Central State Hospital
Client Accident and Injury Report

Date: ☐ of occurrence ____________ **Time:** ☐ of occurrence __________________ AM/PM
☐ of discovery ____________ ☐ of discovery __________________ AM/PM

Accident/Injury Information:
Location of Occurrence: ________________________________ ***Mental Condition:*** ☐ Quiet ☐ Excited ☐Other
State how accident/injury occurred or what happened: ____
____

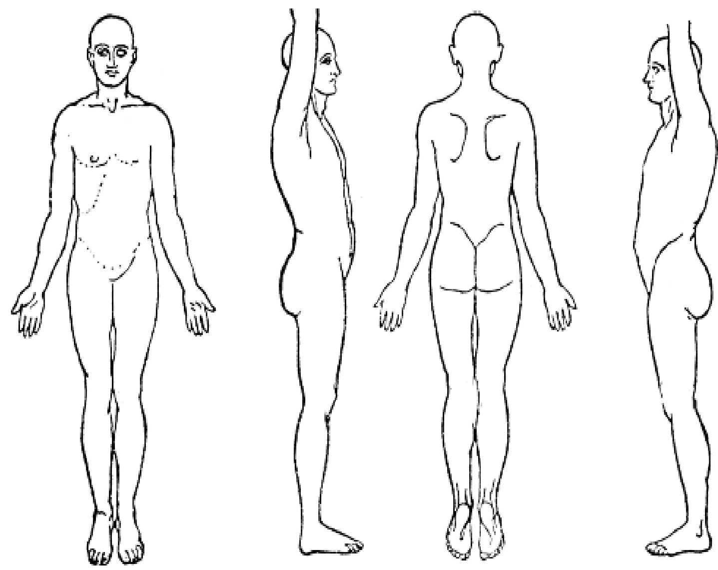
Accident/Injury Category: Check only one ☐ Unknown
☐ Accident: Fall ☐ Assault: Sexual (☐ Client-Client/☐ Employee-Client) ☐ Self-inflicted: Suicide Attempt
☐ Accident: Other ☐ Assault: Physical (☐ Client-Client/☐ Employee-Client) ☐ Self-inflicted: Other:__________
Assaulted by (Name & BHIS #): ___________________________ ☐ ***Aggressor NOT Injured*** ☐ ***Aggressor Injured***
NOTE: If aggressor is injured, a Client Accident and Injury Report must be completed on the aggressor.

Type of Injury: Check all that apply
☐ No Injury ☐ Choking ☐ Head Trauma ☐ Scratch
☐ Bite ☐ Contusion/Hematoma ☐ Laceration/Cut ☐ Swelling/Edema
☐ Bruise ☐ Fracture ☐ Scrape/Abrasion ☐ Other _________________

Characteristics of Injury: Check all that apply
☐ Not Applicable ☐ Discoloration ☐ Pain ☐ Skin Broken
☐ Bleeding ☐ Lethargic ☐ Redness/Erythema ☐ Swelling/Edema
☐ Death ☐ Nausea/Vomiting ☐ Respiratory Distress ☐ Unresponsive

Severity/Treatment:
Severity Level: Check only one ***Treatment: Check all that apply***
☐ No Treatment ☐ Treatment on the Unit ____
☐ 0 (First Aid Only) ☐ Lab/X-Ray ☐ Cast/Splint/etc.
☐ 1 (Beyond First Aid) ☐ Medication: _______________________ ☐ Head Trauma Protocol
☐ 2 (Hospitalization) ☐ Referred to Emergency Department ☐ Other ________________________
☐ 3 (Death) ☐ Sutures

Pain Rating: ☐
Note: Complete pain assessment form if: 1) pain rating is >0, 2) client fell or 3) there is a potential for delayed pain.



Indicate site of injury on diagram to the left.

STAMP PLATE

CSH-464 (Rev. 1/06) **Front**

Potential Risk Factors:
Cause of Accident/Injury: Check all that apply
☐ Environmental/Safety Issues ☐ Abuse ☐ Physical Condition ☐ Staff Knowledge
☐ Medication (Specify)__________________ ☐ Restraint/Seclusion/Time Out ☐ Other: _______________

Environmental/Safety Issues: Check all that apply
☐ Bed Height ☐ Equipment Failure ☐ Side Rails Up ☐ Wet/Slippery Floor
☐ During Transfer ☐ Side Rails Down ☐ Tripping Hazard ☐ Other (Specify) __________________

Physical Conditions: Check all that apply
☐ Alteration in Mental Status ☐ Hypoglycemia ☐ Hyperthermia
☐ Difficulty Swallowing ☐ Hyperglycemia ☐ Seizures
☐ Fragile Skin ☐ Hypothermia ☐ Unsteady Gait
☐ Other (Specify): ____

Fall Risk: ☐ Yes ☐ No
Indicate Observation Category: ☐ Routine ☐ 1:1 ☐ Line of Sight ☐ Q 15 Min. ☐ Q 30 Min.
Observation Category Followed: ☐ Yes ☐ No
If incident occurred during restraint/seclusion/time out, specify type: ____

Witnesses: ☐ Yes ☐ No ***Witness Name(s):*** __________________________ ______________________________
______________ __________________________ ________________________ ______________________
Unit Staffing Level Met? ☐ Yes ☐ No
Staff Assigned to Client: ____________________________________ ***Assigned Staff SS# (last 4 digits):*** ____________

Staff Completing Form:_______________________________ **Title:** ________________ **Date:**__________

Physician's Evaluation: ***Should representative be notified?*** ☐ Yes ☐ No
Findings: ____
Treatment: ____
Was medication contributing factor to the accident/injury? ☐ ***Yes*** ☐ ***No If yes, explain:*** ______________________
____
Physician's Signature: ____ ***Date:*** ___________________________

Notification of Representative:
Representative Notified: ☐ Yes ☐ No ☐ Not to be notified at request of: ☐ representative; ☐ Client
Representative Name: ____
Method of Notification: ☐ In Person ☐ Letter ☐ Phone ***Notification: Date:*** _____________ ***Time:*** __________
Representative Notified by: ________________________________ ***Comments:*** ________________________________
____

Management Review:
Remarks: ____
Action taken: ____
Employee SS#(last 4 digits): _________ ***Signature:*** _______________________________ ***Date:*** _______________

____________________________	____________________________	____________________________
Nurse Executive/Designee	**Clinical Director/Designee**	**Division Chief/Designee**
____________________________	____________________________	____________________________
Date	**Date**	**Date**

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