Patient Treatment Form

Date			**TEAM**	
			WORK SITE ID	
Time			**GPS LOCATION**	**Lat:**
			PT ENCOUNTER	**Long:**

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

PATIENT NAME **VICTIM NUMBER (victim extrication form)**
NATIONALITY

DATE OF BIRTH/ AGE **GENDER**

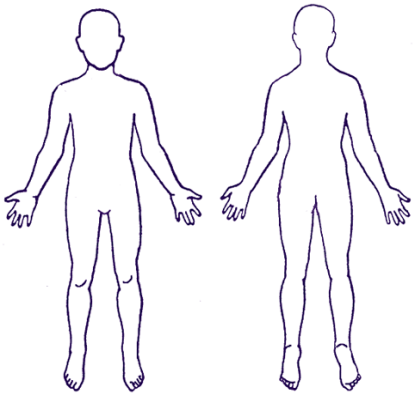
HANDOVER TO:

Organization	**Individual**	**Location**	**Contact information**

Type of Entrapment/Medical Incident/Exposure

	Date	**Time**
First Detection		
First USAR Contact		
First Physical Contact		
Extrication		

Physical exam



Injuries/illnesses identified

ADDITIONAL MEDICAL INFORMATION (Past medical history, medications, allergies)

ADDITIONAL INFORMATION (e.g. family members notified)

NAME: **TITLE:** **SIGNATURE:**