Canterbury District Health Board

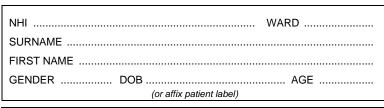
Te Poari Hauora ō Waitaha

| NHI | WARD | | | | | |
|--------------------------|------|--|--|--|--|--|
| SURNAME | | | | | | |
| FIRST NAME | | | | | | |
| GENDER DOB | AGE | | | | | |
| (or affix patient label) | | | | | | |

Acute Post-Strangulation Documentation

| NOTE: women may better understand, and be more responsive to the word choked rather than strangled | | | | | | | |
|--|---|----------|-----|----------|--------------|------------------|--|
| SUBJECTIVE/HISTORY | | | | | | | |
| Description of event | | | | | | | |
| Date(s), time(s), event(s), | | | | | | | |
| hospital/location and any | | | | | | | |
| other persons present | | | | | | | |
| Who choked/strangled | | | | | | | |
| you (and relationship)? | | | | | | | |
| Did the person | | | | | | | |
| approach you from | Front Behind | | | | | | |
| Where on your body | | | | | | | |
| were you held? | | | | | | | |
| How did the person | One arm: Left Right Ur | nknown | | | | | |
| choke/strangle you? | 🗌 One hand: 🗌 Left 🔲 Right 🗌 Ur | nknown | F | ist: 🗌 C | Dpen 🗌 Close | ed 🗌 Unknown | |
| | Two hands | | | | | | |
| | Ligature/rope/wire: | | | | | | |
| | Other: (please specify) | | | | | | |
| Consciousness | Did you faint or lose consciousness (LOC |)? | | | | 🗌 Yes 🗌 No | |
| •••••• | Estimated length LOC: (please insert minute | , | .) | | | | |
| lu a cu du cu a c | | es/nouis | / | | | | |
| Incontinence | Did you wet or soil yourself? | | | | | Yes No | |
| | Urination Defecation | | | | | | |
| Do you have other | | | | | | | |
| injuries? | | | | | | | |
| Did you try to protect yourself? | ☐ Yes ☐ No How: | | | | | | |
| | | | | | YES, at | YES, at time of | |
| Symptoms | | | | NO | presentation | event to present | |
| | Headache or head pain | | | | · | | |
| | | | | | | | |
| | Neck pain | | | | | | |
| | Neck pain | | | | | | |
| | Neck pain Difficulty breathing | | | | | | |
| | Neck pain | | | | | | |
| | Neck pain Difficulty breathing Tongue swelling | | | | | | |
| | Neck pain Difficulty breathing Tongue swelling Fits or seizures | | | | | | |
| | Neck pain Difficulty breathing Tongue swelling Fits or seizures Confusion Drowsiness | | | | | | |
| | Neck pain Difficulty breathing Tongue swelling Fits or seizures Confusion Drowsiness Dizziness or light-headedness | ch | | | | | |
| | Neck pain Difficulty breathing Tongue swelling Fits or seizures Confusion Drowsiness Dizziness or light-headedness Difficulty speaking or understanding spee | ch | | | | | |
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| | Neck pain Difficulty breathing Tongue swelling Fits or seizures Confusion Drowsiness Dizziness or light-headedness Difficulty speaking or understanding spee Numbness, paralysis, or weakness | ch | | | | | |
| | Neck pain Difficulty breathing Tongue swelling Fits or seizures Confusion Drowsiness Dizziness or light-headedness Difficulty speaking or understanding speet Numbness, paralysis, or weakness (usually on one side of the body) | ch | | | | | |
| | Neck pain Difficulty breathing Tongue swelling Fits or seizures Confusion Drowsiness Dizziness or light-headedness Difficulty speaking or understanding spee Numbness, paralysis, or weakness (usually on one side of the body) Loss of balance or coordination | ch | | | | | |
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| Pregnancy | Neck pain Difficulty breathing Tongue swelling Fits or seizures Confusion Drowsiness Dizziness or light-headedness Difficulty speaking or understanding spee Numbness, paralysis, or weakness (usually on one side of the body) Loss of balance or coordination Difficulty walking Drooping eyelid Vision problems Vomiting Difficulty swallowing, painful throat Voice changes, eg. raspy or hoarse, | ch | | | | | |
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| | Neck pain Difficulty breathing Tongue swelling Fits or seizures Confusion Drowsiness Dizziness or light-headedness Difficulty speaking or understanding spee Numbness, paralysis, or weakness (usually on one side of the body) Loss of balance or coordination Difficulty walking Drooping eyelid Vision problems Vomiting Difficulty swallowing, painful throat Voice changes, eg. raspy or hoarse, <i>if yes, please describe</i> Are you pregnant? | ch | YES | | | | |
| Pregnancy Medications and drugs | Neck pain Difficulty breathing Tongue swelling Fits or seizures Confusion Drowsiness Difficulty speaking or understanding speed Numbness, paralysis, or weakness (usually on one side of the body) Loss of balance or coordination Difficulty walking Drooping eyelid Vision problems Vomiting Difficulty swallowing, painful throat Voice changes, eg. raspy or hoarse, <i>if yes, please describe</i> Are you pregnant? If pregnant, vaginal bleeding? | NO |] | | | | |
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Approved by: Chief Medical Officer, Executive Director of Nursing, Director of Allied Health



