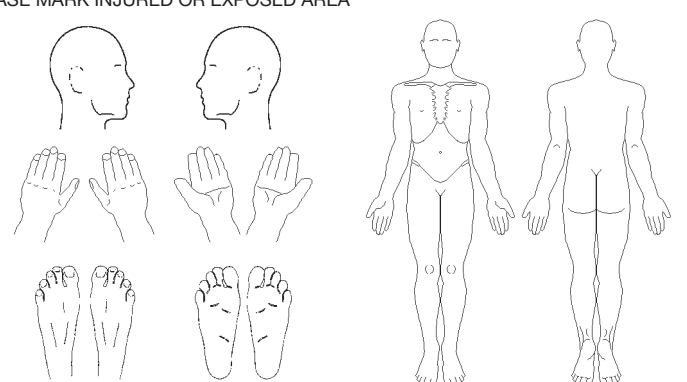



OCCUPATIONAL FIRST AID PATIENT ASSESSMENT

EMPLOYEE NAME	DATE OF BIRTH	D	M	Y	
DATE AND TIME OF ILLNESS / INJURY	AM / PM	DATE AND TIME REPORTED TO FIRST AID	AM / PM		
TIME OF ARRIVAL AT FIRST AID (WALK IN)	AM / PM	TIME ON SCENE (IF APPLICABLE)	AM / PM		

GLASGOW COMA SCALE EYE OPENING RESPONSE 4 SPONTANEOUSLY 3 SPEECH 2 TO PAIN 1 NO RESPONSE	BEST VERBAL RESPONSE 5 ORIENTED 4 CONFUSED 3 INAPPROPRIATE WORDS 2 INCOMPREHENSIBLE SOUNDS 1 NO RESPONSE	BEST MOTOR RESPONSE 6 OBEYS COMMANDS 5 LOCALIZES PAIN 4 WITHDRAWS FROM PAIN 3 FLEX TO PAIN (DECORTICATE) 2 EXTENDS TO PAIN (DECEREBRATE) 1 NO RESPONSE
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VITAL SIGNS	TIME	TIME	TIME	TIME	PLEASE MARK INJURED OR EXPOSED AREA 		
RESPIRATIONS							
PULSE							
LOC / GCS	E V M	TOTAL	E V M	TOTAL		E V M	TOTAL
PUPIL SIZE & REACTION +/-	L	R	L	R		L	R
SKIN							
							

PATIENT'S CHIEF COMPLAINT ALLERGIES MEDICATIONS PREVIOUS MEDICAL HISTORY MECHANISM OF INJURY / HISTORY OF ILLNESS	RECOMMENDATIONS <input type="checkbox"/> RETURN TO WORK <input type="checkbox"/> FIRST AID FOLLOW UP <input type="checkbox"/> MEDICAL AID TRANSPORTED BY (PLEASE CHECK) <input type="checkbox"/> ETV <input type="checkbox"/> INDUSTRIAL AMBULANCE <input type="checkbox"/> B.C. AMBULANCE SERVICE <input type="checkbox"/> AIR EVACUATION <input type="checkbox"/> OTHER (PLEASE EXPLAIN) CHANGES IN PATIENT'S CONDITION (PLEASE EXPLAIN) INTERVENTIONS (PLEASE CHECK) <input type="checkbox"/> AIRWAY CLEARED <input type="checkbox"/> MAINTAINED <input type="checkbox"/> OROPHARYNGEAL AIRWAY <input type="checkbox"/> VENTILATED <input type="checkbox"/> PKT. MASK <input type="checkbox"/> BVM <input type="checkbox"/> CONTROLLED BLEEDING <input type="checkbox"/> OXYGEN ADMINISTERED LPM _____ DEFINITIVE TREATMENTS (PLEASE CHECK) <input type="checkbox"/> TRACTION <input type="checkbox"/> SPLINTED <input type="checkbox"/> IMMOBILIZED <input type="checkbox"/> SPINAL IMMOBILIZATION <input type="checkbox"/> ADDITIONAL TREATMENTS (PLEASE EXPLAIN)
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P P Q R FINDINGS IN HEAD TO TOE	R S T
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F.A.A. NAME (PLEASE PRINT)	F.A.A. SIGNATURE	OFA CERTIFICATE #	OFA LEVEL <input type="checkbox"/> 1 <input type="checkbox"/> TE <input type="checkbox"/> 2 <input type="checkbox"/> 3
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NAME OF WITNESSES (PLEASE PRINT)	EMPLOYER MAILING ADDRESS
EMPLOYEE SIGNATURE	CITY / TOWN
	STREET / AVENUE
	POSTAL CODE