

Patient Report

Incident Report No. _____



PATIENT DETAILS (1 patient per form)			
Name: _____	Post Town: _____	Postcode: _____	Country: _____
D.O.B.: __/__/__		<input type="checkbox"/> Male	<input type="checkbox"/> Female

PATIENT CONDITION (on initial examination)			
<ul style="list-style-type: none"> A Abrasion (Graze) B Burn C Contusion (Bruise) D Dislocation F Fracture H Haemorrhage HC Heart Condition L Laceration O Other P Pain S Swelling SP Suspected Spinal 		Symptoms <input type="checkbox"/> Disorientated <input type="checkbox"/> Faint <input type="checkbox"/> Fitting <input type="checkbox"/> Hyperventilating <input type="checkbox"/> In Shock <input type="checkbox"/> Nauseated <input type="checkbox"/> Pale <input type="checkbox"/> Sweating <input type="checkbox"/> Weak <input type="checkbox"/> Vomiting	Level of Consciousness <input type="checkbox"/> Alert <input type="checkbox"/> Voice (responds to) <input type="checkbox"/> Pain (responds to) <input type="checkbox"/> Unresponsive Temperature <input type="checkbox"/> Hyperthermic <input type="checkbox"/> Normal <input type="checkbox"/> Hypothermic
DETAILS OF TREATMENT GIVEN <input type="checkbox"/> Rest <input type="checkbox"/> Reassurance <input type="checkbox"/> Warmed <input type="checkbox"/> Cooled <input type="checkbox"/> Raised legs <input type="checkbox"/> Bag & Mask <input type="checkbox"/> Manual Suction <input type="checkbox"/> Other* * Give Details...		<input type="checkbox"/> Cleaned <input type="checkbox"/> Plaster <input type="checkbox"/> Ice Applied <input type="checkbox"/> Dressing Applied <input type="checkbox"/> AED <input type="checkbox"/> Oxygen Therapy <input type="checkbox"/> Spinal Board / Collar <input type="checkbox"/> None	ALLERGIES / PAST MEDICAL HISTORY _____ _____ _____
		Airway <input type="checkbox"/> Clear <input type="checkbox"/> Partially Obstructed <input type="checkbox"/> Obstructed	Breathing <input type="checkbox"/> Present <input type="checkbox"/> Absent
		Circulation <input type="checkbox"/> Strong <input type="checkbox"/> Normal <input type="checkbox"/> Weak	

PATIENT RELEASE	PATIENT HANDOVER
<input type="checkbox"/> No further action <input type="checkbox"/> Advised to attend doctor Patient / Parent / Guardian Signature: _____ Declined treatment <input type="checkbox"/> Patient / Witness Name: _____ Patient / Witness Signature: _____	<input type="checkbox"/> Land Ambulance <input type="checkbox"/> Air Ambulance Duty of Care handed over to: <input type="checkbox"/> SAR / Ambulance <input type="checkbox"/> Relative <input type="checkbox"/> Friend Other: _____ Name: _____ Signature: _____

DETAILS OF ALL LIFEGUARDS INVOLVED			
	Name	Signature	Field / Vol (P & V)
1			
2			
3			
4			
5			
6			

All injuries that incapacitate a worker to be absent from or unable to do work that they would reasonably be expected to do as part of their normal work for more than 7 days, must be kept recorded and reported to the HSE within 15 days of the incident. To report the incident go to www.hse.gov.uk/riider and complete the appropriate online report form or call the Incident Contact Centre on 0845 300 9923 (opening hours Monday to Friday 8.30am to 5.00pm)

Medic Patient Report Form

PT Brinkman



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