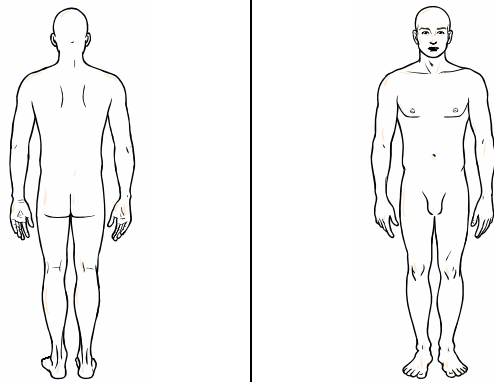
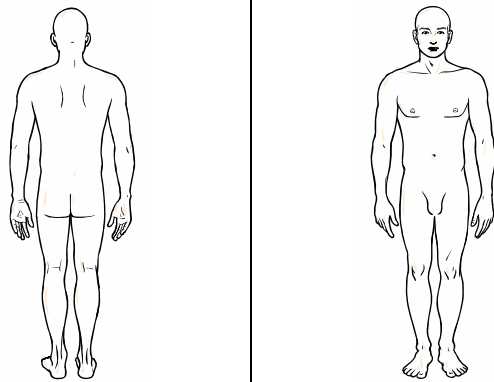
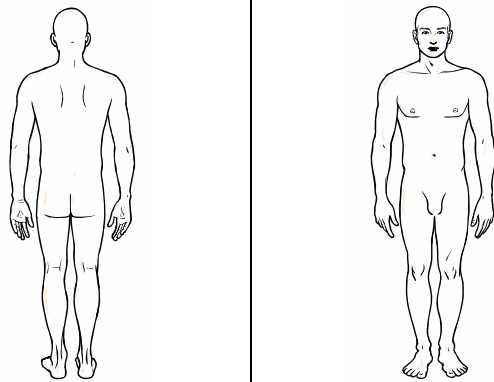
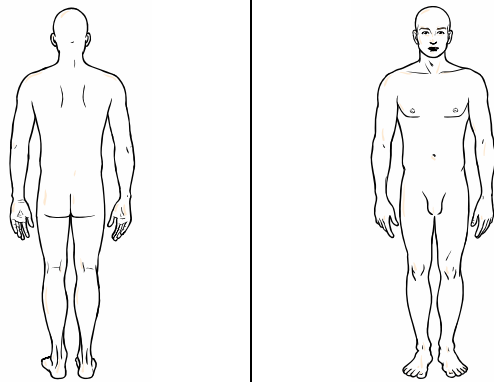


FIRST AID REPORT Form 3.3

Form 3.3 First Aid Report Form Version 2.0 April 2023

Langton Hotel Ltd	FIRST AID ASSESSMENT	FA Report No:	Date:	Time:					
Location:		Date of accident/injury:		Time of Accident/Injury:					
Patient Name:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Age:	Patient Consent Yes <input type="checkbox"/> No <input type="checkbox"/> Implied <input type="checkbox"/>					
First Aider Name:		Date of Treatment:		Time of Treatment:					
First Aider Training Level: FAR <input type="checkbox"/> Emergency First Aid <input type="checkbox"/> CFR <input type="checkbox"/> Basic First Aid <input type="checkbox"/> EFR <input type="checkbox"/> No First Aid Training <input type="checkbox"/>									
PRIMARY SURVEY			SIGNS & SYMPTOMS						
Catastrophic Haemorrhage (bleed)? Yes <input type="checkbox"/> No <input type="checkbox"/>			Extent and nature of presenting condition/injuries sustained:						
A - Airway:			A - Abrasion	<input type="checkbox"/>					
Clear <input type="checkbox"/> Partial Obstruction <input type="checkbox"/> Obstructed <input type="checkbox"/>			B - Burn	<input type="checkbox"/>					
C - Spine: Cervical Spine Injury:			C - Contusion	<input type="checkbox"/>					
Suspected <input type="checkbox"/> Not Suspected <input type="checkbox"/>			D - Dislocation	<input type="checkbox"/>					
B - Breathing:			F - Fracture	<input type="checkbox"/>					
Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Fast <input type="checkbox"/> Slow <input type="checkbox"/> Absent <input type="checkbox"/>			Depth of Burns:						
C - Circulation:			Presenting Condition:						
Pulse	Present <input type="checkbox"/>	Absent <input type="checkbox"/>	Wounds/Pain/Problem Area Mark area with letter below A= Abrasion, P= Pain etc.						
	Regular <input type="checkbox"/>	Irregular <input type="checkbox"/>							
	Pulse Rate BPM		Burn % of Body Area = %						
External Haemorrhage: Yes <input type="checkbox"/> No <input type="checkbox"/>									
Cap refill:	Normal <2 seconds <input type="checkbox"/>	Slow >2 seconds <input type="checkbox"/>							
Skin Condition:	Warm & Dry <input type="checkbox"/>	Cold & Clammy <input type="checkbox"/>							
Skin Colour:	Normal <input type="checkbox"/>	Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Cyanosed <input type="checkbox"/>							
Level of Consciousness:									
Loss of consciousness before arrival: Yes <input type="checkbox"/> No <input type="checkbox"/>									
<input type="checkbox"/> A – Fully Alert									
<input type="checkbox"/> V – Responds to voice									
<input type="checkbox"/> P – Responds to painful stimulus									
<input type="checkbox"/> U - Unresponsive									
Clinical Impression:									
Cardiac <input type="checkbox"/>	Respiratory <input type="checkbox"/>								
Medical <input type="checkbox"/>	Trauma <input type="checkbox"/>								
Neurological <input type="checkbox"/>	Other <input type="checkbox"/>								
State other:									
Mechanism of Injury:			ALLERGIES: Does the patient have any allergies: Yes <input type="checkbox"/> No <input type="checkbox"/>						
			Details:						
General Observations:			MEDICATIONS: Is the patient on any medication: Yes <input type="checkbox"/> No <input type="checkbox"/>						
			Details:						
			PAST MEDICAL HISTORY: Relevant medical history: Yes <input type="checkbox"/> No <input type="checkbox"/>						
			Details:						
			LAST ORAL INTAKE: Last food & drink						
			Unknown <input type="checkbox"/>						
			<input type="checkbox"/> Solids: Time: HH;MM						
			<input type="checkbox"/> Liquids: Time: HH;MM						
Vital Signs Every 5 min. for Trauma, Every 10 min. for Medical									
Time	HH	MM	HH	MM	HH	MM	HH	MM	EVENTS: Patient activities leading up to incident:
Pulse Rate (R) (I)									
Cap Refill									
Respiratory Rate									
Skin Condition									
Skin Colour									Self/Assisted Medication Yes <input type="checkbox"/> No <input type="checkbox"/>
Temperature									Administered:
AVPU									Time: HH;MM
Pain Score									Time: HH;MM

