Submersion Report Form

Please indicate the type of submersion event being reported:
- [ ] Drowning
- [ ] Near-Drowning
- [ ] Near Drowning resulting in traumatic brain injury due to anoxia

Please Print

### Demographics

1.) Patients Name  
   - Last: ____________________  
   - First: ____________________  
   - MI: ____________________

2.) Date of Birth  
   - Month (01-12)  
   - Day (0-31)  
   - Year (4 digits)

3.) Gender  
   - [ ] Male  
   - [ ] Female  
   - [ ] Unknown

4.) Race/Ethnicity  
   - [ ] White  
   - [ ] Asian/Pacific Islander  
   - [ ] Black  
   - [ ] American Indian  
   - [ ] Hispanic  
   - [ ] Other: ____________________  
   - [ ] Unknown (specify)

5.) Patient’s State of Residence  
   - [ ] TX  
   - [ ] Other (skip question 6)  
   - (specify)

6.) Patient’s Address  
   - Street: ____________________  
   - City: ____________________  
   - Zip Code: ____________________

### Injury Circumstances

7.) Date of Injury  
   - Month (01-12)  
   - Day (0-31)  
   - Year (4 digits)

8.) Time of day when the injury occurred  
   - Hour: __________:____________ (use military time)

9.) Day of the Week  
   - [ ] Monday  
   - [ ] Tuesday  
   - [ ] Wednesday  
   - [ ] Thursday  
   - [ ] Friday  
   - [ ] Saturday  
   - [ ] Sunday

10.) City where injury occurred  

   Address where injury occurred  
   - Street: ____________________  
   - City: ____________________  
   - Zip Code: ____________________

   County where injury occurred  

Form Version 10/98
11.) Where did the injury occur?
   A.) ☐ Swimming pool  
      Was fence around pool?  
      ☐ Yes ☐ No ☐ Unknown
      If yes to fence, was there a self-latching gate?  
      ☐ Yes ☐ No ☐ Unknown

   B.) ☐ Bathtub  
      ☐ Hot tub/Spa  
      ☐ Bucket  
      ☐ Toilet

   C.) ☐ Ocean (Gulf of Mexico)  
      ☐ Bay  
      ☐ Bayou  
      ☐ Drainage ditch /Canal  
      ☐ Lake/Pond (specify)
      ☐ River/Creek (specify)
      ☐ Other (specify e.g. farm tank, quarry, etc.)
      ☐ Unknown

12.) If the answer to question 11 is A or B: Which of the following best describes the location?
   ☐ Patient’s private home (not an apartment)  
   ☐ Apartment complex  
   ☐ Someone else’s private home (not an apartment)  
   ☐ Hotel/Motel  
   ☐ Other public place (specify)

13.) If answer to question 11 is A or C: What activity was the patient doing?
   ☐ Swimming  ☐ Scuba diving/snorkel  
   ☐ Wading  ☐ Tubing/ Floating  
   ☐ Playing  
   ☐ Fishing (no boat)  
   ☐ Boating (includes fishing from boat)  
   ☐ Water skiing, crash related  
   ☐ Jet skiing, crash related  
   ☐ Driving/riding in vehicle
      If yes to driving, due to floods/heavy rains  
      ☐ Yes ☐ No
      If yes to driving, due to motor vehicle crash  
      ☐ Yes ☐ No
     ☐ Other (specify)
     ☐ Unknown

14.) At the time of injury, who was supervising the child?
   (Answer question 14 only if the injured person was younger than 15 years old.)
   ☐ Parent  ☐ Babysitter/childcare provider  ☐ Sibling ____age of sibling ☐ Other (specify)

15.) At the time of injury were any of the following floatation devices being used? (Check all that apply)
   ☐ Life jacket  ☐ Water wings  ☐ Air mattress  ☐ Child’s inflatable ring or inflatable riding toy
   ☐ Tractor tube  ☐ Raft (inflatable)  ☐ Bath tub seat or ring

16.) Was the patient knocked unconscious prior to the injury (hit by boat, hit by head on rock, etc.)?
   ☐ Yes ☐ No ☐ Unknown

17.) What was the estimated time the patient was underwater?
   ☐ 1-4 minutes ☐ 5-9 minutes ☐ 10-14 minutes
   ☐ 15-30 minutes ☐ More than 30 minutes ☐ Unknown ☐ Not applicable

18.) A. Rescue assistance performed at the scene:
   ☐ Rescue breaths only  
   ☐ Cardiopulmonary resuscitation  
   ☐ Other (specify)
   ☐ Unknown  ☐ None

   B. Who provided rescue assistance?
   ☐ Emergency Medical Service (EMS)  
   ☐ Parent  
   ☐ Babysitter/child care provider  
   ☐ Other (specify)
   ☐ Unknown  ☐ Not applicable

