
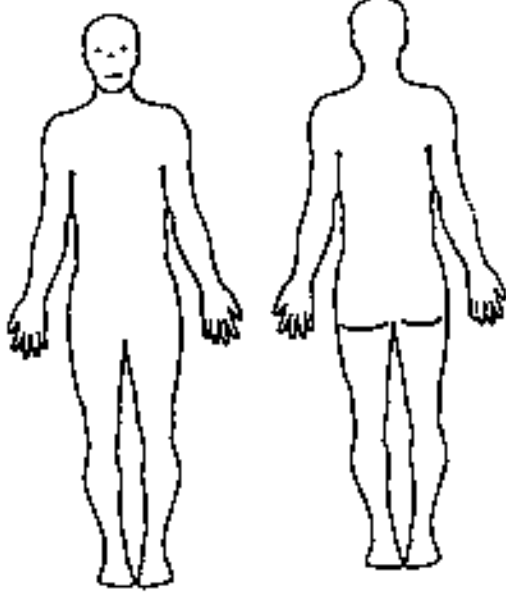


1. Institution	2. Name of Injured	3. Register Number
4. Housing Assignment	5. Date and Time of Injury	6. Where Did Injury Happen (Specify location)
7. Work Related <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Date and Time Reported for Treatment	
9. Subjective: (Injured's statement as to how injury occurred) (Additional history as indicated)		
Signature of Patient		
10. <input type="checkbox"/> X-ray not indicated <input type="checkbox"/> X-ray taken X-ray results:		
11 Objective (Observations or findings from examination)		
12. Assessment: (analysis of facts based on subjective and objective data)		
13. Plan: (Diagnostic procedures with results, treatment and recommended follow-up)		
14. This injury required <input type="checkbox"/> a. No medical attention <input type="checkbox"/> b. Minor First Aid <input type="checkbox"/> c. Hospitalization <input type="checkbox"/> d. Other: _____ _____ _____ <input type="checkbox"/> e. Civilian first aid only <input type="checkbox"/> f. Civilian referred to community physician <hr/> Signature of Provider <hr/> Signature of Physician Date		

THIS PORTION IS FOR PERFORMANCE IMPROVEMENT PURPOSES ONLY AND NOT FOR INCLUSION IN THE MEDICAL RECORD

Reporting:

Physician Notified: No Yes **Physician's Signature:** _____

Physician Statement (Describe current or potential problems and treatment indicated) _____

HSA Review: _____

HSA Signature: _____ **Date:** _____

DATE PRESENTED TO PERFORMANCE IMPROVEMENT COMMITTEE (Complete on copy to PI Committee only)

Date: _____ **Signature:** _____