Therap®

Delaware GER - Injury

Injury Type:*

☐ Abrasion ☐ Airway Obstruction ☐ Allergic Reaction ☐ Bite/Sting ☐ Bleeding ☐ Blister
☐ Bruise ☐ Burn ☐ Choking ☐ Concussion ☐ Cut ☐ Dislocation
☐ Fracture ☐ Frostbite ☐ Hematoma ☐ Hyperthermia ☐ Infection ☐ Laceration
☐ Lesion ☐ Loss of Consciousness ☐ Pain ☐ Poisoning ☐ Pressure Ulcer ☐ Puncture
☐ Rash/Hives ☐ Redness ☐ Scrape ☐ Scratch ☐ Sprain/Strain ☐ Sunburn
☐ Swelling/Edema ☐ Other:______________________________

Injury Cause:*

☐ Abuse ☐ Accident Motor Vehicle ☐ Accident Other ☐ Adaptive Equipment ☐ Assault
☐ Bumped Into ☐ Eating Behavior ☐ Environmental Hazard ☐ Exposure ☐ Fall
☐ Ingestion of Foreign Material (Pica) ☐ Insect ☐ Medical Condition ☐ Medical Procedure ☐ Restraint
☐ Seizure ☐ Self Injurious Behavior ☐ Undetermined ☐ Other:______________

This event was:* ☐ Observed ☐ Discovered Time of Injury:* ______________________am/pm

Specific Location:

☐ Activity Area ☐ Bathroom ☐ Bedroom ☐ Dining Room ☐ Hallway ☐ Kitchen ☐ Living Room
☐ Outdoors ☐ Recreation Area ☐ Staircase ☐ Unknown ☐ Other:______________________________

Treatment by: ☐ None ☐ Self ☐ Family ☐ Staff/LPN ☐ RN Nurse ☐ Physician/other medical ☐ ER/Hospital

Time of Treatment:_____________am / pm Treatment date, if different than event date:________________

Injury Size:

Length (cm):______________ Width (cm):________________ Depth (mm):________________

Injury Color: ☐ Beige ☐ Black ☐ Green ☐ Multi-colored ☐ Pink ☐ Purple ☐ Red ☐ Yellow ☐ Other:___________

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

Body Part(s):*

☐ Abdomen	☐ Ankle Left	☐ Ankle Right	☐ Arm Left
☐ Arm Right	☐ Back	☐ Buttock Left	☐ Buttock Right
☐ Buttocks	☐ Calf Left	☐ Calf Right	☐ Chest
☐ Ear Left	☐ Ear Right	☐ Elbow Left	☐ Elbow Right
☐ Eye Left	☐ Eye Right	☐ Face	☐ Finger Index Left
☐ Finger Index Right	☐ Finger Little Left	☐ Finger Little Right	☐ Finger Middle Left
☐ Finger Middle Right	☐ Finger Ring Left	☐ Finger Ring Right	☐ Finger Thumb Left
☐ Finger Thumb Right	☐ Fingers Left	☐ Fingers Right	☐ Foot Left
☐ Foot Right	☐ Forearm Left	☐ Forearm Right	☐ Forehead
☐ Genitals	☐ Hand Left	☐ Hand Right	☐ Head
☐ Hip Left	☐ Hip Right	☐ Internal	☐ Knee Left
☐ Knee Right	☐ Leg Left	☐ Leg Right	☐ Lips

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

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

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☐ Lower Back	☐ Mouth	☐ Neck	☐ Nose
☐ Rectum	☐ Shin Left	☐ Shin Right	☐ Shoulder Left
☐ Shoulder Right	☐ Systemic	☐ Teeth	☐ Thigh Left
☐ Thigh Right	☐ Throat	☐ Toe 2nd Left	☐ Toe 2nd Right
☐ Toe 3rd Left	☐ Toe 3rd Right	☐ Toe 4th Left	☐ Toe 4th Right
☐ Toe Big Left	☐ Toe Big Right	☐ Toe Left	☐ Toe Little Left
☐ Toe Little Right	☐ Upper Back	☐ Waist	☐ Wrist Left
☐ Upper Arm Right	☐ Upper Back	☐ Thigh Right	
☐ Wrist Right			

Injury Summary:____

____

____

Witness 1:____

Witness 2:____

Injury Photo: ☐ Attached Attached Photo Date:________________________

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

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