Patient Care Report   Aid Station: ______________________

Location:		Pt Num:	Date: / /	Time: :
Last Name:		**Reason for Call**		**Care Providers**
First Name:		☐ Abd Pain ☐ Chest Pain ☐ Trbl Breath		1
Address:		☐ Bleeding ☐ Cardiac Arrest ☐ Trauma		2
Age:	DOB: Sex:	☐ Burns ☐ Gen Malaise ☐ Other		3

Airway	Circulation					Skin	Thorax	Other Symptoms
☐ Normal ☐ Part Obstructed ☐ Full Obstructed		*Time*	*BP*	*Pulse*	*Resp*	☐ Normal ☐ Moist ☐ Cool ☐ Pale ☐ Cyanotic ☐ Fever ☐ Rash ☐ Localized Lesions	**Chest** ☐ Normal ☐ Flail ☐ Tender **Abdomen** ☐ Tender ☐ Rigid ☐ Soft	**Neuro** ☐ Normal ☐ Flaccid ☐ Paralysis **Gastrointestinal** ☐ Nausea ☐ Vomiting ☐ Diarrhea
Breathing	1	:	/					
☐ Normal	2	:	/					
☐ Rapid	3	:	/					
☐ Slow ☐ Irregular	4	:	/					
☐ Labored	5	:	/					
☐ None	6	:	/					

Glasgow Coma Score

Eye Opening	*1*	*2*	*3*	*Verbal Resp*	*1*	*2*	*3*	*Motor Resp*	*1*	*2*	*3*
Spontaneous(4)	☐	☐	☐	Oriented (5)	☐	☐	☐	Obeys (6)	☐	☐	☐
To Speech (3)	☐	☐	☐	Confused (4)	☐	☐	☐	Localized (5)	☐	☐	☐
To Pain (2)	☐	☐	☐	Inapprop Words (3)	☐	☐	☐	Withdraws (4)	☐	☐	☐
None (1)	☐	☐	☐	Incomp Sounds (2)	☐	☐	☐	Flexes (3)	☐	☐	☐
				None (1)	☐	☐	☐	Extends (2)	☐	☐	☐
								None (1)	☐	☐	☐

Pupils

(3 2 1)

		1	2	3
Size	L			
	R			
Reactive	L			
	R			
Non-reactive	L			
	R			

Injury Description

Identify the area of injury with the following numbers

1 - Amputation
2 - Blunt Injury
3 - Burn
4 - Crush
5 - Dislocation/Fracture
6 - Gunshot
7 - Laceration
8 - Pain
9 - Puncture/Stab
10 - Soft Tissue Injury

Airway	Oxygen	Treatment	
☐ Oral	☐ Nasal Cannula	☐ Limb Splints	☐ Citizen CPR
☐ Nasal	☐ Non-rebreather	☐ Traction Splints	☐ Suction
☐ Combi	☐ B-V-M	☐ Spine Board	☐ Extrication
☐ Other	☐ Other	☐ Cervical Collar	☐ Control Bleeding
	LPM:	☐ CPR	☐ Other

Defibrillation			Meds Given
Time	*Num of Shocks*	*Outcome*	

History ☐ Cardiac ☐ CA ☐ COPD ☐ Diabetes ☐ HTN ☐ Psych ☐ Stroke ☐ Other:

Meds ☐ Unknown ☐ None

Allergies ☐ Unknown ☐ None

Time /Location of Onset of Symptoms :

Narrative

Attach Triage Tag Transport Record Sticker Below

Refusal - Responsible Party and Witness Statement

I understand that I may have a condition that requires care by a physician. I understand that there may be a risk to my health if I do not seek medical care from a physician. I **assume the risks and consequences** involved and **release** those offering to treat and/or transport me, as well as their employers, from any responsibility whatsoever for any unfavorable conditions or injuries caused by my refusal. I **refuse treatment and/or transportation** to a hospital. I forever **waive all actions and claims** by me or on my behalf resulting from my refusal or treatment and/or transportation.

Signature________________________________ Date_______________

Witness Statement
I observed the above named person review and sign the statement above. The person was alert and did not appear confused. The person appeared to understand the statement and did not state otherwise.

Signature________________________________ Date________________ Print Name______________________________

Category ☐ 1 ☐ 2 ☐ 3 ☐ Treat & Release ☐ Treat and Transport by

Time Exit	Provider Signature
:	