

Firearm Injury Report Form

State of Alaska, Section of Epidemiology



Per 7 AAC 27.013, health care providers are required to report all injuries caused by a firearm to the Division of Public Health. Reports must be made within 5 working days of the date of diagnosis. Forms and definitions may be found at <http://dhss.alaska.gov/dph/Epi/Pages/pubs/conditions/crforms.aspx>

Reporting Agency _____ **Agency Phone Number** _____

Patient Name _____ **Agency Record Number** _____
Last Name First Name Middle Initial

Residence _____
City or Village

Date of birth ____/____/____ **Sex:** Male Female Unknown
MM DD YYYY

Race White Other _____ **Ethnicity** Non-Hispanic
 Black Unknown Hispanic
 Asian/Pacific Islander Unknown
 American Indian/Alaska Native

Date of shooting ____/____/____ **Time of shooting (24-Hour)** _____
MM DD YYYY

Where shooting occurred _____ Check if out-of-state
City/Village/Closest Community

Was Victim at work or working
 Yes No Unknown

Location of Victim when shot
 Victim's home (including entranceway, yard, or driveway)
 Other person's home (including entranceway, yard or driveway)
 Street/road/parking lot
 Inside automobile/other vehicle
 Bar/Club
 Inside public building/store/restaurant
 School
 Park/playfield/public use area
 Natural area (Field, river, beaches, woods)
 Motel/hotel
 Other (Specify): _____
 Unknown

Gun type
 Handgun Shotgun BB/pellet gun
 Rifle Black Powder Paintball
 Other (Specify): _____
 Unknown

Intent
 Suicide (Attempt or Fatal) Assault
 Accident Shot by Police Unknown

Relationship between Victim and Shooter (Check one)
 Self Spouse/Lover/Boyfriend/Girlfriend (Current or Ex)
 Other Family Member Acquaintance
 Gang-related Gang-like Stranger
 Shot by police Unknown

Circumstance
 Hunting Weapon Cleaning
 Child playing with weapon
 Family or intimate partner violence
 Other fight or argument-related
 Other _____ Unknown

Toxicology Circumstance
 Alcohol Suspected or Proven BAC _____
 Drugs Suspected or Proven

Location of Gunshot Wound(s) (Check all that apply)
 Head/Face/Neck Upper Extremities
 Shoulders Chest Abdomen Back/Buttocks
 Lower Extremities Unknown

Disposition (Check all that apply)
 Hospitalized (Admit Date ____/____/____ Discharge Date ____/____/____)
MM DD YYYY MM DD YYYY
 ER Outpatient Died Unknown
 Transferred to other medical facility (Specify): _____

Please FAX reports to (907) 269-2041 – Please verify FAX has been transmitted.

If line is busy, please FAX again.