

# 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 |                       |

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

|  |   |             |             |             |             |             |       |   |   |
|--|---|-------------|-------------|-------------|-------------|-------------|-------|---|---|
| PATIENTS CHIEF COMPLAINT                 | <b>VITAL SIGNS</b>                        | <b>TIME</b> | <b>TIME</b> | <b>TIME</b> | <b>TIME</b> |             |       |   |   |
|  | RESPIRATIONS                              |             |             |             |             |             |       |   |   |
| MECHANISM OF INJURY / HISTORY OF ILLNESS | <b>PULSE</b>                              |             |             |             |             |             |       |   |   |
|  | <b>LOC / GCS</b>                          | E<br>V<br>M | TOTAL       | E<br>V<br>M | TOTAL       | E<br>V<br>M | TOTAL |   |   |
| PHYSICAL FINDINGS                        | <b>PUPIL SIZE &amp; REACTION</b><br>+ / - | L           | R           | L           | R           | L           | R     | L | R |
|  | <b>SKIN</b>                               |             |             |             |             |             |       |   |   |
|  | <b>ALLERGIES</b>                          |             |             |             |             |             |       |   |   |

PLEASE MARK INJURED OR EXPOSED AREA

**MEDICATIONS**

**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<br><input type="checkbox"/> 1 <input type="checkbox"/> TE <input type="checkbox"/> 2 <input type="checkbox"/> 3 |
|----------------------------|------------------|-------------------|---|

|                                  |                          |
|----------------------------------|--------------------------|
| NAME OF WITNESSES (PLEASE PRINT) | EMPLOYER MAILING ADDRESS |
| EMPLOYEE SIGNATURE               | STREET / AVENUE          |
|                                  | CITY / TOWN              |
|                                  | POSTAL CODE              |