

## MAJOR INJURY DETERMINATION FORM

**This form must be completed, IF the facility is relying on the physician, designee\*, or extender to determine whether a major injury has occurred. (NOTE: The facility may independently determine that a major injury has occurred and submit a self report.)**

- The facility shall submit this Form to the Physician, Designee\*, or Extender within 24 hours of when the injury occurred.
- A signed copy of this Form must be obtained by the facility from the physician, designee\*, or extender within 72 hours of the injury.
- If the physician, designee\*, or extender refuses to complete the Form or is unavailable for completion and signature, the DIA Director (or designee) must be notified of the injury within one business day.
- If the physician, designee\* or extender determines a major injury has occurred, this signed Form shall be maintained by the facility in the resident's clinical record and the facility shall notify the department of the major injury,
- If the physician, designee\*, or extender determines the injury sustained is not a major injury, this signed Form shall be maintained by the facility with the resident's clinical record.

**TO BE COMPLETED BY THE FACILITY:**

Resident name: \_\_\_\_\_

Date and time of the injury: \_\_\_\_\_

Description of injury: \_\_\_\_\_

Circumstances of the incident causing the injury: \_\_\_\_\_

Resident's previous functional ability: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Signature of Facility Representative Completing Form    Print Name

**TO BE COMPLETED BY THE PHYSICIAN, DESIGNEE\*, OR EXTENDER:**

Patient's prognosis: \_\_\_\_\_

(CHECK ONE)

\_\_\_\_ After reviewing the circumstances, injury, and prognosis of the patient, I believe the injury sustained is a major injury pursuant to 481 Iowa Administrative Code 50.7(1)(a)(3).

\_\_\_\_ After reviewing the circumstances, injury and prognosis of the patient, I believe the injury sustained is NOT a major injury and, to the best of my knowledge, barring any complications, I believe the patient will return to his/her previous functional status.

I, \_\_\_\_\_ (please print name), the attending physician, designee\* of the physician, or physician extender, of the above named patient, state that I have read the foregoing Determination Form, know the content thereof, and have made the determination of whether the patient's injury should be designated as a major injury based on the disclosure of the above information available on this date.

\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Signature of Physician, Designee\* of Physician, or Physician Extender

\*Designee means another physician or physician extender in lieu of the attending physician.