
Incident Details

Incident Date _____ Call Time _____ At Pt Side Time _____ Incident Address _____

Patient Demographics

Patient Name: _____ Pt D.O.B: _____ Pt Age: _____

Patient Address: _____ Pt Gender: M F U ID Collected: Y N

ILI Symptoms	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/E <input type="checkbox"/>	Covid Symptoms	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/E <input type="checkbox"/>	Covid Vaccination	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/E <input type="checkbox"/>
---------------------	------------------------------	-----------------------------	------------------------------	-----------------------	------------------------------	-----------------------------	------------------------------	--------------------------	------------------------------	-----------------------------	------------------------------

Chief Complaint: _____

History of Chief Complaint: (OPQRST) _____

Past Medical History _____

Family History: _____
 Any health conditions that run within family e.g. heart disease, strokes, diabetes? _____

Social History: _____
 Recent/ rapid weight loss/Gain. Normally fit and well?. Smoker, alcohol/ drug use _____

Medications: _____
 Inc _____
 OTC/Prescribed/Herbal/Recreational/Illicit _____

Allergies: _____
 Environmental, Food, Insects, Medications _____

Primary Survey

Pt Location	C-Spine
Home <input type="checkbox"/> Work <input type="checkbox"/> Public <input type="checkbox"/> Other _____	No SMR Required <input type="checkbox"/> Parathesis <input type="checkbox"/> C-Collar <input type="checkbox"/> Scoop <input type="checkbox"/>

LOC	Orientation	Social Interaction
Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive <input type="checkbox"/>	Person <input type="checkbox"/> Date/Time <input type="checkbox"/> Place <input type="checkbox"/> Event <input type="checkbox"/>	Calm <input type="checkbox"/> Anxious <input type="checkbox"/> Combative <input type="checkbox"/> Unconscious <input type="checkbox"/>

Airway

Airway Status	Adjunct Used
Patent <input type="checkbox"/> Partial Blockage <input type="checkbox"/> Full Blockage <input type="checkbox"/>	Size _____ Size _____ Size _____ Size _____
Positioning Suction <input type="checkbox"/> Head Tilt Chin Lift <input type="checkbox"/> Jaw Thrust <input type="checkbox"/>	NPA <input type="checkbox"/> OPA <input type="checkbox"/> SGA <input type="checkbox"/> ET <input type="checkbox"/>

Breathing	Circulation
Rhythm Regular <input type="checkbox"/> Irregular <input type="checkbox"/>	Location Right Carotid <input type="checkbox"/> Brachial <input type="checkbox"/> Radial <input type="checkbox"/> Femoral <input type="checkbox"/>
Strength Regular <input type="checkbox"/> Shallow <input type="checkbox"/> Deep <input type="checkbox"/>	Left Carotid <input type="checkbox"/> Brachial <input type="checkbox"/> Radial <input type="checkbox"/> Femoral <input type="checkbox"/>
Rate Regular <input type="checkbox"/> >20 <input type="checkbox"/> <12 <input type="checkbox"/> Agonal <input type="checkbox"/> Absent <input type="checkbox"/>	Rhythm Regular <input type="checkbox"/> Irregular <input type="checkbox"/>
O2 Delivery RA <input type="checkbox"/> Nasal <input type="checkbox"/> NRB <input type="checkbox"/> BVM <input type="checkbox"/>	Strength Regular <input type="checkbox"/> Shallow <input type="checkbox"/> Deep <input type="checkbox"/>
Breathing Signs Accessory Muscle Use <input type="checkbox"/> Pursed Lip Breathing <input type="checkbox"/> Flail Chest <input type="checkbox"/> Nasal Flaring <input type="checkbox"/>	Rate Regular <input type="checkbox"/> >100bpm <input type="checkbox"/> <60bpm <input type="checkbox"/> Absent <input type="checkbox"/>
	Blood Loss None <input type="checkbox"/> <500ml <input type="checkbox"/> 500 - 1000ml <input type="checkbox"/> >1000ml <input type="checkbox"/>

