

REPORT OF HEAT / COLD INJURY

FROM: (Reporting Activity) _____ DATE _____ TO: NAVY ENVIRONMENTAL HEALTH CENTER (NEHC-35) 2510 WALMER AVENUE NORFOLK, VA 23513-2617 	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> </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)	WGBT	DIAGNOSIS (Check one) <input type="checkbox"/> HEAT CRAMPS <input type="checkbox"/> CHILBLAIN <input type="checkbox"/> HEAT EXHAUSTION <input type="checkbox"/> FROSTBITE <input type="checkbox"/> HEAT STROKE <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° SHOULD HAVE SERUM SGOT DRAWN 24 HOURS AFTER THE INJURY.

SYMPTOMS (Check all applicable) <input type="checkbox"/> UNCONSCIOUS <input type="checkbox"/> WEAK <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> DIZZY <input type="checkbox"/> NAUSEA <input type="checkbox"/> CONFUSED <input type="checkbox"/> CRAMPS <input type="checkbox"/> NUMBNESS <input type="checkbox"/> VOMITING <input type="checkbox"/> VISUAL DISTURBANCES (Specify)	SKIN (Check all applicable) <input type="checkbox"/> RED <input type="checkbox"/> NORMAL <input type="checkbox"/> PALE <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> WET <input type="checkbox"/> DRY <input type="checkbox"/> RASH	TEMP(R)	RESP.
		PULSE	
		HEIGHT	
		WEIGHT	

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"/> NONE <input type="checkbox"/> SLIGHT
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LAST HISTORY OF HEAT/COLD ILLNESS (Specify type)		
DATE (MONTH AND DAY)	DIAGNOSIS	NONE

RECENT ILLNESS OR IMMUNIZATION		
DATE	DIAGNOSIS	NONE

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