

SAFETY FIRST,



EARLY

<input type="checkbox"/> A ~ Airway	<input type="checkbox"/> "C" Spine
<input type="checkbox"/> B ~ Breathing	<input type="checkbox"/> Bleeding
<input type="checkbox"/> C ~ Circulation	<input type="checkbox"/> Shock

Patient Name: _____

Sex: M F Age: _____

MERT Member's Name: _____

Chief Complaint - What Happened? _____

Distress Level

Mild Moderate Severe

LOC X0 X1 X2 X3 X4

Unconscious

Responds to voice? Yes No

Responds to pain? Yes No

Skin Signs

Color Normal Pale Blue Flush

Temp. Normal Warm Hot Cold

Moist. Normal Normal Moist

50-100	>100/p<160/p	12-22	1:00pm
Pulse	BP	Resp.	Time
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

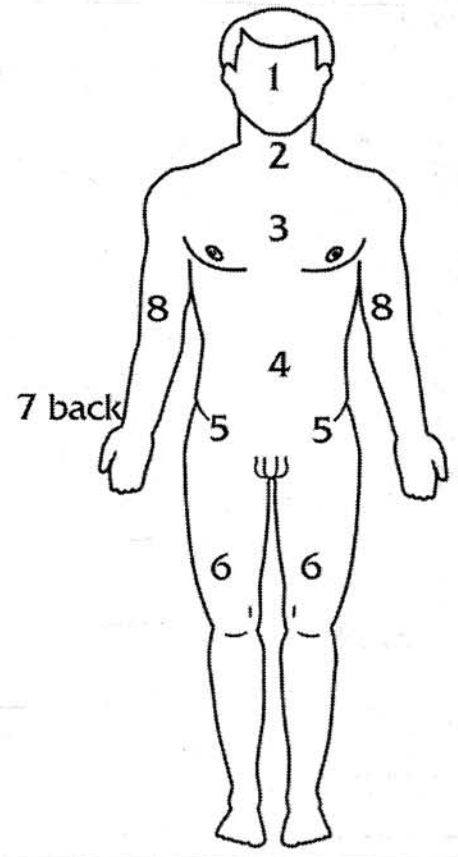
Medical History _____

Medications _____

Allergies _____

SECONDARY SURVEY (Head to toe exam)

- 1 Head _____
- 2 Neck _____
- 3 Chest _____
- 4 Abdomen _____
- 5 Hip/Pelvis _____
- 6 Legs _____
- 7 Back _____
- 8 Shoulders/Arms _____



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