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	BEST VERBAL RESPONSE	BEST MOTOR RESPONSE
	4 SPONTANEOUSLY	5 ORIENTED	6 OBEYS COMMANDS
	3 SPEECH	4 CONFUSED	5 LOCALIZES PAIN
	2 TO PAIN	3 INAPPROPRIATE WORDS	4 WITHDRAWS FROM PAIN
	1 NO RESPONSE	2 INCOMPREHENSIBLE SOUNDS	3 FLEX TO PAIN (DECORTICATE)
		1 NO RESPONSE	2 EXTENDS TO PAIN (DECEREBRATE)
			1 NO RESPONSE

VITAL SIGNS	TIME		TIME		TIME		TIME	
RESPIRATIONS								
PULSE								
LOC / GCS	E V M	TOTAL	E V M	TOTAL	E V M	TOTAL	E V M	TOTAL
PUPIL SIZE & REACTION + / -	L	R	L	R	L	R	L	R
SKIN								

9 8 7 6 5 4 3 2

PATIENT'S CHIEF COMPLAINT

ALLERGIES

MEDICATIONS

PREVIOUS MEDICAL HISTORY

MECHANISM OF INJURY / HISTORY OF ILLNESS

PLEASE MARK INJURED OR EXPOSED AREA

RECOMMENDATIONS

☐ RETURN TO WORK ☐ FIRST AID FOLLOW UP ☐ MEDICAL AID

TRANSPORTED BY (PLEASE CHECK)

☐ ETV ☐ INDUSTRIAL AMBULANCE ☐ B.C. AMBULANCE SERVICE
☐ AIR EVACUATION ☐ OTHER (PLEASE EXPLAIN)

CHANGES IN PATIENT'S CONDITION (PLEASE EXPLAIN)

INTERVENTIONS (PLEASE CHECK)

☐ AIRWAY CLEARED ☐ MAINTAINED ☐ OROPHARYNGEAL AIRWAY
☐ VENTILATED ☐ PKT. MASK ☐ BVM
☐ CONTROLLED BLEEDING ☐ OXYGEN ADMINISTERED LPM ________________

DEFINITIVE TREATMENTS (PLEASE CHECK)

☐ TRACTION ☐ SPLINTED ☐ IMMOBILIZED
☐ SPINAL IMMOBILIZATION ☐ ADDITIONAL TREATMENTS (PLEASE EXPLAIN)

P
P
Q
R

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FINDINGS IN HEAD TO TOE

F.A.A. NAME (PLEASE PRINT)	F.A.A. SIGNATURE	OFA CERTIFICATE #	OFA LEVEL ☐ 1 ☐ TE ☐ 2 ☐ 3

NAME OF WITNESSES (PLEASE PRINT)	EMPLOYER MAILING ADDRESS STREET / AVENUE
EMPLOYEE SIGNATURE	CITY / TOWN POSTAL CODE