Skin	Pupils
Colour Cyanotic <input type="checkbox"/> Dusky <input type="checkbox"/> Flushed <input type="checkbox"/> Pale <input type="checkbox"/> Pink <input type="checkbox"/>	Quality Normal <input type="checkbox"/> Constricted <input type="checkbox"/> Pinpoint <input type="checkbox"/> Dilated <input type="checkbox"/>
Condition Normal <input type="checkbox"/> Clammy <input type="checkbox"/> Dry <input type="checkbox"/> Wet <input type="checkbox"/>	Reactivity Normal <input type="checkbox"/> Brisk <input type="checkbox"/> Sluggish <input type="checkbox"/> Fixed <input type="checkbox"/>
Temperature Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot <input type="checkbox"/>	Size Right <input type="checkbox"/> mm Left <input type="checkbox"/> mm

Physical Exam

Head				Neck				Neuro				Chest				Respiratory			
Deformities	Yes	No	N/E	Deformities	Yes	No	N/E	Dizziness	Yes	No	N/E	Deformities	Yes	No	N/E	Shortness of Breath	Yes	No	N/E
Contusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abrasions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abrasions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abrasions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	↑ Work of Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Punctures/ Penetrations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Punctures/ Penetrations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Punctures/ Penetrations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Talking in full sentences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	= Rise and Fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lacerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lacerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lacerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cyanosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No of episodes	_____			Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crepitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slurred Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain on Inhalation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crepitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crepitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	New Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crepitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Photophobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cap Refill > 2 Sec	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stridor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Battle Signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	JVD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LOC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Centrally WP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	New Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSF Visible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trachea Midline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripherally WP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boggy Mass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C-spine tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased Lethargy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sputum Colour	_____		
												Air Entry							
												L R N/E							
												Good							
												Decreased							
												Absent							
												Crackles							
Abdo				Pelvis				Lower Extremities				Upper Extremities				Back			
Soft	Yes	No	N/E	Deformities	Yes	No	N/E	Deformities	Yes	No	N/E	Deformities	Yes	No	N/E	Deformities	Yes	No	N/E
Rigid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abrasions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abrasions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abrasions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abrasions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rebound Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Punctures/ Penetrations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Punctures/ Penetrations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Punctures/ Penetrations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Punctures/ Penetrations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulsating Masses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lacerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lacerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lacerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lacerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain on palpation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Last Meal	_____			Crepitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crepitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crepitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crepitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Last Fluid	_____			Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bilateral CMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bilateral CMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Last Bowl	_____			Stool Urine										Battle Signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Last Bladder	_____			Incontinence	<input type="checkbox"/>	<input type="checkbox"/>													
Pregnancy																			
Yes No N/E																			
Menstruating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																
Gestational Age	_____																		
Gravida	_____																		
Para	_____																		

Pt Care Notes

Vital Signs

Time (hh:mm) →						Normal Ranges											
O ² Saturation	%	%	%	%	%	94 - 100% RA											
Pulse	bpm	bpm	bpm	bpm	bpm	60 - 100 bpm											
Blood Pressure	/ mm/Hg	/ mm/Hg	/ mm/Hg	/ mm/Hg	/ mm/Hg	90/60 - 140/90 mm/Hg											
Respiration Rate	/min	/min	/min	/min	/min	12 - 20 /min											
Blood Glucose	mmol/L	mmol/L	mmol/L	mmol/L	mmol/L	3.9 - 5.6 mmol/L											
Temperature	°C	°C	°C	°C	°C	36.5 - 37.9 °C											
ETCO ²	mm/Hg	mm/Hg	mm/Hg	mm/Hg	mm/Hg	35 - 45 mm/Hg											
GCS	E	V	M	Total	E	V	M	Total	E	V	M	Total	E	V	M	Total	
Stroke	Red Finding	LAMS Score															
Sepsis Suspected	No																
Shock Index	0.5 - 0.7																

OA / OE Detailed Notes

Treatment

Treatment No.	Time	Treatment	Administered By
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Cardiac Arrest

Occurrence		Witnessed By			Cardiac Arrest Etiology			
Prior to LLFD Arrival <input type="checkbox"/>	After LLFD Arrival <input type="checkbox"/>	Witnessed by HCP <input type="checkbox"/>	Witnessed by lay person <input type="checkbox"/>	Unwitnessed <input type="checkbox"/>	Electrocution <input type="checkbox"/>	Terminal Illness <input type="checkbox"/>	Mechanical Obstruction <input type="checkbox"/>	Non-Traumatic Exsang. <input type="checkbox"/>
Duration					Environmental <input type="checkbox"/>	Drowning <input type="checkbox"/>	Poisoning/OD/CBRN <input type="checkbox"/>	SIDS <input type="checkbox"/>
0-2 min <input type="checkbox"/>	2-4 min <input type="checkbox"/>	4-6 min <input type="checkbox"/>	6-8 min <input type="checkbox"/>	8-10 min <input type="checkbox"/>	10-15 min <input type="checkbox"/>	15-20min <input type="checkbox"/>	>20 min <input type="checkbox"/>	Allergy/Envenomation <input type="checkbox"/>
Resuscitation Attempted by LLFD			First AED Rhythm		ROSC			
Attempted Defib <input type="checkbox"/>	Attempted Ventilation <input type="checkbox"/>	Initiated Chest Compressions <input type="checkbox"/>	Shockable <input type="checkbox"/>	Non-Shockable <input type="checkbox"/>	Yes - Pt with EMS <input type="checkbox"/>	Max Duration of ROSC _____	No ROSC <input type="checkbox"/>	
Not Attempted - Futile <input type="checkbox"/>	Not Attempted - DNR <input type="checkbox"/>	Not Attempted - ROSC <input type="checkbox"/>						

Pt Handover						
EMS Unit _____	EMS On Scene _____	Paramedics _____				
Incident Details						
AHS Event Number _____	Agency Number _____	MPDS Code _____				
Other Agencies on Scene						
Agency _____	Name _____	Contact Info _____				
Agency _____	Name _____	Contact Info _____				
PPE Used/ Applied						
Attending 1	Procedure Mask <input type="checkbox"/>	N95 <input type="checkbox"/>	Eye Protection <input type="checkbox"/>	Gown <input type="checkbox"/>	Gloves <input type="checkbox"/>	Other _____
Attending 1	Procedure Mask <input type="checkbox"/>	N95 <input type="checkbox"/>	Eye Protection <input type="checkbox"/>	Gown <input type="checkbox"/>	Gloves <input type="checkbox"/>	Other _____
Patient	Procedure Mask <input type="checkbox"/>	Other _____				
Attending Members						

Attending 1		
Name _____	RO _____	Signature _____
Attending 2		
Name _____	RO _____	Signature _____
Other Crew with pt contact		
Name _____	Name _____	Name _____

GCS Assessment		
4. Opens Eyes Spontaneously	5. Orientated	6. Obeys commands
3. Opens eyes in response to voice	4. Confused	5. Localizing pain
2. Opens eyes in response to painful stimuli	3. Inappropriate words	4. Withdrawal from pain
1. Does not open eyes	2. Incomprehensible sounds	3. Abnormal flexion to pain
	1. No verbal response	2. Abnormal extension to pain
		1. No motor response

Sepsis Assessment				
If two or more of the follow are present without explanation sepsis should be suspected. Alert EMS unit on radio patch that you suspect sepsis and why				
Temperature Over 38oC or Under 36oC	Heart rate greater than 90 bpm	Respiration Rate greater than 20	Systolic BP >220	New Confusion

Stroke Assessment				
Stroke Red Findings Any of the following should be reported to EMS		LAMS Scores Calculated by adding the corresponding scores		
Unresponsive or responds to pain only	Leg falls rapidly	Facial Smile	Hand Grips	Arm Strength
Incompressible or mute speech	Arm drifts down or falls rapidly	Droop – 1	No Grip – 2	Falls Rapidly – 2
	No grip strength	Normal – 0	Weak Grip – 1	Drifts Down – 1
			Normal – 0	Normal – 0