BLS/ALS Patient Care Report Form

CENTER FOR WILDERNESS SAFETY

The information on this form is ***CONFIDENTIAL***.

PCR Number: ___ ___– ___ ___ ___ ___ ___ ___ ___
Y Y M M D D N N N

Incident Location:	**Date:** / / 20 **Time:** :
PATIENT INFORMATION **Name:**______________________ FIRST MIDDLE LAST **Address:** ______________________ ______________________	**Gender:** M / F **DOB:**___/___/___ **Age:**________ **Weight:**________ **Race:** ________

Chief Complaint:

Allergies:	**Medications:**	**Medical History:**

TIME	LOR	RESP	PULSE	BP	SKIN	PUPILS
	__ALERT 4 | 3 __DISORIENTED 2 | 1 __VERBAL __PAIN __UNRESPONSIVE	RATE:____ O_2 SAT:______ *CLEAR* L R *RALES* L R *ABSENT* L R	RATE:_____/MIN __BOUNDING __SHALLOW __IRREGULAR	/ __BY PALP __UTA	__ UNRK __ CYAN __ PALE __ DRY __ COOL __ HOT __ FLUSHED	PERRL R>L L>R __DILATED __CONSTRICTED __UNREACTIVE
	__ALERT 4 | 3 __DISORIENTED 2 | 1 __VERBAL __PAIN __UNRESPONSIVE	RATE:____ O_2 SAT:______ *CLEAR* L R *RALES* L R *ABSENT* L R	RATE:_____/MIN __BOUNDING __SHALLOW __IRREGULAR	/ __BY PALP __UTA	__ UNRK __ CYAN __ PALE __ DRY __ COOL __ HOT __ FLUSHED	PERRL R>L L>R __DILATED __CONSTRICTED __UNREACTIVE
	__ALERT 4 | 3 __DISORIENTED 2 | 1 __VERBAL __PAIN __UNRESPONSIVE	RATE:____ O_2 SAT:______ *CLEAR* L R *RALES* L R *ABSENT* L R	RATE:_____/MIN __BOUNDING __SHALLOW __IRREGULAR	/ __BY PALP __UTA	__ UNRK __ CYAN __ PALE __ DRY __ COOL __ HOT __ FLUSHED	PERRL R>L L>R __DILATED __CONSTRICTED __UNREACTIVE
	__ALERT 4 | 3 __DISORIENTED 2 | 1 __VERBAL __PAIN __UNRESPONSIVE	RATE:____ O_2 SAT:______ *CLEAR* L R *RALES* L R *ABSENT* L R	RATE:_____/MIN __BOUNDING __SHALLOW __IRREGULAR	/ __BY PALP __UTA	__ UNRK __ CYAN __ PALE __ DRY __ COOL __ HOT __ FLUSHED	PERRL R>L L>R __DILATED __CONSTRICTED __UNREACTIVE

Procedures:	**Notes:**

Patient Care Refusal Form

The information on this form is CONFIDENTIAL.

PCR Number: ___ ___– ___ ___ ___ ___ ___ ___ ___
Y Y M M D D N N N

CAPACITY of patient or guardian making the refusal:

___ *Alert and oriented to person, place, time and events (A&O x4)*

___ *Clear and coherent speech*

___ *No known or presumptive specific medical, legal or psychological conditions precluding competence*

___ *The patient is willing and able to engage in meaningful conversation*

___ *No evidence of alcohol or mind altering drug use*

If any of the above are not checked, or the patient is less than 8 or greater than 55 years old, consider contacting Emergency Services (911) or releasing the patient to immediate family for further care.

PRECAUTIONS AND WARNINGS to patient:

___*Explained potential for fatal or permanently disabling consequences including, but not limited to:*

_____

___*Advised patient to seek care with an Emergency Department or physician as soon as possible.*

___*Advised the patient to call 911 if their condition changes or they change their mind regarding care/transport.*

Patient:

I,_____, understand that people maintain the right to refuse medical care, treatment and/or the advice to be transported via local Emergency Medical Services. I further acknowledge that I have been advised by staff members of _____ [Agency], that they recommend that I receive emergency medical care, treatment and/or transportation to a hospital emergency department for further evaluation by a physician. I further understand that I may refuse medical care, treatment and/or transportation, but do so at my own risk. I do not have any known physical or mental condition that would prohibit me from making an informed decision to refuse the medical care, treatment and/or transportation that has been offered or recommended.

The risk associated with refusal may include possible loss of life or limb or permanent disability. I have also been advised that if I develop any medical complaints or symptoms I should immediately contact an ambulance, hospital emergency department or my physician. I hereby release _____ [Agency], its officers, agents, personnel, and employees from any and all claims, causes of action or injuries, of whatsoever kind ornature, arising out of or in connection with my refusal of medical care, treatment and/or transportation.

_____ _____
Patient or Guardian (*Signature*) Patient or Guardian (*Printed Name*)

_____ _____/_____/_____
First Aid Provider (Printed Name) Date

❒ CPR/FA/WFA ❒ WFR/EMR ❒ W/EMT ❒ RN/PA/MD

❒ ***This patient was given the information noted above and refused to sign the form as requested.***