

Physician Survey
Case Report Form for Oklahoma City Blast-Related Injuries

Blast-Related Injuries and Other Conditions Are Mandated Reportable Conditions (O.S. 63-1-106)

Doctor's Name and Address _____

Please complete a form as completely as possible for EACH patient you treated for a blast-related injury: (i.e., any physical injury that was a result of the blast itself, rescue or clean-up efforts, or complications stemming from these injuries). If information is unknown, please specify as such. Copy this form as necessary for additional patients.

1. HAVE SEEN NO BLAST-RELATED PATIENTS

2. Practice setting where you first saw patient:
 private office
 clinic/health center
 other -- specify: _____

3. Was the patient seen in a hospital emergency department prior to this visit?
 Yes -- specify hospital: _____
 No
 Unknown

4. Patient Name: (Last) _____ (First) _____ Telephone: (____) _____

5. Birth Date: ____/____/____ 6. Age: _____ 7. Sex: Male Female

8. Occupation: _____ 9. Employer: _____

10. Date of Injury: ____/____/____

11. Date of first outpatient visit for this condition: ____/____/____

12. Total number of visits for this problem: _____

13. Was the injury:
 Directly blast-related Search & Rescue Other -- specify: _____

14. Where was the patient when the injuries occurred:
 1. Inside a building, mark one:
 Murrah Bldg YMCA Water Resources Journal Record
 Regency Tower Unknown Bldg Other -- specify: _____
 2. Outdoor location -- specify: _____
 3. Unknown

15. List diagnosis, site of injury, treatment (e.g., fracture from fall, left wrist, cast)

Diagnosis:	Sites of Injury:	Treatment:
a. _____	a. _____	a. _____
b. _____	b. _____	b. _____
c. _____	c. _____	c. _____

16. Did you observe or did the patient complain of any of the following symptoms indicative of possible emotional disturbance? (*Check all that apply.*)

<input type="checkbox"/> Sleep disturbances or nightmares	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Increased consumption of alcohol or other chemicals	<input type="checkbox"/> Hypervigilance
<input type="checkbox"/> Other _____	<input type="checkbox"/> Social withdrawal, silence

17. Was the patient referred for treatment for any of these symptoms: Yes No

Please return forms as soon as possible in the enclosed postage-paid green envelope or to the Injury Prevention Service, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1299. If you have any questions please call the Injury Prevention Service at 405/271-3430.