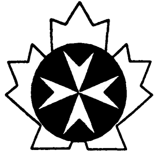
AED Annex D

Annex A
to StJCI 2-7-4



St. John Ambulance

PATIENT CARE RECORD

CONFIDENTIAL WHEN COMPLETED

Case No.

Duty

PERSONAL INFORMATION

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

Report Date	Report Time	Incident Date	Incident Time	Incident Location
/ /	hrs	/ /	hrs	

Brought in by: ❑ Friend/Relative ❑ Self Ambulance Unit: ___________ Police Badge: ___________ Other (Specify): ___________

HISTORY/DESCRIPTION

History and Description of Injury/Illness (Be specific.)

Medications

Allergies

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.)

Time	Medication/Procedure	Result

PLEASE COMPLETE ALL SECTIONS OF THE FORM

Form No.	of

White – SJA Unit Canary – Health Care Agency Pink – SJA Medical Director

AED Annex D

TREATMENT (cont'd)

Case No.

Advised to see Physician? ❑ Yes ❑ No Patient Consent ❑ Given ❑ Refused

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	

CARDIAC ARREST / AED TREATMENT

❑ **Arrest Witnessed** Time________h. ❑ **Arrest Not Witnessed**

CPR started by ❑ Bystander ❑ Police/Firefighter ❑ Other______________

Time CPR started __________ Time AED hooked up __________ Time of first shock __________ Total number of shocks give __________

DISPOSITION

Disposition: Discharge time____________hrs Hospital____

Accompanied by: ❑ Friend/Relative ❑ Self Ambulance Unit:_________ Police Badge:_________ Other (Specify):_________

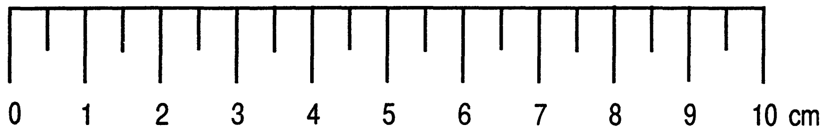
PATIENT TRANSPORT

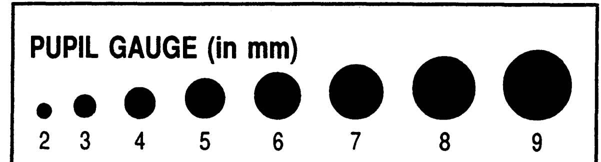
To Scene:	Time Out: hrs	Km Start:	Lights❑ Siren❑ P/A❑	Time Arrive: hrs	Km Scene:
To Destination:	Time Leaving: hrs	Lights❑ Siren❑ P/A❑		Time Arrive: hrs	Km Destination:
Vehicle No.:	Authorization:	Driver (Print)		Attendant (Print)	
Condition on Arrival	Explain:______________________			❑Unchanged ❑Improved	❑Deteriorated

Equipment/Supplies used:

SIGNATURES

Treated by (Print Name(s))	Signature(s)	SJA Unit
Medical Director (Print Name) - for delegated medical act	Signature	SJA Unit





White – SJA Unit Canary – Health Care Agency Pink – SJA Medical Director