1. Hospital name __________________________________________ 2. Medical Record # __________________________

3. Patient name ________________________________________________________________________________
   Last name                           First name                           Middle initial

4. Residence __________________________________________ City or Town   State   ZIP

5. Date of Birth ___________ | ________ | ________ month   day   year

6. Gender   1 ☐ Male   2 ☐ Female

7. Date of shooting ___________ | ________ | ________ month   day   year

8. Time of shooting (military) ___________

9. Where shooting occurred __________________________________________
   ☐ check if outside city limits   ☐ check if County out of state

10. Was Victim at work or working
    1 ☐ Yes   2 ☐ No   3 ☐ Unknown

11. Location of Victim when shot
    1 ☐ Victim’s home (including entranceway, yard or driveway)
    2 ☐ Other person’s home (including entranceway, yard or driveway)
    3 ☐ Bar / club (including parking lot)
    4 ☐ School
    5 ☐ Street / road / parking lot
    6 ☐ Inside automobile
    7 ☐ Inside public building / store / restaurant
    8 ☐ Motel / hotel
    9 ☐ Park / play field / other outdoor setting
    10 ☐ Other (specify): __________________________________________

12. Gun type
    1 ☐ Handgun   2 ☐ Shotgun   3 ☐ Rifle
    4 ☐ BB / pellet gun   5 ☐ Other (specify): __________________________________________
    6 ☐ Unknown

13. Intent
    1 ☐ Assault   2 ☐ Suicide (attempt or fatal)
    3 ☐ Accident   4 ☐ Shot by Police
    5 ☐ Unknown

14. Relationship between Victim and Shooter (check one)
    1 ☐ Self   2 ☐ Stranger   3 ☐ Gang related
    4 ☐ Shot by police   5 ☐ Acquaintance
    6 ☐ Spouse / lover / boyfriend / girlfriend (current or ex)
    7 ☐ Other family member   8 ☐ Unknown

15. Circumstance
    1 ☐ Child playing with weapon   2 ☐ Weapon cleaning
    3 ☐ Hunting   4 ☐ Family or intimate partner violence
    5 ☐ Other fight or argument related
    6 ☐ Other / unknown

16. Location of gunshot wound(s) (check all that apply)
    1 ☐ Head / neck / face   2 ☐ Chest / abdomen / back
    3 ☐ Shoulders / buttocks / limbs / hands/ feet / digits
    4 ☐ Other (specify): __________________________________________

17. Disposition from emergency department
    1 ☐ Admitted   2 ☐ Discharged   3 ☐ Died
    4 ☐ Transferred to other medical facility (specify): __________________________________________

Please return to:
Washington Firearm Injury Reporting System
Department of Health, PO Box 47832, Olympia, WA 98504-7832
Questions? Call Injury and Violence Prevention Program at (360) 236-2800

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