|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Individual Name: | | Region: | | | | | DOB: | |
| Date of Incident: | | | | | Time of incident:       am pm | | | |
| Name of agency providing services at the time of incident: | | | | | | | | |
|  | | | |  | | | | |
| **Describe Nature of Injury** | | | | | | | | |
|  | | | | | | | | |
| **What was the follow up care?** | | | | | | | | |
|  | | | | | | | | |
| Phone conversation  In-person evaluation | | | | | | | | |
|  | | | | | | | | |
| **Summary of treatment** | | | | | | | | |
| Clinicians Name: | | | | | | | | |
| Facility Type (ex.: PCP, ER, ect.): | | | | | | | | |
| Date: | Time: | | | | | Physicians order attached?  Yes  No | | |
|  | | | | | | | | |
| Reporter Printed Name | | | Title | | | | | |
| Signature | | | | | | | | Date |
|  | | | | | | | | |
| **REMINDER: *Any change in medication requires guardian approval.*** | | | | | | | | |

**Nursing/Medical Intervention Report**