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
☐ Black
☐ Asian/Pacific Islander
☐ American Indian/Alaska Native
☐ Other _____
☐ Unknown

Ethnicity
☐ Non-Hispanic
☐ Hispanic
☐ Unknown

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.

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