Canterbury District Health Board

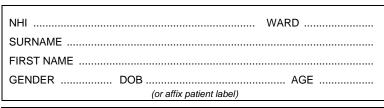
Te Poari Hauora ō Waitaha

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						
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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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Medications and drugs	Neck pain Difficulty breathing Tongue swelling Fits or seizures Confusion Drowsiness Dizziness or light-headedness 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? Have you taken any aspirin or warfarin or blood thinners? Have you taken any other medications?	NO		WHAT AN			

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).

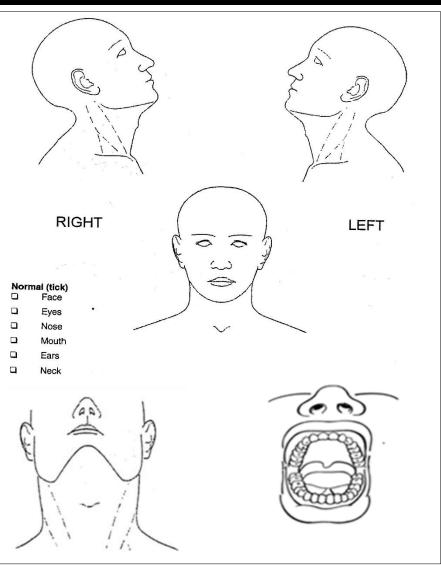
Good lighting is essential for a thorough examination of the head, neck, ears and inside the mouth.

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						