

Emergency Response – Patient Report

Carry 2 copies of this form in your first aid kit. In the event of a major accident, lost person, etc. use one copy to send for help. Use the second copy to maintain a record of the patient's conditions. When used for this purpose, include a copy of this form when filing the Incident Report once your return home.

Patient Name		Sex M F	Age	Weight	Date	Time
Consent to treat? Y N	Describe how injury occurred:		Chief Complaint			
Cleared-Spine? Y N						
S T O P	Life Threatening Conditions (A B C D E) Airway Breathing Circulation/Severe Bleeding Disability (c-spine) Environment (cold/heat) Shock					T R E A T
P A T I E N T H I S T O R Y	<u>Allergies (medications, food, stings)</u>		NOTE: See Back for Continuing Monitoring			
	<u>Medications (dose, frequency)</u>		Time			
	<u>Past Injury/Illness</u>		Pulse			
	<u>Last Oral Intake</u>		Respiratory Rate/Quality			
	<u>Events Leading to Incident</u>		Skin	W P D	W P D	W P D
			Pupils (PERRL)	E R R L	E R R L	E R R L
			Mental Status	Alert x __ V P U	Alert x __ V P U	Alert x __ V P U
		S I G N S	Skin – Is it W arm, P ink and D ry? Pupils – Are the E qual, R ound, and R eactive to L ight? Mental Status – Does patient know the 4 questions? 1. Who they are? 3. What Happened? 2. Where they are? 4. What time/day is it? If patient is not Alert X 4 , does he/she respond to V erbal command or P ain? If not, then patient is U nconscious.			
Results of Head-to-Toe Exam:						
Spinal Assessment:						
Release Spinal Precautions		Neurological Exam		Range of Motion Test		
Summary of Assessment:						
Treatment Plan:						
Stabilize Cervical Spine Treat for Shock		Prevent Heat Loss Circulation/Sensation/Motion Check		Cool (if appropriate)		
Specific Treatments:						
Lost Person(s)						
Name(s) of lost person(s) _____						
Where Last Seen _____						
When last seen _____ AM PM						
Probable Location _____						
Description of person, clothing, experience level, equipment they are carrying: _____ _____						
Plan of remaining party: _____ _____						

Vital Signs & Continued Care (Minimum Information Necessary, add as needed)							
Time							
Pulse							
Respiratory Rate/Quality							
Skin	W P D	W P D	W P D	W P D	W P D	W P D	W P D
Pupils (PERRL)	E R R L	E R R L	E R R L	E R R L	E R R L	E R R L	E R R L
Mental Status	Alert x ___ V P U	Alert x ___ V P U	Alert x ___ V P U	Alert x ___ V P U	Alert x ___ V P U	Alert x ___ V P U	Alert x ___ V P U
Heat/Cool							
Treatment Site							

Evacuation Plan

Name of Leader reporting emergency: _____ _____ Names of Messengers: _____ _____ _____ Messengers should be able to assist rescuers with directions to the scene, and guide them to the scene if necessary.	<u>Messengers to Notify:</u> <input type="checkbox"/> Park Ranger if in a National Park: <input type="checkbox"/> Local Sheriff in all other cases Phone # _____
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Assistance Needed ___ Medical ___ Helicopter ___ Carry-out ___ Search ___ Backboard
 ___ Technical Evacuation: Raise or Lower ___ Other:

Exact Location of Patient:

Marked Map Attached: or UTM coordinates:

GPS Coordinates:

Will evacuate to:

<u>Resources on Site</u> (tents, bags, food, water, technical equipment, etc.) <u>Personnel on Site:</u> Number & experience <u>Medical or other technical qualifications</u> <u>Will they all remain at the scene until help arrives</u>	<u>Communication Equipment on Site?</u> Cell Phone # Do you have reception at the site? 2 Way Radio? ___ Type: freq/channel:	<u>Current Weather</u> <u>Weather trend:</u>
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Patient's Family Member ___ Please contact

Name	Address	Phone	Relation
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Message: _____

On Site Plans:
