

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: _____