Incident Report Form

Date: Location: Time In:

Casualty's Family Name: Given Name: Sex: DOB:

Patient Address: Telephone:

Allergies? Medication?

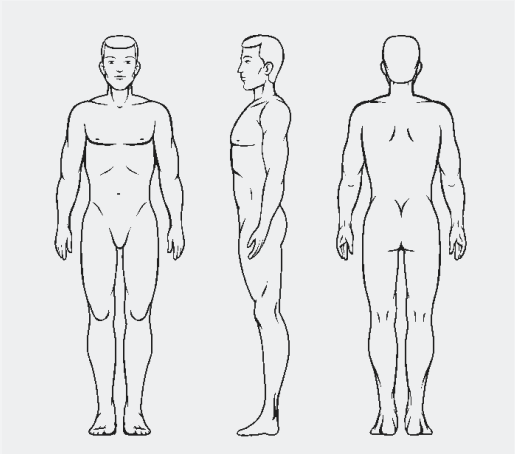
What happened? How, Where, When?

Witness Family Name: Given Name: Telephone:

Past Medical History ☐ Not Known ☐ Asthma ☐ Cardiac ☐ Diabetic
☐ Nil ☐ Epilepsy ☐ Hypertension ☐ Loss of consciousness
☐ Others? _____ ☐ Medi Alert- What? _____

TIME	BREATHING	PULSE	CONSCIOUS LEVEL ALERT VOICE PAIN UNCONSCIOUS	OTHER OBSERVATION

A abrasion
Bl bleeding
Bu burns
C contusion
D deformity
F fracture
L laceration
P pain
S swelling
T tenderness



Treatment:

Rufused Treatment: Witness and Signature:

Discharged How? ☐ Ambulance ☐ Hospital ☐ Return to work ☐ others _____

First Aiders Name and Signature:	Patient Signature:	Time out: