



FIREWORKS INJURY REPORTING

State Form 51497 (R3 / 3-08)
INDIANA STATE DEPARTMENT OF HEALTH

CONFIDENTIAL INFORMATION

- INSTRUCTIONS:** 1. Print information to ensure legibility.
 2. Fill in circles for appropriate choice.
 3. Complete all items on the forms.
 4. Per HEA 1131, report must be completed within 5 business days after examination of the injury.

Section 1: Demographic Information on Injured Person

Date of Medical Evaluation: _____

Last Name: _____ First Name: _____ MI: _____

Phone Number: (____) _____ - _____ Date of birth: _____ Age: _____

If child, name of parent or guardian (*Last, First, MI*): _____

Street Address: _____

City / Town: _____ State: _____ ZIP: _____ County: _____

Sex:	Race (<i>choose all that apply</i>)	Ethnicity
<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown	<input type="radio"/> White <input type="radio"/> Black or African American <input type="radio"/> Asian <input type="radio"/> Native Hawaiian or Other Pacific Islander <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Multiracial	<input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino
	<input type="radio"/> Unknown	

Section 2—Site of Report: Hospital / Emergency Department / Physician Office / Surgical Center

Hospital Name: _____
 Hospital / Related Site: _____ Emergency Department Urgent Care Center
 Ambulatory Surgical Center (Name): _____
 If reporting from a Health Care Provider Office, State Name of Practice: _____

Physician Name: _____

Contact through: _____ Email: _____ Office: (____) _____ - _____

Street Address: _____

City / Town: _____ State: _____ ZIP: _____ County: _____

(Person Reporting) Title: _____

Last Name: _____ First Name: _____

Phone Number: (____) _____ - _____ Email: _____

Name of Injured Person: _____

Section 3: Injury and Surrounding Circumstances	
Body Part Involved (<i>note all involved</i>)	Type of Injury (<i>note all involved</i>)
<input type="checkbox"/> Hand(s) / Finger <input type="checkbox"/> Arm <input type="checkbox"/> Eye(s) <input type="checkbox"/> Face / Ears / Head <input type="checkbox"/> Leg(s) / Foot / Toe(s) <input type="checkbox"/> Trunk <input type="checkbox"/> Other _____	<input type="checkbox"/> Burn <input type="checkbox"/> 1 st Degree <input type="checkbox"/> 2 nd Degree <input type="checkbox"/> 3 rd Degree <input type="checkbox"/> Contusion / Laceration / Abrasion <input type="checkbox"/> Puncture Wound <input type="checkbox"/> Penetrating Foreign Body / Missile <input type="checkbox"/> Sprain / Fracture <input type="checkbox"/> Other _____
Outcome (<i>note all that apply</i>)	Circumstances of Injury
<input type="checkbox"/> Death <input type="checkbox"/> Evaluated in Emergency Department <input type="checkbox"/> Released to home <input type="checkbox"/> Admitted to hospital <input type="checkbox"/> Transferred to _____ <input type="checkbox"/> Evaluated in provider office <input type="checkbox"/> Released to home <input type="checkbox"/> Admitted to hospital <input type="checkbox"/> Other (<i>Specify</i>) _____ If hospitalized: Date of admission: _____ Date of discharge: _____ (<i>if available</i>)	Date of injury: _____ Time of injury: _____ o AM o PM <u>Locale of injury:</u> <input type="checkbox"/> Private home / yard / property <input type="checkbox"/> Friend / neighbor / relative home / yard / property <input type="checkbox"/> Public park / street / property <input type="checkbox"/> School property <input type="checkbox"/> Other (<i>Specify</i>) _____ If eye injury: <input type="checkbox"/> No eye protection <input type="checkbox"/> Eyeglasses or safety glasses <input type="checkbox"/> Contact lenses
Risk Factors at the time of injury	Type of Fireworks / Pyrotechnics
<input type="checkbox"/> Alcohol Consumption <input type="checkbox"/> By injured person <input type="checkbox"/> Within 3 hours of injury <input type="checkbox"/> Blood alcohol tested <input type="checkbox"/> Unknown <input type="checkbox"/> By other people at the scene <input type="checkbox"/> If injured person is less than 18 years of age, was an adult present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Injured person was a bystander	<input type="checkbox"/> Firecrackers <input type="checkbox"/> Rockets (i.e., bottle rockets) <input type="checkbox"/> Sparklers <input type="checkbox"/> Twisters / "Jumping Jacks" <input type="checkbox"/> Lighting gunpowder <input type="checkbox"/> Homemade, altered device <input type="checkbox"/> Aerial devices <input type="checkbox"/> Other (fountains, roman candles, etc.) <input type="checkbox"/> Pyrotechnics (indoor fireworks event) – <i>Specify Event or Location involved</i> _____ <input type="checkbox"/> Unspecified / Unknown
Mechanism / Problem (<i>if known</i>)	Comments / Additional Information
<input type="checkbox"/> Malfunction / timing of firework <input type="checkbox"/> Errant path of rocket <input type="checkbox"/> Debris from aerial fireworks <input type="checkbox"/> Mishandling (relighting, throwing, etc.) <input type="checkbox"/> Other <input type="checkbox"/> Unknown	

Please fax this form to (317) 233-7761: Attn: Injury Epidemiologist
 Or mail to: Indiana State Dept of Health
 2 North Meridian Street, 2 Selig
 Indianapolis, IN 46204
 Please direct any questions to (317) 234-6325