



Minnesota Department of Health
 Injury and Violence Prevention Unit
 Trauma Data Bank
 PO Box 64882
 St. Paul, MN 55164-0882
 (651) 215-8954
www.health.state.mn.us/injury

Report of Injury, 6.03

Reportable Injuries (Mark all that apply.) <input type="checkbox"/> Burn Injury <input type="checkbox"/> Firearm Injury <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Work-Related Injury <input type="checkbox"/> Other: _____	HOSPITAL MEDICARE PROVIDER NUMBER	SOCIAL SECURITY NUMBER - -
	MEDICAL RECORD NUMBER	PATIENT ACCOUNT NUMBER

PATIENT INFORMATION

PATIENT LAST NAME			PATIENT FIRST NAME			MI
GUARDIAN LAST NAME/RELATIONSHIP			GUARDIAN FIRST NAME			MI
PATIENT PERMANENT ADDRESS						APT. NO.
CITY		STATE	ZIP	COUNTY OF RESIDENCE	TELEPHONE NUMBER () -	
DATE OF BIRTH (mm/dd/yyyy)		GENDER	ETHNICITY	RACE	PAY SOURCE (Mark all that apply)	
Month	Day	Year	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/ Other Pacific Islander	<input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown
						<input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured/Self Pay/None <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown

PATIENT CARE INFORMATION

INITIAL PRESENTATION (Mark all that apply.)				
Transportation		EMS Service / City Name		Run / Incident Number
<input type="checkbox"/> Self-present <input type="checkbox"/> Ground EMS <input type="checkbox"/> Air EMS Helicopter <input type="checkbox"/> Air EMS Fixed Wing	<input type="checkbox"/> EMS, Unspecified <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown			
Choose ONLY ONE Type of Care below and complete Date of Admission/Date of Discharge field(s). <input type="checkbox"/> Prehospital Death (Date of Admission) <input type="checkbox"/> ER/ED Only < 24 hours(Date of Admission) <input type="checkbox"/> ER/ED Only > 24 hours (Date of Admission) <input type="checkbox"/> Hospitalized (Date of Admission and Discharge)		DATE OF ADMISSION (mm/dd/vvvh/hhmm) Month Day Year Time		
		DATE OF DISCHARGE (mm/dd/yyyy/hhmm) Month Day Year Time		

INJURY INFORMATION

CAUSE OF INJURY		PLACE OF OCCURRENCE: LOCATION <input type="checkbox"/> Home (E849.0) <input type="checkbox"/> Farm (E849.1) <input type="checkbox"/> Mine and quarry (E849.2) <input type="checkbox"/> Industrial place and premises (E849.3) <input type="checkbox"/> Place for recreation and sport (E849.4) <input type="checkbox"/> Street and Highway (E849.5) <input type="checkbox"/> Public building (E849.6) <input type="checkbox"/> Residential institution (E849.7) <input type="checkbox"/> Other specified place (E849.8) <input type="checkbox"/> Unspecified place (E849.9)	COUNTY OF INJURY: STATE <input type="checkbox"/> MN <input type="checkbox"/> IA <input type="checkbox"/> ND <input type="checkbox"/> SD <input type="checkbox"/> WI <input type="checkbox"/> Canada <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown	ACTIVITY AT TIME OF INJURY <input type="checkbox"/> While working for income (i.e. workers' comp) <input type="checkbox"/> While engaged in other types of work <input type="checkbox"/> While engaged in leisure activity <input type="checkbox"/> While engaged in sports activity <input type="checkbox"/> While resting, sleeping, eating or engaging in other vital activities <input type="checkbox"/> While engaged in education activity <input type="checkbox"/> During other specified activity <input type="checkbox"/> During unspecified activity
Principal E-Code	Secondary E-Code			
E	E			
Secondary E-Code	Secondary E-Code			
E	E			
DATE AND TIME OF INJURY (mm/dd/yyyy/hhmm)				
Month	Day	Year	24 Hr. Clock	

