

NOAA DIVING PROGRAM

DIVING ACCIDENT MANAGEMENT FIELD REFERENCE GUIDE



NOAA Diving Center
7600 Sandpoint Way NE
Seattle, WA 98115

Updated September 2015 (3)

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Treatment of the Conscious Diver

Assess for life threatening or other severe injuries?

Assess if the diver is alert and oriented

Is the incident diving related?

Remove exposure suit and keep diver dry and warm

Hydrate with appropriate fluids

Place in position of comfort

Take and record vitals q 15 min or as needed

Contact medical control or EMS

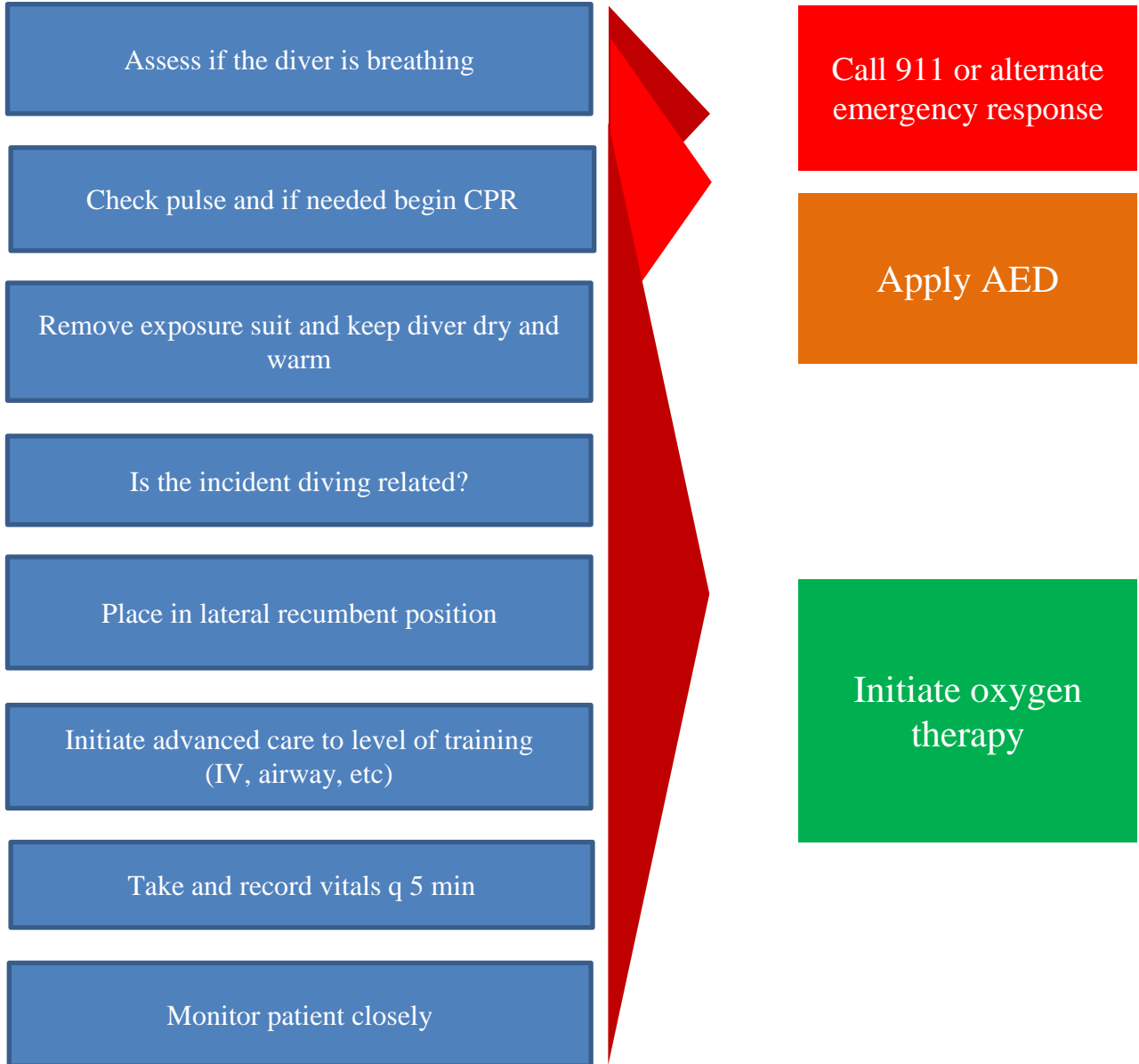
Monitor patient closely

Call 911 or alternate emergency response

Initiate oxygen therapy

Perform neuro exam

Treatment of the Unconscious Diver



Sign and Symptoms of DCS

Type I DCS

Musculoskeletal

- Discomfort or abnormal feeling in or near a joint.
- Constant aching pain, usually not tender to touch or movement.
- No outward change in appearance

Skin

- Itching
- Rash
- Localized swelling of the skin
- Marbling (patchy blue and pink areas) – Cutis Marmorata – Not simple skin bends and may require treatment

Lymphatic

- Swelling of extremity
- Pain in the area of swelling

Type II DCS

Neurologic

- Headache
- Numbness or tingling
- Weakness or paralysis
- Nausea
- Loss of bowel or bladder control
- Extreme fatigue
- Visual disturbances
- Difficulty standing or walking
- Chest pain
- Shortness of breath
- Behavioral changes
- Feeling of something's wrong

Vestibular (inner ear)

- Hearing loss
- Tinnitus (ringing in the ears)
- Vertigo
- Nausea/vomiting
- Lack of coordination

Pulmonary

- Chest tightness
- Difficulty breathing
- Chest pain
- Rapid breathing
- Abnormal breath sounds

Signs and Symptoms of AGE

Symptoms occur at or near the surface or generally within 10 minutes of surfacing

- Extreme fatigue
- Difficulty in thinking
- Vertigo
- Nausea and/or vomiting
- Hearing abnormalities
- Bloody sputum
- Loss of control of bodily functions
- Tremors
- Loss of coordination
- Loss of consciousness
- Cardiopulmonary arrest
- Other stroke like symptoms

Oxygen Toxicity

V – Visual disturbances

E – Ears (ringing, extraneous noises)

N – Nausea

T – Twitching/Tingling

I – Irritability

D – Dizziness

CON - Convulsions

NOAA DIVER CONTACT INFORMATION

Name of Diver: _____ DOB: _____

Present Address: _____ Zip: _____

Height: _____ Weight: _____ Age: _____ M ___ F ___

Home Phone: _____ Work: _____ Cell: _____

Present Employer: _____

Significant Medical History / Allergies: _____

Preferred contacts in event of an emergency:

Name: _____ Phone: _____

Name: _____ Phone: _____

DIVE HISTORY

Date: _____ Time of Day: _____ Depth: _____ Bottom Time: _____

Breathing Gas: _____ Equipment Used: _____

Did anything unusual occur prior to or during dive? If so, describe

If repetitive, list specifics of previous dives in past 24 hours:

Depth: _____ Bottom Time: _____ Surface Interval: _____

Depth: _____ Bottom Time: _____ Surface Interval: _____

Depth: _____ Bottom Time: _____ Surface Interval: _____

Depth: _____ Bottom Time: _____ Surface Interval: _____

Location at time of injury: _____ Time of onset: _____

Was symptom noticed before, during, or after the dive? _____

If during, was it while descending, on the bottom, or ascending? _____

Has symptom increased or decreased since first noticed? _____

Diver's description of symptoms (include location, type, quality, etc.)

ADDITIONAL DIVE HISTORY

Does pain radiate? If so, where from _____ to _____

Does pain increase with movement or palpation? _____

Have any other symptoms occurred since the first one was noticed? If so, describe _____

Has patient ever had a similar symptom? If so, describe _____

Has patient ever had DCS or AGE before? If so, note when and describe: _____

Dive Buddy's comments: _____

ADDITIONAL BACKGROUND INFORMATION

Does the patient smoke? ____ yes or ____ no

Has there been any recent exposure to altitude? ____ yes or ____ no

Are there any dive-related problems that could explain the present symptoms? _____

Current medication list: _____

List all medications taken during the previous 24-hours _____

If the diver is female, when was her last menstrual cycle? _____

When did the diver last eat and drink? _____

Describe the activities performed during the dive: _____

Describe the activities performed following the dive: _____

NOAA NEUROLOGIC EXAM FOR DIVING CASUALTIES

Name: _____ Date/Time: _____

Describe symptom: _____

Dive Profile: D/BT ____ / ____ SI ____ min D/BT ____ / ____ SI ____ min D/BT ____ / ____ SI ____ min D/BT ____ / ____

MENTAL STATUS/STATE OF CONSCIOUSNESS

(Circle one)

