Texas Department of Health
Injury Epidemiology and Surveillance Program

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_____ **(specify)**
❑ Unknown

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 0-12) Day (0-31) Year (4 digits)

8.) Time of day when the injury occurred
_____:_____**(use military time)**
hour minutes

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_____

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 <u>knocked</u> 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)
❑ 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

of drinking alcohol (including beer, wine, wine coolers, etc.) the day of the injury?

Patient ❑ Yes ❑ No ❑ Unknown _____

Medical Record ❑ Yes ❑ No ❑ Unknown _____

EMS ❑ Yes ❑ No ❑ Unknown _____

Someone else ❑ Yes ❑ No ❑ Unknown _____
(give details)

If someone else, _____
(specify)

21.) Did the patient=s 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.)

Patient ❑ Yes ❑ No ❑ Unknown _____

Medical Record ❑ Yes ❑ No ❑ Unknown _____

EMS ❑ Yes ❑ No ❑ Unknown _____

Someone else ❑ Yes ❑ No ❑ Unknown _____
(give details)

If someone else, _____
(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.

❑ None ❑ Medication/Drug 1._____ 3._____
❑ Unknown 2._____ 4._____

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

A.) Blood Alcohol ❑ Yes Result_____ **B.) Drug Screen** ❑ Yes Positive Results_____
❑ No ❑ No
❑ Unknown ❑ Unknown

24.) Was patient hospitalized following injury? ❑ Yes ❑ No ❑ Unknown

25.) Date of Admission_____/_____/_____ **Date of Discharge**_____/_____/_____
Month (0-12) Day (0-31) Year (4 digits) (Month 0-12) Day (0-31) Year (4digits)

26.) Medical Record Number_____

27.) ICD -9 Codes

1._____ 3._____ 5._____

2._____ 4._____ 6._____

28.) E Codes 1._____ 2._____ 3._____

29.) Vital Signs:

A.) At the scene **B.)** Emergency Department **C.)** *If emergency department data not recorded* then first time vital signs recorded

Pulse_____ Pulse _____ Pulse_____
Respirations _____ Respirations_____ Respirations_____

30.) Glasgow Coma Score

A.) At the scene **B.)** Emergency Department **C.)** *If emergency department data not recorded* then time Glasgow Coma score recorded

Eye_____	Eye _____	Eye_____
Verbal _____	Verbal_____	Verbal_____
Motor_____	Motor_____	Motor_____
Total_____	Total_____	Total_____

31.) Status 24 hours after submersion ❑ Alive ❑ Deceased ❑ Unknown

32.) Patient status at discharge

❑ Good, returned to previous level of functioning
❑ Mild impairment, able to function at previous level
❑ Moderate disability but able to perform self care
❑ Severe disability, dependent on others for care
❑ Vegetative, no higher mental functioning
❑ Dead

33.) Discharge to

❑ Home with no specialized care
❑ Home with skilled Nursing care
❑ Skilled Nursing Facility
❑ Rehabilitation Center
❑ Nursing Home
❑ Residential Facility
❑ Left AMA
❑ Morgue/funeral home
❑ Other _____ **(specify)**
❑ Unknown

34.) Deficits at the time of discharge
(Very Important! See instructions for definitions)

❑ 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_____
(Complete formal name of facility or name of health department)

Facility phone number (direct line to person filling out this report) ( ) _____ - _____

37.) How where patient=s hospital costs paid?

❑ Medicaid ❑ BlueCross/Shield ❑ Other Group ❑ Auto Insurance
❑ Medicare ❑ Champus ❑ Self-Pay ❑ Unknown
❑ Worker=s Compensation ❑ HMO ❑ Other_____

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