INJURY INFORMATION (Continued)

<p>SUPPLEMENTAL CAUSE OF INJURY (Mark all that apply)</p> <p>DID THIS INJURY RESULT FROM:</p> <p>FIREARMS AND OTHER OBJECTS USED AS WEAPONS:</p> <input type="checkbox"/> Firearm, handgun <input type="checkbox"/> Firearm, other _____ <input type="checkbox"/> Weapon, other _____	<p>USE OF PROTECTIVE EQUIPMENT</p> <table style="width: 100%; text-align: center;"> <tr> <td></td> <td>Yes</td> <td>No</td> <td>N/A</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Unknown</td> </tr> </table> <p>Airbag <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Child Safety Seat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eye Protection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Helmet <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Personal Flotation Device <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Safety Belt <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other: _____</p>		Yes	No	N/A				Unknown	<p>INJURY INTENT</p> <input type="checkbox"/> Assault confirmed <input type="checkbox"/> Assault suspected <input type="checkbox"/> Intentionally self-inflicted confirmed <input type="checkbox"/> Intentionally self-inflicted suspected <input type="checkbox"/> Legal intervention (injured during law enforcement) <input type="checkbox"/> Unintentional <input type="checkbox"/> Undetermined
	Yes	No	N/A							
			Unknown							
<p>SPORTS / RECREATION:</p> <input type="checkbox"/> Archery <input type="checkbox"/> Boxing, prize fighting <input type="checkbox"/> Diving <input type="checkbox"/> Football <input type="checkbox"/> Hockey <input type="checkbox"/> Hunting <input type="checkbox"/> Skateboarding <input type="checkbox"/> Skating, ice <input type="checkbox"/> Skating, inline <input type="checkbox"/> Skating, snow <input type="checkbox"/> Skiing, water <input type="checkbox"/> Snow sports, recreation, other: _____ <input type="checkbox"/> Soccer <input type="checkbox"/> Sports, other: _____ <input type="checkbox"/> Trampoline	<p>VEHICULAR TRANSPORTATION:</p> <input type="checkbox"/> All-Terrain vehicle <input type="checkbox"/> Personal watercraft, jet-ski <input type="checkbox"/> Snowmobile	<p>OTHER:</p> <input type="checkbox"/> Bathtub-related <input type="checkbox"/> Bleachers <input type="checkbox"/> Farm equipment <input type="checkbox"/> Horseback riding / Equestrian <input type="checkbox"/> Industrial machinery <input type="checkbox"/> Tree stand, fall from <input type="checkbox"/> Window, fall from <input type="checkbox"/> Other specified or known cause of injury: <div style="border: 1px solid black; width: 150px; height: 20px; margin: 5px auto;"></div> <input type="checkbox"/> UNKNOWN <input type="checkbox"/> NONE OF THE ABOVE APPLY								
		<p>ALCOHOL USE Fill in 1 value only</p> <p>.000 - .699 Blood Alcohol Concentration in g/DL .700 = BAC >.699 g/DL .777 = BAC not tested, clinical evidence of alcohol .888 = BAC not tested, no alcohol used .999 = Unknown / Not Available</p>	<p>DRUG INVOLVEMENT</p> <p>Do not include drugs dispensed by EMS/ED.</p> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> No tox screen, clinical evidence of drugs <input type="checkbox"/> Not Done/Unknown							
		<p>BLOOD ALCOHOL LEVEL REPORTING (g/DL)</p> <table style="width: 100%; text-align: center;"> <tr> <td style="width: 25%;">.</td> <td style="width: 25%;">.</td> <td style="width: 25%;">.</td> <td style="width: 25%;">.</td> </tr> </table>				
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GLASGOW COMA SCALE SCORE (GCS) Please answer all that apply.	AVPU Please answer all that apply.	DESCRIPTION OF INJURY:
<input type="checkbox"/> GCS at Scene (Ambulance Run Sheet)	<input type="checkbox"/> AVPU at Scene (Ambulance Run Sheet)	
<input type="checkbox"/> GCS in ER/ED	<input type="checkbox"/> AVPU in ER/ED	
<input type="checkbox"/> GCS Other: _____	<input type="checkbox"/> AVPU Other: _____	

