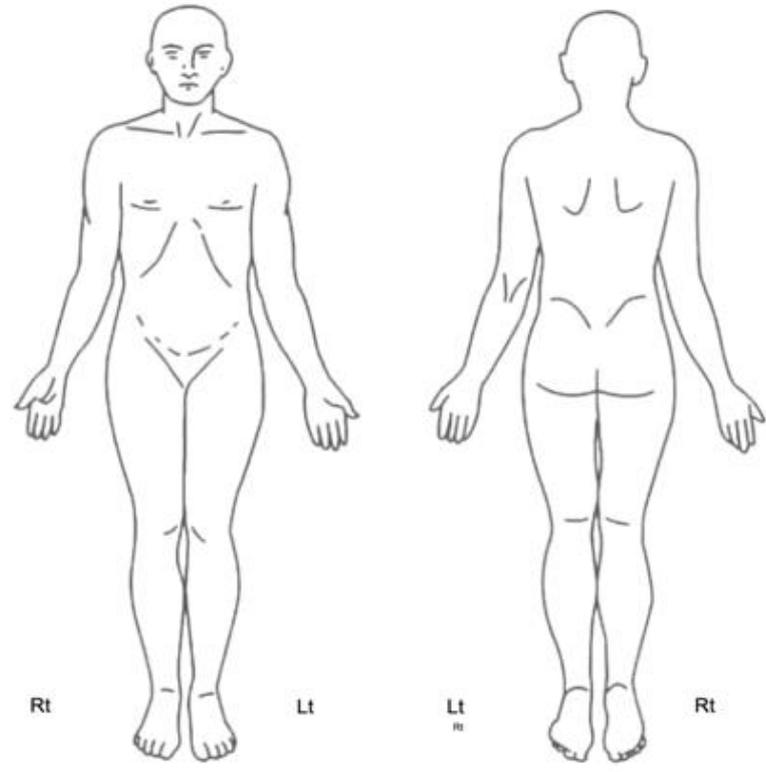


Patient Report Form

Date:	Casualty Age: <input type="checkbox"/> < 18 <input type="checkbox"/> > 18	Casualty Sex: <input type="checkbox"/> M <input type="checkbox"/> F	URN:
Time On Scene:	Time Off Scene:	Time EMS Arrived:	Firearms Deployment: <input type="checkbox"/>
Transport:	<input type="checkbox"/> Land Ambulance	<input type="checkbox"/> Air Ambulance	<input type="checkbox"/> Police Vehicle <input type="checkbox"/> Other
Hospital:	<input type="checkbox"/> Example 1	<input type="checkbox"/> Example 2	<input type="checkbox"/> Example 3 <input type="checkbox"/> Example 4
Mechanism of Injury:	<input type="checkbox"/> Blunt trauma	<input type="checkbox"/> Penetrating injury	<input type="checkbox"/> Medical <input type="checkbox"/> Mental health
<input type="checkbox"/> Stabbing	<input type="checkbox"/> Alcohol/ drugs	<input type="checkbox"/> Vehicle RTC	<input type="checkbox"/> Self-harm
<input type="checkbox"/> Shooting	<input type="checkbox"/> Punched/ kicked	<input type="checkbox"/> Pedestrian hit by vehicle	<input type="checkbox"/> Suicide / parasuicide
<input type="checkbox"/> Burn	<input type="checkbox"/> Hanging	<input type="checkbox"/> Cyclist	<input type="checkbox"/> Fall < 6ft <input type="checkbox"/> Fall > 6ft
<input type="checkbox"/> Other (please specify):			

Injuries

Notes:



(Please use numbers to code and mark location of injuries on body map)

1. Amputation <input type="checkbox"/>	6. Fracture closed <input type="checkbox"/>
2. GSW entry <input type="checkbox"/>	7. Burns <input type="checkbox"/>
3. GSW exit <input type="checkbox"/>	8. Head injury <input type="checkbox"/>
4. Stab <input type="checkbox"/>	9. Laceration <input type="checkbox"/>
5. Fracture open <input type="checkbox"/>	10. Other <input type="checkbox"/> <i>(please sepecify):</i>

On arrival	<input type="checkbox"/> Cat Haem	Airway: <input type="checkbox"/> Clear <input type="checkbox"/> Obstructed	<input type="checkbox"/> Breathing <input type="checkbox"/> Not Breathing	1. <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U
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Observations carried out by EMS

