

Basic Life Support Patient Note

Date	Time	Location
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PATIENT [name]

Email	Weight	Age
Address	Height	Sex
	Phone	

EMERGENCY CONTACT [name]

Relationship	Email	Phone
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PATIENT FOUND

R Side
 L Side
 Front
 Back
 Sitting
 Standing
 Walking
 In water
 Snow Burial
 Other [describe]:

WHAT HAPPENED

Mechanism for spine injury
 Patient remained Awake and remembers what happened
 Patient temporarily lost consciousness but is Awake now*

MECHANISM OF INJURY

* Indicates a potential life-threatening problem

Trauma <input type="checkbox"/> Head trauma* <input type="checkbox"/> Chest trauma* <input type="checkbox"/> Abdominal trauma* <input type="checkbox"/> Pelvic trauma* <input type="checkbox"/> Extremity trauma	Environmental <input type="checkbox"/> Drowning* <input type="checkbox"/> Lightning* <input type="checkbox"/> Snow Burial* <input type="checkbox"/> Extreme Heat* <input type="checkbox"/> Extreme Cold* <input type="checkbox"/> Bite or sting with systemic toxic reaction or anaphylaxis*	Medical <input type="checkbox"/> Persistent & increasing pain* <input type="checkbox"/> Abrupt, new, severe pain* <input type="checkbox"/> Abrupt change in mental status* <input type="checkbox"/> Chest pain or pressure* <input type="checkbox"/> Acute Respiratory Distress* <input type="checkbox"/> Localized abdominal pain* <input type="checkbox"/> Severe bleeding from mouth or anus*
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WEATHER CONDITIONS

Current Temperature _____

Sun
 Partly Cloudy
 Overcast
 Wind
 Rain
 Snow
 Impending Storm

BLS Assessment & Treatment

PROBLEM

FIELD TREATMENT

<input type="checkbox"/> Severe Bleeding [from]	<input type="checkbox"/> Direct Pressure <input type="checkbox"/> Packed with _____ <input type="checkbox"/> Pressure Bandage <input type="checkbox"/> Tourniquet [time] _____ <input type="checkbox"/> TK Conversion [time] _____
<input type="checkbox"/> No pulse or breathing	<input type="checkbox"/> Chest compressions & rescue breaths <input type="checkbox"/> AED
<input type="checkbox"/> Not breathing	<input type="checkbox"/> Rescue breaths
<input type="checkbox"/> VPU patient	<input type="checkbox"/> Suspected opioid overdose. Administered naloxone nasal spray <input type="checkbox"/> Suspected diabetic emergency. Administered <input type="checkbox"/> oral glucose paste <input type="checkbox"/> Mechanism for spine injury suspected: patient handled gently <input type="checkbox"/> Patient placed on L / R side in recovery position <input type="checkbox"/> Patient in respiratory distress and placed on injured side in recovery position
<input type="checkbox"/> Obstructed Airway	<input type="checkbox"/> Patient was awake and not coughing. Administered <input type="checkbox"/> abdominal thrusts <input type="checkbox"/> chest thrusts <input type="checkbox"/> back blows <input type="checkbox"/> Patient was VPU with obstructed airway. Administered <input type="checkbox"/> CPR <input type="checkbox"/> Removed obstruction/foreign body <input type="checkbox"/> finger sweep <input type="checkbox"/> suction <input type="checkbox"/> Patient was VPU with debris [tissue, teeth, etc.], vomitus, or blood visible in airway: <input type="checkbox"/> placed patient on L / R side in recovery position Cleared airway with <input type="checkbox"/> finger sweep <input type="checkbox"/> suction
<input type="checkbox"/> Respiratory Distress due to chest trauma	<input type="checkbox"/> Assisted awake patient to sitting or semi-sitting position <input type="checkbox"/> Patient presented with sucking chest wound. Sealed with: <input type="checkbox"/> improvised occlusive dressing <input type="checkbox"/> Commercial chest seal
<input type="checkbox"/> Moderate to extreme cold	<input type="checkbox"/> Shelter <input type="checkbox"/> Removed wet clothes & dry patient <input type="checkbox"/> Provided calories <input type="checkbox"/> Placed in sleeping bag(s) and on insulating pad
<input type="checkbox"/> Extreme heat	<input type="checkbox"/> Stop exercise <input type="checkbox"/> Shade <input type="checkbox"/> Cold water immersion <input type="checkbox"/> Fan & mist
<input type="checkbox"/> Respiratory Distress due to asthma	<input type="checkbox"/> Assisted patient with prescribed rescue inhaler <input type="checkbox"/> Administered 0.3 cc epinephrine
<input type="checkbox"/> Respiratory Distress due to anaphylaxis	<input type="checkbox"/> Administered _____ dose(s) of 0.3 cc epinephrine followed by <input type="checkbox"/> 10 mg loratadine (Claritin®) once a day [preferred] or <input type="checkbox"/> 50 mg diphenhydramine (Benadryl®) every 4-6 hours [alternate]
<input type="checkbox"/> Chest Pain or Pressure	<input type="checkbox"/> Suspected heart attack. Administered <input type="checkbox"/> four 81 mg chewable baby aspirin or <input type="checkbox"/> one 325 mg regular aspirin dissolved in water <input type="checkbox"/> Assisted patient with prescribed nitroglycerin

