreases narcotic requirement |  |
| **Anti-anxiolytics**  
• Lorazepam IV, PO, Enteral  
• Clonidine PO, Enteral  
• Amitriptyline PO, Enteral | **Wound Care**  
• Wound care should include washing the wounds with mild soap and warm tap water with a wash cloth and patting dry  
• Burned scalp and faces should be shaved daily during wound care  
• Lotion for all superficial (1st degree) burns  
• Polysporin (Bacitracin) and petroleum based dressings for mild 2nd degree  
• Mafenide and silver sulfadiazine creams should be used when available for deeper wounds  
• Alternatives include silver-based dressings and aqueous mafenide acetate solution  
• Alternative durable dressings that are not changed daily:  
  - Acticoat  
  - Aquacel  
  - Mepilex |  |
| **20% TBSA** will require enteral feeding supplementation (Non-Obese, Adults only)  
30-35 kcal per kg every 24 hours  
Patients who are intubated or unable to take in required nutritional needs, place an oral or nasogastric feeding tube in order to supplement needs |  |  |
### Common Supplies for Burn Patients

<table>
<thead>
<tr>
<th>Wound Care</th>
<th>Pharmacy</th>
<th>General Care</th>
<th>Oral Rehydration Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Kerlix (6 inch rolls easiest to work with)</td>
<td>- Ringers Lactate</td>
<td>- Fluid warmers</td>
<td>- 1 liter of water with 1 teaspoon of table salt (3g) and 3 tablespoons of sugar (36g)</td>
</tr>
<tr>
<td>- 4x4’s</td>
<td>- Plasmaryte (if available)</td>
<td>- Bear Huggers</td>
<td>- A worldwide list of manufacturers and distributors of ORS products can be found at <a href="http://rehydrate.org/resources/suppliers.htm">http://rehydrate.org/resources/suppliers.htm</a></td>
</tr>
<tr>
<td>- Scissors or Trauma Sheers</td>
<td>- Pain Medications</td>
<td>- Blankets</td>
<td></td>
</tr>
<tr>
<td>- Xeroform. Petroleum based dressing or Non-stick dressing</td>
<td>- Albumin</td>
<td>- Indwelling or external catheters, Urinals (Equipment for accurate Output measurement)</td>
<td></td>
</tr>
<tr>
<td>- Hibiclens or Mild Soap</td>
<td>- Silvadene (Silver Sulfadiazine)</td>
<td>- Extra pillows to elevate extremities</td>
<td></td>
</tr>
<tr>
<td>- Water Basins</td>
<td>- Polysporin (Bacitracin)</td>
<td>- Extra Chucks</td>
<td></td>
</tr>
<tr>
<td>- Washcloths and Towels</td>
<td></td>
<td>- Isolation Gowns (if possible)</td>
<td></td>
</tr>
<tr>
<td>- Tape</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Solution

<table>
<thead>
<tr>
<th>Solution</th>
<th>Na⁺ (mEq/L)</th>
<th>K⁺ (mEq/L)</th>
<th>Cl⁻ (mEq/L)</th>
<th>Base</th>
<th>Glucose (g/L)</th>
<th>Osmolality (mOsm/kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehydration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHO-UNICEF ORS salts</td>
<td>90</td>
<td>20</td>
<td>80</td>
<td>10 (citrate)</td>
<td>111 (20 g/L)</td>
<td>310</td>
</tr>
<tr>
<td>WHO-UNICEF reduced osmolarity ORS salts</td>
<td>75</td>
<td>20</td>
<td>65</td>
<td>10 (citrate)</td>
<td>75 mmol/L</td>
<td>245</td>
</tr>
<tr>
<td>Meyer’s solution</td>
<td>85</td>
<td>0</td>
<td>63</td>
<td>29 (citrate)</td>
<td>0</td>
<td>160</td>
</tr>
<tr>
<td>Rehydralyte®</td>
<td>75</td>
<td>20</td>
<td>65</td>
<td>30</td>
<td>139 (25 g/L)</td>
<td>325</td>
</tr>
<tr>
<td>Infalyte® or Ricelyte®</td>
<td>50</td>
<td>25</td>
<td>45</td>
<td>36 (citrate)</td>
<td>30 g/L as ricc syrup solids</td>
<td>270</td>
</tr>
<tr>
<td>Lyten® or Lyten® liquid, oral</td>
<td>50</td>
<td>25</td>
<td>45</td>
<td>10 (citrate)</td>
<td>111 (20 g/L)</td>
<td>290</td>
</tr>
<tr>
<td>PediaLyte®</td>
<td>45</td>
<td>20</td>
<td>35</td>
<td>10 (citrate)</td>
<td>140 (25 g/L)</td>
<td>250</td>
</tr>
<tr>
<td>Resol®</td>
<td>50</td>
<td>20</td>
<td>50</td>
<td>11 (citrate)</td>
<td>111 (20 g/L)</td>
<td>270</td>
</tr>
<tr>
<td>Gatorade®</td>
<td>20</td>
<td>3</td>
<td>20</td>
<td>3</td>
<td>250 (35 g/L)</td>
<td>280</td>
</tr>
<tr>
<td>Cola</td>
<td>2</td>
<td>0.1</td>
<td>2</td>
<td>13 (HCO₃⁻)</td>
<td>730</td>
<td>750</td>
</tr>
<tr>
<td>Ginger ale</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4 (HCO₃⁻)</td>
<td>500</td>
<td>540</td>
</tr>
<tr>
<td>Apple juice</td>
<td>3</td>
<td>28</td>
<td>30</td>
<td>0</td>
<td>690</td>
<td>730</td>
</tr>
<tr>
<td>Chicken broth</td>
<td>250</td>
<td>8</td>
<td>250</td>
<td>0</td>
<td>0</td>
<td>450</td>
</tr>
<tr>
<td>Tea</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Helipad</th>
<th>Total Unit Beds</th>
<th>Adult</th>
<th>Peds</th>
<th>Facility Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
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Outside of Portland Metro area OR Significant disruption to transportation infrastructure

Burn Mass Casualty Incident

>90% TBSA All Ages

Transport to closest hospital for palliative care

>20% TBSA?

