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: ☐ 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.)	Advised to see Physician? ☐ Yes ☐ No
	Patient Consent ☐ Given ☐ 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☐ Siren☐ P/R☐	Time Arrive: hrs	Km Scene:
To Destination:	Time Leaving: hrs	Lights☐ Siren☐ P/R☐		Time Arrive: hrs	Km Destination:
Vehicle No.:	Authorization:	Driver (Print)		Attendant (Print)	

Condition on Arrival Explain: _____ ☐Unchanged ☐Improved ☐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_____