Extended Practice Patient Record

St John

Event Name:		**Location:**
Date:	**Arrival Time:**	**OB12** Reference Number:

Patient Registration (place registration sticker over details below):

Last Name			**First Name**	
Street Address				
Suburb		**State**	**Postcode**	**Country**
DOB / /	**Age**	**Sex**	**Phone**	

Next of Kin/ Event Contact		
Name:	Relationship:	Phone:

Triage Assessment

Time:_____ Triage Category ☐

Presenting Problem: _____

Triage By:

Name: _____ Signature:_____

Member No:_____ Qualification: _____

Initial Observations	
AVPU	
RR	
HR	
BP	
GCS	
SPO_2	
TEMP	
BGL	

SURVEILLANCE ☐ Employee / Event Staff ☐ Patron

☐ Vomiting ☐ Rash ☐ Diarrhoea ☐ Unconscious ☐ Fever

☐ Other _____

Past Medical History	**Current Medications**
Allergies	

Treatment Prior to Triage

- ☐ C.Collar
- ☐ IV Access
- ☐ Limb Splinting
- ☐ Airway Type _____
- ☐ IPPV
- ☐ Defibrillation No: _____
- ☐ Positioning _____
- ☐ Oxygen _____

Drugs Administered			
Drug	**Dose**	**Route**	**Time**

Patient Name:_____

DOB: ____/_____/_____ **OB12 Ref No:**_____

St John

Allergies

OBSERVATIONS

Pupil size mm

1 2 3 4 5 6 7 8 9

Pupillary size - mm Pupillary reactivity
(+) Reacts
(-) No response
(C) Eye closed or swollen

Date	Time	Temp	Pulse	Rhythm	Blood Pressure	RR	SpO2	EtCO2	BGL	Pain Score 0-10	R Pupil Size	R Pupil Reac	L Pupil Size	L Pupil Reac	GCS Eyes Open	GCS Verbal Response	GCS Motor Response	GCS TOTAL

INTRAVENOUS FLUID ORDER

Date	Intravenous Fluids	Rate	Additives	Volume	Prescriber / HCP Initiator Signature	Time Started	Time Finished	Given By

ONCE ONLY MEDICATIONS & HCP INITIATED MEDICINES

Date Prescribed	Medication Print Generic Name	Route	Dose	Date/Time of Dose	Prescriber/HCP Initiator Signature Print Name	Given by	Time Given

Patient Name:____

DOB: ____/_____/_____ **OB12 Ref No**:____________________________________

St John

Progress Notes:

Date / Time		Signature / Qualifications

Patient Name:_____

DOB: ____/_____/_____ **OB12 Ref No:**_____

St John

Progress Notes:		
Date / Time		Signature / Qualifications

DISCHARGE INFORMATION ☐ Referral Letter ☐ Discharge Advice Sheet

Discharge Date: ____/____/_____ **Discharge Time:**_____ **Discharged By:**_____

☐ Returned to Event ☐ Home ☐ GP/ Health Practitioner ☐ Hospital

Transport Means: ☐ Aeromedical ☐ Ambulance ☐ Taxi ☐ Public Transport ☐ Private Car

Destination Name:_____

Vehicle Identifier (Ambulance/Car Registration):_____

Accompanied By:_____

DATA COLLECTION

Procedure: ☐ IV Access ☐ IV Fluid ☐ Wound Closure ☐ Physical Restraint
☐ Adv Airway Management ☐ CPR ☐ Defibrillation

Monitoring: ☐ SpO_2 ☐ Cardiac Monitor ☐ 12 Lead ECG ☐ NIBP
☐ $EtCO_2$

Medication: ☐ PO ☐ IM/SC ☐ IV ☐ IV Infusion