Patient Care Form - Treatment Plan

Plan: Treatment Plan for every problem on Assessment List:

1)

2)

3)

4)

Monitor: How and how often do you plan to monitor this patient? Any changes needed to treatment?

Sign Off: Anyone 18 and older can refuse care.

I decline further medical care by the AMC and/or transportation to a local hospital.

Patent Name (printed): _____

Signature: _____

Date: _____ Time: _____

Witness: _____ Date: _____

Witness: _____ Date: _____

Patient Care Form

Patient Information

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: M / F

Address: _____

_____

Phone #: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____

Course Name: _____ Date of Injury: _____

Care-Giver: _____ Location: _____

Chief Complaint and **Mechanism of Injury**
(Pain Questions: onset, palliates/provokes, quality, radiating, severity (1-10), and trend)

_____

_____

_____

_____

Primary Survey Problems

Airway _____

Breathing _____

Circulation _____

Central Nervous System _____

Deformity _____

Environmental _____

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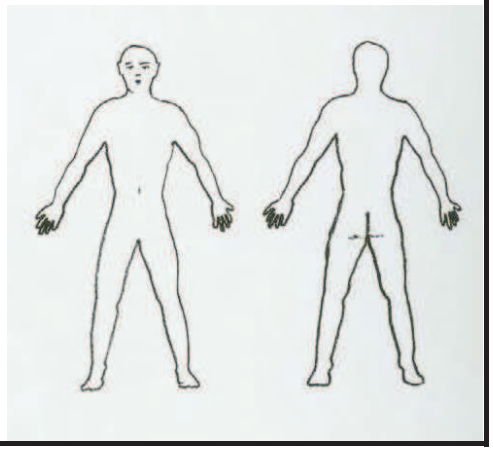
Patient Care Form - Secondary Survey

Physical Exam: Describe locations of pain, tenderness, and injuries:



Patient History

Signs, Symptoms _____

Allergies _____

Medications _____

_____

Past/Previous _____

_____

Last food/drink & urination/defecation _____

_____

Events _____

_____

Patient Care Form - Secondary Survey and Assessment

Vitals (every 5 minutes for critical, every 15 for non-critical)

Time						
LOC oriented x ?						
Resp. R & effort						
Heart R & effort						
Skin Color, Temp, Moisture						
BP						
Pupils						

Assessment: Problem List or Field Diagnosis

1)

2)

3)

4)

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