

DEPARTMENT OF HEALTH
Fireworks-Related Injury (FWRI) Surveillance
Patient Information Sheet

Date:	Region:	Hospital:	
PATIENT DATA			
Patient's Name:			
Last Name:	First Name:	Middle Name:	
Permanent Address:			
House No. & Street:	Barangay:	Municipality/City:	Province: Region:
Telephone No.:	Sex:	Date of Birth:	Age:
	<input type="radio"/> Male <input type="radio"/> Female	__ / __ / __ mm dd yyyy	
INCIDENT INFORMATION			
Date of Injury:	Time of Injury:	Date of Consultation/ Admission:	Time of Consultation/ Admission:
__ / __ / __ mm dd yyyy	__:__:__ hh mm ss	__ / __ / __ mm dd yyyy	__:__:__ hh mm ss
		Referral from another hospital : <input type="radio"/> Yes <input type="radio"/> No	Place of Occurrence:
		If yes, name of hospital: _____	<input type="radio"/> Home <input type="radio"/> Street <input type="radio"/> Designated area for community fireworks display <input type="radio"/> Other, specify: _____
Place of Injury:			
House No. & Street:	Barangay:	Municipality/City:	Province: Region:
Type of Involvement:	Nature of Injury:		
<input type="radio"/> Active <input type="radio"/> Passive	<input type="radio"/> Fireworks injury <input type="radio"/> Stray bullet injury <input type="radio"/> Fireworks ingestion <input type="radio"/> Tetanus		
If fireworks injury, Type of Injury:	Diagnosis (include nature and site):		
<input type="radio"/> Blast/burn injury WITH amputation <input type="radio"/> Blast/burn injury NO amputation <input type="radio"/> Eye injury			
If fireworks injury, Multiple injuries:			
<input type="radio"/> Yes <input type="radio"/> No			
Anatomical Location:		Name of Firework:	Liquor Intoxication:
<input type="radio"/> Head <input type="radio"/> Abdomen <input type="radio"/> Knee <input type="radio"/> Eye <input type="radio"/> Pelvis <input type="radio"/> Foot <input type="radio"/> Neck <input type="radio"/> Thigh <input type="radio"/> Forearm/Arm <input type="radio"/> Chest <input type="radio"/> Buttocks <input type="radio"/> Hand <input type="radio"/> Back <input type="radio"/> Legs			<input type="radio"/> Yes <input type="radio"/> No
Treatment Given:	Disposition		Outcome:
<input type="radio"/> ATS/TIG <input type="radio"/> Toxoid <input type="radio"/> None <input type="radio"/> Other, specify: _____	<input type="radio"/> Treated and sent home <input type="radio"/> Refused admission <input type="radio"/> Admitted <input type="radio"/> Transferred/Referred to: _____		<input type="radio"/> Alive <input type="radio"/> Died
			Date Died: __ / __ / __ mm dd yyyy
Are you aware of any health education materials regarding fireworks? <input type="radio"/> Yes <input type="radio"/> No			
If yes, check all that applies: <input type="radio"/> TV <input type="radio"/> Newspaper/Print <input type="radio"/> Radio <input type="radio"/> Poster/Tarpaulin <input type="radio"/> Internet/Social Media			
Prepared by:	Name:	Signature:	
Noted by:	Name: (officer-of-the-day)	Signature:	

Input instruction Form

No.	Field Name	Instruction
1	Date	The date when the form was accomplished must be entered on this portion.
2	Region	Write the region where the hospital is located.
3	Hospital	Write the name of the Hospital, Center or Clinic which submits the report.
4	Name of Patient	Write the patient's Last name, First name and Middle name on the appropriate spaces provided. Note: Mr. X or None may be written if no informant can provide the information.
5	Permanent Address	Write the patient's permanent address - House No. and Street, Barangay, Municipality/City, Province and Region
6	Telephone No.	Write the patient's contact details such as landline number, mobile number
7	Sex	Check the appropriate circle for the sex of the injured by birth.
8	Date of birth	Write the date of birth in the format mm/dd/yyyy (e.g. July 1, 2007 should be entered as <u>07/01/2007</u>)
9	Age	Write the age of the patient in years
10	Date of Injury	Write the date when the injury occurred in the format mm/dd/yyyy (eg. July 1, 2007 should be entered as <u>07/01/2007</u>) (Note: Date of injury should not be greater than the date of consultation)
11	Time of Injury	Write the time of injury in 12-hour format (e.g. 5:00 PM or 8:00 AM)
12	Date of Consultation/Admission	Write the date when the patient sought consult in the facility in the format mm/dd/yyyy (eg. July 1, 2007 should be entered as <u>07/01/2007</u>)
13	Time of Consultation/Admission	Write the time of consultation/admission in 12-hour format (e.g. 5:00 PM or 8:00 AM)
14	Place of Occurrence	Check the appropriate place where the injury occurred – home, street, designated area; if others, please specify.
	Home	Within the vicinity of the residence (including backyard and front yard)
	Street	Outside the residence along streets
	Designated areas	Areas designated by the local authority for fireworks display
	Others	Other areas not defined as home, street, or designated area and may include school, office, beach, rice field, etc.
15	Place of injury	Write the location or address where the injury occurred, specifically the Street, Barangay, Municipality/City, Province, and Region.
16	Type of Involvement	Check the appropriate type of involvement whether the patient is active or passive.
	Active	Injured while lighting or holding any firework
	Passive	Injured while watching, passing by, or near a firework being lighted
17	Nature of Injury	Check the appropriate specific nature of injury/ies sustained by the patient. Whether fireworks injury, fireworks ingestion, stray bullet injury, or tetanus.
	Fireworks injury	Any person who sustained injury from fireworks in any form
	Fireworks ingestion	Any person who ingested any firework intentionally or accidentally
	Stray bullet injury	Any person who sustained injury from gun shot fired into the air related to the yuletide celebration and was validated or verified by the Philippine National Police (Note: Hospitals to report all injuries from gunshot which are alleged stray bullet injuries, EB and KMITS to verify with PNP.)
	Tetanus	Any person diagnosed with Tetanus caused by an injury due to firework from Dec. 24 to Jan. 21
18	If fireworks Injury, Type of Injury	Check the appropriate type of injury sustained by the patient. (Note: It can be multiple response)
	Blast/Burn injury WITH amputation	Any burn or blast injury (May include but not limited to laceration, abrasion, avulsion, contusion, redness, swelling) which includes amputation (removal of a limb) of a body part
	Blast/Burn injury NO amputation	Any burn or blast injury (May include but not limited to laceration, abrasion, avulsion, contusion, redness, swelling) which did not lead to amputation of a body part
	Eye injury	Injury involving the eyebrow, upper and lower eyelids, and the eye (orbital area)
19	Multiple Injuries	Any person who sustained blast/burn injury and eye injury
20	Diagnosis	Enter the complete final diagnosis of the patient including the nature and site of injury. Other important details of the injury must also be written on this portion.
21	Anatomical Location	Check the affected body location or site.
	Head	Injury to from the top of the head to chin except the eye as previously defined
	Neck	Anterior and posterior neck area
	Chest	Includes the area below the neck to the diaphragm
	Back	Includes the thoracic to the lumbar areas
	Abdomen	Below the diaphragm until above the pelvic area
	Pelvis	Between the abdomen and thigh not including the buttocks
	Thigh	Anterior and posterior thigh
	Buttocks	Buttocks area (Posterior of the pelvis)
	Legs	Anterior and posterior legs
	Knee	Anterior and posterior knee areas
	Foot	Includes the ankle and feet
	Forearm/Arm	Forearm and arm including the elbow
	Hand	Wrist and hands
22	Name of Firework	Write the name of firework/s which caused the injury.
23	Liquor Intoxication	Check whether the patient is intoxicated with liquor or not.
24	Treatment Given	Check the appropriate choice to indicate whether patient was given ATS or Toxoid/HTIg or no treatment was provided. In the space for "others, specify", state other treatment given (e.g. wound care, medicine given)
25	Disposition	Check the appropriate choice to indicate the disposition of the patient.
	Treated and sent home	Treatment was provided on outpatient basis
	Admitted	Patient was admitted in the hospital
	Refused admission	Patient advised admission but refused
	Transferred/Referred	Patient was seen in hospital and advised to be transferred/referred to another hospital. If "transferred", write the name of hospital/facility where the injured was transferred
26	Outcome	Indicate whether patient is alive or dead
27	Prepared by	The name and signature of the personnel completing the form must be entered on this portion.
28	Noted by	The name and signature of the Officer in-charge must be entered on this portion.