A = Awake and alert Knows: person ____ place ____ time ____ year ____ Identify objects? _____
 V = Responsive to voice Can add nickel, quarter, and dime? _____ Glasgow Coma Scale score: _____
 P = Responsive to pain Recite 3 unrelated objects after wait? _____
 U = Unresponsive Speech: ____ normal ____ abnormal

VITAL SIGNS Pulse/min _____ Respirations _____ Blood Pressure _____ Temp (warm, cool, normal)

COORDINATION (Normal/Abnormal)

Walk: _____
 Heel-to-toe: _____
 Romberg: _____
 Finger-to-nose: _____
 Heel-shin slide: _____
 Rapid movement: _____

STRENGTH

Graded 0-5:
 0 = Paralysis (no motion possible)
 1 = Profound weakness (trace of muscle contraction)
 2 = Severe weakness (muscle contraction but not against gravity)
 3 = Moderate weakness (can overcome gravity but not resistance)
 4 = Mild weakness (able to resist slight force)
 5 = Normal (equal strength, able to resist force)

CRANIAL NERVES (Normal/Abnormal)

Sense of smell (I) _____
 Vision/visual field (II) _____
 Eye movements, pupils (III, IV, VI) _____
 Facial sensation, chewing (V) _____
 Facial expression muscles (VII) _____
 Hearing (VIII) _____
 Upper mouth, throat sensation (IX) _____
 Gag and voice (X) _____
 Shoulder shrug (XI) _____
 Tongue (XII) _____

Upper body: Deltoids: L _____ R _____
 Latissimus: L _____ R _____
 Biceps: L _____ R _____
 Triceps: L _____ R _____
 Forearms (grip): L _____ R _____
 Hands (finger spread): L _____ R _____
Lower body: Hips - Flexion: L _____ R _____
 Extension: L _____ R _____
 Abduction (spread): L _____ R _____
 Adduction (squeeze): L _____ R _____
 Knees - Flexion: L _____ R _____
 Extension: L _____ R _____
 Ankles - Dorsiflexion: L _____ R _____
 Plantarflexion: L _____ R _____

REFLEXES

Grade: (0-absent, 1-hypoactive, 2-normal, 3-hyperactive)

Biceps: L _____ R _____ Forearm: L _____ R _____ Knees: L _____ R _____ Ankles: L _____ R _____

