EMR Patient Assessment Form

DATE AND TIME OF ILLNESS / INJURY AM / PM	DATE AND TIME ON SCENE AM / PM

NAME	DATE OF BIRTH DD MM YYYY

GLASGOW COMA SCALE	EYE OPENING RESPONSE	BEST VERBAL RESPONSE	BEST MOTOR RESPONSE
	4 SPONTANEOUSLY 3 SPEECH 2 TO PAIN 1 NO RESPONSE	5 ORIENTED 4 CONFUSED 3 INAPPROPRIATE WORDS 2 INCOMPREHENSIBLE SOUNDS 1 NO RESPONSE	6 OBEYS COMMANDS 5 LOCALIZES PAIN 4 WITHDRAWS FROM PAIN 3 FLEX TO PAIN (DECORTICATE) 2 EXTENDS TO PAIN (DECEREBRATE) 1 NO RESPONSE

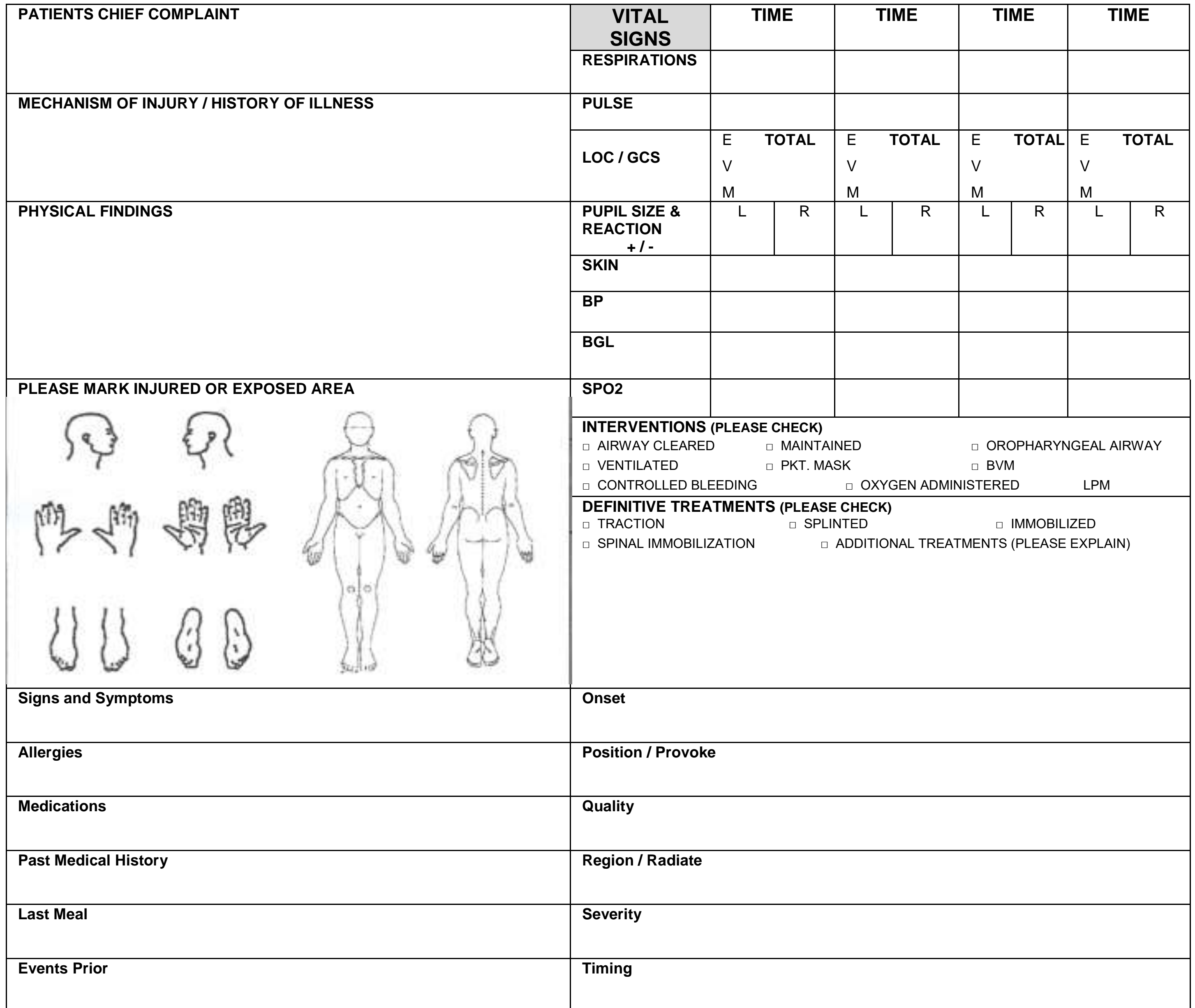
PATIENTS CHIEF COMPLAINT

MECHANISM OF INJURY / HISTORY OF ILLNESS

PHYSICAL FINDINGS

VITAL SIGNS	TIME		TIME		TIME		TIME	
RESPIRATIONS								
PULSE								
LOC / GCS	E V M	TOTAL	E V M	TOTAL	E V M	TOTAL	E V M	TOTAL
PUPIL SIZE & REACTION + / -	L	R	L	R	L	R	L	R
SKIN								
BP								
BGL								
SPO2								

PLEASE MARK INJURED OR EXPOSED AREA



INTERVENTIONS (PLEASE CHECK)

- ☐ AIRWAY CLEARED ☐ MAINTAINED ☐ OROPHARYNGEAL AIRWAY
- ☐ VENTILATED ☐ PKT. MASK ☐ BVM
- ☐ CONTROLLED BLEEDING ☐ OXYGEN ADMINISTERED LPM

DEFINITIVE TREATMENTS (PLEASE CHECK)

- ☐ TRACTION ☐ SPLINTED ☐ IMMOBILIZED
- ☐ SPINAL IMMOBILIZATION ☐ ADDITIONAL TREATMENTS (PLEASE EXPLAIN)

Signs and Symptoms	**Onset**
Allergies	**Position / Provoke**
Medications	**Quality**
Past Medical History	**Region / Radiate**
Last Meal	**Severity**
Events Prior	**Timing**

TRANSPORTED BY (PLEASE CHECK)

☐ B.C. AMBULANCE SERVICE ☐ AIR EVACUATION ☐ OTHER (PLEASE EXPLAIN)

CHANGES IN PATIENT'S CONDITION (PLEASE EXPLAIN)

EMR NAME (PLEASE PRINT)	EMR SIGNATURE

REFUSAL OF TREATMENT SECTION (COMPLETE THIS SECTION IN FULL IF TREATMENT IS REFUSED)

AID TO CAPACITY FOR REFUSING TREATMENT

Indicate to whom this refers (injured person or substitute decision-maker):_________________________________.
*Person understands what is wrong with him/her. *Person understands what could happen if further medical attention is not sought. *Person has a plan for follow-up care. *Person is left with a responsible adult. *NOTE: NO to any of these questions requires consideration of incapacity. DOCUMENT WHY IN NOTES!

REFUSAL OF TREATMENT

I HAVE RECEIVED FIRST AID TREATMENT AS INDICATED ABOVE AND WISH NO FURTHER TREATMENT. I HAVE BEEN ADVISED THAT FURTHER TREATMENT IS AVAILABLE IMMEDIATELY; HOWEVER, I WISH TO REFUSE SUCH TREATMENT AT THIS TIME. I HAVE BEEN INFORMED OF THE RISKS INVOLVED BY REFUSING FURTHER TREATMENT AND I ASSUME FULL RESPONSIBILITY FOR MY ACTIONS.

INJURED PERSON/SUBSTITUTE DECISION-MAKER: PRINT NAME AND ADDRESS

RELATIONSHIP	SIGNATURE OF INJURED PERSON OR SUBSTITUTE DECISION-MAKER
TIME	WITNESS #1 (NAME, ADDRESS, SIGNATURE)
DATE	WITNESS #2 (NAME, ADDRESS, SIGNATURE)

I have advised this person, and/or the party responsible, of the risks involved to the ill/injured person’s health if treatment is refused.

Time – Hours	Date	Signature of Responder

I was witness to the above-mentioned statement being explained.

Time – Hours	Date	Signature of witnessing Responder