INJURY SURVEILLANCE FORM
(all information is confidential)

Give completed form to: Ph:

BACKGROUND INFORMATION FOR INJURED PERSON

Date of Injury (Year/Month/Day) (/ /) **GENDER:**

Age: _____ **Date of Birth** (Year/Month/Day) (/ /) ☐ Male ☐ Female ☐ Other

COMMUNITY INFORMATION

COMMUNITY OF INJURY ☐ On-Reserve ☐ Off-Reserve Community: _____

COMMUNITY OF RESIDENCE ☐ On-Reserve ☐ Off-Reserve Community: _____

TIME OF INJURY EVENT INFORMATION

☐ 12 AM–4 AM ☐ 4 AM– 8 AM ☐ 8 AM–12 PM ☐ 12 PM–4 PM ☐ 4 PM–8 PM ☐ 8 PM–12 AM ☐ UNKNOWN

Was the injury RELATED to:

☐ Work Related ☐ Vehicle Related ☐ Sports Related

Was the injury REPORTED to:

☐ WCB ☐ ICBC ☐ Other:

Were OTHER PEOPLE INJURED in this incident?

☐ YES ☐ NO ☐ Unknown

If YES – How many were injured?

(please indicate if number is unknown)

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/River/Lake
☐ OTHER (please specify)

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

_____

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 (specify)

_____

13) In your opinion, what was the most SERIOUS injury?

_____

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 (specify)

_____ ☐

☐OTHER (specify)

_____

CAUSE OF INJURY – check (✓) only ONE:

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

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:** ☐ 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	☐ Alcohol ☐ Gas ☐ Household cleaner or chemical ☐ Illicit drugs ☐ Over the counter drug ☐ Plant/Bush ☐ Prescription drugs	☐ Bathtub-Sink-Toilet ☐ Furniture ☐ Icy or wet surfaces ☐ Stairs/ steps ☐ Natural terrain (roots-rocks-trees) ☐ Sidewalk (lack of) ☐ Playground equipment ☐ Sports	☐ Cold ☐ Heat **Asphyxiation** ☐ Choking ☐ Drowning ☐ Asthma ☐ Ventilation (air quality: ie: carbon monoxide) ☐ Suffocation ☐ SIDS	Violence ☐ Sexual Assault ☐ Intimate-Partner ☐ Gang related ☐ Suicide ☐ Self-harm (cutting, etc.)

ADDITIONAL CIRCUMSTANCES

Altered State:
☐ Alcohol
☐ Solvents
☐ Prescription drugs
☐ Over the counter drugs
☐ Illicit drugs

Social Determinants of Health:
☐ Income related (expenses)
☐ Education & Awareness
☐ Housing
☐ Health Services (or lack of)
☐ Working Conditions
☐ Road Conditions

Medical Condition(s): *OPTIONAL
☐ Disability (varying abilities)
☐ Previous Injury
☐ Previous illness, sickness or condition

Other:
☐ Weather
☐ Unknown
☐ Not Applicable

Describe **WHAT** the injured person was doing at time of injury:

_____

Explain **WHY** the injury occurred:

_____

PROTECTIVE EQUIPMENT

☐ Not applicable
☐ Unknown
☐ None used
☐ Seatbelt
☐ Child restraint
☐ Helmet
☐ Smoke/Fire Alarm
☐ Life jacket/Survival suit
☐ Protective **occupational** equipment (e.g. eye goggles)
☐ Protective **recreational** equipment (e.g. helmets)
☐ OTHER (please specify) equipment (e.g. knee pads)

_____

OUTCOME – check (✓) only ONE:

☐ **NO treatment**-released
☐ **TREATED**-released
☐ **REFERRED**-to health professional
☐ **SELF**-treated
☐ **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)