DESCRIBE ALL ABNORMAL FINDINGS: _____

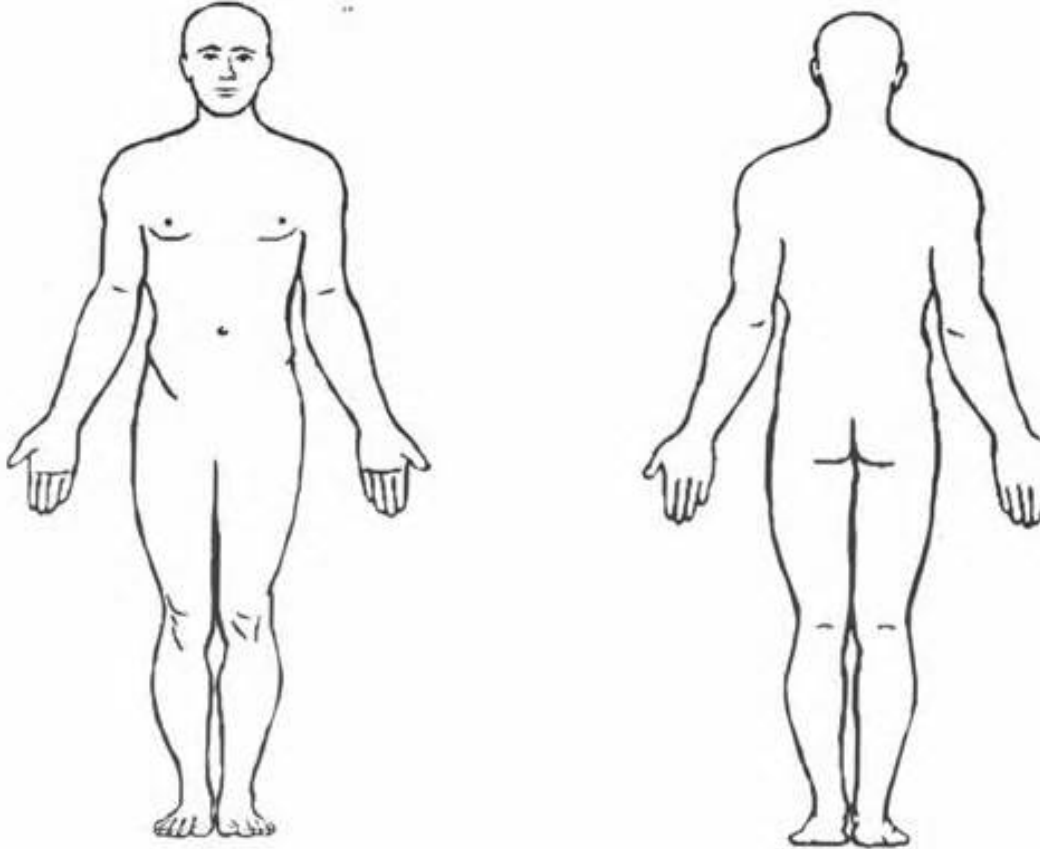
Glasgow Coma Scale

Eye Opening	
Spontaneously	4
To verbal command	3
To painful stimulus	2
None	1

Verbal Response	
Talking/Oriented	5
Confused/Disoriented	4
Inappropriate words	3
Incomprehensible words	2
None	1

Motor Response	
Obeys commands	6
Localizes to pain	5
Withdraws from pain	4
Abnormal Flexion	3
Abnormal extension	2
None	1

NEUROLOGIC EXAMINATION
(Page 2 of 2)



SENSORY EXAMINATION FOR SKIN SENSATION

(Check for sharp, dull, light touch sensation; use diagram to record location of numbness/tingling, pain)

LOCATION

Comments: _____

Examiner (print) Signature Title Date

GLASGOW COMA SCALE

I. Motor Response

- 6 - Obeys commands fully
- 5 - Localizes to noxious stimuli
- 4 - Withdraws from noxious stimuli
- 3 - Abnormal flexion, i.e. decorticate posturing
- 2 - Extensor response, i.e. decerebrate posturing
- 1 - No response

II. Verbal Response

- 5 - Alert and Oriented
- 4 - Confused, yet coherent, speech
- 3 - Inappropriate words, and garbled phrases consisting of words
- 2 - Incomprehensible sounds
- 1 - No sounds

III. Eye Opening

- 4 - Spontaneous eye opening
- 3 - Eyes open to speech
- 2 - Eyes open to pain
- 1 - No eye opening

Glasgow Coma Scale = I + II + III. A Coma Score of 13 or higher correlates with a mild brain injury, 9 to 12 is a moderate injury, and 8 or less a severe brain injury.

EMERGENCY CALL-IN SCRIPT

“I am a NOAA Divemaster and I am calling to report a diving-related emergency requiring immediate medical assistance. The victim is a _____ (age) year old _____ (gender) who is _____ (conscious/unconscious), with the following symptoms after diving with compressed gas..... (describe pain, dizziness, etc.)”

“We have placed the victim in the supine position, and have initiated basic first aid. We have also completed a field neurological exam, with the following results..... (note any deficits). The victim is on 100% oxygen by mask, and we have rendered the following additional treatment..... (CPR, IV fluids, medications, etc.) Last vital signs are as follows.....”

Temp: _____ Pulse: _____ Resp: _____ B/P: _____/_____

“ We are at the following location.....(location of diver / landmarks) and request immediate medical transport to..... (receiving facility of choice) via (air / ground) transport”

Note: Do not terminate call....the receiving unit will end the call.

CONTACT INFORMATION

MEDICAL

Local EMS(911)
USCG VHF Channel 16
On-Call DMO.....(855) 822-3483
(206) 526-6986
CAPT Joel Dulaigh, DMO (non-emergency) (206) 526-6474 (work)
(206) 300-2098 (cell)
LT Gary Montgomery, DMO.....(206) 256-6430
(830) 624-6283
MOC-P Medical Officer on call..... (206) 409-8725 (cell)
MOC-A Medical Officer on call..... (757) 615-6619 (cell)
Diver's Alert Network (DAN).....(919) 684-9111

ADMINISTRATIVE CONTACTS

Greg McFall, NOAA Diving Program Director (206) 526-6705 (work)
(912) 596-2464 (cell)
Roger Mays, Acting NOAA Diving Safety Officer (252) 728-8798 (work)
(252) 723-1612 (cell)

CHAMBER LOCATIONS & QUALIFIED PHYSICIANS (Seattle, WA)

Primary: Virginia-Mason Medical Center
1202 Terry Ave., Seattle, WA
Hyperbaric Department: (206) 583-6543
24-hour emergency line: (206) 583-6433

Secondary: Diver's Institute of Technology
1341 Northlake Way, Seattle, WA
Chamber phone: (206) 783-5542

Tertiary: St. Joseph's Medical Center – Tacoma
Hyperbaric Medical Service: (253) 426-6630
24-hour emergency line: (253) 426-6630

Additional Assistance: Divers Alert Network
24-hour emergency line: (919) 684-9111

CONTACT INFORMATION CON'T.

OTHER TRANSPORTATION CONTACTS

U.S. Coast Guard – Boat or Helicopter
(206) 220-7001 or (800) 982-8813
VHF Ch-16 or SFD dispatch

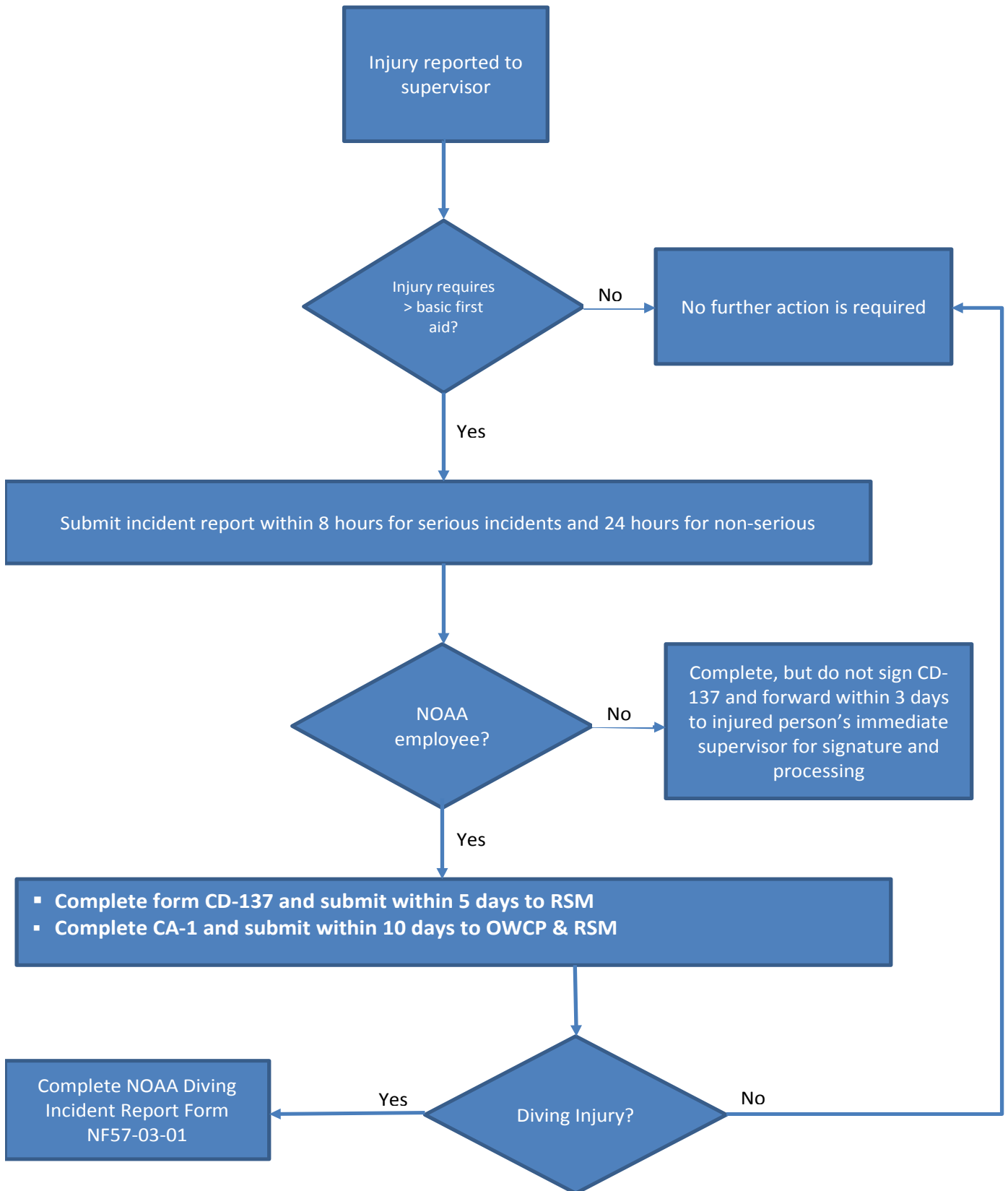
SPD Harbor Patrol
(206) 684-4071
VHF Ch-16 or SFD dispatch

