



London **NHS** Ambulance Service

### Patient Report Form (LA4)

NHS CONFIDENTIAL

CAO/Event number: **1 0 3** Date: **01/01/2011** Call sign: **1234** Fleet number: **751** M.I. Patient No. **00000000**

<b>Patient's details</b> Date of birth: <b>21/04/1981</b> Age: <b>29</b> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/> Race: <b>L</b> NHS No: <b>0000000000</b> Home address: <b>123 Main St</b> Postcode: <b>W1A 1AA</b> Tel no: <b>020 7123 4567</b> Next of Kin: <b>Mr John Smith</b> Relationship: <b>Spouse</b> Contact details: <b>020 7123 4567</b> GP Name: <b>Dr Sarah Jones</b> Address: <b>45 High Street</b> Mental Health Team / CPN / AMHP: <b>None</b> Name of H.V. / Primary Carer: <b>None</b> Name of School / Nursery: <b>None</b> Patient accompanied by: <b>None</b>	<b>Presenting complaint</b> Incident time / onset of symptoms: <b>01/01/2011 15:00</b> Date: <b>01/01/2011</b> Airway: <input type="checkbox"/> Clear <input type="checkbox"/> Partially obstructed <input type="checkbox"/> Obstructed Breathing: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent Circulation: <input checked="" type="checkbox"/> B-mucosa cyanosis <input type="checkbox"/> Peripherally mottled <input checked="" type="checkbox"/> Capillary refill > 2 sec <input checked="" type="checkbox"/> Distal pulse <input type="checkbox"/> Other: <input type="checkbox"/> Sweating <input type="checkbox"/> Vomiting <input type="checkbox"/> Fitting <input type="checkbox"/> Number of fits: <input type="checkbox"/> Burns: <input type="checkbox"/> Estimated blood loss: <input type="checkbox"/>	<b>Observations</b> Time: <b>15:00</b> AVPU: <b>A</b> Resp rate: <b>12</b> Resp depth: <b>Normal</b> % O <sub>2</sub> sats: <b>98</b> Peak flow: <b>350</b> CO <sub>2</sub> : <b>20</b> Pulse rate: <b>60</b> Pulse character: <b>Normal</b> BP: <b>120/80</b> Colour: <b>Normal</b> BM: <b>Normal</b> Temp: <b>36.5</b> Pain 0-10: <b>0</b> Pupil size: <b>4</b> Pupils reactive: <b>Yes</b> GCS: <b>15</b> ECG rhythm: <b>Normal</b>	<b>Allergies</b> <b>Past medical history</b> <b>Medication</b> Medication brought in: <input type="checkbox"/> List brought in: <input type="checkbox"/> <b>FAST</b> Facial weakness: <input type="checkbox"/> Arm weakness: <input type="checkbox"/> Speech: <input type="checkbox"/> <b>Consciousness</b> Line 1: <input type="checkbox"/> Line 2: <input type="checkbox"/> <b>Fluid and drug administration</b> Total Controlled Drug amount wanted: <b>0</b> Signed: <b>[Signature]</b> Witnessed: <b>[Signature]</b>	<b>12 Lead ECG</b> Normal ECG <input type="checkbox"/> Inferior MI <input type="checkbox"/> Anterior MI <input type="checkbox"/> Lateral MI <input type="checkbox"/> Posterior MI <input type="checkbox"/> LBBB <input type="checkbox"/> ST depression <input type="checkbox"/> T wave changes only <input type="checkbox"/> Other abnormality <input type="checkbox"/> Inconclusive ECG <input type="checkbox"/> Chest pain (local or global) <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other symptoms / pain (specify in notes) <input type="checkbox"/> T-LOC <input type="checkbox"/> Palpitations <input type="checkbox"/> Asymptomatic <input type="checkbox"/>
	<b>Alway and Respiratory management</b> Maintenance: <input type="checkbox"/> CP <input type="checkbox"/> NP <input type="checkbox"/> ET <input type="checkbox"/> SGA <input type="checkbox"/> Postural head tilt: <input type="checkbox"/> Suction: <input type="checkbox"/> ET <input type="checkbox"/> SGA <input type="checkbox"/> Jaw thrust: <input type="checkbox"/> Manual: <input type="checkbox"/> SGA <input type="checkbox"/> <b>Cardiac arrest, CPR, Defib, &amp; ROSC</b> Arrest witnessed: <input type="checkbox"/> Cause of cardiac arrest: <input type="checkbox"/> Cardiac <input type="checkbox"/> Trauma <input type="checkbox"/> Respiratory <input type="checkbox"/> Other <input type="checkbox"/> Pre-LAS CPR: <input type="checkbox"/> LAS CPR: <input type="checkbox"/> Pre-LAS Defib: <input type="checkbox"/> LAS Defib: <input type="checkbox"/> Return of spontaneous respiration: <input type="checkbox"/> Return of Spontaneous Circulation: <input type="checkbox"/> ROSC sustained to hospital: <input type="checkbox"/>	<b>Recovery of Life District</b> Heart sounds absent: <input type="checkbox"/> Asystolic rhythm strip: <input type="checkbox"/> Apnoeic: <input type="checkbox"/> Confused / Seized at hospital: <input type="checkbox"/> Fixed dilated pupils: <input type="checkbox"/>	<b>Injury = I</b> <b>Fracture = F</b> <b>Burns = B</b> <b>Pain = P</b>  Transporting / Left score: <b>0</b> Pre-Alert: <b>0</b>	