Emergency First Aid Form

A copy of this completed form should be sent to the referral facility.

Patient Name (LAST, First)		**Date of birth (day-month-year)**		**Age**		**Sex**	Male Female Unknown
Patient contact information		**Patient's contact person**	Name: Contact information:				
Referral facility (where patient being sent to)	Name of facility: Focal point: Phone No:		**Ambulance** (if available)	Name of ambulance service: Focal point: Phone No:			
Date & time of:	Event	Departure from scene					

Situation

Problem ❑ Medical ❑Trauma Pregnant? (circle) Yes / No / unknown

Background

What happened to the patient: date/time of injury/illness start, where, how

Past medical & surgical history

Current medications or allergies

Assessment

CABCDE Conditions		
	Assessment	**Intervention**
Major Bleeding	❑None	❑Direct Pressure ❑Deep Wound Packing ❑None ❑Tourniquet (ONLY if life threatening bleeding) Time of tourniquet application: ❑Uterine Massage
Airway	❑Normal	❑ Neck Immobilization ❑None ❑ Jaw Thrust ❑Head-Tilt Chin-Lift ❑ Choking Care
Breathing	❑Normal	❑ Maintained position of patient comfort ❑None
Circulation	❑Normal	❑ Pelvic Binder ❑ Control minor bleeding ❑None ❑ Fracture Care ❑ Oral Hydration ❑ Lie down to improve circulation (left-lateral position)
Disability	❑Normal	❑Spinal Immobilisation ❑None ❑Glucose Given ❑Seizure Care ❑ High Temperature Care ❑Low Temperature Care
Exposure/Other	❑Normal	❑ Recovery Position ❑None ❑ Burn Care ❑ Wound Care ❑ Drowning Care ❑ Snakebite Care
Any medication taken?		❑None

Recommendations

Next steps in transport plan:

Any problems anticipated:

Any other concerns:

Precautions: ❑Highly infectious disease ❑Spinal immobilization ❑Possible fracture ❑Fall risk ❑Altered mental status ❑Other:

Community First Aid Responder	Name:	Signature:
	Contact information:	CFAR Organization: