

**KEMENTERIAN KESIHATAN MALAYSIA  
PHYSIOTHERAPY DEPARTMENT  
BURN ASSESSMENT FORM**

Name :----- Age: ----- Sex: M / F RN /IC : -----Date :-----

**DIAGNOSIS**

**DOCTOR'S MANAGEMENT**

**PROBLEMS**

**PAIN SCORE: 0 1 2 3 4 5 6 7 8 9 10**

**SPECIAL QUESTION**

General Health:

PMHX / Surgery:

Medication/Steroid:

Occupation/Recreation:

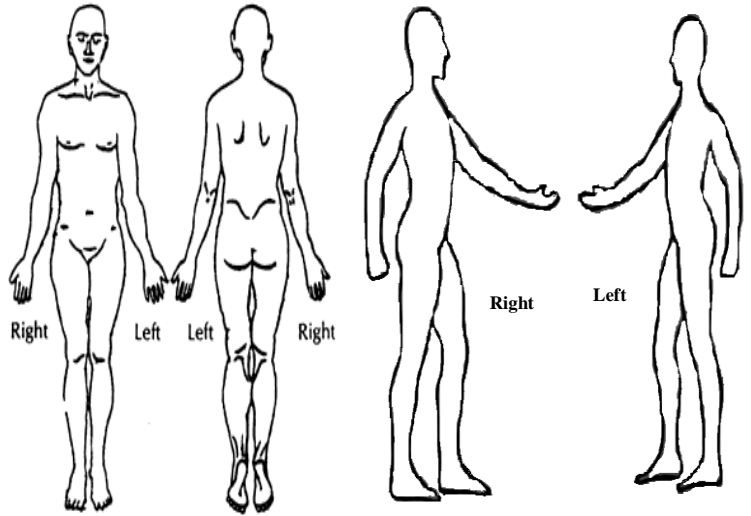
**INVESTIGATION**

Wound C & S

CXR

ABG

**CURRENT HISTORY**



TBSA .....%

**RESPIRATORY ASSESSMENT**

Observation :

Ventilated: N / Y .....

O2 Therapy: N / Y .....

Breathing Pattern:

Coughing: Productive / Non-Productive  
Effective / Ineffective

Sputum: Colour .....  
Amount .....  
Consistency .....

Hoarseness / Sore Throat: N / Y .....

**CHEST EXPANSION**

Chest Expansion : Symmetrical/asymmetrical

Apical (anterior)	Symmetrical/asymmetrical
Middle (anterior)	Symmetrical/asymmetrical
Lower Costal (posterior)	Symmetrical/asymmetrical

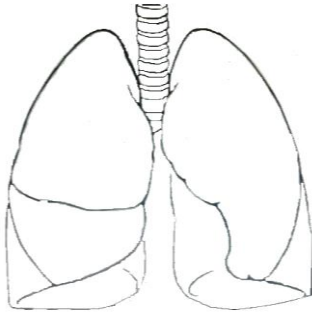
**ASSOCIATED INJURY / PRECAUTION**

**AUSCULTATION**

Crepitating: Mild /Moderate

Coarse / Ronchi / Wheezing

Air Entry :



**PHYSIOTHERAPIST'S IMPRESSION**

**MOVEMENT**

**JOINT**

**ACTIVE**

**PASSIVE**

**SHORT TERM GOALS**

**MOBILITY AND AMBULATORY STATUS**

**LONG TERM GOALS**

**GAIT ANALYSIS**

**PLAN OF TREATMENT**

**Attending Physiotherapist:** .....

Date :

Sign & Stamp:

**KEMENTERIAN KESIHATAN MALAYSIA  
GUIDELINES FOR THE USE OF BURN ASSESSMENT FORM**

**DIAGNOSIS**

- As in referral

**DOCTOR'S MANAGEMENT**

- The doctor management related to type of dressing, escharotomy or fasciotomy or skin graft.

**PROBLEMS**

- What is the presenting complaint

**PAIN SCALE**

- Choose the appropriate by observation of patient's facial expression.

**SPECIAL QUESTION**

**General Health**

- General Unwell - indicates systemic problem.

**PMHx / Surgery**

- Other medical illness example Diabetes, Hypertension.

**Medication / Steroid**

- Especially NSAIDS, Corticosteroids
- Side effect of long term -osteoporosis.

**Occupation / Recreation**

- Nature of job and related stress of job
- Hobby

**INVESTIGATION**

**Wound C&S**

- Note down the C&S result.

**CXR**

- Note the lung inflation
- Describe the lung field, note any change to the structures e.g. mediasternal shift, trachea shift.

**ABG**

- Interpret the ABG from the doctor's note

**CURRENT HISTORY**

- How did the injury occur? Details of onset, insidious or traumatic from BHT, patient or family member.
- E.g. date of burn, cause of burn i.e Thermal / chemical / electrical / Radiation
- It is presence of smoke?

## **ASSOCIATED INJURY / PRECAUTION**

- Note any other injury such as Head Injury, chest injury, abdominal injury, Fractures, Etc. and any precaution to take eg. SSG done, Tendon expose.

## **DIAGRAM ESTIMATION**

- Locate the burn surface area and depth of burn - Partial thickness / full thickness
- Partial thickness
  - first degree
  - superficial second degree
- Full Thickness
  - Deep second degree
  - Third degree
- Note down total Burn Surface Area ( TBSA ) in percentage / extent of injury .

## **RESPIRATORY ASSESSMENT**

### **Observation**

- Is the patient in pain, distress, comfortable, restless, unresponsive to command, fully conscious and rational?
- Identify body lesion
- Vital sign : obtained from BHT (include Heart Rate, Temperature, Blood Pressure, Respiration Rate.

### **Respiratory Status**

- Ventilated ( if relevant )
- Is patient on O2 therapy such as high flow mask, O2 mask etc?

### **Breathing**

- Identify breathing pattern if needed

### **Sputum:**

- Colour - Whitish , black streaked , yellowish, greenish
- Amount- minimal, moderate, large amount
- Consistency – mucoid, loose, watery, thick etc.

### **Hoarseness / sore throat**

- Note down any hoarseness or sorethroat

## **CHEST EXPANSION PALPATION**

- Identify chest expansion if needed

## **AUSCULTATION (if relevant)**

- Circle the relevant
- Lung diagram – indicate examination result of Air Entry and breathe sounds – normal / added sound.

## **MOVEMENT**

- Active and passive range of movement.

## **MOBILITY AND AMBULATORY STATUS**

### **Bed Mobility**

- Is the patient able to roll side to side / sitting from lying to sitting position/ bridging
- Independence/ required some assistance / dependant?

### **Transfer/ ADL / Ambulation**

- Is the patient able to move from bed to chair and vice versa independence/ required some assistance / dependant?
- Is the patient able to take care of personal hygiene example toileting / bathing.
- Is the patient able to feeding, dressing independence / required some assistance / dependant?
- Is the patient able to ambulate?

## **GAIT ANALYSIS**

- Analyse the gait pattern

## **PHYSIOTHERAPIST'S IMPRESSION**

- Note the problem according to priority with regards to physiotherapy.

## **SHORT TERM GOALS**

- The goals which are set according to priority.
- Must include the expected outcomes and time frame.

## **LONG TERM GOALS**

- The goals which are set for a longer time frame based on patient's and physiotherapy goals

## **PLAN OF TREATMENT**

- The physiotherapy treatment that will be given according to the goals set up.

## **SIGN/ STAMP/DATE :**

- Need to be filled by attending physiotherapist