Government of South Australia
SA Health

CALHN RAH BURNS UNIT Referral Form	Surname: Given names: Date of birth: Gender: Unspecified

I	Patient Address: Patient Phone: RAH MRN (if known) Interpreter required: Unknown Language: Medicare #: Medicare Expiry date:
S	Burn Date: Cause: Burn Time: Event description: First Aid: Unknown
B	Relevant past medical history: Medications: Allergies: Unknown ADT status (booster required for >5 years): Unknown
A	Burn Site: Estimated Burn %TBSA (Palmar method: Patients palm = 1% of total body surface area) : % Burn depth/appearance: Unknown Burn Treatment:
R	**Referral information** Burns Unit Inpatient: ☐ Burns OPD: ☐ Referral Date: Referral Time: Photos sent: ☐ Referral discussed with (Name): Recommendations by RAH Burns: Referring Clinician: Phone Role: Referring Facility:

Please email completed referral and photographs to: health.rahburnsreferrals@sa.gov.au