Acute Post-Strangulation Documentation

OBJECTIVE/EXAMINATION

A study of 300 strangulation cases suggested that only 50% have physical findings on initial evaluation (Strack G, McClane G & Hawley D, 2001).

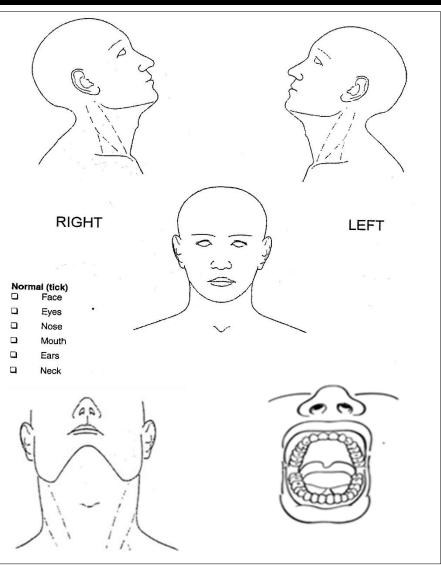
Good lighting is essential for a thorough examination of the head, neck, ears and inside the mouth.

Look for strangulation injuries behind and in the ears, back of neck, chest and shoulder areas, eyelids (above and under), jaw and upper chin. Tick all that apply. Use body maps to record injuries.

□ No injury noted/visible

- Scratch/Abrasion/Bruise marks
- Bruising
- Sub-conjunctival haemorrhages and Fundoscopy
- Petechiae above the site of application (ie. face/eyelids/oral mucosa, palate, EAM or TM)
- Neck, face or tongue swelling/tenderness
- Coughing/Raspy or hoarse voice

Consider follow-up examination as many signs evolve or resolve over time



| Assessment | | NO | YES | DETAIL | | |
|--|---|----|-----|--------------|--|--|
| | Airway or breathing problems? | | | | | |
| | Suspected brain injury? | | | | | |
| | Other visible injuries? | | | | | |
| | Other problems (describe) | | | | | |
| | No obvious serious problems | | | | | |
| Plan | | NO | YES | DETAIL | | |
| | Discharge home? | | | | | |
| | Refer for further assessment? | | | | | |
| | Police contacted? (with/out patient consent) | | | | | |
| | Other referrals? | | | | | |
| Follow-up appointment | | | | | | |
| Assessment | Date: | | | Time: | | |
| | Assessor's name: | | | | | |
| | Designation: | | | . Signature: | | |
| A COPY OF THIS REFERRAL FORM AND A COPY OF THE CLINICAL NOTES MUST BE SENT TO THE CHILD AND FAMILY SAFETY SERVICE OR SMHS FST OR COMPLETED ON OR ATTACHED TO AN ePROSAFE REFERRAL | | | | | | |