GER Event Type – Injury

*Time of Injury: ___________ AM/PM  □ Unknown  *This event was:  ○ Observed  ○ Discovered

Discovered Date/Time: ____________________________ AM/PM

Specific Location:

□ Activity Area  □ Bathroom  □ Bedroom  □ Dining Room  □ Hallway  □ Kitchen  □ Living Room  □ Outdoors
□ Recreation Area  □ Staircase  □ Unknown  □ Other  If Other: ____________________________

Type:

□ Abrasion  □ Airway Obstruction  □ Allergic Reaction  □ Bite/Sting  □ Bleeding  □ Blister  □ Bruise  □ Burn  □ Choking
□ Concussion  □ Cut  □ Dislocation  □ Fracture  □ Frostbite  □ Hematoma  □ Hypothermia  □ Infection  □ Laceration
□ Lesion  □ Loss of Consciousness  □ Pain  □ Poisoning  □ Pressure Ulcer  □ Puncture  □ Rash/Hives
□ Lesion  □ Redness  □ Scrape  □ Scratch  □ Sprain  □ Strain  □ Sunburn  □ Swelling/Edema  □ Other
If Other: ____________________________

Cause:

□ Abuse  □ Accident Motor Vehicle  □ Accident Other  □ Adaptive Equipment  □ Assault  □ Bumped Into
□ Eating Behavior  □ Environmental Hazard  □ Exposure  □ Fall  □ Ingestion of Foreign Material (Pica)  □ Insect
□ Medical Condition  □ Medical Procedure  □ Restraint  □ Seizure  □ Self Injurious Behavior  □ Undetermined
□ Other  If Other: ____________________________

Severity:

□ Very Minor (No treatment)  □ Minor (First aid)  □ Moderate (Nurse/Physician treatment)  □ Severe (Hospital/ER admission)  □ Death

Color:

□ Beige  □ Black  □ Green  □ Multicolored  □ Pink  □ Purple  □ Red  □ Yellow  □ Other  If Other: ___________

Size: ___________ Length (cm)  ___________ Width (cm)  ___________ Depth (cm)

*Body Parts:

□ Abdomen  □ Ankle Left  □ Ankle Right  □ Arm Left  □ Arm Right  □ Back  □ Buttock Left  □ Buttock Right
□ Buttocks  □ Calf Left  □ Calf Right  □ Chest  □ Ear Left  □ Ear Right  □ Elbow Left  □ Elbow Right  □ Eye Left
□ Eye Right  □ Face  □ Finger Index Left  □ Finger Index Right  □ Finger Little Left  □ Finger Little Right  □ Finger Middle
□ Finger Middle Right  □ Finger Ring Left  □ Finger Ring Right  □ Finger Thumb Left  □ Finger Thumb Right
□ Fingers Left  □ Fingers Right  □ Foot Left  □ Foot Right  □ ForeArm Left  □ ForeArm Right  □ Forehead  □ Genitals
□ Hand Left  □ Hand Right  □ Head  □ Hip Left  □ Hip Right  □ Internal  □ Knee Left  □ Knee Right  □ Leg Left  □ Leg Right
□ Lips  □ Lower Back  □ Mouth  □ Neck  □ Nose  □ Rectum  □ Shin Left  □ Shin Right  □ Shoulder Left  □ Shoulder Right
□ Systemic  □ Teeth  □ Thigh Left  □ Thigh Right  □ Throat  □ Toe 2nd Left  □ Toe 2nd Right  □ Toe 3rd Left  □ Toe
□ 3rd Right  □ Toe 4th Left  □ Toe 4th Right  □ Toe Big Left  □ Toe Big Right  □ Toe Left  □ Toe Little Left  □ Toe Little Right
□ Toe Right  □ Tongue  □ Upper Arm Left  □ Upper Arm Right  □ Upper Back  □ Waist  □ Wrist Left  □ Wrist Right
Treatment By:
☐ None  ☐ Self  ☐ Family  ☐ Staff/LPN  ☐ RN Nurse  ☐ Physician/other medical  ☐ ER/Hospital  ☐ Contractor

Time of Treatment: ___________(AM/PM)  Treatment date, if different than event date: ________________
Injury Photo:  ☐ Attached  Attached Photo Date: ________________

*Summary: ____________________________________________________________________________________
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Witness(es)

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SIGNATURE ..................................  NAME ........................................  DATE .........................  TIME ...................... am/pm

Note: Required fields are marked with an asterisk (*)