

INJURY SURVEILLANCE FORM
(all information is confidential)



Give completed form to: Skwlax Wellness Centre

Ph: 250-679-3702

BACKGROUND INFORMATION FOR INJURED PERSON

Age: _____ Date of Injury (Year/Month/Day) (/ /)
Date of Birth (Year/Month/Day) (/ /) Gender Male Female

COMMUNITY INFORMATION

COMMUNITY OF INJURY (community where injury occurred): _____

COMMUNITY OF RESIDENCE (community where injured person lives): _____

INJURY EVENT INFORMATION

TIME OF INJURY

- | | |
|---|---|
| (1) <input type="checkbox"/> 12 AM – 4 AM | (4) <input type="checkbox"/> 12 PM – 4 PM |
| (2) <input type="checkbox"/> 4 AM – 8 AM | (5) <input type="checkbox"/> 4 PM – 8 PM |
| (3) <input type="checkbox"/> 8 AM – 12 PM | (6) <input type="checkbox"/> 8 PM – 12 AM |
| (7) <input type="checkbox"/> UNKNOWN | |

Was the injury WORK RELATED?

YES NO

Was the injury SPORTS RELATED?

YES NO

PLACE OF INJURY

- | | |
|---|--|
| <input type="checkbox"/> Home (inside a home or on home property) | <input type="checkbox"/> Outdoor Recreational Area (e.g. rodeo ground) |
| <input type="checkbox"/> Playground | <input type="checkbox"/> Indoor Recreational Area (e.g. indoor hockey arena) |
| <input type="checkbox"/> Daycare | <input type="checkbox"/> Public Place (e.g. shopping mall, church) |
| <input type="checkbox"/> School | <input type="checkbox"/> Wilderness/Bush |
| <input type="checkbox"/> Roadway | <input type="checkbox"/> 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

- | | |
|---|---|
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Not Applicable |
| <input type="checkbox"/> Alcohol | |
| <input type="checkbox"/> Solvents | |
| <input type="checkbox"/> Prescription drugs | |
| <input type="checkbox"/> Over the counter drugs | |
| <input type="checkbox"/> Illicit drugs | |
| <input type="checkbox"/> OTHER (please specify) | |

PROTECTIVE EQUIPMENT

- | | |
|--|--|
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Seatbelt | <input type="checkbox"/> Protective occupational equipment (e.g. eye goggles) |
| <input type="checkbox"/> Child restraint | <input type="checkbox"/> Protective recreational equipment (e.g. knee pads) |
| <input type="checkbox"/> Helmet | <input type="checkbox"/> OTHER (please specify) |
| <input type="checkbox"/> Smoke/Fire Alarm | |
| <input type="checkbox"/> Life jacket/Survival suit | |

INTENT OF INJURY

- | | |
|--|--|
| <input type="checkbox"/> Intentional (harmful by SELF) | <input type="checkbox"/> UNINTENTIONAL (i.e. accidental) |
| <input type="checkbox"/> Intentional (harmful by ANOTHER PERSON) | <input type="checkbox"/> UNKNOWN intent |



CAUSE OF INJURY – check (✓) one only:

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

- | | | |
|--|---|--|
| <input type="checkbox"/> NO treatment -released | <input type="checkbox"/> SELF -treatment | <input type="checkbox"/> DEATH |
| <input type="checkbox"/> TREATED -released | <input type="checkbox"/> REFUSED -treatment | <input type="checkbox"/> OTHER (please specify) |
| <input type="checkbox"/> REFERRED -to health professional | <input type="checkbox"/> ADMITTED -to hospital | _____ |

FORM completed by: (please print)

UNIQUE IDENTIFIER FOR DATA ENTRY STAFF ONLY

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

