



PATIENT CARE RECORD	CONFIDENTIAL WHEN COMPLETED	Case No.
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Event

PERSONAL INFORMATION

Patient Name Mr./Mrs./Miss/Ms			Date of Birth (DD/MM/YYYY)	
Mailing Address			Telephone Number ()	
City		Province		Postal Code
Report Date / /	Report Time	Incident Date / /	Incident Time	Incident Location
Brought in by <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Self Ambulance Unit Police Badge: Other (Specify)				

HISTORY/DESCRIPTION

History and Description of Injury/Illness (Be specific)						Medications	
Time	Blood Pressure	Pulse	Respiration	Temperature	Pupils		Allergies
hrs.	mmHg	/min.	/min.	°C	Lt:	Rt:	
hrs.	mmHg	/min.	/min.	°C	Lt:	Rt:	
hrs.	mmHg	/min.	/min.	°C	Lt:	Rt:	

TREATMENT Care rendered (Be specific)

Time	Medication/Procedure	Result

PLEASE COMPLETE ALL SECTIONS OF THE FORM

Form No.	of
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TREATMENT (cont'd)

Advised to see Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Consent <input type="checkbox"/> Given <input type="checkbox"/> Refused
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Case No.

REFUSAL OF TREATMENT

I hereby refuse patient care treatment and acknowledge that patient care treatment and further medical treatment was advised by the St. John Ambulance member. I therefore release St. John Ambulance and its members from all liability for respecting my express wish.

Signature - Patient/Substitute Decision Maker	Date	Time
Signature - First Witness	Signature - Second Witness	

CARDIAC ARREST / AED TREATMENT

<input type="checkbox"/> Arrest Witnessed	Time	h.	<input type="checkbox"/> Arrest Not Witnessed
CPR started by	<input type="checkbox"/> Bystander	<input type="checkbox"/> Police/Firefighter	<input type="checkbox"/> Other
Time CPR started	Time AED hooked up	Time of first shock	Total number of shocks given

DISPOSITION

Disposition:	Discharge time	hrs.	Hospital
Accompanied by:	<input type="checkbox"/> Friend/Relative	<input type="checkbox"/> Self	Ambulance Unit <input type="checkbox"/> Police Badge <input type="checkbox"/> Other (specify)

PATIENT TRANSPORT

To Scene:	Time Out: hr	Km Start:	Lights <input type="checkbox"/> Siren <input type="checkbox"/> P/A <input type="checkbox"/>	Time Arrive: hrs.	Km Scene:
To Destination:	Time leaving: hrs.	Lights <input type="checkbox"/> Siren <input type="checkbox"/> P/A <input type="checkbox"/>	Time Arrive: hrs.	Km Scene:	
Vehicle No.:	Authorization:	Drive (Print)	Attendant (Print)		
Condition on Arrival:	Explain	<input type="checkbox"/> Unchanged	<input type="checkbox"/> Improved	<input type="checkbox"/> Deteriorated	

Equipment/Supplies used:

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SIGNATURES

Treated by (Print Name(s))	Signature(s)	SJA Unit
Treated by (Print Name(s))	Signature(s)	SJA Unit

