Patient Encounter Form

Event: _____

DATE & TIME (24hr) _____
Last Name: _____
First Name: _____
Phone #: _____
Age: _____ ☐Female ☐Male ☐Transgender
DOB*: _____ PHN*: _____
Family Physician*: _____

PATIENT CATEGORY _____
(**A**=Athlete, **E**=Event Staff, **P**=Performer, **S**=Spectator, **U**=Unknown)

PARTICIPANT ID _____
(Race/Bib Number)

TRIAGE ACUITY SCALE**
☐Black ☐Red ☐Yellow ☐Green ☐White

PRESENTING COMPLAINT _____

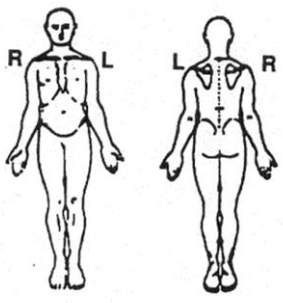
HISTORY _____

Past History _____

Medications _____

Allergies _____

Level of Consciousness
(AVPU)
_____



VITAL SIGNS

	#1	#2	#3
Time	____	____	____
Temp.	____	____	____
Pulse	____	____	____
B.P.	____	____	____
R.R.	____	____	____
SaO2	____	____	____
Glucose	____	____	____
GCS	____	____	____

PHYSICAL FINDINGS
_____

***DOB, PHN, Family Physician** (Optional)

****Triage/Discharge Acuity Scale Level**
Black/Deceased – obvious non-survivable injury
Red/Emergent – critical, resuscitation, chest pain, collapse
Yellow/Urgent – overdose no ABC compromise, SOB
Green/Minor – assessment required, wound care, prescriptions
White/Dispensary – product requests, customer service

*****Level of Training of Care Provider**
PCP, SFA, OFA #, EMR, LPN, RN, NP, MD, Chiro, Physio, etc.

MGM Pt. ID: _____

RA ID: _____

CLINICAL IMPRESSION OF CARE PROVIDER

☐Abrasion	☐ Dental	☐Hypothermia
☐Blister	☐ Dislocation	☐ Intoxication
☐Chest Pain	☐ Dizziness	☐Laceration
☐Concussion	☐ Fracture	☐Sprain/Strain
☐Contusion	☐Hyperthermia	

☐ Other _____

MEDICATION or IV GIVEN

Time:	Medication/IV	Provider Name:

TREATMENT & SERVICES PROVIDED

☐ Antacid	☐Splint/Taping/Tensor
☐ Counselling	☐Stretching
☐ Ibuprofen	☐Tylenol
☐ Immobilization	☐ Vaseline
☐ R.I.C.E	☐ Wound Management
☐ Sling	☐ Other _____
☐ Other _____	☐ Other _____

DISCHARGE ACUITY SCALE**
☐Black ☐Red ☐Yellow ☐Green ☐White

FOLLOW-UP
☐ Event Medical Team
☐ ER
☐ Family Physician/Clinic
☐ Other _____

DISPOSITION
☐ Returned to Event/work
☐ Left Event (private vehicle)
☐ Left Event (taxi)
☐ Left Event (event staff)
☐ Ambulance Transport
☐ Air Evacuation
☐ AMA
☐ Other _____

DISCHARGE INSTRUCTIONS _____

ADDITIONAL NOTES _____

Did the care provided on site prevent a visit to another medical facility (i.e. hospital, clinic, family doctor)? ☐ Yes ☐ No

LEVEL OF TRAINING OF CARE PROVIDER*** _____

LOCATION CARE WAS PROVIDED _____

DISCHARGE TIME _____

Name of Attendant (please PRINT) _____

Signature of Attendant _____