WORK SAFE BC

Occupational First Aid
Patient Assessment

Date of illness/injury (yyyy-mm-dd)	Time of illness/injury AM PM	Date reported to first aid (yyyy-mm-dd)	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's name	Date of birth (yyyy-mm-dd)

Employer's name	Employee's doctor	Contact person

AVPU

A – Alert
V – Responds to voice
P – Responds to pain
U – Unresponsive

GCS

Eye opening response	**Best verbal response**	**Best motor response**
4 Spontaneously	**5** Orientated	**6** Obeys commands
3 To speech	**4** Confused	**5** Localizes pain
2 To pain	**3** Inappropriate words	**4** Withdraws from pain
1 No response	**2** Incomprehensible sounds	**3** Flexes to pain (decorticate)
	1 No response	**2** Extends to pain (decerebrate)
		1 No response

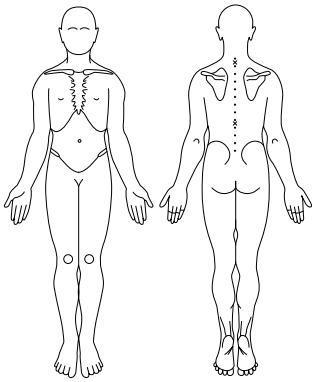
Chief complaint

P	R
P	S
Q	T
R	

AVPU (circle)	A V P U	A V P U	A V P U	A V P U
GCS LOC	Total E V M	Total E V M	Total E V M	Total E V M
Vital signs	Time	Time	Time	Time
Resp.				
SPO2				
Pulse				
Pupils = / +				
Skin				

Mechanism of injury/history of illness

Please mark injured or exposed areas



Physical findings

Changes in patient's condition (specify)

Allergies

Medications

Interventions

☐ Airway cleared ☐ Maintained ☐ OPA ☐ Suction
☐ Ventilated ☐ PKT mask ☐ BVM ☐ Control bleed
☐ Tourniquet applied (time) _____
☐ Oxygen applied (time _____ LPM _____

Definitive treatment

☐ Spinal motion restriction ☐ Immobilized ☐ Splinted
☐ Additional treatment (please specify)

Recommendations

☐ First aid followup ☐ RTW
☐ Medical aid

Transport

☐ ETV ☐ Industrial ambulance ☐ BC ambulance
☐ Air evacuation ☐ Other (please specify)

F.A.A. name	F.A.A. signature	OFA certification no.	OFA level ☐ 1 ☐ TE ☐ 2 ☐ 3

Name of witness (please print)	Employer's mailing address
Employee's signature	City/town / Postal code