INJURY SURVEILLANCE FORM

Date 
Time 

Person ID 
Name 
Address 

Transport to hospital by 
Ambulance ☐ Helicopter ☐ Taxi ☐ Other ☐ 

Profession 
Telephone 

PLEASE ANSWER THE FOLLOWING QUESTIONS
BEFORE YOU MEET THE DOCTOR

When did the accident take place?

Year Month Day Time Leisure time School time Work time Transport to/from work/school

Where did the accident take place?

E.g.:
■ Crossing Main Rd-Park Ave
■ E4, 30 km south of Umeå
■ Kitchen at home
■ Workshop J.B.Corp. Umeå

Describe how the accident happened

(PREFERABLY DRAW A SKETCH)

E.g.:
■ I was cycling westbound on Main Rd and collided with a car from the left on E4.
■ Fell from the swing and hit the back of my head on some concrete.

What objects/substances (make) caused:

The accident? 
The injury?

Fill in information where applicable!

Did you have 
Yes No

Seat belt on 
Head restraint 

Helmet 

Child seat 

Did the airbag deploy

Do you have any suggestions for preventive measures?

THANK YOU!

This information shall be used in our injury preventive work. The information is handled with the same professional secrecy as other medical files. We hope you will contribute!