Patient Treatment Form

DATE			TEAM	
			SECTOR	
TIME			GPS LOCATION	Lat:
				Long:

TREATED BY: CONTACT DETAILS Tel:
QUALIFICATION: Email:

PATIENT DETAILS
NAME NATIONALITY
AGE GENDER M/F

HANDOVER TO:

Locals/family	☐	_____	Medical team	☐	_____
Ambulance	☐	_____	Helicopter	☐	_____
Hospital	☐	_____	Field Hospital	☐	_____
Mortuary	☐	_____	Other	☐	_____

Type of Entrapment/Incident		Date	Time
	First Detection		
	First USAR Contact		
	First Physical Contact		
	Extrication		

INJURIES IDENTIFIED				Add Details
Penetrating Trauma	☐	Blunt Trauma	☐	
Amputation	☐	Dehydration	☐	
Burns	☐	Fractures	☐	
Crush	☐	Blast	☐	
Head Injury	☐	Other	☐	

VITAL SIGNS (Where Applicable)	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE
RESPIRATORY RATE									
PULSE									
BLOOD PRESSURE									
AVPU/GCS									
BLOOD GLUCOSE									
SPO2									
ETCO2									
Temperature									
Urine Output									
OTHER									

TREATMENT GIVEN

INTERVENTIONS	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	

FLUIDS	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TOTAL

DRUGS	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TIME/DATE	TOTAL

ADDITIONAL INFORMATION

NAME: TITLE: SIGNATURE: