GER Offline Form for
Delaware Users

General Event Report
Data Collection for Event: Injury

Profile Information

Individual Name * _____

Provider Name _____ **Program Name** _____

Entered By _____ **Title** _____

Report Date * _____ **Time Zone** _____

Event Information

Event Date * _____

If not at responsible program O Community O Home O Recreation/Leisure O Vehicle O School O Work O Family home visit O Unknown **If Other** _____

Location Address

Street 1 _____ **Street 2** _____

City _____ **County** _____ **State** _____

Zip Code _____ **Phone** _____ **Fax** _____

Injury Information

Injury Type * O Abrasion O Airway Obstruction O Allergic Reaction O Bite/Sting O Bleeding O Bruise O Burn O Choking O Concussion O Cut O Dislocation O Fracture O Frostbite O Hematoma O Infection O Laceration O Lesion O Loss of Consciousness O Pain O Poisoning O Puncture O Rash/Hives O Scrape O Sprain/Strain O Sunburn O Swelling/Edema **If Other** _____

Injury Cause * O Abuse O Accident Motor Vehicle O Accident Other O Adaptive Equipment O Assault O Bumped Into O Eating Behavior O Environmental Hazard O Exposure O Fall O Ingestion of Foreign Material O Insect O Medical Condition O Medical procedure O Restraint O Seizure O Self Injurious Behavior O Undetermined

If Other _____

SIGNATURE _____ **NAME** _____ **DATE** _____ **TIME** _____ **am/pm**

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

This event was * O Observed O Discovered **Time of Injury** * _____ am / pm

Specific Location O Living Room O Bedroom O Dining Room O Kitchen O Bathroom O Hallway O Staircase O Activity Area O Recreation Area O Outdoors O Unknown

If Other _____

Treatment by O None O Self O Family O Staff/LPN O RN Nurse O Physician/other medical O ER/Hospital

Time of Treatment _____ am / pm **Treatment date, if different than event date** _____

Injury Size

Length (cm) _____ **Width (cm)** _____ **Depth (mm)** _____

Injury Color O Beige O Black O Green O Multi-colored O Pink O Purple O Red O Yellow **If Other** _____

Injury Severity * O Very Minor (No treatment) O Minor (First aid) O Moderate (Nurse/Physician treatment) O Severe (Hospital, ER/admission) O Death

Body Part(s) * O Abdomen O Ankle Left O Ankle Right O Arm Left O Arm Right O Back O Buttocks O Chest O Ear Left O Ear Right O Elbow Left O Elbow Right O Eye Left O Eye Right O Face O Fingers Left O Fingers Right O Foot Left O Foot Right O Genitals O Hand Left O Hand Right O Head O Hip Left O Hip Right O Internal O Knee Left O Knee Right O Leg Left O Leg Right O Lips O Mouth O Neck O Nose O Rectum O Shoulder Left O Shoulder Right O Systemic O Teeth O Throat O Toe Left O Toe Right O Tongue O Wrist Left O Wrist Right

Injury Summary _____

_____

_____

_____

_____

_____

SIGNATURE _____ **NAME** _____ **DATE** _____ **TIME** _____ **am/pm**

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

Therap® SERVICES

Witness 1 _____

Witness 2 _____

Injury Photo ☐ **Attached** **Photo Date** _____

General Information

Abuse Suspected ? O Yes O No

Type of Abuse O Civil Rights Violation O Physical O Sexual O Emotional O Verbal O Psychological **If Other** _____

Neglect Suspected ? O Yes O No

Type of Neglect O Neglect by Responsible Provider **If Other** _____

Internal Report only ? O Yes O No **Notification Level** * O Low O Medium O High

Reported By * _____

Reporter's Relationship to Individual O Family O Self O Staff **If Other** _____

Notification Information

Person/Entity Notified*	Name of Person Notified	Date*/Time* of Notification	Notified By*	Method of Notification*

Corrective Action Taken _____

_____

_____

_____

_____

_____

SIGNATURE _____ **NAME** _____ **DATE** _____ **TIME** _____ **am/pm**

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

Plan of Future Corrective Actions _____

_____

_____

_____

_____

Review/Follow-up Comments

☐ I have reviewed this report

Review/Follow-up Comments _____

_____

_____

_____

_____

Photo ☐ Attached Photo Date _____

SIGNATURE _____ NAME _____ DATE_____ TIME _____ am/pm

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