CANADIAN RED CROSS

Sample Workplace First Aid Incident Form

Name:	Date:
Sex: ☐ M ☐ F	Time:
Address:	
Phone Number:	Location:
Date of Birth: YEAR MONTH DAY	
Chief Complaint:	Mechanism of Injury/History of Event:

INTERVIEW

S	**O**
A	**P**
M	**Q**
P	**R**
L	**S**
E	**T**

ALLERGIES

☐ None ☐ Environmental (e.g., food, pollen) ☐ Medications (ASA, Penicillin, Sulpha, Codeine) ☐ Not Determined

MEDICATIONS

☐ None	☐ Over-the-Counter	☐ Erectile Dysfunction Drugs	☐ Ventolin®/ Salbutamol	☐ Insulin	☐ Birth Control
	☐ Prescribed (ASA, Nitroglycerin, Erectile Dysfunction Drugs, Insulin)	☐ Lasix®/Furosemide	☐ Flovent®	☐ Oral Sugar Pills	☐ Not Determined

RELEVANT MEDICAL HISTORY

☐ Previously Healthy	☐ Cardiac	☐ Respiratory	☐ Stroke/TIA	☐ Seizures	☐ Falls
	☐ Diabetes	☐ Psychiatric	☐ Cancer	☐ High Blood Pressure	☐ Not Determined
☐ Other (specify)					

HEAD-TO-TOE PHYSICAL EXAMINATION

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				

General Appearance:

Head/Neck:

Chest:

Abdomen:

Back/Pelvis:

Extremities:

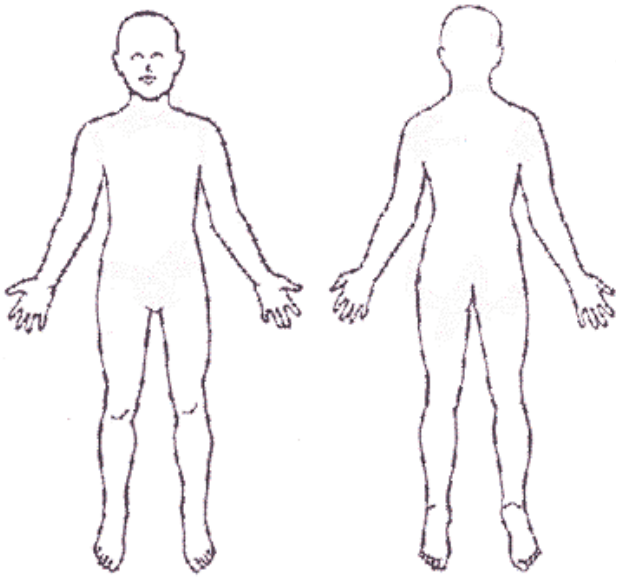
Other:

TREATMENT

TIME	CARE PROVIDED	RESPONDER INITIALS

☐ OXYGEN USED	☐ Nasal Cannula	☐ NRB	☐ Simple	☐ BVM	Flow Rate: LPM
CARDIAC ARREST:	☐ Witnessed	☐ AED Used		Minutess of CPR Done:	
	☐ Unwitnessed	# Shocks:		# No Shocks:	

INJURY LOCATION DIAGRAM



FOLLOW-UP NOTES

OUTCOME			
Destination:	☐ Return to Work Comments:	☐ Return to Activity	☐ Home
	☐ To Physician	☐ To Hospital	☐ Other:
By:	☐ Private Car	☐ Taxi	☐ Air Transport
	☐ Paramedics (Unit #:)	☐ Other:	

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

Comments: _____

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**