King County Marine Unit
911 or (206) 296-3311
VHF Ch-16 or SFD dispatch

Mercer Island Police / Fire
Rescue (206) 236-3600
VHF Ch-16 or SFD dispatch

Airlift Northwest
(206) 329-2569

NOAA DIVING PROGRAM ACCIDENT MANAGEMENT & REPORTING PROCEDURES



NOAA Diving Field Reference Guide

Revised: February 2004

TO: LO Management,
 CC: NOAA Safety Director, RSM

Complete **the form then email to appropriate parties.** Forward completed form within 24 hours of a job related injury, illness or near-miss. **Note:** Save to your Desktop.

Immediate Notification Report	
Supervisor Completing Form	
Job Title	
Last/First/Middle Name	
Facility	
Telephone Number	
Injured Employee or Affected Property Information	
Work Location	
Job Title	
Last/First/Middle Name	
Telephone Number	
Property Identification	
Date/Time of Accident Occurrence	
Location of Accident	
Accident Type (injury/death/equipment)	
Description of Mishap	
Facility Corrective/Preventative Actions Implemented in Response to Accident	
Preventative Action Recommendations	
Additional Comments	
Date/Time Form Completed/Submitted	

NOAA Diving Field Reference Guide

NOAA Diving Field Reference Guide

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.

Witness: Complete bottom section 16.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data			
1. Name of employee (Last, First, Middle)			2. Social Security Number
3. Date of birth Mo. Day Yr.	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Home telephone	6. Grade as of date of injury Level Step
7. Employee's home mailing address (Include city, state, and ZIP code)			8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other

Description of Injury
9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred Mo. Day Yr.	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	11. Date of this notice Mo. Day Yr.	12. Employee's occupation
--------------------------------------	--	-------------------------------------	---------------------------

13. Cause of injury (Describe what happened and why)

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)	a. Occupation code
	b. Type code c. Source code
	OWCP Use - NOI Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

- b. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.
- a. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ Date _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness	Signature of witness	Date signed
Address	City	State ZIP Code

Form CA-1
Rev. Apr. 1999

NOAA Diving Field Reference Guide

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and zip code)	OWCP Agency Code
	OSHA Site Code
ZIP Code	

18. Employee's duty station (Street address and ZIP code)

19. Employee's retirement coverage CSRS FERS Other, (identify)

20. Regular work hours From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	21. Regular work schedule <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.
--	--

22. Date of Injury Mo. Day Yr.	23. Date notice received Mo. Day Yr.	24. Date stopped work Mo. Day Yr. Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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25. Date pay stopped Mo. Day Yr.	26. Date 45 day period began Mo. Day Yr.	27. Date returned to work Mo. Day Yr. Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
----------------------------------	--	---

28. Was employee injured in performance of duty? Yes No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? Yes (If "Yes," explain) No

30. Was injury caused by third party? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," go to item 32.)	31. Name and address of third party (Include city, state, and ZIP code)
--	---

32. Name and address of physician first providing medical care (Include city, state, ZIP code)	33. First date medical care received Mo. Day Yr.
	34. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? Yes No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.	37. Pay rate when employee stopped work \$ Per
--	--

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor Date

Supervisor's Title Office phone

39. Filing instructions No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
 No lost time, medical expense incurred or expected: forward this form to OWCP
 Lost time covered by leave, LWOP, or COP: forward this form to OWCP
 First Aid Injury

NOAA Diving Field Reference Guide

FORM CD-137 (Rev. 5/89) LF DAO 209-4	U.S. DEPARTMENT OF COMMERCE	Case: _____ Control: _____ Date Received: _____ Type/Source: ____ / ____ Org. Code: _____
Report of Accident/Illness SAFETY & HEALTH MANAGEMENT INFORMATION		
TO BE COMPLETED BY EMPLOYEE		
1. Reason for Report: <input type="checkbox"/> Accident <input type="checkbox"/> Illness		
2. Name: _____ <small style="margin-left: 150px;">(Last, First, M.I.)</small>		3. SSN: _____
4. Occupation: _____		5. Phone: _____
6. Date of Birth: _____		7. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
8. Date/Time of Accident/Illness: _____		Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
9. Duty Station Address: _____		10. Location of Incident: _____
11. Description of Incident:		
12. Extent of Injury or Illness and Body Parts Affected:		
Signature: _____		Date: _____
TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR		
13. Medical Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		14. Lost Time? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Investigator's Name: _____		15. Investigation Date: _____
16. Findings:		
17. Amount of Property Damage: \$ _____		
18. Corrective Action:		
19. Completion Date: _____		<input type="checkbox"/> Estimated <input type="checkbox"/> Actual
Investigator's Signature: _____		Date: _____
Title: _____		Phone: _____

