



**PATIENT CARE RECORD**

Case Number
Duty

**PERSONAL INFORMATION**

Patient Name Mr./Mrs./Miss/Ms		Date of Birth (DD/MM/YYYY)	
Mailing Address		Telephone Number ( )	
City		Province	
Postal Code		Incident Location	
Report Date / /	Report Time hrs	Incident Date / /	Incident Time hrs
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	
					Allergies	
(continue on back)						
Time	Blood Pressure	Pulse	Respiration	Temperature	Pupils	
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.)	Advised to see Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Patient Consent <input type="checkbox"/> Given <input type="checkbox"/> Refused
(continue on back)	

**DISPOSITION**

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

**PATIENT TRANSPORT**

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

Treated by (Print Name)	Signature	Brigade Unit	Page No.
Supervisor (Print Name)	Signature	Brigade Unit	of
Medical Director(Print Name)	Signature		

## REFUSAL OF TREATMENT

I hereby refuse first aid treatment and acknowledge that first aid treatment and further medical treatment was advised by the St. John Ambulance Brigade 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	

## HISTORY/DESCRIPTION

(Continued from front)

Arrest Witnessed                       Arrest Not Witnessed

Time \_\_\_\_\_ h.

### CPR started by

- Bystander  
 Police/Firefigther  
 Other \_\_\_\_\_

Time CPR started \_\_\_\_\_

Time AED hooked up \_\_\_\_\_

Time of first shock \_\_\_\_\_

Total number of shocks given \_\_\_\_\_

## TREATMENT

Time	Medicine or Procedure	Result

Name of Medical Director \_\_\_\_\_

