

Data Collection Form for Injured Rescue Personnel

Patient's Name: _____

Agency/Task Force: _____

Address: _____

Telephone WORK: () _____ - _____ HOME: () _____ - _____

Age in years: _____ Sex: Male _____ Female _____

Occupation: _____ Employer: _____

Date First Employed at Bomb Site: ____/____/____

What kind of work/rest schedule was patient following in this rescue effort? _____

Date of Injury: ____/____/____ Time of Injury: _____ (military)

How many hours had patient been working on the shift when the injury occurred?
_____ hours

What was patient doing at the time of injury? _____

Where was patient at the time of the injury (in building? outside building?)? _____

Describe the Injury: _____

Medical Diagnosis: _____

Where was the injury treated (facility)? _____

Disposition (check one):
___ treated at scene and released
___ transported to facility for treatment and released
 (to which facility _____)
___ transported to facility for admission
 (to which facility _____)

Describe the initial treatment? _____

Was patient able to return to work? Yes___ No___ N/A___