Distribution: Original; Employee Supervisor; Employee; Safety Representative.
 ADMINISTRATION/IPSG ELECTRONIC FORM

NOAA Diving Field Reference Guide

NOAA Form 57-03-01
(1-13) Page 1 of 2

U.S. DEPARTMENT OF COMMERCE
NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

DIVING INCIDENT REPORT

NOTE: The Unit Diving Supervisor (UDS) shall use this form to report serious diving related injuries, including near-drowning, arterial gas embolism (AGE), decompression sickness (DCS), pulmonary barotrauma, or any diving injury that requires hospitalization. An additional narrative and detailed analysis of the incident must be attached. Contact the NOAA Diving Center (NDC) to determine whether an event or minor injury requires an incident report.

DIVER NAME		TIME of INCIDENT	DATE of INCIDENT
DIVER CERTIFICATION	DIVE UNIT	LOCATION of INCIDENT	
DIVER CURRENT MEDICATIONS		DIVER CURRENT HEALTH PROBLEMS	

AGE	SEX (M/F)	HIGHEST DIVE CERTIFICATION LEVEL	CERTIFYING DIVING ASSOCIATION
TOTAL # of YEARS DIVING	TOTAL # of DIVES	TOTAL # of DIVES in the PAST 6 MONTHS	PREVIOUS DIVE INCIDENTS and DATES

BREATHING LOOP <input type="checkbox"/> Open Circuit <input type="checkbox"/> Semi Closed / Closed Circuit <input type="checkbox"/> Surface Supplied <input type="checkbox"/> Snorkel	DIVER DRESS <input type="checkbox"/> None / Dive Skin <input type="checkbox"/> Wet Suit Thickness _____ <input type="checkbox"/> Dry Suit	DIVE CYLINDER TYPE and SIZE	CYLINDER PRESSURE IN	SEP ISSUED EQUIPMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
		BREATHING GAS	CYLINDER PRESSURE OUT	DIVER FAMILIAR WITH EQUIPMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO

NAME of ON-SITE DIVING SUPERVISOR / LEAD DIVER		AIR TEMP (°F)	WATER TEMP (°F)	U/W VISIBILITY (FT)	CURRENT SPEED (KTS)
NAME of DIVE BUDDY		DIVE PURPOSE		DIVE LOCATION	
DIVE BUDDY AFFILIATION		DIVE PLATFORM		SURFACE CONDITIONS	
# of DIVES on DAY of INCIDENT	# of DIVES on PREVIOUS DAY	TYPE of DIVE <input type="checkbox"/> DUTY <input type="checkbox"/> non-DUTY		DIVES CONDUCTED WITH <input type="checkbox"/> Dive Tables <input type="checkbox"/> Dive Computer (Model _____)	

Was this dive typical of the diver's normal type of diving? <input type="checkbox"/> YES <input type="checkbox"/> NO	If NO, explain:
---	-----------------

Describe any problems encountered during the incident dive or previous dives:

Dive #	Start Time	Max Depth (Feet)	Bottom Time (Minutes)	End Time	Surface Interval (HH:MM)	Deco Stop? (Y/N)	Safety Stop? (Y/N)	Stop Profile (Depth / Time)	Cold or Arduous? (Y/N)	Fast Ascent? (Y/N)	Incident Dive? (Y/N)
1.											
2.											
3.											
4.											
5.											
6.											

