

CVH-635 **CONNECTICUT VALLEY HOSPITAL**
 New 5/18 **INJURY ASSESSMENT/REASSESSMENT**

Patient Name: _____

- ☐ General Psychiatry Division
☐ Addiction Services Division

MPI# _____ *Print or Addressograph Imprint*

Date injury first observed: _____

***For open areas on the skin, use
 Wound Tracking form CVH-617***

Location of Injury (*Describe and indicate location on figure*): _____

Physician Notified? ☐ Yes: _____ AM/PM
 Physician's Name _____ Date _____ Time _____

☐ No – Indicate reason: _____

Nursing note completed in the Physical Health Progress Note Section? ☐ Yes

Infection Prevention Notified? ☐ Yes: Date: _____ Time: _____ AM/PM

☐ N/A – Indicate reason: _____

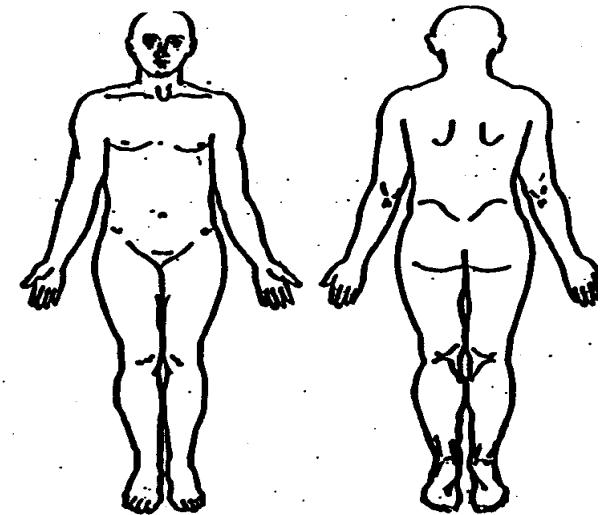
Date Nursing Plan of Care Revised: _____ If N/A Indicate Reason: _____

Interventions (*check all that apply*):

- ☐ Visual Assessment ☐ Dressing Change
☐ Pain Assessment ☐ Range Of Motion
☐ Circulation Check ☐ Ice ☐ Heat
☐ Other: _____

Frequency of Monitoring as Ordered:

- ☐ Every Shift ☐ Weekly
☐ Every Day ☐ Other (specify): _____
☐ Every 2 Days _____



TYPE OF INJURY CODES:

B Bruise **F** Fracture **I** Insect Bite **N** Burn **S** Superficial Abrasion (*Scratch*) **C** Cellulitis **ST** Soft Tissue Injury **O** Other (*specify*): _____

UPON INITIATION FAX TO THE NURSING SUPERVISOR'S OFFICE: ☐ General Psych 5689 ☐ Addiction Services 6186

Date	Time	Injury Code	Size	Color	Pain Yes No	Pain Intervention Yes No	Other Assessment Data/Treatments Administered	RN Signature

RESOLUTION: Date of Resolution: _____ Physician Notified: _____ Date: _____

File in the Physical Health Section of the medical record

Patient Name: _____ MPI# _____

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[illegible]

RESOLUTION: Date of Resolution: _____ Physician Notified: _____ Date: _____