

COLUMBUS OTOLARYNGOLOGY CLINIC

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Ear, Nose and Throat
Head and Neck Surgery
Facial Plastic Surgery

INJURY REPORT

TODAY'S DATE: _____

PATIENT'S NAME: _____

PATIENT'S BIRTH DATE: _____

DATE OF INJURY: _____

PLEASE DESCRIBE THE INJURY AND HOW IT OCCURRED:

CHECK ONE OF THE FOLLOWING:

1. No injury occurred.
2. Injury other than work or auto related.
3. Referral from EPSDT Program.
4. Work related injury - see below.
5. Auto Accident.-----> Driver or Passenger

If this injury is work related, please write your employer's full name, address, & phone:

