INJURY SURVEILLANCE FORM
(all information is confidential)

Give completed form to: Three Corners Health Services Society Ph: 250-398-9814

BACKGROUND INFORMATION FOR INJURED PERSON

Date of Injury (Year/Month/Day) (/   /   )

Age: __________ **Date of Birth** (Year/Month/Day) (/   /   ) **Gender** ☐ Male ☐ Female

COMMUNITY INFORMATION

COMMUNITY OF INJURY (community where injury occurred): ______________________

COMMUNITY OF RESIDENCE (community where injury person lives): ______________________

INJURY EVENT INFORMATION

TIME OF INJURY

(1) ☐ 12 AM – 4 AM
(2) ☐ 4 AM – 8 AM
(3) ☐ 8 AM – 12 PM
(4) ☐ 12 PM – 4 PM
(5) ☐ 4 PM – 8 PM
(6) ☐ 8 PM – 12 AM
(7) ☐ UNKNOWN

Was the injury WORK RELATED?

☐ YES ☐ NO

Was the injury SPORTS RELATED?

☐ YES ☐ NO

PLACE OF INJURY

☐ Home(inside a home or on home property)
☐ Playground
☐ Daycare
☐ School
☐ Roadway
☐ Outdoor Recreational Area (e.g. rodeo ground)
☐ Indoor Recreational Area (e.g. indoor hockey arena)
☐ Public Place (e.g. shopping mall, church)
☐ Wilderness/Bush
☐ OTHER (please specify) ______________________

If known-specify place of injury (location) e.g. name of playground, school, public place)

____

Describe **WHAT** the injured person was doing when the injury occurred, what went wrong, and what actually caused the injury (please indicate if ☐ UNKNOWN)

____

Explain **WHY** the injury occurred (e.g. medical problems, recent depression, weather or road conditions)

ADDITIONAL CIRCUMSTANCES

☐ Unknown
☐ Not Applicable
☐ Alcohol
☐ Solvents
☐ Prescription drugs
☐ Over the counter drugs
☐ Illicit drugs
☐ OTHER (please specify)

____

PROTECTIVE EQUIPMENT

☐ Unknown
☐ Seatbelt
☐ Child restraint
☐ Helmet
☐ Smoke/Fire Alarm
☐ Life jacket/Survival suit
☐ Not applicable
☐ Protective **occupational** equipment (e.g. eye goggles)
☐ Protective **recreational** equipment (e.g. knee pads)
☐ OTHER (please specify)

____

INTENT OF INJURY

☐ Intentional (harmed by SELF)
☐ Intentional (harmed by ANOTHER PERSON)
☐ UNINTENTIONAL (i.e. accidental)
☐ UNKNOWN intent

CAUSE OF INJURY – check (✓) one only:

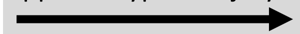
BURN	VEHICLE RELATED	PERSON or OBJECT	POISONING	FALL	EXPOSURE	OTHER CAUSE
☐ Chemical ☐ Electricity ☐ Explosion ☐ Flames ☐ Hot object or liquid	☐ ATV ☐ Bicycle/Tricycle ☐ Boat/Canoe ☐ Car ☐ Motorcycle ☐ Snowmobile ☐ Train ☐ Truck/Van **PERSON INJURED** was: ☐ Driver/Rider ☐ Passenger ☐ Pedestrian (person walking)	☐ Animal kick ☐ Bite (animal-insect-person) ☐ Bullet ☐ Collision with person or object (include assault) ☐ Knife or other weapon ☐ Power tool/other household implement ☐ Sexual assault	☐ Alcohol ☐ Gas ☐ Household cleaner or chemical ☐ Illicit drugs ☐ Over the counter drug ☐ Plant/Bush ☐ Prescription drugs	☐ Bathtub-Sink-Toilet ☐ Furniture ☐ Icy or wet surfaces ☐ Medical condition ☐ Natural terrain (including roots-rocks-trees) ☐ Playground equipment ☐ Sports ☐ Stairs or steps	☐ Cold ☐ Heat	☐ Drowning ☐ Foreign body in natural opening ☐ Hanging

☐ **OTHER** for any of the above causes of injury (please specify)

NATURE OF INJURY *(body region codes)*

1) Teeth
2) Eyes
3) Head
4) Face
5) Neck
6) Chest/Abdomen
7) Back
8) Shoulder/Arm/Hand
9) Hip/Leg/Foot
10) Spinal cord
11) Internal organs
12) Multiple sites (please specify) ______________________________
13) In your opinion, which was the **MOST SERIOUS** injury? *(please specify)*

Use body region code #s opposite type of injury



Code #s	**Check MOST SERIOUS (✓)TYPE OF INJURY**
	☐ Amputation
	☐ Bruising/Scrape
	☐ Burn
	☐ Choking, unable to breath
	☐ Concussion
	☐ Head injury
	☐ Crushing injury
	☐ Cut/Laceration
	☐ Dental injury
	☐ Dislocation
	☐ Fracture (broken bone)
	☐ General or multi-system trauma
	☐ Hemorrhage or damage to blood vessels
	☐ Inflammation, swelling, pain
	☐ Penetrating wound/Puncture
	☐ Poisoning
	☐ Sprain/Strain

Where was the form completed?

☐ Ambulance
☐ Band/Council Office
☐ Cariboo Memorial Hospital
☐ 100 Mile House Hospital
☐ Daycare
☐ Fire Station
☐ Health Centre
☐ School (please specify) ______________
☐ OTHER (please specify) ______________

Were there OTHER PEOPLE INJURED in this injury incident?
☐ YES ☐ NO ☐ Unknown

If YES – How many were injured?
(please indicate if number is unknown)

OUTCOME – check (✓) one only:

☐ **NO treatment**-released
☐ **TREATED**-released
☐ **REFERRED**-to health professional
☐ **SELF**-treatment
☐ **REFUSED**-treatment
☐ **ADMITTED**-to hospital
☐ **DEATH**
☐ OTHER (please specify) ______________________________

FORM completed by: (please print)

UNIQUE IDENTIFIER **FOR DATA ENTRY STAFF ONLY**

7 digit UNIQUE IDENTIFIER = (3 digit Band Identifier) + (4 digit Case Number)