**FIRST RESPONDERS, Inc.**

**FIELD INCIDENT REPORT**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Venue \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location if Incident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assessment: **(Checked boxes indicate areas assessed. Abnormal assessments detailed below)**

Grips  Pushes/Pulls  Pupils  Speech  Gait  ROM  Abd  Bowel Sounds  Breath Sounds

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial Assessment**  **Skin:** warm dry pink cool pale  flushed moist diaphoretic cyanotic  **LOC:** A & O x4 confused  Combative Unconscious  Alcohol related: YES NO | Time: \_\_\_\_\_\_\_\_  BP: \_\_\_\_\_\_\_\_\_**/**\_\_\_\_\_\_\_\_\_  P: \_\_\_\_\_\_\_ SaO2\_\_\_\_\_\_\_\_  R: \_\_\_\_\_\_\_ T: \_\_\_\_\_\_\_\_\_\_  Accucheck \_\_\_\_\_\_\_\_\_\_\_\_ | Time: \_\_\_\_\_\_\_\_  BP: \_\_\_\_\_\_\_\_\_**/**\_\_\_\_\_\_\_\_\_  P: \_\_\_\_\_\_\_ SaO2\_\_\_\_\_\_\_\_  R: \_\_\_\_\_\_\_ T: \_\_\_\_\_\_\_\_\_\_  Accucheck \_\_\_\_\_\_\_\_\_\_\_\_ | Time: \_\_\_\_\_\_\_\_  BP: \_\_\_\_\_\_\_\_\_**/**\_\_\_\_\_\_\_\_\_  P: \_\_\_\_\_\_\_ SaO2\_\_\_\_\_\_\_\_  R: \_\_\_\_\_\_\_ T: \_\_\_\_\_\_\_\_\_\_  Accucheck \_\_\_\_\_\_\_\_\_\_\_\_ |

Physical findings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Treatment and times:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other Disposition: Back to seat/work Hospital via POV Home via POV Discharge Time \_\_\_\_\_\_\_\_

**Signature(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Notified yes no**

**PERMISSION TO TREAT/**

**RELEASE OF INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do hereby authorize ***First Responders, Inc*.** to perform the necessary and appropriate treatment and care within the guidelines of the nursing scope of practice and the accepted protocols and standards of care for the injury/ illness I or this minor for which I am the legal guardian. I further authorize ***First Responders, Inc.*** for the release of information about myself or the minor and/or my injury/illness to the hosts of the event I or the minor am attending. I acknowledge that such information may contain personal demographic information collected by ***First Responders, Inc.*** and/or information related to the illness/injury I or the minor sustained while in attendance of the event as well as information regarding any treatment that was afforded to me or the minor by the staff of ***First Responders, Inc****.* Further, ***First Responders, Inc.*** is released and discharged from any liability, and the undersigned will hold ***First Responders, Inc.***harmless for complying with this “Release of Information.” This authorization expires 60 days from the date below and covers only treatment rendered by ***First Responders, Inc.***

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Patient or legally authorized representative Relationship to patient

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***First Responders, Inc* Staff** Date