FIRST AID REPORT Form 3.3

Form 3.3 First Aid Report Form Version 2.0 April 2023

Langton Hotel Ltd	FIRST AID TREATMENT	FA Report No:	Date:	Time:
Location:		Date of accident/injury:		Time of Accident/Injury:
Patient Name:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Age:	Patient Consent Yes <input type="checkbox"/> No <input type="checkbox"/> Implied <input type="checkbox"/>
First Aider Name:		Date of Treatment:		Time of Treatment:
First Aid Treatment Details				
Chief Complaint:		Time of onset/injury:	Chief Complaint:	
Angina	<input type="checkbox"/>	Time:	Fainting	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Time:	Fracture	<input type="checkbox"/>
Breathing Difficulties	<input type="checkbox"/>	Time:	Head Injury	<input type="checkbox"/>
C-Spine Injury	<input type="checkbox"/>	Time:	Poisoning	<input type="checkbox"/>
Cardiac Arrest	<input type="checkbox"/>	Time:	Seizure	<input type="checkbox"/>
Cardiac Chest Pain	<input type="checkbox"/>	Time:	Shock	<input type="checkbox"/>
Chemical Burns	<input type="checkbox"/>	Time:	Sprain or Strain	<input type="checkbox"/>
Choking	<input type="checkbox"/>	Time:	Stroke	<input type="checkbox"/>
Diabetic Emergency	<input type="checkbox"/>	Time:	Thermal Burns	<input type="checkbox"/>
Dislocation	<input type="checkbox"/>	Time:	Unconscious	<input type="checkbox"/>
Electric Shock	<input type="checkbox"/>	Time:	Wounds/Bleeding	<input type="checkbox"/>
State other presenting conditions and times:				
Was the injured person treated on-site?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Time:
Were the Emergency Services called to the incident?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Time:
Emergency Services arrival at scene?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Time:
First Aid Administered:				
Details of First Aid Treatment:		Was Patient treated for Cardiac Arrest? Yes <input type="checkbox"/> No <input type="checkbox"/>		
		CPR Administered?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Time:
		AED Used?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Time:
		Was patient treated for Cardiac chest pain? Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Aspirin administered?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Time:
		300mg Dose?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dose:
Patient disposition: Discharged <input type="checkbox"/> Transferred to hospital <input type="checkbox"/> Referred to GP <input type="checkbox"/> Refused Further Care <input type="checkbox"/>				
If taken to doctor, state which practice:				
If taken to hospital, name of hospital:			Admitted <input type="checkbox"/> Released <input type="checkbox"/>	
Name of the person who took the injured person to Doctor/Hospital/Home:				
Names and details (employee/contractor/visitor) of any witnesses to the incident/bystanders who assisted in care:				
Did the injured person continue to work after the incident?				Yes <input type="checkbox"/> No <input type="checkbox"/>
If "No" when is the injured person expected to return to work?				
Attending First Aiders Details:				
NAME:		SIGNED:		DATE:
NAME:		SIGNED:		DATE:
Declined Treatment: If the patient declined treatment, FAR and witness please sign below				
Witness declaration: I witnessed that the patient declined first aid treatment:				
NAME:		SIGNED		DATE:
First Aider declaration: I offered to treat the patient, but the patient declined treatment:				
NAME:		SIGNED		DATE: