



Family Wellness Hospital

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## INJURY REPORT FORM

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

NAME: \_\_\_\_\_

AGE/SEX: \_\_\_\_\_

HIGHT(CM): \_\_\_\_\_

WEIGHT (KG): \_\_\_\_\_

UHID NO: \_\_\_\_\_

IPD NO: \_\_\_\_\_

VENUE: \_\_\_\_\_

L LACERATION: \_\_\_\_\_

B BLEEDING: \_\_\_\_\_

D DISLOCATION: \_\_\_\_\_

F FRACTURE: \_\_\_\_\_

M MUSCLE INJURY \_\_\_\_\_

J JOINT INJURY \_\_\_\_\_

H HEAD INJURY \_\_\_\_\_

S SPINAL INJURY \_\_\_\_\_

I INTERNAL INJURY \_\_\_\_\_

REMOVAL FROM FIELD \_\_\_\_\_

WALKED \_\_\_\_\_

ASSISTED \_\_\_\_\_

STRETCHER \_\_\_\_\_

AMBULANCE \_\_\_\_\_

COMPLETE GAME \_\_\_\_\_

### SIGNIFICATION OBSERVATION

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### IMMEDIATE CARE

ICE \_\_\_\_\_

COMPRESSION \_\_\_\_\_

BLEEDING CONTROLLED \_\_\_\_\_

WOUND DRESSING \_\_\_\_\_

OTHER \_\_\_\_\_

### ADVISE TO FOLLOW UP

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_