GER Event Type - Injury

Injury Information

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 _____

Specific Location: ☐ Activity Area ☐ Bathroom ☐ Bedroom ☐ Dining Room ☐ Hallway ☐ Kitchen ☐ Living Room ☐ Outdoors
☐ Recreation Area ☐ Staircase ☐ Unknown ☐ Other If Other _____

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

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

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

Time of Treatment _____am/pm **Treatment date, if different than event date _____am/pm**

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

Body Parts: ☐ Abdomen ☐ Finger Thumb Right ☐ Shoulder Left ☐ Ankle Right ☐ Fingers Left ☐ Shoulder Right ☐ Arm Left
☐ Fingers Right ☐ Systemic ☐ Arm Right ☐Foot Left ☐ Teeth ☐ Back ☐ Foot Right ☐ Thigh Left ☐ Buttock Left
☐ Forearm Left ☐Thigh Right ☐ Buttock Right ☐ Forearm Right ☐ Toe 2nd Left ☐ Buttocks ☐ Forehead ☐ Toe 2nd Right
☐ Calf Left ☐ Genitals ☐ Toe 3rd Left ☐ Calf Right ☐ Hand Left ☐ Toe 3rd Right ☐ Chest ☐ Hand Right ☐ Toe 4th Left
☐ Head ☐ Toe 4th Right ☐ Right ☐ Hip Left ☐Toe Big Left ☐ Elbow Left ☐ Hip Right ☐ Toe Big Right ☐ Elbow Right
☐ Internal ☐ Toe Left ☐ Eye Left ☐ Knee Left ☐ Toe Little Left ☐ Eye Right ☐ Knee Right ☐ Toe Little Right ☐ Face
☐ Leg Left ☐ Toe Right ☐ Finger Index Left ☐ Leg Right ☐Tongue ☐ Finger Index Right ☐ Lips ☐ Upper Arm Left
☐ Finger Little Left ☐ Lower Back ☐ Upper Arm Right ☐ Finger Little Right ☐ Mouth ☐ Upper Back ☐ Finger Middle Left
☐ Neck ☐ Waist ☐ Finger Middle Right ☐ Nose ☐ Wrist Left ☐ Finger Ring Left ☐ Rectum ☐ Wrist Right ☐ Finger Ring Right
☐ Shin Left ☐ Finger Thumb Left ☐ Shin Right

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

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

Injury Summary _____

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Witness 1:

_____

Witness 2:

_____

Injury Photo:

Attached Photo Date_____

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

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