

FIREWORKS INJURY SURVEY

Directions: Complete one survey form for each firework related injury treated by your facility. Please email them to osfminv@ks.gov or you can fax, or mail completed forms to the above address. Thank you, in advance, for your participation.

Date of Injury ____/____/____ **Sex of Injured Person (Circle One):** M or F **Age of Injured Person** _____

A. Nature of Injury (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Burns | <input type="checkbox"/> Trauma/Blunt Force |
| <input type="checkbox"/> Inhalation Injury/Asphyxia (Smoke) | <input type="checkbox"/> Complaint of Pain |
| <input type="checkbox"/> Wound/Cut/Bleeding | <input type="checkbox"/> Shock |
| <input type="checkbox"/> Dislocation/Fracture | <input type="checkbox"/> Other Injury (Specify) _____ |

B. Part of Body with Largest Percentage of Injury (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Face | <input type="checkbox"/> Hand |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Leg |
| <input type="checkbox"/> Head (Not Facial Area) | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Body/Trunk/Back/Neck | <input type="checkbox"/> Internal (Smoke Inhalation) |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Other Part (Specify) _____ |

C. Type of Firework Causing Injury (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Firecracker | <input type="checkbox"/> Mortars/Artillery |
| <input type="checkbox"/> Bottle Rocket | <input type="checkbox"/> Public Fireworks Display |
| <input type="checkbox"/> Sparkler | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Roman Candle | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Smoke Bombs | <input type="checkbox"/> Homemade (Specify) _____ |

D. Activity of Injured Party (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Fireworks Operator/Shooter | <input type="checkbox"/> Bystander Watching Fireworks |
| <input type="checkbox"/> Assisting Fireworks Operator/Shooter | <input type="checkbox"/> Uninvolved |

E. If Injured Party was the Operator/Shooter or Assistant what was Used to Light the Firework?

- | | |
|--|--|
| <input type="checkbox"/> Punk | <input type="checkbox"/> Long Handled Lighter |
| <input type="checkbox"/> Cigarette Lighter | <input type="checkbox"/> Other (Specify) _____ |

F. Disposition (check that all apply):

- | | |
|---|--|
| <input type="checkbox"/> Refused Treatment | <input type="checkbox"/> Admitted for Treatment |
| <input type="checkbox"/> Treated & Released | <input type="checkbox"/> Died |
| <input type="checkbox"/> Admitted for Observation | <input type="checkbox"/> Transfer to Burn Center |
| | <input type="checkbox"/> Other (Specify) _____ |

Completed By _____ Title _____

Name of Facility _____ No Injuries to Report

City of Facility _____ County _____

Type of Facility (Choose one): Urgent Care Emergency Room Physician's Office Other