DISCHARGE INFORMATION

<p>OUTCOME AT DISCHARGE</p> <table style="width: 100%;"> <tr> <td style="width: 33%;">SCI Extent</td> <td style="width: 33%;">TBI Outcome</td> <td style="width: 33%;">Overall Performance</td> </tr> <tr> <td> <input type="checkbox"/> Normal <input type="checkbox"/> Incomplete, Functional <input type="checkbox"/> Incomplete, Nonfunctional <input type="checkbox"/> Complete <input type="checkbox"/> Death <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown </td> <td> <input type="checkbox"/> Good Recovery <input type="checkbox"/> Mild Disability <input type="checkbox"/> Moderate Disability <input type="checkbox"/> Severe Disability <input type="checkbox"/> Vegetative State <input type="checkbox"/> Death <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown </td> <td> <input type="checkbox"/> Good Recovery <input type="checkbox"/> Mild Disability <input type="checkbox"/> Moderate Disability <input type="checkbox"/> Severe Disability <input type="checkbox"/> Vegetative State <input type="checkbox"/> Death <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown </td> </tr> </table>	SCI Extent	TBI Outcome	Overall Performance	<input type="checkbox"/> Normal <input type="checkbox"/> Incomplete, Functional <input type="checkbox"/> Incomplete, Nonfunctional <input type="checkbox"/> Complete <input type="checkbox"/> Death <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	<input type="checkbox"/> Good Recovery <input type="checkbox"/> Mild Disability <input type="checkbox"/> Moderate Disability <input type="checkbox"/> Severe Disability <input type="checkbox"/> Vegetative State <input type="checkbox"/> Death <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	<input type="checkbox"/> Good Recovery <input type="checkbox"/> Mild Disability <input type="checkbox"/> Moderate Disability <input type="checkbox"/> Severe Disability <input type="checkbox"/> Vegetative State <input type="checkbox"/> Death <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	<p>VITAL STATUS</p> <p>To your knowledge is this patient:</p> <input type="checkbox"/> Alive – As of: _____ <input type="checkbox"/> Expired – As of: _____ <input type="checkbox"/> Unknown	<p>ICD-9-CM N-CODES (DIAGNOSIS CODE)</p> <table style="width: 100%; text-align: center;"> <tr> <td style="width: 50%;">Principal N-Code</td> <td style="width: 50%;">Diagnosis N-Code</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td>Diagnosis N-Code</td> <td>Diagnosis N-Code</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td>Diagnosis N-Code</td> <td>Diagnosis N-Code</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> </table>	Principal N-Code	Diagnosis N-Code			Diagnosis N-Code	Diagnosis N-Code			Diagnosis N-Code	Diagnosis N-Code		
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<p>DISCHARGE STATUS</p> <input type="checkbox"/> Home or Foster Home – Self Care <input type="checkbox"/> Home or Foster Home – Non-skilled Assistance <input type="checkbox"/> Home or Foster Home – Skilled Assistance <input type="checkbox"/> Transfer to Acute Care Hospital → <input type="checkbox"/> Inpatient Rehab Facility <input type="checkbox"/> Transitional Care Unit Transfer to Acute Care Hospital <input type="checkbox"/> Inpatient Facility without Skilled Nursing <input type="checkbox"/> Inpatient Facility with Skilled Nursing <input type="checkbox"/> AMA <input type="checkbox"/> Death <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown	<p>ADDITIONAL DIAGNOSIS N-CODES:</p> <p>HOSPITAL/CITY TO WHICH PATIENT WAS TRANSFERRED:</p> <p>NAME OF PERSON REPORTING:</p> <p>REPORTING HOSPITAL CITY</p> <p>TELEPHONE DATE OF REPORT ()</p>																			