



St. John Ambulance

**CONFIDENTIAL
WHEN COMPLETED**

ANNEX _____

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	
Report Date / /	Report Time hrs	Incident Date / /	Incident Time hrs	Incident Location	
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	
<h1>SAMPLE</h1>					Allergies	
Time hrs	Blood Pressure mmHg	Pulse /min.	Respiration /min.	Temperature °C	Pupils 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

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 <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

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 _____

