



ACCIDENT REPORT FORM

Event Name: _____
 Base: _____
 Facility: _____
 Location: _____
 Date: (MM/DD/YY) _____ Time of Injury: _____

Name of Injured Person: _____
 SN: _____ Rank: _____ Unit: _____
 Age: _____ DOB: (MM/DD/YY) _____ Gender: _____
 Address: _____
 Postal Code: _____ City: _____ Province: _____
 Phone Number: _____

Name of escort : _____
 SN: _____ Rank: _____ Unit: _____
 Relationship with Injured Person: _____
 Address: _____
 Postal Code: _____ City: _____ Province: _____
 Phone Number: _____

Primary Assessment

Chief Complaint/Nature of the Injury:

History and description of Injury/Illness (Be specific.)

Allergies : _____
 Medications: _____

Past Medical History: _____

Vitals Signs

Time – (Local)	Blood Pressure	Pulse	Respiration	Temp	Pupils (Use Gage)	LOC
hrs	/ mmHg	/min	/min	°C	Lt: Rt:	<input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U
hrs	/ mmHg	/min	/min	°C	Lt: Rt:	<input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U
hrs	/ mmHg	/min	/min	°C	Lt: Rt:	<input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U
hrs	/ mmHg	/min	/min	°C	Lt: Rt:	<input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U

Secondary Assessment + Treatment

Mark injury area with X

Explain treatment provided, recommendations made as well as any other pertinent information. Remember to mark the adjacent diagram to give the location of the injury.

Cardiac Arrest/ AED Treatment

Arrest Witnessed Not witnessed Time: _____h
 CPR Started By: _____
 Time of CPR started: _____ Time AED connected: _____
 Time of First Shock: _____ Total Number of Shocks given: _____

Oxygen Administration

O2 Started (time) : _____ L/min: _____
 Mask Type: _____ Removed (time) : _____
 Reason: _____

Refusal of Treatment

I hereby refuse patient treatment and acknowledge that patient care treatment and further medical treatment was advised. I therefore release the current medical attendant and all their colleagues from all liability for respecting my expressed wish. Date (MM/DD/YY): _____ Time: _____
 Patient (Print name + Signature): _____
 Escort (Print name + Signature): _____

Release

Time of Release: _____
 Was Patient Accompanied by someone at the time of release ? No Yes
 If Yes, by Who? (Print Name + Signature) _____
 Patient's Condition: _____

Emergency Medical Services

EMS Call Time: _____ EMS Contact Person: _____ EMS Arrival Time: _____ EMS Departure Time: _____
 Ambulance Vehicle Number: _____ EMS Report Number: _____

Head to Toe	A— B— C
<ul style="list-style-type: none"> * Contusion (Any form of bruises or discolouration of the skin) * Laceration (Any form of cut or open wound in the skin) * Abrasion (Any form of scrape or multiple open and shallow wounds in the skin) * Puncture (Any form of hole or small and deep wounds in the skin) * Symmetry (Left to right the body structure and shape doesn't appear to be the same) * Tenderness (Any form of spot or general discomfort from touch or otherwise) * Instability (Lack of range of motion of ability to support weight) * Crepitus (Grinding noise resulting from normal range of motion) * Sub-Cutaneous Pressure (Air bubbles or other deformities present in the skin) 	<p>Airway</p> <ul style="list-style-type: none"> * Clear: (No objects and easy passage of air from the mouth to the lungs) * Partial Obstruction: (There is an object that limits the passage of air from the mouth to the lungs) * Complete Obstruction: (There is an object that blocks all passage of air from the mouth to the lungs) * Restricted: (No objects, but the passage of air from mouth to lungs seems difficult) * Maintain Manually: (An oropharyngeal airway was inserted) <p>Breathing</p> <ul style="list-style-type: none"> * Present: By observation (Look, listen, feel) some breathing is apparent (rate, rhythm, Depth) * Absent: By observation (Look, listen, and feel) no breathing is apparent <p>Circulation :</p> <ul style="list-style-type: none"> * Skin : Color—temperature— Texture * Present: (Skin is warm and normal colour and a test of capillary refill shows blood movement) * Absent: (Skin is cool or unusual colour and a test of capillary refill shows very limited or no blood movement) * Major Bleed: (The injured person losing a large amount of blood)

S A M P L E	Vital Signs
<p>Symptoms: (Does the injured person have any pain, discomfort, or any other sensation associated with the injury)</p> <p>Allergies: (i.e. allergies, nuts, animals....)</p> <p>Medications: (Is the injured person currently taking any medications such as, but not limited to prescriptions, aspirin, or birth control)</p> <p>Past Medical History: (Does the injured person have any medical conditions such as, but not limited to Diabetes, Epilepsy, or Sports Injuries)</p> <p>Last In & Out: (What has the injured person eaten, drank, or otherwise consumed recently and has the injured person gone to the bathroom recently)</p> <p>Events Prior: (Did the injured person describe any recent events related to the injury)</p>	<p>Record the injured person's vital signs at least every 5 minutes until your treatment is complete or care for the injured person has passed to advanced medical care.</p> <p>Level of Consciousness (L.O.C): Assess the injured person's level of mental awareness as one of the following options: Alert (Responds to all questions and is aware of surroundings). Verbal Responsive (Responds to noises, but appears to have impaired mental function). Pain Responsive (Responds to a pin stimulus such as pinch, but has no reaction to noises).</p> <p>Pulse: If you are capable assess the injured person's pulse from the neck or the wrist. Record the number of heart beats per minute. Record if the rhythm of the beats is regular or irregular pattern. Record if the depth of the beats is strong and deep or shallow and weak.</p> <p>Respirations: Assess the injured person's respirations by observation (look, listen, and feel). Record the number of breaths per minute. Record if the rhythm of the breaths are regular or irregular. Record if the Depth of the breaths is strong and deep or shallow and weak.</p> <p>Skin: Assess the injured person's skin by observation. Record if the skin colour is a normal or unusual. Record if the skin temperature feels warm or cool. Record if the skin feels supply and dry or stiff and clammy.</p> <p>Blood Pressure: If you are capable and have the appropriate equipment record the blood pressure systolic and diastolic.</p> <p>Pupils: Assess the injured person's pupils by observation. Record if the pupils are a normal or unusual shape, size, or colour. Record if the pupils are equal to each other. Record if both pupils are reactive to light.</p>

Treatment & Additional Notes

Treatment & Additional Notes
Attending Staff Name: _____ Date: _____ Signature: _____
Attending Staff Name: _____ Date: _____ Signature: _____
Attending Staff Name: _____ Date: _____ Signature: _____
Event Head Trainer : _____ Date: _____ Signature: _____

Follow-Up
Corrective Action Taken: _____ _____ _____
Supervisor Name: _____ Date: _____ Signature: _____
Follow-Up Phone Call to Injured Person Notes: _____ _____ _____
Supervisor Name: _____ Date: _____ Signature: _____