

REPORT OF HEAT/COLD INJURY

FROM: (Reporting Activity) - DATE _____ TO: NAVY ENVIRONMENTAL HEALTH CENTER NEHC-OEM Directorate 620 JOHN PAUL JONES CIRCLE PORTSMOUTH, VA 23708-2103 	NAME _____ SSN _____ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">GRADE</td> <td style="width: 15%;">RATE</td> <td style="width: 15%;">RACE</td> <td style="width: 15%;">SEX</td> <td style="width: 15%;">AGE</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table> BIRTHPLACE _____ DATE AND TIME OF EXAMINATION _____ UNIT TO WHICH ATTACHED _____ DATE REPORTED TO PRESENT STATION _____	GRADE	RATE	RACE	SEX	AGE					
GRADE	RATE	RACE	SEX	AGE							

PRESENT ILLNESS (Onset Date And Time)	WBGT	DIAGNOSIS (Check one) <input type="checkbox"/> HEAT CRAMPS <input type="checkbox"/> HEAT EXHAUSTION <input type="checkbox"/> HEAT STROKE	<input type="checkbox"/> DEHYDRATION <input type="checkbox"/> CHILBLAIN <input type="checkbox"/> FROSTBITE <input type="checkbox"/> HYPOTHERMIA	TIME ON ACTIVE DUTY (Months)
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DESCRIBE BRIEFLY WHAT PATIENT WAS DOING AT TIME OF INJURY. INCLUDE DESCRIPTION OF CLOTHING.

NOTE:
 (1) ALL HEAT STRESS INJURIES SHOULD HAVE RECTAL TEMPERATURES.
 (2) ALL HEAT STRESS INJURIES WITH RECTAL TEMPERATURES GREATER THAN 104°F SHOULD HAVE SERUM SGOT DRAWN 24 HOURS AFTER THE INJURY.

SYMPTOMS (Check all applicable) <table style="width: 100%;"> <tr> <td><input type="checkbox"/> UNCONSCIOUSNESS</td> <td><input type="checkbox"/> WEAK</td> <td><input type="checkbox"/> RED</td> <td><input type="checkbox"/> NORMAL</td> </tr> <tr> <td><input type="checkbox"/> DIZZY</td> <td><input type="checkbox"/> NAUSEA</td> <td><input type="checkbox"/> PALE</td> <td><input type="checkbox"/> OTHER (Specify)</td> </tr> <tr> <td><input type="checkbox"/> CONFUSED</td> <td><input type="checkbox"/> CRAMPS</td> <td><input type="checkbox"/> WET</td> <td><input type="checkbox"/> IV REQUIRED</td> </tr> <tr> <td><input type="checkbox"/> NUMBNESS</td> <td><input type="checkbox"/> VOMITING</td> <td><input type="checkbox"/> DRY</td> <td></td> </tr> <tr> <td><input type="checkbox"/> VISUAL DISTURBANCES (Specify)</td> <td><input type="checkbox"/> OTHER (Specify)</td> <td><input type="checkbox"/> RASH</td> <td></td> </tr> </table>	<input type="checkbox"/> UNCONSCIOUSNESS	<input type="checkbox"/> WEAK	<input type="checkbox"/> RED	<input type="checkbox"/> NORMAL	<input type="checkbox"/> DIZZY	<input type="checkbox"/> NAUSEA	<input type="checkbox"/> PALE	<input type="checkbox"/> OTHER (Specify)	<input type="checkbox"/> CONFUSED	<input type="checkbox"/> CRAMPS	<input type="checkbox"/> WET	<input type="checkbox"/> IV REQUIRED	<input type="checkbox"/> NUMBNESS	<input type="checkbox"/> VOMITING	<input type="checkbox"/> DRY		<input type="checkbox"/> VISUAL DISTURBANCES (Specify)	<input type="checkbox"/> OTHER (Specify)	<input type="checkbox"/> RASH		SKIN (Check all applicable)	TEMP(R) RESP. PULSE HEIGHT WEIGHT
<input type="checkbox"/> UNCONSCIOUSNESS	<input type="checkbox"/> WEAK	<input type="checkbox"/> RED	<input type="checkbox"/> NORMAL																			
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<input type="checkbox"/> NUMBNESS	<input type="checkbox"/> VOMITING	<input type="checkbox"/> DRY																				
<input type="checkbox"/> VISUAL DISTURBANCES (Specify)	<input type="checkbox"/> OTHER (Specify)	<input type="checkbox"/> RASH																				

HOURS OF SLEEP (Last 24 Hours)	LAST MEAL (Date and time) AMOUNT <input type="checkbox"/> LIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> HEAVY	BLOOD PRESSURE SYSTOLIC _____ DIASTOLIC _____
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AMOUNT OF WATER IN QTS. (Last 12 Hours)	SWEATING (Check one) <input type="checkbox"/> EXCESS <input type="checkbox"/> MODERATE <input type="checkbox"/> SLIGHT <input type="checkbox"/> NONE
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LAST HISTORY OF HEAT/COLD ILLNESS (Specify type)	<input type="checkbox"/> HEAT <input type="checkbox"/> COLD <input type="checkbox"/> NONE
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DATE (MONTH AND DAY)	DIAGNOSIS	NONE
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RECENT ILLNESS OR IMMUNIZATION

DATE	DIAGNOSIS	NONE
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DISPOSITION-PRESENT ILLNESS	<input type="checkbox"/> BINNACLE LIST/SIQ (NUMBER OF DAYS)	<input type="checkbox"/> LIGHT DUTY (NUMBER OF DAYS)
<input type="checkbox"/> CLINIC <input type="checkbox"/> HOSPITAL (Admitted)		

REMARKS (Initial treatment, long-term treatment potential, extent of injury, remission)

SIGNATURE	SUBMITTED:
PREPARED:	COMMANDING OFFICER