TREATMENT RESULTS

Spontaneous return of pulse
 Spontaneous return of breathing
 Respiratory distress resolves
 Bleeding is controlled
 Airway is clear
 Patient is awake
 Patient is warm/cool and comfortable

Recovery efforts stopped at _____; patient is presumed dead

Patient History

SYMPTOMS

Examples include: pain, including headache (1-10), feeling hot or cold, tingling or numbness, abnormal vision or hearing, etc. Describe onset, location, & possible cause.

KNOWN ALLERGIES

MEDICATIONS Prescription, over-the-counter, herbal, homeopathic, & recreational.

DRUG	REASON	DOSE	CURRENT
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Notes

CURRENT MEDICAL PROBLEMS

INTAKE & OUTPUT over the past 24 hours * Indicates a potential life-threatening problem

<p>Calorie Intake</p> <input type="checkbox"/> Appears adequate <input type="checkbox"/> Low	<p>Urine</p> <input type="checkbox"/> Clear or light yellow <input type="checkbox"/> Dark yellow or brown* <input type="checkbox"/> Strong smell <input type="checkbox"/> Normal output <input type="checkbox"/> Decreased output <input type="checkbox"/> Increased output	<p>Water Intake</p> Liters _____
<p>Stool</p> <input type="checkbox"/> Normal <input type="checkbox"/> Firm <input type="checkbox"/> Loose <input type="checkbox"/> Watery diarrhea <input type="checkbox"/> Dark reddish-black ± tar-like* <input type="checkbox"/> Strong smell	<p>Vomitus</p> <input type="checkbox"/> Looks like coffee grounds* <input type="checkbox"/> Bright red blood* <input type="checkbox"/> Strong smell	

Physical Exam

Look for bone & joint deformity. Feel for tenderness & instability. Check joint range-of-motion and ability to use limbs. Check circulation, sensation, and movement below injury site.

Vital Signs

Time	AVPU	Heart Rate
Normal		

Time	AVPU	Heart Rate

Follow-up Evaluation & Treatment

PROBLEM

FIELD TREATMENT

Life-threatening Problems

- | | |
|-----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Traumatic Emergency | <input type="checkbox"/> Kept patient quiet and comfortable |
| <input type="checkbox"/> Traumatic Brain Injury:
awake with temporary
loss of consciousness
or amnesia | <input type="checkbox"/> No exercise if Traumatic MOI |
| <input type="checkbox"/> Respiratory Distress
at rest | <input type="checkbox"/> Protect spinal cord if MOI is present |
| <input type="checkbox"/> Internal Bleeding:
increased heart rate &
anxious or weird | <input type="checkbox"/> Sips of water to maintain hydration if awake |
| <input type="checkbox"/> VPU | <input type="checkbox"/> Traumatic Brain Injury patients may vomit; if VPU place on side
in recovery position. Be prepared to clear their airway. |
| | <input type="checkbox"/> Other [describe] |

Environmental Emergency

Medical Emergency

 Extremity injury

Splinted patient's R / L _____

Minor wound

Washed with soap & water, then covered with a clean dressing

Other [describe]

Requested Medical Consult from _____ at _____

Requested Evacuation Assistance from _____ at _____

Evacuation Plan

URGENT EVACUATION NON-URGENT EVACUATION NO EVACUATION

EVAC INITIATED Date _____ Time _____

Vehicle transport Careful self-evac Improvised "backpack" carry Stretcher or litter carry

RESPONDER [name]

Phone

Email