



Entered By.....  
Entry Date & Time.....

Data Collection for Event: Injury

Injury Information

- Injury Type \*
Abrasion, Bruise, Fracture, Loss of Consciousness, Scrape, Airway Obstruction, Burn, Frostbite, Sprain/Strain, Choking, Hematoma, Pain, Allergic Reaction, Concussion, Infection, Poisoning, Sunburn, Bite/Sting, Cut, Laceration, Puncture, Swelling/Edema, Bleeding, Dislocation, Lesion, Rash/Hives, Other

If Other .....

- Injury Cause \*
Abuse, Bumped Into, Ingestion of Foreign Material, Restraint, Accident Motor Vehicle, Eating Behavior, Seizure, Accident Other, Environmental Hazard, Insect, Undetermined, Adaptive Equipment, Exposure, Medical Condition, Medical procedure, Assault, Fall, SIB, If Other .....

This event was \* Observed Discovered Time of Injury \* ..... am / pm

- Specific Location
Living Room, Hallway, Unknown, Bedroom, Staircase, Other, Dining Room, Activity Area, Kitchen, Recreation Area, Bathroom, Outdoors, If Other .....

- Treatment by
None, ER/Hospital, Self, Family, Staff/LPN, Physician/other medical, RN Nurse

Time of Treatment ..... am / pm Treatment date, if different than event date ..... am / pm

Injury Size
Length (cm) Width (cm) Depth (mm)

- Injury Color
Beige, Black, Green, Multi-colored, Pink, Purple, Red, Yellow, Other, If Other .....

- Injury Severity \*
Very Minor (No treatment), Severe (Hospital, ER/admission), Minor (First aid), Death, Moderate (Nurse/Physician treatment)

SIGNATURE.....NAME.....DATE.....TIME.....am pm

Note:- Required fields are marked with an asterisk (\*)



- Body Part(s) \***
- Abdomen     Ankle Left     Ankle Right     Arm Left     Arm Right     Back
  - Buttocks     Chest     Ear Left     Ear Right     Elbow Left     Elbow Right
  - Eye Left     Eye Right     Face     Fingers Left     Fingers Right     Foot Left
  - Foot Right     Genitals     Hand Left     Hand Right     Head     Hip Left
  - Hip Right     Internal     Knee Left     Knee Right     Lips Mouth     Neck
  - Nose     Rectum     Shoulder Left     Shoulder Right     Systemic     Teeth
  - Throat     Toe Left     Toe Right     Tongue     Wrist Left     Wrist Right

**Event Summary** .....

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**Witness 1** .....

**Witness 2** .....

**Photo**       **Attached**      **Photo Date** .....

**SIGNATURE**.....**NAME**.....**DATE**.....**TIME**.....am pm

Note:- Required fields are marked with an asterisk (\*)