CHIRURGEON'S INCIDENT REPORT

EVENT:_____

SPONSORING BRANCH: _____ **DATES:** _____

CONSENT – I hereby give consent for ☐ **Myself** ☐ **My Child** to be treated.

Patient's Legal Signature: _____ Date:_____

PARENT / GUARDIAN (Please Circle One)

Patient Information (Please Print)

SCA Name:	**Date:**
Legal Name:	**Time:**
Address:	**Date Of Birth:**
	☐M ☐F
Phone:	**Waiver On File:** ☐**Yes** ☐**No**

Allergies:	**Medications**: ☐None ☐Unknown	**Prior Medical History:**

Signs / Symptoms:

_____

_____

_____

_____

☐ Fighting Injury/Trauma ☐Recurring Injury/ Illness

Who Landed Blow?	Other Participants:

NEURO (GCS)

☐ N/A

Eye Opening	**Verbal Responses**	**Motor Responses**
4 ☐ Spontaneous	5 ☐ Oriented	6 ☐ Follows Command
3 ☐ To Voice	4 ☐ Confused	5 ☐ Localizes Pain
2 ☐ To Pain	3 ☐ Inappropriate Words	4 ☐ Withdraws from Pain
1 ☐ None	2 ☐ Incomprehensible Sounds	3 ☐ Flexes to Pain
	1 ☐ None	2 ☐ Extends to Pain
		1 ☐ None

First Aid / Care Given

Musculo-Skeletal	**CMS**	**Motor Behavior**
☐ N/A	☐ Intact Distal To Injury	☐ Cooperative
☐ Warm ☐ Dry	☐ Circulation Altered	☐ Restless
☐ Cool ☐ Diaphoretic	☐ Confused	☐ Agitated
Edema	☐ Motor Function Altered	
☐ Absent ☐ Present	☐ Sensation Altered	
Location: _____	☐ Pain	**Pain**
_____	☐ Swelling	☐ N/A
Color	☐ Deformity	☐ Yes ☐ No
☐ Normal ☐ Pale	**Location:**_____	Indicate Level:
☐ Cyanotic ☐ Mottled	_____	1 2 3 4 5 6 7 8 9 10
☐ Jaundice		

Advice Given: ☐ Rest ☐ Ice ☐ Seek Further Medical Care

☐ Other:_____

Follow-Up

☐ **Patient Is Encouraged To Seek Appropriate Follow-Up Medical Care**

How / Where:	**Relative:**
SCA Contact:	**Phone:**
Patient Transported To (Facility):	
Address:	**Time:**
How:	**By Whom:**

☐ By Emergency Medical Services (EMS) ☐ By Private Vehicle

Time	**T**	**P**	**R**	**B/ P**	**Pupils** L / R	**Other**
				/	☐ NORMAL ☐ ☐ DILATED ☐ ☐ CONSTRICTED ☐ ☐ UNRESPONSIVE ☐	
				/	☐ NORMAL ☐ ☐ DILATED ☐ ☐ CONSTRICTED ☐ ☐ UNRESPONSIVE ☐	
				/	☐ NORMAL ☐ ☐ DILATED ☐ ☐ CONSTRICTED ☐ ☐ UNRESPONSIVE ☐	
				/	☐ NORMAL ☐ ☐ DILATED ☐ ☐ CONSTRICTED ☐ ☐ UNRESPONSIVE ☐	

REFUSAL: This is to certify that I refuse the medical treatment suggested by the undersigned Chirurgeon(s) and understand that this action is contrary to said Chirurgeon(s) and SCA best advice. I fully understand that my refusal to be treated may jeopardize my health and/or my life. I assume the risks and accept sole responsibility for the consequences of my refusal. I also release the Chirurgeon(s) and all SCA authorities form any and all liability for any ill effects that may result.

Patient (Legal Signature): _____

Date:_____ | ☐ **Patient Refused To Sign Form**

Witness (Legal Signature:)

Witness (Legal Signature:)

*** Supplies Used:**

Attending Chirurgeon (Legal Signature):

Chirurgeon In Charge (Legal Signature):

Phone Number:

Medical Certs: ☐ Red Cross (Or Equivalent) CPR ☐ Red Cross Basic F/A ☐ 1st Responder, EMT ☐ RN/LPN ☐ MD/DO ☐ Other: _____

Replaces NCR incident form

May 03, 2006