Intubated?

TBSA 40-90%

No

Closest Trauma Center or Hospital with Critical Care capabilities

Contact the Oregon Burn Center for care guidance and potential transfer.

<15 yoa

No

As determined by scene incident commander

Transport to closest hospital qualified and able to care for pediatrics.

No

Yes

<15 yoa

Yes

No
Appendix B

Incident in Portland Metro Area **AND** all transportation routes open

- **Burn Mass Casualty Incident**
  - Yes: >90% TBSA All Ages
    - Yes: Transport to closest hospital for palliative care
    - No: >20% TBSA?
      - Yes: Intubated?
        - Yes: Transport to Legacy Emanuel
        - No: >20% TBSA?
          - Yes: TBSA 40-90%
            - No: <15 yoa
              - No: <15 yoa
                - No: Destination assigned by MRH Preferably local Trauma Center
                - Yes: Determined by MRH Transport to Hospital qualified and able to care for pediatrics.
              - Yes: <15 yoa
                - Yes: Transport to Legacy Emanuel
    - No: <20% TBSA?
      - Yes: Intubated?
        - Yes: Transport to Legacy Emanuel
        - No: TBSA 40-90%
          - No: <15 yoa
            - No: <15 yoa
              - No: Destination assigned by MRH Preferably local Trauma Center
              - Yes: Determined by MRH Transport to Hospital qualified and able to care for pediatrics.
# BMCI Patient Medical Data Form

**Patient Identification**
- Name: 
- DOB: 
- AGE: 
- SEX: M/F
- Weight: __ kg/lb
- Burn Date: 
- Burn Type: 
- TBSA: 
- Mechanism of Injury: 
- Inhalation injury: Y/N
- Intubated: Y/N
- Fluid Resuscitated: Y/N
- Peripheral IV: ☐ Central Line
- ☐ A-Line
- Escharotomy: ☐
- Fasciotomy: ☐

**Contact Information**
- Referring Hospital: 
- Referring Physician: 
- Contact Number: 
- Accepting Hospital: 
- Accepting Physician: 
- Contact Number: 
- Telemedicine Completed: Y/N
- Notification: ☐ Spouse/S.O.
- ☐ Parent
- ☐ Other: 
- Notification Number: 

**Patient Information**
- Code Status: Full code/No code: ☐ DNR
- ☐ DNI
- ☐ Advanced directives
- Is Document Present: Y/N
- Traumatic Injuries: Y/N
- Type: 
- Diabetic: Y/N
- Last meal: 
- Insulin Drip: Y/N
- Last Blood Sugar (date, time and value): 
- Tetanus Booster: Y/N
- Last Date of Tetanus: 
- Critical Meds: MAR Attached: Y/N
- (If not attached: include medication, dose, route and time given):
- Critical Labs: 
- Pertinent DX Exams: 

**Organ Systems**
- Neuro: Dx: 
- GCS: ___________ PERRLA: 
- Pulmonary: Dx: 
- ETT Size: ___ Depth: ___ FIO2: ___
- Vent Settings: 
- Chest tube: ___ ABG: 
- Cardiovascular: Dx: 
- Rhythm/ Ectopy: 
- Vasoactive Drips: 
- Renal: Dx: 
- Foley: Y/N
- Volume last hour: ___ ml
- Dialysis: Y/N
- Last Dialysis (Date/Time): 
- GI: Dx: 
- NPO: Y/N
- Reason: ___________
- Feeding Tube: Y/N

**Sending Facility**
- Time & Date departed: 
- Equipment Sent with Patient: ☐ IV Pumps
- ☐ Monitor
- ☐ Pulse Oximeter
- Ventilator/CPAP/EIBPAP: 
- Other: 
- Items Sent with the Patient: 

**Receiving Facility**
- Time & Date Arrived: 
- Received by: 
- Receiving Facility MR#: 
- Equipment Received with Patient: 
- Items Received with Patient:
Past Medical History:

Allergies:

Medications (include dose, route, time given):

All Continuous IV infusions including rate & dose:

Feeding Tube: Formula Type and Rate:

Labs:

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<th>Na</th>
<th>Cl</th>
<th>BUN</th>
<th>Gluc</th>
<th>WBC</th>
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<td>Creat</td>
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Mag______
Phos______

Narrative Summary of Care:
Referring Facility ____________________________
Referring Physician __________________________
Date of Injury _________ Approximate Time of Injury ______
Age ____________  Sex __________
Cause of Burn_________________________________

Burn Size Estimation by Percent

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<tr>
<td>% Total Area Burned</td>
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</table>
Referring Facility ____________________________
Referring Physician __________________________
Date of Injury __________   Approximate Time of Injury _______
Age __________   Sex___________
Cause of Burn__________________________________________

**Burn Size Estimation by Percent**

The patient’s palm represents 1% TBSA and can be used to help measure total TBSA.

Color in areas that are burned
2\textsuperscript{nd} and 3\textsuperscript{rd} degree ONLY

---

**SEVERITY DETERMINATION**

**Second Degree (Partial Thickness)**
Skin may be red, blistered, swollen, wet

**Third Degree (Full Thickness)**
Skin may be white (non-blanching), cherry red, or charred

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