



London NHS Ambulance Service NHS Trust

Patient Report Form (LA4)

NHS CONFIDENTIAL

CAD / ECU number Date Call sign Fleet number M.I. Patient No.

Patient's details Last name: _____ First name: _____ Date of birth: [] [] [] [] [] [] Age: [] [] Male <input type="checkbox"/> Female <input type="checkbox"/> Race: [] [] [] [] NHS No.: [] Home address: _____ Postcode: [] [] [] [] [] [] Telephone: _____ Next of Kin: _____ Relationship: _____ GP Name: _____ Address: _____ Mental Health Team / CPN / AM/PP: _____ Contact details: _____ Name of HV / Primary Carer: _____ Name of School / Nursery: _____ Patient accompanied by: _____		Presenting complaint Incident time / onset of symptoms: _____ Date: [] [] [] [] [] [] Airway Clear <input type="checkbox"/> Partially obstructed <input type="checkbox"/> Obstructed <input type="checkbox"/> Breathing Present <input type="checkbox"/> Absent <input type="checkbox"/> Complete a sentence in one breath <input type="checkbox"/> Unable to assess <input type="checkbox"/> Circulation Brucous cyanosed <input type="checkbox"/> Peripheral cyanosis <input type="checkbox"/> Capillary refill > 2 sec <input type="checkbox"/> Distal pulse <input type="checkbox"/> Other Sweating <input type="checkbox"/> Vomiting <input type="checkbox"/> Flitting <input type="checkbox"/> Number of fits: _____ Burns <input type="checkbox"/> Estimated blood loss: _____		Observations Time: [] [] [] [] [] [] AVPU: [] [] [] [] Resp rate: [] [] [] [] Resp depth: [] [] [] [] % O2 sats: [] [] [] [] Peak flow: [] [] [] [] CO2: [] [] [] [] Pulse rate: [] [] [] [] Pulse character: [] [] [] [] BP: [] [] [] [] [] [] Colour: [] [] [] [] [] [] BM: [] [] [] [] Temp: [] [] [] [] Pain 0-10: [] [] [] [] Pupils size: [] [] [] [] [] [] [] [] [] [] [] [] Pupils reactive: [] [] [] [] [] [] [] [] [] [] [] [] GCS: [] [] [] [] [] [] [] [] [] [] [] [] ECG rhythm: [] [] [] []		Allergies : _____ Known infectious : _____ Past medical history : _____ Medication : _____ Medication brought in <input type="checkbox"/> List brought in <input type="checkbox"/> FAST Facial weakness (Unilateral smile or observed weakness) [] [] [] [] Arm weakness (One arm drifts down or falls) [] [] [] [] Speech (Word finding difficulties or slurred speech) [] [] [] [] Cannulation Line 1: IV [] [] [] [] [] [] [] [] [] [] [] [] Line 2: IV [] [] [] [] [] [] [] [] [] [] [] [] Fluid and drug administration Code Amount Dose Route Time By Total Controlled Drug amount witnessed: _____ Signed: _____ Witnessed: _____ Return of spontaneous respiration : _____ Return of spontaneous circulation : _____ ROSC sustained to hospital <input type="checkbox"/>		12 Lead ECG 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"/>	
Airway and respiratory management Maintenance: _____ Perivital: _____ Head tilt: _____ Jaw thrust: _____ Cardiac arrest, CPR, Defib, & ROSC Arrest witnessed <input type="checkbox"/> Cause of cardiac arrest: _____ Cardiac <input type="checkbox"/> Trauma <input type="checkbox"/> Respiratory <input type="checkbox"/> Other <input type="checkbox"/> Pre-LAS CPR: _____ Pre-LAS Defib: _____ LAS CPR: _____ LAS Defib: _____ ROSC sustained to hospital <input type="checkbox"/>									
 Injury = X Fracture = F Burns = B Pain = P Transporting / Left score: [] Pre-Alert: []									

131