

# Emergency Initial Assessment Form

## Emergency Details

Incident Date: \_\_\_\_\_

Time of Incident: \_\_\_\_\_

Location of Incident: \_\_\_\_\_

## Patient Information

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

## Symptoms and Observations

Describe symptoms or injuries:

\_\_\_\_\_

Has the patient lost consciousness?  Yes  No

Any signs of distress (e.g., difficulty breathing, severe pain)?  Yes  No

## Immediate Actions Taken

List any first aid or treatments provided:

\_\_\_\_\_

## Consent

I consent to the treatment provided during this emergency assessment.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_