PATIENT UNIFIED FORM

for

RADIATION INCIDENT EMERGENCY MEDICAL MANAGEMENT

1	**PATIENT INFO**			
	Name		Identity Card No/Passport	
	Age		Sex	
	Current complaint			
2	**History & event**			
	Description of incident			
	Time of Incident			
	ATTENDING HEALTH/MEDICAL PHYSICIST ***Name:*** ***Designation :***			
3	**Determine either Contaminated or Exposure only**			
	Radiological Survey perfomed by :	(state name & position)		
	Contaminated or Exposure			
	Survey findings			

	Findings
Type of ray/ radiation source	
Energy of ray/source	
Dose rate/activity	
Safe distance	

Comments/added information :

	ATTENDING EMERGENCY MEDICINE DOCTOR ***Name:*** ***Designation :***		
4	**Symptoms & Signs**		
	Gastrointestinal Symptoms		

	Mark 'v' if yes	State Time of symptom
Nausea		
Vomiting		
Others (Please state)		

	Cardiovascular Symptoms	<table><tr><th></th><th>Mark 'V' if yes</th></tr><tr><td>tachycardia</td><td></td></tr><tr><td>hypotension</td><td></td></tr><tr><td>Others (Please state)</td><td></td></tr></table>
	Skin symptoms	<table><tr><th></th><th>Mark 'V' if yes</th></tr><tr><td>erythema</td><td></td></tr><tr><td>exfoliation</td><td></td></tr><tr><td>ulcer</td><td></td></tr><tr><td>Others (Please state)</td><td></td></tr></table>
	Other symptoms (please state)	
5	**Take & Send Investigations**	
	Full Blood Count with differentials	<table><tr><th></th><th>Mark 'V' if yes</th></tr><tr><td>Taken & sent</td><td></td></tr></table> <table><tr><th></th><th>Level</th></tr><tr><td>Hemoglobin</td><td></td></tr><tr><td>White cell count</td><td></td></tr><tr><td>platelet</td><td></td></tr><tr><td>HCT</td><td></td></tr><tr><td>Lymphocytes count</td><td></td></tr></table>
	Renal Profile	<table><tr><th></th><th>Mark 'V' if yes</th></tr><tr><td>Taken & sent</td><td></td></tr></table> <table><tr><th></th><th>Level</th></tr><tr><td>Urea</td><td></td></tr><tr><td>Na</td><td></td></tr><tr><td>K</td><td></td></tr><tr><td>Creatinine</td><td></td></tr></table>
	Thyroid Function Test	<table><tr><th></th><th>Mark 'V' if yes</th></tr><tr><td>Taken & sent</td><td></td></tr></table> <table><tr><th></th><th>Level</th></tr><tr><td>TSH</td><td></td></tr><tr><td>T3</td><td></td></tr><tr><td>T4</td><td></td></tr><tr><td></td><td></td></tr></table>
	Liver Function Test	<table><tr><th></th><th>Mark 'V' if yes</th></tr><tr><td>Taken & sent</td><td></td></tr></table> <table><tr><th></th><th>Level</th></tr><tr><td>AST</td><td></td></tr><tr><td>ALP</td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>

	Blood sample for biodosimetry	<table><tr><td></td><td>Mark 'V' if yes</td></tr><tr><td>Taken & sent</td><td></td></tr></table>	<table><tr><td>Report</td></tr><tr><td></td></tr></table>
	ATTENDING MEDICAL/INTERNAL MEDICINE DOCTOR ***Name:*** ***Designation :***		
6	**Monitor hematopoietic Effect**		
	Absolute lymphocyte count	<table><tr><td>Day</td><td>Level</td></tr><tr><td>1</td><td></td></tr><tr><td>2</td><td></td></tr><tr><td>3</td><td></td></tr><tr><td>4</td><td></td></tr><tr><td>5</td><td></td></tr><tr><td>6</td><td></td></tr><tr><td>7</td><td></td></tr></table> (chart may be used if longer duration of observation required)	• Monitor this daily on separate chart
7	**Supportive Management**		
	Fluids		
	Analgesia		
	Antiemetics		

	(note what given)			
8	**Prophylaxis consideration**			
	If involve radio-iodine or radioactive plume situation	Mark 'v' if yes	Prophylaxis options 1. Iodine tablet 2. KCL	
	Involve children	Mark 'v' if yes		
	Involve pregnant?	Mark 'v' if yes		
	Involve adult < 40 years old	Mark 'v' if yes		
9	**Antibiotics/Antiviral/Antifungal consideration**			
	Risk of infection (eg. Exfoliation, ulceration etc)	Mark 'v' if yes	Antibiotics options 1. quinolones	
10	**Treatment Modes**			
	Blood transfusion	Given : Mark 'v' if yes	Indication/comments :	
	Cytokines	Given : Mark 'v' if yes	Indication/comments :	
	Stem cell transplant	Given : Mark 'v' if yes	Indication/comments :	
11	**Decorporation Needs**			
	Involve ingestion	Mark 'v' if yes	Decorporation given : (list of decorporation agent in appendix) Mark 'v' if yes State type of agent and dose given :	
12	**Chromosome aberrations**			
	Dicentrics			

	Ring forms			
	(note findings)			
	ATTENDING PSYCHOLOGIST/COUNSELLOR ***Name:*** ***Designation :***			
13	**Psychosocial Support**			
	For patient	Given : Mark 'v' if yes		
	For family	Given : Mark 'v' if yes		
	For friends	Given : Mark 'v' if yes		
14	**Notes**			