19.) Check any of the following factors that contributed to this accident:
   ☐ Seizure  ☐ Other (please list pre-existing condition)  
   ☐ Mental Retardation  ☐ None  
   ☐ Impaired Mental Status

20.) Did the patient’s medical record or someone else (family, friend, nurse, etc.) report that the patient was suspected
21.) Did the patient or medical record or someone else (family, friend, nurse, etc.) report that the patient was suspected of using mind-altering drugs (including marijuana, cocaine, PCP, amphetamines, etc.)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Record</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>EMS</td>
<td></td>
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<tr>
<td>Someone else</td>
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<tr>
<td>If someone else, (give details)</td>
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</table>

(specify)

22.) Please list any and all medications (prescription, non-prescription, over the counter) and drugs (marijuana, cocaine, PCP, etc.) the patient was taking the day of the injury.

<table>
<thead>
<tr>
<th>Medication/Drug</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Unknown</td>
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</table>

23.) Was a blood alcohol level or drug screen drawn on the patient?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Result</th>
<th>B.) Drug Screen</th>
<th>Yes</th>
<th>Positive Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.) Blood Alcohol</td>
<td></td>
<td></td>
<td>No</td>
<td>No</td>
<td>Unknown</td>
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<td></td>
<td></td>
<td></td>
<td>Unknown</td>
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</table>

24.) Was patient hospitalized following injury?  

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
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</table>

25.) Date of Admission / /  

<table>
<thead>
<tr>
<th>Month (0-12)</th>
<th>Day (0-31)</th>
<th>Year (4 digits)</th>
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<tbody>
<tr>
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</table>

Date of Discharge / /  

<table>
<thead>
<tr>
<th>Month (0-12)</th>
<th>Day (0-31)</th>
<th>Year (4 digits)</th>
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26.) Medical Record Number

27.) ICD -9 Codes

<table>
<thead>
<tr>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
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28.) E Codes

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</table>

29.) Vital Signs:

<table>
<thead>
<tr>
<th>A.) At the scene</th>
<th>B.) Emergency Department</th>
<th>C.) If emergency department data not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse</td>
<td>Pulse</td>
<td>Pulse</td>
</tr>
<tr>
<td>Respiration</td>
<td>Respiration</td>
<td>Respiration</td>
</tr>
</tbody>
</table>

30.) Glasgow Coma Score

<table>
<thead>
<tr>
<th>A.) At the scene</th>
<th>B.) Emergency Department</th>
<th>C.) If emergency department data not recorded</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Eye___________</td>
<td>Eye ____________</td>
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<td>---------------</td>
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<tr>
<td>Verbal ________</td>
<td>Verbal__________</td>
<td>Verbal___________</td>
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<tr>
<td>Motor_________</td>
<td>Motor__________</td>
<td>Motor___________</td>
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</tbody>
</table>
| Total__________ | Total___________ | Total_____________

### 31.) Status 24 hours after submersion
- □ Alive
- □ Deceased
- □ Unknown

### 32.) Patient status at discharge
- □ Good, returned to previous level of functioning
- □ Severe disability, dependent on others for care
- □ Mild impairment, able to function at previous level
- □ Vegetative, no higher mental functioning
- □ Moderate disability but able to perform self care
- □ Dead

### 33.) Discharge to
- □ Home with no specialized care
- □ Rehabilitation Center
- □ Left AMA
- □ Home with skilled Nursing care
- □ Nursing Home
- □ Morgue/funeral home
- □ Skilled Nursing Facility
- □ Residential Facility
- □ Other _____________________ (specify)
- □ Unknown

### 34.) Deficits at the time of discharge
| □ None | □ Moderate |
| □ Mild | □ Severe |

### 35.) Was patient transported to the hospital by Emergency Medical Service?
- □ Yes  If yes, firm name_________________________
- □ No

### 36.) Trauma Registry Facility Number______________________________
- If no Trauma Facility Number_____________________________________
- Facility phone number (direct line to person filling out this report) (_________ ) ___________ - ___________

### 37.) How where patient’s hospital costs paid?
- □ Medicaid
- □ Medicare
- □ Worker’s Compensation
- □ BlueCross/Shield
- □ Champus
- □ HMO
- □ Other Group
- □ Self-Pay
- □ Other Insurance
- □ Auto Insurance
- □ Champus
- □ Self-Pay
- □ Other Insurance
- □ Unknown

### 38.) Describe circumstances or factors that may have contributed to this injury (such as swimmer or non-swimmer, etc.):
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Return completed form to: HDHHS Bureau of Epidemiology
8000 North Stadium Drive
Houston, TX 77054
(832) 393-5232 Fax