

Name of victim _____ DOB _____ email/phone _____ M/F _____
 Date _____ Time _____ am/pm Place _____ Weather conditions _____ Altitude _____
 First aider/leader's name _____ signature _____ email/phone _____
 Witness name _____ signature _____ email/phone _____
SCENE DESCRIPTION: (who, what, where, how, MOI)

1. **Take control**
 - Self
 - Others
2. **Is it safe? MOI**
3. **Primary survey**
 - Response
 - Airway
 - Breathing
 - CPR
 - deadly bleeding
4. **Shock management**
 - Rest & reassure
 - Pain relief
 - Environmental protection
5. **Secondary survey**
 - Head to toe
 - Vital signs
 - Medical history
6. **Plan of action**
7. **Treatment**
8. **Evacuation**

VITAL SIGNS

Check vital signs every 15 minutes until condition is stable (ie 4 sets of signs with same, or better recordings). Then every hour until condition is stable. Then every 4 hours.

Levels of consciousness

A -Alert and oriented: A x 4= the victim knows their name, the place, the time and what happened
 A x 3= can only answer three of the above questions
 A x 2= can only answer two of the above questions
 A x 1= can only answer one of the above questions

V - Verbal: the victim responds vaguely to shouted commands or questions
 P - Pain: the victim responds only to painful stimuli (pinch ear)
 U - Unresponsive: there is no response at all

		TIME →						
LEVEL OF CONSCIOUSNESS <i>normal: Ax4</i>	Ax4, Ax3, Ax2, Ax1, V, P, U (see box above)							
	PULSE <i>normal: 50 to 80, regular</i>	Rate (beats/min)						
		Rhythm (regular? irregular?)						
RESPIRATION <i>normal: 12 to 16 average (up to 20 at high altitude)</i>	Rate (breaths/min)							
	Comments eg. sputum, noisy shallow, etc.							
SKIN (OR MUCOUS MEMBRANE) <i>normal: pink, warm, dry</i>	Colour (pink, red, white, bluish)							
	Temperature (hot, warm, cool, cold)							
	Moisture (dry, moist, clammy, sweaty)							
TEMPERATURE <i>normal: oral 36.5°C</i>	Take temp if skin is hot or infection is a possibility, or you cannot make a diagnosis.							
COMMENTS	e.g. Lake Louise score, pain score, CSM, pupil size, urine (quantity/colour hourly)							
ASSESSMENT	e.g. victim is OK, mild, moderate, serious, shocked							

MEDICAL HISTORY

Symptoms (ask these questions for each symptom, as appropriate)

What is the problem? When did it start? How did it start/happen? Describe the symptom/pain. Where is it? Does it move anywhere else? Is it coming and going? Is it getting better or worse? On a scale of 1 to 10 (1 being no pain at all, 10 being the worst pain you can imagine), how severe is the pain?

What makes symptom/pain better or worse (e.g. food, drink, position, medication)? Have you taken anything for it? Has this problem happened before? (if so, what was it called, how was it treated?).

Do you have any other symptoms or pain anywhere else? (Repeat questions above for each symptom or pain).

Is there anything else? How have you been sleeping? How are you feeling (worried, depressed, frightened)? What do you think is wrong with you?

Ins & Outs

Liquid: amount drunk in last 24 hrs (e.g. water, juice, cordial, tea, coffee, soup). Is this normal for you?

Urination: how many times in last 24 hrs? What was the colour, amount and smell of last pee?

Food: quantity eaten in last 24 hrs (usual amount, less, much less or none)

Bowel movements: how many times in last 24 hrs? Is this normal for you?

Vomit: what was vomited, amount? How many times in last 24 hrs?

Menstruation (women): if appropriate ask: Are your periods normal? Could you be pregnant?

PHYSICAL EXAMINATION

Any loss of consciousness? If yes, how long for? Any chance of spinal injury?

Head to Toe (describe in detail and/or draw a diagram)

Head and neck

Chest and rib cage

Back and spine

Belly (abdomen)

Pelvis

R leg

L leg

R arm

L arm

CSM (*circulation, sensation, movement*)

BOM (*bites, odours, medi alert tags*)

AT ALTITUDE: *Lake Louise Score*

HAPE? listen to chest

HACE? heel-to toe walking test, finger-nose test, standing test, mental test

General Medical History

Previous medical history: Do you have any medical conditions or illnesses (e.g. asthma, blood pressure, depression, diabetes, epilepsy etc)? Have you been to the doctor in the last 12 months? What for? Have you had any serious illnesses, injuries or operations in the past?

Medications/recreational drugs/alcohol/smoking: Are you taking any medications? What for?

Dose? Did a doctor prescribe them? Have you missed any medications you should be taking?

Have you been drinking alcohol or using any recreational drugs? Do you smoke tobacco?

Allergies: Are you allergic to anything (e.g. medications, food, stings, adhesive tape, pollen)? What is the reaction? Do you think your present problem could be caused by your allergy?

DIAGNOSIS

(if you have one)

What else could it be?

WHAT COULD GO WRONG NEXT?

TREATMENT AND

MANAGEMENT PLAN (what are you going to do now and over the next few days?)