

DATE			TEAM	
TIME			SECTOR	
			GPS LOCATION	Lat: _____
				Long: _____

TREATED BY:	CONTACT DETAILS	Tel: _____
QUALIFICATION:		Email: _____

PATIENT DETAILS		
NAME	NATIONALITY	
AGE	GENDER	M/F

HANDOVER TO:					
Locals/family	<input type="checkbox"/>		Medical team	<input type="checkbox"/>	
Ambulance	<input type="checkbox"/>		Helicopter	<input type="checkbox"/>	
Hospital	<input type="checkbox"/>		Field Hospital	<input type="checkbox"/>	
Mortuary	<input type="checkbox"/>		Other	<input type="checkbox"/>	

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

INJURIES IDENTIFIED				Add Details	
Penetrating Trauma	<input type="checkbox"/>	Blunt Trauma	<input type="checkbox"/>		
Amputation	<input type="checkbox"/>	Dehydration	<input type="checkbox"/>		
Burns	<input type="checkbox"/>	Fractures	<input type="checkbox"/>		
Crush	<input type="checkbox"/>	Blast	<input type="checkbox"/>		
Head Injury	<input type="checkbox"/>	Other	<input type="checkbox"/>		

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	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:
-------	--------	------------