LAP-BELT SYNDROME (LBS)

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REPORTING INFORMATION
(To be completed by the CPSP Senior Coordinator)

Report number:	
Month of reporting:	
Province:	
Today's date:	

Please complete the following sections for the case identified above.
Confidentiality of information will be assured.

CASE DEFINITION FOR LAP-BELT SYNDROME

Report any child up to 18 years of age inclusively, restrained in a motor vehicle at the time of a crash (seat restraints are defined as: child safety seat, booster seat, lap belt only, or lap and shoulder belt), with either:

1. **An abdominal injury,** as determined by operation, ultrasound or abdominal CT scan. Splenic, liver, kidney and duodenal injuries will be graded according to their specific injury scale.

   Abdominal injuries include those involving:
   - small intestine, colon
   - spleen
   - kidney
   - liver
   - pancreas
   - mesentery
   - bladder
   - uterus
   - any vascular structure within the abdominal cavity

or

2. **Thoraco-lumbar spine injuries**

   Major spinal injuries:
   - compression fractures
   - burst fractures
   - seat-belt type injuries
   - fracture dislocations

   Minor spinal injuries:
   - fracture of transverse process
   - fracture of articular process
   - spinous process fractures
   - pars interarticularis fractures

SECTION 1 – DEMOGRAPHIC INFORMATION

1.1 Date of birth: ____/____/_____ (DD MM YYYY)

1.2 Sex: Male ___ Female ___

1.3 Weight: _____ kg

1.4 Paediatric trauma score (if available): _____

SECTION 2 – MECHANISM OF INJURY

2.1 Type of motor vehicle in which the patient was a passenger:
Passenger car ___ Minivan ___ Light truck ___ Sport utility car ___

2.2 Type of impact (*select all appropriate*)
Head-on ___ Rear-end ___ Side ___ Roll-over ___ Ejection ___ Entrapment ___ Unknown ___
Other *(specify)*: _____

2.3 Approximate speed at time of impact: _____ km/h

2.4 Death of another passenger in the same vehicle: Yes ___ No ___

2.5 Position in vehicle (select ONE most appropriate)
Passenger ___ Front ___ Rear ___ Driver ___
Other *(specify)*: _____

2.6 Restraining devices *(select all appropriate)*

2.6.1 Seat belt: Yes ___ No ____

If yes:
- proper use of lap belt only ___
- proper use of lap and shoulder belt ___
- improper use
  - worn under arm ___
  - behind back ___
  - around more than one person ___
  - on abdomen ___

2.6.2 Child safety seat: Yes ___ No ____

If yes:
- anchored to the vehicle
  - with seat belt ___
  - without seat belt ___

2.6.3 Booster seat: Yes ___ No ___

If yes:
- anchored to the vehicle
  - with seat belt ___
  - without seat belt ___

2.6.4 Others *(specify)*: _____

2.6.5 Unknown ___

2.7 Air bags: Yes ___ No ____

If yes, specify: Front ___ Side ___

SECTION 3 – SYSTEM FACTORS

3.1 Date of incident ____/____/_____
DD MM YYYY

3.2 Hospital length of stay:

3.2.1 Admission to hospital: Yes ___ No ___

If yes, date of admission: ____/____/_____ (DD MM YYYY) date of discharge: ____/____/_____ (DD MM YYYY)

Still hospitalized ___

3.2.2 ICU: Yes ___ No ___

If yes, specify length of stay: _____ days _____ weeks _____ months

SECTION 4 – PATIENT ASSESSMENT

4.1 Description of injuries *(describe all the injuries sustained by the patient)*

4.1.1 Head and neck: Yes ___ No ___ If yes, describe:

_____

_____

_____

4.1.2 Face: Yes ___ No ___ If yes, describe:

_____

_____

_____

4.1.3 Thorax: Yes ___ No ___ If yes, describe:

_____

_____

_____

4.1.4 Abdomen: Yes ___ No ___ If yes, describe (duodenal, hepatic, splenic and renal injuries according to their specific injury scale):

Intestinal injuries: _____

Duodenal: _____

Hepatic: _____

Splenic: _____

Renal: _____

Others: _____

_____

4.1.5 Extremities: Yes ___ No ___ If yes, describe:

_____

_____

4.1.6 External: Yes ___ No ___ If yes, describe (contusions, abrasions, burns of teguments):

_____

_____

4.1.7 Spine: Yes ___ No ___ If yes, describe (fractures, dislocations, and subluxations, with location of injury):

_____

_____

_____

4.1.8 Spinal cord injury: Yes ___ No ___ If yes, describe:

_____

_____

SECTION 5 – TREATMENT

5.1 Surgical interventions

Date:	Intervention:
____/____/_____ DD MM YYYY	_____
____/____/_____ DD MM YYYY	_____
____/____/_____ DD MM YYYY	_____
____/____/_____ DD MM YYYY	_____

SECTION 6 – OUTCOME / COMPLICATIONS

6.1 What was the status of the patient after the incident?

Survived ___

Deceased ___ Date ____/____/_____ (DD MM YYYY) Cause of death: _____

If child is deceased, you do not need to answer any further questions; please go to section 7.0.

6.2 Permanent neurologic deficits secondary to spinal cord injuries: Yes ___ No ___

If yes, describe deficits: _____

_____

6.3 Other complications (*specify*): _____

_____

6.4 Functional outcome in child 0-3 years old

Date of evaluation ____/____/_____
DD MM YYYY

After the injury, were there any changes in the child's

- sleeping habits Yes ___ No ___ Unknown ___
- eating habits Yes ___ No ___ Unknown ___
- daily routines Yes ___ No ___ Unknown ___
- motor activities Yes ___ No ___ Unknown ___
- behaviour (fears, aggression, anger) Yes ___ No ___ Unknown ___

6.5 Functional outcome in child 4-17 years old

Date of evaluation ____/____/_____
DD MM YYYY

After the injury, were there changes in the child's ability to

- stand Yes ___ No ___ Unknown ___
- walk Yes ___ No ___ Unknown ___
- run Yes ___ No ___ Unknown ___
- climb/descend stairs Yes ___ No ___ Unknown ___
- maintain balance Yes ___ No ___ Unknown ___
- get up/lie down Yes ___ No ___ Unknown ___
- move in bed Yes ___ No ___ Unknown ___
- get to toilet Yes ___ No ___ Unknown ___
- eat Yes ___ No ___ Unknown ___
- comb hair Yes ___ No ___ Unknown ___
- bathe Yes ___ No ___ Unknown ___
- dress Yes ___ No ___ Unknown ___
- control sphincters (continence) Yes ___ No ___ Unknown ___
- comprehend in school and everyday activities Yes ___ No ___ Unknown ___
- speak Yes ___ No ___ Unknown ___
- concentrate Yes ___ No ___ Unknown ___
- write Yes ___ No ___ Unknown ___
- handle objects Yes ___ No ___ Unknown ___
- carry objects Yes ___ No ___ Unknown ___
- see Yes ___ No ___ Unknown ___
- hear Yes ___ No ___ Unknown ___

After the injury, were there any changes in the child's

- orientation Yes ___ No ___ Unknown ___
- sensitivity to light Yes ___ No ___ Unknown ___
- sensitivity to cold/heat Yes ___ No ___ Unknown ___
- sensitivity to pain Yes ___ No ___ Unknown ___

SECTION 7 – REPORTING PHYSICIAN

First name_____ Surname_____

Address_____

City_____ Province_____ Postal code_____

Telephone number_____ Fax number_____

E-mail_____ Date completed_____

Thank you for completing this form.