

Iowa Department of Public Safety - State Fire Marshal Division

Burn Injury Report

Submission of this report is required pursuant to

Iowa Statue Section 147.113A.

<https://www.legis.iowa.gov/docs/code/147.113a.pdf>

Patient Full Name: _____ Patient Phone: _____

Street Address: _____ City: _____

County: _____ State: _____ Zip Code: _____

Street address where burn occurred: _____ City where burn occurred: _____

Patient Gender: ☐ Male ☐ Female Patient Date of Birth: _____ Date/Time of Injury: _____

Area(s) of body injured:

- | | |
|--------------------------------|--|
| <input type="checkbox"/> Face, | <input type="checkbox"/> Head |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Back | <input type="checkbox"/> Buttocks |
| <input type="checkbox"/> Groin | <input type="checkbox"/> Genitals |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Foot | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Leg | <input type="checkbox"/> Left <input type="checkbox"/> Right |

☐ Internal
(including trachea and larynx)

	%1 st	%2 nd	%3 rd	%Total
Initial Burn Estimate:				
12+ Hr. Burn Estimate:				
24+ Hr. Burn Estimate:				

- ☐ Check if patient sustained airway burns
☐ Check if burns compromised vision
☐ Check if burns were limited to fingers or toes

Toxicology at initial hospital admission:

☐ Drug(s): _____

☐ Admitted Use ☐ Tested – Value: _____

Alcohol (Y/N): _____

☐ Admitted Use ☐ Tested – BAC: _____

Causes of Burn Injury: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Hot Liquid Contact (scald) | <input type="checkbox"/> Chemical |
| <input type="checkbox"/> Hot Object Contact | Describe: _____ |
| <input type="checkbox"/> Contact with Burning Solid | <input type="checkbox"/> Electrical |
| <input type="checkbox"/> Contact with Burning Liquid | Describe: _____ |
| <input type="checkbox"/> Contact with Burning Vapor | <input type="checkbox"/> Explosion |
| <input type="checkbox"/> Direct Flame Contact | Describe: _____ |
| <input type="checkbox"/> Flammable Liquid | <input type="checkbox"/> Fireworks |
| <input type="checkbox"/> Outside Fire (grass, camping) | Type: _____ |
| <input type="checkbox"/> Radiation | |
| <input type="checkbox"/> Sunburn | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Structure Fire | |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Unknown: _____ |

Reporting Facility – Name/Address/City/Zip: _____

Attending Physician: _____ Reporting Person: _____ Date Reported: _____

Has a copy of this burn injury form been sent to the local law enforcement agency (Y/N): _____

***If yes, please
provide the agency
name, address, and
date form was sent.***

Local Agency Name: _____

Local Agency Address: _____

Date Form Sent to Local Agency: _____

Mail completed form to your local law enforcement agency per 147.113A.

Please mail a copy to: Iowa State Fire Marshal Division, Burn Injury Reporting, 215 East 7th St, Des Moines, IA 50319

or email a copy to Iowa State Fire Marshal Division at: fminfo@dps.state.ia.us