Freezing Cold Injury (FCI or frostbite)

Transfer of Care Form

Patient details

Name: Date of birth:

Email: Mobile:

Address:

Event

Date of injury: Time of injury:

Place of injury:

Were there freeze-thaw cycles of the affected part before reaching medical facility: If yes, how many:

Brief history of injury (including any associated trauma):

Medical facility

Date of 1st contact with medical facility: And time:

Injury to first contact with medical facility (hours):

Injury to initiation of rewarming (hours):

Time spent rewarming (hours):

Type of rewarming:

Injury to initiation of drug treatment (hours):

Injury details

Affected part	Cauchy Grade after rewarming	Cauchy Grade @ day 1 post injury	Cauchy grade @ day 2 post injury
Example: *Distal phalanx 3rd finger right*	*2*	*3*	*3*

Treatment summary

Topical	Formulation	Dose		Date & time given
Aloe vera				
Antibiotic cream				
Dressings				
Systemic	**Formulation**	**Dose**	**Route administered**	**Date & time given**
Aspirin				
Ibuprofen				
Intravenous fluids				
Oxygen				
Iloprost				
tPA				

Heparin				
Other				

Additional comment: PLEASE INCLUDE PHOTOGRAPHS WHERE POSSIBLE AND ENCOURAGE THE PATIENT TO TAKE AND STORE PHOTOGRAPHS AT EACH STAGE OF TREATMENT AND DAILY DURING RECOVERY

Clinician name

Medical Treatment Facility name

Job title

Date

Clinician email

Patient consent

Is the patient willing to be contacted by the International FCI Working Group for audit/research purposes:

Yes ☐
No ☐

If yes, please provide details of preferred mode of contact: