Patient name: «FullName»

Minnesota Educators' Study

We are interested in collecting health care information on ***work-related assault injuries between <<date and date>>.*** Below is a list of possible types of physical injuries, and body parts that may have been injured, as a result of work-related assault. Please complete the following information for any work-related physical assaults for «FullName» **between** <<**date and date**>>and return it in the enclosed envelope. If there have been more than one possible work-related assault injury, please copy this form, or call 1-877-708-3224 (toll free) for additional copies.

1. Did «FullName» **have any documented work-related assault injuries between <<*date and date*>>*?***

- Yes ***If yes, please continue with questions 2-4.***
- No ***If no, please sign, date and return this form.***

2. What was the type of physical injury/ involvement? *Check all that apply.*

1	Abrasion	1 •
2	Amputation	2 •
3	Asphyxia	3 •
4	Bite	4 •
5	Bruise/contusion	5 •
6	Burn	6 •
7	Concussion (Loss of consciousness/ awareness/amnesia)	7 •
8	Crushing/mangling	8 •
9	Cut/laceration/scratch	9 •
10	Fracture/dislocation	10 •
11	Nerve injury	11 •
12	Penetration injury including puncture	12 •
13	Poisoning	13 •
14	Rupture	14 •
15	Sexual assault	15 •
16	Sprain/strain	16 •
17	Temporary discoloration/slap mark	17 •
18	Torn ligament	18 •
19	Contamination from spitting	19 •
20	Other Specify _____	20 •
21	Unknown	21 •

3. What body part(s) were injured/affected? *Check all that apply.*

1	Head/skull/brain	1 •
2	Face (Forehead/cheek/nose/lip/jaw/ ear)	2 •
3	Eye/eyelid	3 •
4	Teeth	4 •
5	Neck (cervical area)	5 •
6	Back (muscles, skin)	6 •
7	Internal chest	7 •
8	External chest (muscles, skin)	8 •
9	Spinal cord/spine (vertebrae, sacrum, tailbone, coccyx, disks)	9 •
10	Internal abdomen	10 •
11	External abdomen (skin, muscles)	11 •
12	Shoulder/collar bone, shoulder blade	12 •
13	Arm/elbow/wrist	13 •
14	Hand/fingers/thumbs	14 •
15	Internal hips/pelvis (uterus, ovaries, bladder, rectum)	15 •
16	External hips/pelvis (muscles, skin)	16 •
17	Buttocks	17 •
18	Genitalia	18 •
19	Leg (thigh, shin, calf, knee, ankle)	19 •
20	Foot/heel, toes	20 •
21	General systems (e.g., respiratory, cardiovascular)	21 •
22	Other Specify	22 •
23	Unknown	23 •

4. Dates of treatment: _____/_____/_____ to _____/_____/_____
Month/Day/Year Month/Day/Year

_____ _____
Signature and title of person completing this form **Date**

Thank you for your participation!
Please return this form in the stamped envelope provided.

«MESid»