NOAA Diving Field Reference Guide

NOAA Form 57-03-01 (1-13) Page 2 of 2	U.S. DEPARTMENT OF COMMERCE NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION																		
DIVING INCIDENT REPORT FORM																			
SECTION V. EMERGENCY PROCEDURES																			
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"><u>YES</u></td> <td style="width: 10%;"><u>NO</u></td> <td style="width: 80%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Was emergency oxygen available on-site?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Were emergency scenarios discussed with all divers prior to diving operations, such as low air, out of air, lost buddy, etc.?</td> </tr> </table>	<u>YES</u>	<u>NO</u>		<input type="checkbox"/>	<input type="checkbox"/>	Was emergency oxygen available on-site?	<input type="checkbox"/>	<input type="checkbox"/>	Were emergency scenarios discussed with all divers prior to diving operations, such as low air, out of air, lost buddy, etc.?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"><u>YES</u></td> <td style="width: 10%;"><u>NO</u></td> <td style="width: 80%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Was there a dive accident management plan in place for dive site?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Was the dive accident management plan reviewed by all divers and support personnel prior to diving operations?</td> </tr> </table>	<u>YES</u>	<u>NO</u>		<input type="checkbox"/>	<input type="checkbox"/>	Was there a dive accident management plan in place for dive site?	<input type="checkbox"/>	<input type="checkbox"/>	Was the dive accident management plan reviewed by all divers and support personnel prior to diving operations?
<u>YES</u>	<u>NO</u>																		
<input type="checkbox"/>	<input type="checkbox"/>	Was emergency oxygen available on-site?																	
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<u>YES</u>	<u>NO</u>																		
<input type="checkbox"/>	<input type="checkbox"/>	Was there a dive accident management plan in place for dive site?																	
<input type="checkbox"/>	<input type="checkbox"/>	Was the dive accident management plan reviewed by all divers and support personnel prior to diving operations?																	
SECTION VI. SYMPTOMS, PRE-DIVE HEALTH, and ON-SITE MEDICAL TREATMENT																			
DATE of SYMPTOM ONSET	DESCRIPTION of SYMPTOMS and LOCATION on BODY																		
TIME of SYMPTOM ONSET																			
DESCRIPTION of PRE-DIVE HEALTH	DESCRIPTION of PRE-DIVE ALCOHOL CONSUMPTION (previous 24 hours)																		
DESCRIPTION of PRE-DIVE REST or FATIGUE LEVELS	DESCRIPTION of STRENUOUS EXERCISE (6 hours prior and 12 hours post-dive)																		
SUSPECTED INJURIES or ILLNESSES <input type="checkbox"/> AGE <input type="checkbox"/> DCS <input type="checkbox"/> Pulmonary Barotrauma <input type="checkbox"/> Other Barotrauma <input type="checkbox"/> None <input type="checkbox"/> Other _____	ON-SITE OXYGEN ADMINISTRATION Delivery Method	ON-SITE FIRST-AID TREATMENT PROVIDED																	
	Time Started	INITIAL EMERGENCY CONTACT (name of person or agency)																	
	Time Stopped	TIME of INITIAL EMERGENCY CONTACT	TIME TRANSPORTATION STARTED																
FIRST-AID TREATMENT PROVIDED DURING TRANSPORT	EMERGENCY TRANSPORT METHOD(S)																		
SECTION VII. MEDICAL INFORMATION – Hospital (Attach all Emergency Room, Hyperbaric Unit, and follow-up medical records.)																			
HOSPITAL NAME and ADDRESS		HOSPITAL TREATMENT																	
		DATE of ARRIVAL																	
		TIME of ARRIVAL																	
HYPERBARIC UNIT NAME and ADDRESS		CHAMBER TYPE	CHAMBER TREATMENT																
		<input type="checkbox"/> Monoplace	Treatment #1 Time Started _____ Time Stopped _____																
		<input type="checkbox"/> Multiplace	Treatment #2 Time Started _____ Time Stopped _____																
			Treatment #3 Time Started _____ Time Stopped _____																
TREATMENT TABLE / DESCRIPTION		TABLE EXTENSIONS	RETREATMENT TABLE / DESCRIPTION																
DESCRIBE WHEN RELIEF FROM SYMPTOMS OCCURED	DESCRIBE ANY RESIDUAL SYMPTOMS AFTER TREATMENT	DAYS of RESIDUAL SYMPTOMS	FINAL DIAGNOSIS																
			<input type="checkbox"/> DCS I <input type="checkbox"/> AGE <input type="checkbox"/> Pulmonary Barotrauma																
			<input type="checkbox"/> DCS II <input type="checkbox"/> Other _____																
SECTION VIII. CERTIFICATION																			
UDS NAME		UDS SIGNATURE	DATE																
NOTE: A Diving Incident Report shall be completed by the UDS and submitted to their Line Office Diving Officer (LODO) within 10 days of the diving incident. A full report includes the following items: 1. Diving Incident Report Form (NOAA Form 57-03-01) 2. Cover memorandum providing a narrative of the diving incident, including causal analysis and recommendations for prevention of future injuries. 3. Medical records associated with any medical treatment of injuries resulting from this incident. The LODO shall submit the UDS report, along with their own causal analysis and recommendations for prevention of future injuries to the Director, NOAA Diving Program within 30 days of the diving incident.																			

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