St. John Ambulance

PATIENT CARE RECORD

Report Date: _____ (DD-MM-YYYY)

Report Time: _____ (hh:mm)

Event Name:

CONFIDENTIAL WHEN COMPLETED

PERSONAL INFORMATION

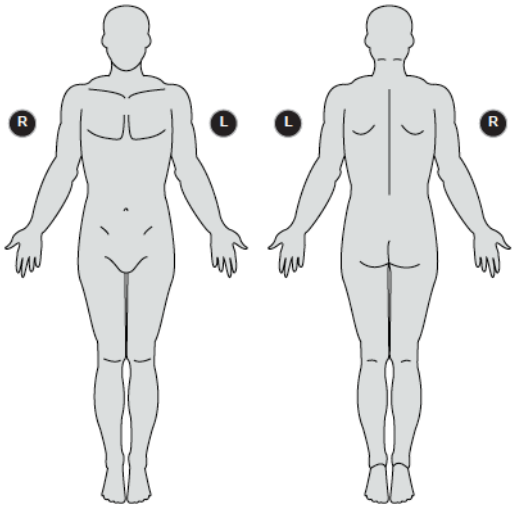
Name Mr./ Mrs./ Miss/ Ms			
Mailing Address			**Date of Birth** (DD-MM-YYYY)
City	**Province**	**Postal Code**	**Telephone #**

Allergies	Medications	Past Medical History
NKA ☐or	None ☐or	None ☐or

INITIAL ASSESSMENT

History/Description of Injury or Illness (be specific)

Patient Consent: □ Given □ Refused

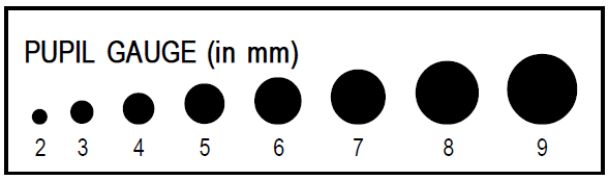


Initial Vital Signs

Time	Pulse	Resps	BP	Skin	LOC	Pain	Pupils		
	/ min	/ min			□ Alert □ Pain □ Verbal □ Unresponsive	___ / 10	Left		+ or -
							Right		+ or -

Instructions for Completion:

- Please Print
- Complete all fields as completely as possible, as appropriate
- Circle and annotate the person diagram to help indicate location of injuries, if required
- Record any after-care instructions, if provided



Top Copy / Original – retained by local unit

Bottom Copy / duplicate – for EMS or Hospital

PATIENT CARE RECORD

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

TREATMENT

Time	Intervention / Procedure	Results / Notes

Time	Pulse	Resps	BP	Skin	LOC	Pain	Pupils		
	/ min	/ min			□ Alert □ Pain □ Verbal □ Unresponsive	___ / 10	Left		+ or -
							Right		+ or -
	/ min	/ min			□ Alert □ Pain □ Verbal □ Unresponsive	___ / 10	Left		+ or -
							Right		+ or -
	/ min	/ min			□ Alert □ Pain □ Verbal □ Unresponsive	___ / 10	Left		+ or -
							Right		+ or -

CARDIAC ARREST / AED TREATMENT

	Time (24hrs)
Approximate time of arrest	
Witnessed Collapse Yes □ No □	
CPR started by: Bystander □ Police/Fire □ SJA □	
AED available/applied Yes □ No□	
Time of First shock (if advised)	
Time Care Transferred	
Number of Shocks Delivered: _____	

DISPOSITION SUMMARY

Discharge Time:_____ **Advised to see Physician? Yes □**

Disposition: Back to Event □
Home □
Hospital □ _____

Accompanied By: Self □ Friend/Relative □
Police □ (Badge # _____) Ambulance □ (Unit # _____)

Discharge Instructions: N/A □ or

SIGNATURES

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

Top Copy / Original – retained by local unit Bottom Copy / duplicate – for EMS or Hospital