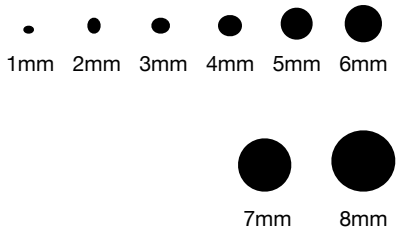
Pt. Assessment Chart

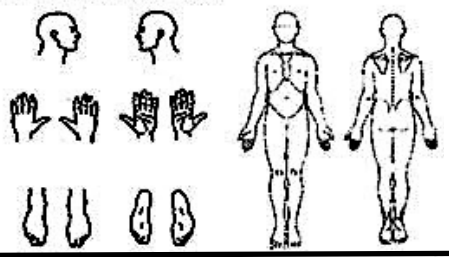
Date & Time of Injury/Illness:	Date and Time Reported to FA:
Time of Arrival to FA:	Time of Scene:
Pt. Name:	Date of Birth:
Pt. Doctor:	Contact Person:
Employer Name:	

ABC's	Eyes		Verbal		Motor	
	4	Spontaneously	5	Oriented	6	Obeys Commands
	3	Speech	4	Confused	5	Localizes Pain
	2	To Pain	3	Inappropriate Words	4	Withdraws form Pain
	1	No Response	2	Incomprehensible Sound	3	Flex To Pain
			1	No Response	2	Extends To Pain
					1	No Response



Vital Signs	Time:		Time:		Time:		Time:	
Respiration								
Pulse Rate								
Skin								
GCS	E V M Total:		E V M Total:		E V M Total:		E V M Total:	
Pupil	L	R	L	R	L	R	L	R

Head To Toe
H & N:
Chest:
Back:
Abdomen:
Ext:
Circulation:
Nerve Function:
Motor Function:



History
Mechanism of Injury:
Chief Complaint:
Allergies:
Medications:
Medical History:
Last Oral Intake:
Events preceding:

Position:	
Provoke:	
Quality:	
Radiate:	
Relief:	
Severity:	
Time:	

Interventions			
Airway Cleared		CPR	
OPA		BVM	
Assisted Vents		O2 LPM	
Controlled Bleeding			

Transportation			
ETV		BC Ambulance	
MTC		Air Evacuation	
Industrial Ambulance		Other	

Treatments:

FAA Name (print):	FAA Signature:
OFA Certification #:	Time of Scene:
Witnesses:	Pt. Signature:
Employer Mailing Address:	