Injury Information:

<table>
<thead>
<tr>
<th>Employee Injured:</th>
<th>Date of Injury:</th>
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<td></td>
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<tr>
<td>Department:</td>
<td>Supervisor Name/Ext.</td>
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How was the patient moved when the injury occurred?

- [ ] Assisting patient to walk/ambulate
- [ ] Assisting patient to sit or stand
- [ ] Lateral transfer of the patient (ie: bed to gurney, gurney to CT table, etc)
- [ ] Lifting the patient from the floor, a chair, or other surface
- [ ] Lifting or holding the patient's limb(s), or a part of their body
- [ ] "Repositioning" the patient in a bed, chair, gurney, or other surface
- [ ] Pushing/Transporting patient in bed, gurney, or wheelchair
- [ ] Other (please explain):

__________________________________________________________________
__________________________________________________________________

Were any of these conditions present during the patient movement?

- [ ] Patient was 300 lbs or heavier
- [ ] Patient was combative/resistant to the movement
- [ ] Unexpected event (ie: bed rolled during lift)
- [ ] Patient moved unexpectedly
- [ ] Equipment failure (please specify):

__________________________________________________________________

Was the Lift Team used?  [ ] Yes  [ ] No

What equipment was used?

(Please select the type of equipment which was used when the employee was injured)

- [ ] Sit/Stand Aid
- [ ] Sling Based Lift (ie: Hoyer Lift)
- [ ] Hovermatt
- [ ] Friction Reduction Sheet (ie: Sally Tube)
- [ ] Assistive Device (ie: Walker)
- [ ] Gait Belt
- [ ] Transfer Board (ie: Supine/Seated)
- [ ] Overhead Trapeze Handle
- [ ] Hover Jack (floor lift)
- [ ] Other:
- [ ] None

Contributing Factors:

1- What other caregivers were involved in the patient movement when the employee was injured?

__________________________________________________________________

2- What date did this employee last complete “hands on” Safe Patient Handling training?  
(Please attach a copy of the sign in sheet)

__________________________________________________________________

3- Was equipment available to the staff when they needed to use it?

__________________________________________________________________

4- Was the patient being moved >300lbs? If so, was bariatric equipment available & used?

__________________________________________________________________

5- Were there any clinical factors or movement precautions affecting movement status?

__________________________________________________________________

6- Were there any other factors which may have contributed to this injury? If so, please explain.

__________________________________________________________________

Please continue to next page
7- What was the patient’s level of mobility and/or BMAT score at the time of injury?

________________________

______________________________

**Employee’s Incident Description:**

*(Please have employee provide a statement relating to the causes of the injury and how they feel we can prevent this injury from occurring in the future)*

What happened during the patient move that caused your injury?

*(ie: patient moved un-expectantly. OR You were manually moving the patient and felt pain, etc… )*  

What could have prevented this injury from occurring?

*(ie: could have used xyz lift or aid to assist patient. OR xyz lift was not available, but could have prevented injury if available, etc…)*

**Incident Description From Other Employees Involved:**

What was taking place when this injury occurred?

How can this type of injury be prevented in the future?

**Recommended Corrective Actions:**

*(Please outline actions to be taken to prevent the re-occurrence of this type of injury)*

1- ________________________________________________________________

2- ________________________________________________________________

3- ________________________________________________________________

4- ________________________________________________________________

5- ________________________________________________________________