



MulticulturalFirstAid.com

Patient Care Report CASE #:

EVENT INFORMATION

Event Name and Description:		
911 Address:		
Setup Location:	GPS:	
Day of Event:	Date of Event:	
Event Host 2-Way Radio?	MFA 2-Way Radio?	Notes:
Event Contact Name:	Title:	Phone:

INCIDENT DATE AND TIME

Incident Date:	Incident Time:
Report Date:	Report Time:

PATIENT INFORMATION

Patient Name:	DOB or AGE:	SEX:
Home Address:	City/ Province:	
Telephone:	Medic Alert?	Details:

SCENE ASSESSMENT & PRIMARY ASSESSMENT


PPE and BSI?	(Consider C-Spine)	Scene Safe?
Additional Resources:		
MOI and/or NOI:		
Verbal Consent:	Implied Consent:	NOTES:
LOC (AVPU):	Alert:	Voice: Pain: Unresponsive:
LOC Questions:	Where are you right now? What day is it? Can you tell me what happened?	
Airway:	Breathing:	Circulation (Pulse):
Chief Complaint:		
Pulse Good?	Respirations Good?	Appearance:
Treat for Shock?	(Blanket, Oxygen, Patient Position)	
30sec. Rapid Body Exam:		
911 Call?	Details:	

VITAL SIGNS – RECHECK Critical Every 5 Minutes - RECHECK Stable Every 15 Minutes

VITALS SET	TIME	BP	Respiration	Heart Rate	Skin Color/ Temp/ Condition	Pupils PEARL (Pupils Equal and React to Light)	Oxygen Saturation	Glucose Level
BASELINE								
2 nd Set								
3rd Set								
4 th Set								

Oxygen Administration - CPR PERFORMED - AED USED

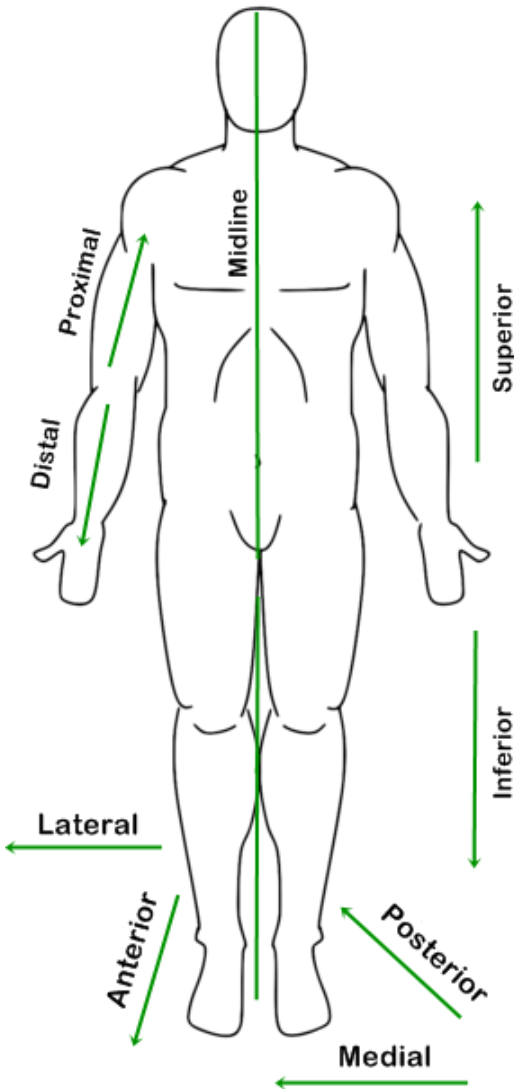
Oxygen Given?	Method	Rate (LPM):	Start	End:
*CPR GIVEN?	*AED USED?	*IF YES, CPR-AED REPORT MUST BE COMPLETED		
Notes:				

SECONDARY ASSESSMENT (SAMPLE – OPQRST – GCS)		
Check DCLAPS – TICS – Burns and Bleeds:		Results:
S	Signs and Symptoms:	
A	Allergies:	
M	Medications:	
P	Past Medical History:	
L	Last Oral Intake:	
E	Events Leading to Incident:	
O	Onset (Symptoms Began):	
P	Provokes (Better or Worse):	
Q	Quality (Description):	
R	Radiates (Affected Areas):	
S	Severity (From 1 to 10):	
T	Time (Started–Between–Ended):	
GLASGOW COMA SCALE (GCS)		
EYE OPENING RESPONSE		
VERBAL RESPONSE		
MOTOR RESPONSE		
TREATMENT		
TIME	DESCRIPTION	RESPONSE
Advised to See Doctor?		
Advised to Go to Hospital?		
Additional Instructions?		

OUTCOME

Injury Location Diagram

Refusal of Treatment



I, _____ herein refuse treatment.

Witnessed by _____

NOTES

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DISCHARGE

To Own Care: _____

Family/Friend: _____

Ambulance: _____

Other: _____

Returned To Activity? _____

Notes: _____

RESPONDERS

Responder 1: _____

Time: _____

Date: _____

Responder 2: _____

Time: _____

Date: _____

*CPR-AED REPORT

Collapse Time: _____

Witnessed By: _____

Suspected Cause:
(Medical or Trauma)

CPR Start Time: _____

CPR End Time: _____

Reason: _____

CPR Given By: _____

AED Given By: _____

Shock Advised? _____

Shock Delivery Time: _____

Result: _____

911 Update: _____

Shock Delivery Time: _____

Result: _____

911 Update: _____

Shock Delivery Time: _____

Result: _____

911 Update: _____