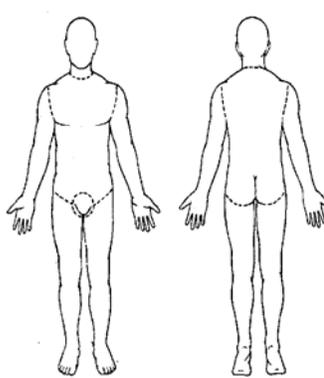


Complete this form if a worker became ill, injured, or was exposed to chemicals or blood/body fluids while working in or for a Hurricane Katrina disaster evacuation center (including transporting human remains and/or waste).

Evacuation center Location				
Name of Evacuation Center	State	County	City	Evacuation center phone number
Type of Evacuation Center <input type="checkbox"/> Military Installation <input type="checkbox"/> Faith-based <input type="checkbox"/> Cruise ship <input type="checkbox"/> Sports Arena/Convention Center <input type="checkbox"/> Hospital-based <input type="checkbox"/> School <input type="checkbox"/> Campground <input type="checkbox"/> Campground <input type="checkbox"/> Other (describe) _____				
Worker Identification and Demographics				
Last name, First name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age (yrs) ____ ____	Volunteer? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Occupation or job title when injured/ill (<i>use several words to describe</i>)			Employer/Aid agency at time of injury/illness	
Worker's general evacuation center duties (<i>briefly describe</i>)				
How long had the worker worked at this evacuation center? _____ days			If not a permanent employee of the evacuation center, who assigned the worker to this evacuation center?	
Normal or permanent occupation			Normal employer	
Injury Information (<i>most current injury that received medical treatment</i>)				
Date of injury ____/____/____ Month Day Year	Time of Injury ____ : ____ HH MM (24 hr clock)	Place of medical treatment <input type="checkbox"/> Evacuation center <input type="checkbox"/> Dr's office <input type="checkbox"/> Emergency Dept <input type="checkbox"/> Other clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Other medical <input type="checkbox"/> DMAT	Type of treatment (sutures, splint, antibiotics, tetanus, etc.)	
Nature of Injury (<i>check all that apply</i>) <input type="checkbox"/> Abrasion/Contusion <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Amputation <input type="checkbox"/> Laceration/puncture <input type="checkbox"/> Body fluid splash <input type="checkbox"/> Lung (smoke/dust) <input type="checkbox"/> Burn (thermal/elec) <input type="checkbox"/> Needle stick/sharps <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Pain, general <input type="checkbox"/> Chest pain <input type="checkbox"/> Poisoning <input type="checkbox"/> Concussion <input type="checkbox"/> Psychological stress <input type="checkbox"/> Crush <input type="checkbox"/> Skin irritation/rash <input type="checkbox"/> Eye injury/irritation <input type="checkbox"/> Sprain/strain <input type="checkbox"/> Fracture <input type="checkbox"/> Other (<i>describe</i>)	Part of Body (<i>check all that apply</i>) Head/Neck <input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Mouth <input type="checkbox"/> Neck Upper Extremity <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Lower Arm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand/Finger Internal & Whole Body <input type="checkbox"/> Internal (lungs, etc) <input type="checkbox"/> 25-50% of body <input type="checkbox"/> All of body (>50%) Trunk <input type="checkbox"/> Upper Trunk <input type="checkbox"/> Lower Trunk <input type="checkbox"/> Pubic Region Lower Extremity <input type="checkbox"/> Upper leg or hip <input type="checkbox"/> Knee <input type="checkbox"/> Lower leg <input type="checkbox"/> Ankle <input type="checkbox"/> Foot/toe	Mark all injured body parts 		
Disposition <input type="checkbox"/> Treat & released <input type="checkbox"/> Hospitalized <input type="checkbox"/> Died <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown				
Severity <input type="checkbox"/> No physical injury <input type="checkbox"/> Minor (<1 hr tx, e.g., minor bruise/ cut) <input type="checkbox"/> Moderate (1-4 hr tx, e.g., fractures, sutures) <input type="checkbox"/> Severe (>4 hr tx, e.g., internal hemorrhage, punctured organ, severed blood vessel)				
Additional information about nature, symptoms, or treatment of injury (e.g., multiple injuries, fever, surgery, etc.): _____ _____ _____				

Injury incident

Mechanism <i>(How was the worker injured?)</i>			PPE worn at the time of injury <i>Check all that apply</i>
Contact/Falls/Overexertion <input type="checkbox"/> Struck by/against object <input type="checkbox"/> Caught in/crushed <input type="checkbox"/> Rubbed or abraded <input type="checkbox"/> Fall <input type="checkbox"/> Slip, trip without fall <input type="checkbox"/> Sprain/strain from bending, reaching, twisting <input type="checkbox"/> Sprain/strain from lifting, pulling, holding <input type="checkbox"/> Repetitive motion	Exposures <input type="checkbox"/> Exposure to hot temperature <input type="checkbox"/> Exposure to cold temperature <input type="checkbox"/> Contact with hot object/liquid/steam <input type="checkbox"/> Contact with cold object/liquid <input type="checkbox"/> Inhalation <input type="checkbox"/> Ingestion of substance <input type="checkbox"/> Skin contact with caustic/noxious substance <input type="checkbox"/> Needle stick/sharp <input type="checkbox"/> Blood or body fluid splash <input type="checkbox"/> Electricity	Transportation/Fires/Assaults <input type="checkbox"/> Motor vehicle incident <input type="checkbox"/> Fire/flare <input type="checkbox"/> Explosion <input type="checkbox"/> Assault by a person <input type="checkbox"/> Assault by an animal <input type="checkbox"/> Venomous bite/sting <input type="checkbox"/> Other <i>(describe)</i>	<input type="checkbox"/> Surgical mask <input type="checkbox"/> Respirator <input type="checkbox"/> ½ mask no cartridge (inc. N-95) <input type="checkbox"/> ½ mask with cartridge <input type="checkbox"/> full face mask <input type="checkbox"/> Eye protection <input type="checkbox"/> Face shield <input type="checkbox"/> Gloves <input type="checkbox"/> Single Gloved <input type="checkbox"/> Double Gloved <input type="checkbox"/> Gown/apron <input type="checkbox"/> Rubber boots

Description of incident: *(provide as many details as possible; e.g., severe strain to lower back while lifting unassisted an adult from chair to bed, occurred near end of 12 hr shift, two days rest and pain meds required)*

Illness Information

Date of symptom onset _____ / _____ / _____ Month Day Year	Onset Time _____ : _____ HH MM (24 hr clock)	Place of medical treatment <input type="checkbox"/> Evacuation center <input type="checkbox"/> Emergency Dept <input type="checkbox"/> Hospital <input type="checkbox"/> DMAT <input type="checkbox"/> Dr's office <input type="checkbox"/> Other clinic <input type="checkbox"/> Other medical	Type of treatment (antibiotics, tetanus, other medications, etc.)
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Symptoms <i>(Check all that apply)</i> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Asthma/Shortness of Breath <input type="checkbox"/> Chest pain <input type="checkbox"/> Cough/Congestion <input type="checkbox"/> Diarrhea <input type="checkbox"/> Elevated Blood Pressure <input type="checkbox"/> Fever <input type="checkbox"/> Fainting/syncope/Loss of consciousness <input type="checkbox"/> Headache <input type="checkbox"/> Musculoskeletal Pain <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Skin Condition or Rash <input type="checkbox"/> Seizure <input type="checkbox"/> Stroke Symptoms <i>Behavior Symptoms</i> <input type="checkbox"/> Anger, voicing threats or acting out <input type="checkbox"/> Anxiety/Stress <input type="checkbox"/> Distress/Insomnia/Emotional Numbing <input type="checkbox"/> Extreme Fatigue/Weakness/Exhaustion <input type="checkbox"/> Suicidal/homicidal intent <input type="checkbox"/> Other: _____	Primary Clinical Impressions <input type="checkbox"/> Acute Respiratory illness: <input type="checkbox"/> URI <input type="checkbox"/> LRI <input type="checkbox"/> Alcohol or Drug Use <input type="checkbox"/> Carbon Monoxide Poisoning <input type="checkbox"/> Cerebrovascular Disease (e.g., stroke) <input type="checkbox"/> Chronic Lower Respiratory Disease (e.g., asthma) <input type="checkbox"/> Dehydration <input type="checkbox"/> Depression, Anxiety, Adjustment Disorder <input type="checkbox"/> Febrile illness <input type="checkbox"/> Gastroenteritis: <input type="checkbox"/> Bloody <input type="checkbox"/> Watery <input type="checkbox"/> Gastritis or other GI, <u>not gastroenteritis</u> <input type="checkbox"/> Heart Disease (e.g., heart attack) <input type="checkbox"/> Heat illness, <u>not dehydration</u> (e.g., heat stroke) <input type="checkbox"/> Hyperglycemia, hypoglycemia, or diabetes mellitus <input type="checkbox"/> Renal Failure <input type="checkbox"/> Skin Wound or Infection <input type="checkbox"/> Other Infectious Disease: _____ <input type="checkbox"/> Not Recorded/ Undetermined <input type="checkbox"/> Other: _____
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Complication of a pre-existing condition? YES NO

If YES, indicate pre-existing condition:

Disposition Treat & released Hospitalized Died Other _____ Unknown

Additional information about nature, symptoms, or treatment of illness:

Interviewer Information

Name	Agency	Date	Source of information
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