



**CANADIAN
RED CROSS**

Sample Patient Care Report

Name:	Date:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Time:
Address:	
Phone Number:	Location:
Date of Birth: YEAR MONTH DAY	
Chief Complaint:	Mechanism of Injury/History of Event:
PRIMARY SURVEY	
Level of Consciousness	
Airway	
Breathing	
Circulation	
SIGNS AND SYMPTOMS	O
	P
	Q
	R
	S
	T

ALLERGIES

None ASA Sulpha Penicillin Codeine Other (Details in lines below) Not Determined

MEDICATIONS

<input type="checkbox"/> None	<input type="checkbox"/> Nitroglycerin	<input type="checkbox"/> Erectile Dysfunction Drugs	<input type="checkbox"/> Ventolin®/Salbutamol	<input type="checkbox"/> Insulin	<input type="checkbox"/> Birth Control
	<input type="checkbox"/> ASA	<input type="checkbox"/> Lasix®/Furosemide	<input type="checkbox"/> Flovent®	<input type="checkbox"/> Oral Sugar Pills	<input type="checkbox"/> Not Determined

Other (specify)

RELEVANT MEDICAL HISTORY

<input type="checkbox"/> Previously Healthy	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Seizures	<input type="checkbox"/> Falls
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Not Determined

Other (specify)

LAST MEAL

EVENTS PRIOR

HEAD-TO-TOE PHYSICAL EXAMINATION

General Appearance:

Head/Neck:

Chest:

Abdomen:

Back/Pelvis:

Extremities:

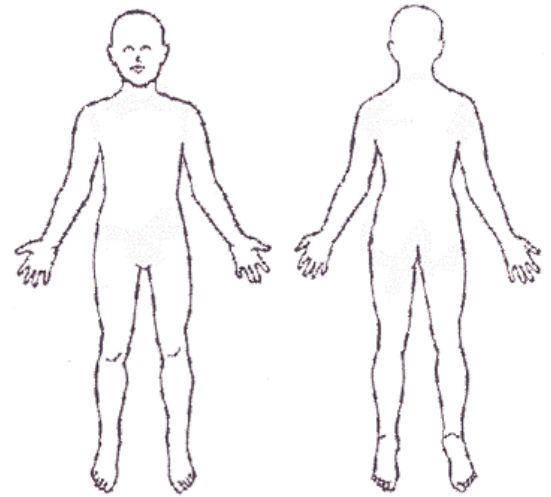
Other:

VITAL SIGNS			
TIME			
PULSE			
RESPIRATIONS			
BLOOD PRESSURE			
SKIN	Colour		
	Temperature		
	Condition		
PUPILS	Right		
	Left		
LOC	Alert and Responsive		
	Responsive But Not Alert		
	Unresponsive (Unconscious)		
GCS			
BGL			

TREATMENT					
TIME	CARE PROVIDED				RESPONDER INITIALS
<input type="checkbox"/> OXYGEN USED	<input type="checkbox"/> Nasal Cannula	<input type="checkbox"/> NRB	<input type="checkbox"/> Simple	<input type="checkbox"/> BVM	Flow Rate: LPM
CARDIAC ARREST:	<input type="checkbox"/> AED Used		Minutes of CPR Done:		
	# Shocks:		# No Shocks:		

NOTES

INJURY LOCATION DIAGRAM



OUTCOME				
Destination:	<input type="checkbox"/> Return to Activity	<input type="checkbox"/> Home	<input type="checkbox"/> To Physician	<input type="checkbox"/> To Hospital
	<input type="checkbox"/> Other:			
By:	<input type="checkbox"/> Private Car	<input type="checkbox"/> Taxi	<input type="checkbox"/> Police (Badge #:)	
	<input type="checkbox"/> Paramedics (Unit #:)		<input type="checkbox"/> Other:	

RESPONDER 1	NAME	SIGNATURE	TIME	DATE
RESPONDER 2	NAME	SIGNATURE	TIME	DATE

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 patient or substitute decision-maker): _____.

*Patient understands what is wrong with him/her. *Patient understands what could happen if further medical attention is not sought. *Patient has a plan for follow-up care. *Patient 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.

PATIENT/SUBSTITUTE DECISION-MAKER (PRINT NAME AND ADDRESS)

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

I have advised this patient, and/or the party responsible, of the risks involved to the patient's health if treatment is refused.

TIME-HOURS	DATE	SIGNATURE OF RESPONDER
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I was witness to the above-mentioned statement being explained.

TIME-HOURS	DATE	SIGNATURE OF WITNESSING RESPONDER
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