Airway	Breathing	Circulation		
Clear <input type="checkbox"/> Obstructed Snoring <input type="checkbox"/> <input type="checkbox"/> Patient position <input type="checkbox"/> Chin lift <input type="checkbox"/> Jaw thrust <input type="checkbox"/> NP; size <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> OP; size <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> SGA; size <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Obstructed Gurgling <input type="checkbox"/> <input type="checkbox"/> Patient turned <input type="checkbox"/> Suction Complete Obstruction <input type="checkbox"/> <input type="checkbox"/> Back blows <input type="checkbox"/> Abdominal / chest thrusts Soft tissue facial injury <input type="checkbox"/> Bony facial injury <input type="checkbox"/> C-Spine <input type="checkbox"/> Normal <input type="checkbox"/> Suspected injury <input type="checkbox"/> Manual control	Rate 1. <input type="checkbox"/> <10 <input type="checkbox"/> 10-30 <input type="checkbox"/> >30 2. <input type="checkbox"/> <10 <input type="checkbox"/> 10-30 <input type="checkbox"/> >30 Volume/ Effort <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <table style="width:100%;"> <tr> <td style="width:50%;">Oxygen <input type="checkbox"/> <input type="checkbox"/> High flow mask <input type="checkbox"/> BVM</td> <td style="width:50%;">% O₂ Saturations 1 <input type="checkbox"/> < 95 <input type="checkbox"/> > 95 2 <input type="checkbox"/> < 95 <input type="checkbox"/> > 95</td> </tr> </table> FLASH <input type="checkbox"/> Holes Front: <input type="checkbox"/> L <input type="checkbox"/> R Chest seal <input type="checkbox"/> Vented <input type="checkbox"/> Non vented Back: <input type="checkbox"/> L <input type="checkbox"/> R Chest seal <input type="checkbox"/> Vented <input type="checkbox"/> Non vented Bruising / abrasion <input type="checkbox"/> Rib Fractures / Flail Chest <input type="checkbox"/> Splinted <input type="checkbox"/> Patient self-splinted	Oxygen <input type="checkbox"/> <input type="checkbox"/> High flow mask <input type="checkbox"/> BVM	% O₂ Saturations 1 <input type="checkbox"/> < 95 <input type="checkbox"/> > 95 2 <input type="checkbox"/> < 95 <input type="checkbox"/> > 95	Tourniquet <input type="checkbox"/> <input type="checkbox"/> Rt arm <input type="checkbox"/> Lt arm <input type="checkbox"/> Rt leg <input type="checkbox"/> Lt leg External Bleeding <input type="checkbox"/> Bleeding Wound <input type="checkbox"/> Direct pressure Dressing <input type="checkbox"/> Field <input type="checkbox"/> Blast <input type="checkbox"/> Windlass <input type="checkbox"/> Haemostatic Internal Bleeding suspected <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Long Bones Pelvis / Femur Fracture <input type="checkbox"/> Splint Radial Pulse 1. <input type="checkbox"/> < 60 <input type="checkbox"/> 60-120 <input type="checkbox"/> >120 2. <input type="checkbox"/> < 60 <input type="checkbox"/> 60-120 <input type="checkbox"/> >120 No Pulse <input type="checkbox"/> <input type="checkbox"/> CPR <input type="checkbox"/> AED <input type="checkbox"/> ROSC <input type="checkbox"/> Dead
Oxygen <input type="checkbox"/> <input type="checkbox"/> High flow mask <input type="checkbox"/> BVM	% O₂ Saturations 1 <input type="checkbox"/> < 95 <input type="checkbox"/> > 95 2 <input type="checkbox"/> < 95 <input type="checkbox"/> > 95			

Disability	Exposure for Examination	
2. <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U 3. <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U	<input type="checkbox"/> Fully undressed <input type="checkbox"/> ? Spinal injury <input type="checkbox"/> Logroll <input type="checkbox"/> Patient cold <input type="checkbox"/> Back & sides check <input type="checkbox"/> Patient covered	Burns <input type="checkbox"/> < 10 mins irrigation <input type="checkbox"/> Clingfilm <input type="checkbox"/> 10 - 20 mins irrigation <input type="checkbox"/> Diphtherine

Pain									
Initial Pain Score					Patient complaining of pain? <input type="checkbox"/>				
0	1	2	3	4	Pentrox used: Y <input type="checkbox"/> N <input type="checkbox"/> Number of vials used: 1 <input type="checkbox"/> 2 <input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
After Dose 1					<i>Time:</i>				
0	1	2	3	4	<i>Batch Number:</i>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Expiry date:</i>				
After Dose 2					<i>Signature:</i>				
0	1	2	3	4					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Breathing					Confirmed: <input type="checkbox"/>				
<input type="checkbox"/> Rate > 10					No contraindications				
<input type="checkbox"/> Normal breathing					Past medical history / Medication				
					No use of Pentrox in last 3 months				
					Alert card given & discussed				
					Consent obtained				
Radial pulse					Adverse Reaction to Pentrox:				
<input type="checkbox"/> Present					Y <input type="checkbox"/> N <input type="checkbox"/>				
					<i>If yes, please specify:</i>				
Age					ADRs reported to CG lead <input type="checkbox"/>				
<input type="checkbox"/> > 18 years					<i>Name:</i>				
					<i>Date:</i>				
<input type="checkbox"/> Currently Alert & able to obey commands					Handover to EMS <input type="checkbox"/>				
					Name of staff receiving patient / EMS call sign:				
					Notes on Pentrox use:				

Overall Patient Outcome:	
Signature:	Date:
Internal review by:	External Review by:

