OCCUPATIONAL FIRST AID
PATIENT ASSESSMENT

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

EMPLOYEE NAME DATE OF BIRTH D M Y	EMPLOYER NAME EMPLOYER PHONE NUMBER
EMPLOYEE'S DOCTOR	CONTACT PERSON

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

PATIENTS CHIEF COMPLAINT

MECHANISM OF INJURY / HISTORY OF ILLNESS

PHYSICAL FINDINGS

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

ALLERGIES

MEDICATIONS

PLEASE MARK INJURED OR EXPOSED AREA

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)

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 PATIENTS CONDITION (PLEASE EXPLAIN)

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