

TORNADO INJURY REPORT FORM*(May 2003)
HOSPITAL RECORDS ABSTRACTION FORM

OSDH Record #: _____

Date: _____

Reviewer: _____

Hospital _____ Hospital Record # _____ Date of Birth _____

Patient Name (last, first) _____ Age _____ Sex _____

SSN#: _____

Race White Native American/Alaska Native Unk/NS Hispanic Yes No Unk/NS
 African American Asian/Pacific Islands

Address _____ City _____ ZIP _____

County of Residence _____ Marital Status
 Single Married Divorced
 Widowed Separated Unk/NS

Employer/Occupation _____ Unemployed Child/Student Retired

Relative/Friend _____ Relationship _____

Phone (_____) _____ Address _____

Date/Time seen _____ Admitted: Yes No Date/Time of Discharge _____

Date of Injury _____

Outcome: Survived Died

Date of Death _____ Time of Death _____ AM/PM

Insurance: (Check all that apply)

Private Insurance Self Pay Workers' Comp Medicare
 Medicaid Unk/NS Other _____

<p>Discharge Disposition</p> <p>01 <input type="checkbox"/> Home</p> <p>02 <input type="checkbox"/> Acute care hospital _____</p> <p>03 <input type="checkbox"/> Skilled nursing facility _____</p> <p>04 <input type="checkbox"/> Intermediate care facility _____</p> <p>05 <input type="checkbox"/> Other hospital (rehab/psych, etc.) _____</p> <p>06 <input type="checkbox"/> Home health care</p> <p>07 <input type="checkbox"/> Left AMA <input type="checkbox"/> Dead on Arrival</p> <p>20 <input type="checkbox"/> Expired in ED <input type="checkbox"/> Expired as inpatient</p> <p>55 <input type="checkbox"/> Other (specify) _____</p> <p>99 <input type="checkbox"/> Unk/NS</p>	<p>List All Primary & Associated ICD-9 Codes (in order):</p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DESCRIPTION</th> </tr> </thead> <tbody> <tr><td>#1 _____</td><td>_____</td></tr> <tr><td>#2 _____</td><td>_____</td></tr> <tr><td>#3 _____</td><td>_____</td></tr> <tr><td>#4 _____</td><td>_____</td></tr> <tr><td>#5 _____</td><td>_____</td></tr> <tr><td>#6 _____</td><td>_____</td></tr> <tr><td>#7 _____</td><td>_____</td></tr> <tr><td>#8 _____</td><td>_____</td></tr> <tr><td>#9 _____</td><td>_____</td></tr> <tr><td>#10 _____</td><td>_____</td></tr> </tbody> </table> <p>Hospital E codes: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/NS</p> <p>E _____</p> <p>E _____</p>	CODE	DESCRIPTION	#1 _____	_____	#2 _____	_____	#3 _____	_____	#4 _____	_____	#5 _____	_____	#6 _____	_____	#7 _____	_____	#8 _____	_____	#9 _____	_____	#10 _____	_____
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Procedure Codes:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Geographic Location:

- Oklahoma City
- Moore
- Del City

- Midwest City
- Choctaw
- Other: _____

Time of Injury (if available): _____

Location of Patient when Injured:

- House
- Apartment
- Mobile Home
- Vehicle
- Storm Shelter

- Public/Commercial Building
- Outdoors: _____
- Other: _____
- Unknown

Location in Structure:

- Basement
- Underground shelter
- Above ground shelter/safe room
- Hallway
- Bath tub
- Bathroom, but not in tub

- Closet
- Bedroom
- Family/living room
- Kitchen
- Other—specify: _____
- Unknown

If not in basement, what floor of the structure was patient on?

- 1st Floor
- 2nd Floor
- 3rd Floor

How did patient get to the hospital?

- Ambulance (name of company): _____
- Private Vehicle
- Public Transportation
- Walked or was carried
- Helicopter
- Other: _____
- Unknown

Was patient transferred between healthcare facilities? Yes No Unknown

IF YES, from _____ to _____

Tetanus screen performed? Yes No Unknown
 Tetanus needed? (more than 5 yrs since last shot) Yes No

Tetanus immunization given? Yes No

Co-morbidities/prior disabilities: _____

Description: _____

REGION	TYPE AND SITE	SIZE, DESCRIPTION AND MEDICAL TREATMENT	CAUSE
Head/Neck	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
Face	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
Chest	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
Abdomen/ Pelvic Contents	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
Extremities or Pelvic Girdle	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>