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| Date of Injury: | Time of Injury: | Start Time of Treatment: |
|  |  |  |
| Completed By: | Position: | YMCA Centre/Program: |
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| --- | --- | --- |
| Date of Report: | Time of Report: | Name of Person/s Notified: |
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| Full Name: | | | Gender: □ Male □ Female |
| Address: | | | |
| Suburb: | | | Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| Phone (Home): | | Phone (Mobile): | |
| Any known allergies?  (ie. latex, band aids, etc) | □ Yes □ No | If yes, provide detail: | |
| Was permission given to perform first aid? | □ Yes □ No | If yes, by whom: | |
| Employment/Relationship Status:  □ Staff □ Volunteer □ Contractor  □ Patron □ User Group □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

**If section is not applicable, tick box □**

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| DANGER  Describe your assessment of dangers: | | Was the patient’s normal skin tone impacted?  □ Yes □ No  If ‘No’, was it:  □ Normal □ Pale □ Grey □ Blue  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| RESPONSE  Did the patient respond verbally/physically?  Was the patient conscious?  SEND FOR HELP  Did you send for assistance/help?  AIRWAY  Was the airway clear?  BREATHING  Was breathing present?  COMPRESSIONS  Was CPR commenced?  DEFIBRILLATOR  Was a Defibrillator available?  Was a Defibrillator used? | □ Yes □ No  □ Yes □ No  □ Yes □ No  □ Yes □ No  □ Yes □ No  □ Yes □ No  □ Yes □ No  □ Yes □ No | Was there foreign matter or loose objects in the patient’s mouth / throat when first attended to?  □ Yes □ No  If ‘Yes’, was it:  □ Vomitus □ Dentures  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Were dentures worn? □ Yes □ No  If ‘Yes’, were they loose? □ Yes □ No  If ‘Yes’, Upper / Lower / Partial (please circle)  Was the patient’s jaw tightly clenched? □ Yes □ No |
| Defibrillator use details: |
| Did the patient regurgitate? □ Yes □ No If ‘Yes’, was it:  □ Before treatment commenced □ During treatment  □ After treatment finished □ Continuously | | |
| Were any medical personnel in attendance at any time during treatment / resuscitation? □ Yes □ No  If ‘Yes’, describe their involvement:  Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| Was the patient on any medication for any condition □ Yes □ No □ Not Known  If ‘Yes’ provide detail (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Was the patient perceived to be under the influence of drugs or alcohol?  □ Yes □ No □ Not Known |

**If section is not applicable, tick box □**

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| Time treatment began: | Time treatment finished: |
| Description of injury/illness: | |
| Please state the equipment/methods used to provide emergency care:  □ CPR □ Oxygen Therapy □ Oxygen Resuscitation □ Basic First Aid □ Defibrillator  □ Spinal Management □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Oxygen treatment administered:  □ Oxy Viva □ Oxy Sock  □ Air Bag □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Flow Rate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long for: \_\_\_\_\_\_\_\_\_  Start Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Time: \_\_\_\_\_\_\_\_\_\_\_\_ |

**If section is not applicable, tick box □**

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| How long was CPR performed for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time Commenced: \_\_\_\_\_\_\_\_\_\_\_\_ Time Ended: \_\_\_\_\_\_\_\_\_\_\_\_ | |
| Who performed CPR? List all rescuers: | During Resuscitation, which techniques were used:  □ Mouth to Mouth □ CPR Mask (pocket mask)  □ Mechanical Oxygen □ Oxygen Resuscitation  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Was there any difficulty in establishing or maintain an airway? □ Yes □ No If ‘Yes’, was it because of:  □ Head tilt □ Clenched or damaged jaw □ Shape of jaw  □ Trauma to face or mouth □ Obstruction (teeth, etc) □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| During resuscitation, did you observe rise and fall of the chest? □ Yes □ No If ‘No’, was it because of:  □ Blocked airway □ Chest trauma □ Mechanical device or equipment  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| How much time passed between learning of the incident to the first breath was administered? \_\_\_\_\_\_\_\_\_ mins | How many operators were involved?  □ One □ Two □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Did the patient’s colour change during resuscitation? □ Yes □ No  If ‘Yes’ describe changes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Did the patient recover before emergency medical assistance arrived? □ Yes □ No | |
| Other Information: | |

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| Nature of Injury: □ Suspected Spinal □ Suspected Fracture □ Dislocation □ Serious Laceration  □ Head Injury □ Amputation □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Location on body: (Circle injured part)  ANATM001 | Detailed description of injury:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Treatment administered:  Treatment / Products Used / Time Periods / Cleaned / Iced / Pressure: (Provide detail) | |

**If section is not applicable, tick box □**

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| Service | Phone No. Called | Called By | Time Called | 2nd Call Time | 3rd Call Time | Time Arrived |
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| Personnel Contacted:  □ Health and Safety Officer □ Centre/Program Manager  □ Health and Safety Coordinator/Manager □ Area Manager/RDM  □ OHS Department □ Senior YMCA Personnel  □ Council / Contract Partner □ External Party |

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| Prevention:  □ Reported to Manager/Duty Manager □ Risk Assessment Completed/Reviewed  □ Fault Report Completed □ Site Preservation (while incident is investigated)  □ Guest Education □ Quarantine Access |

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| Location of Incident: Where did it take place? |

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| Staff / Rescuer Details | | |
| Name | Position | Brief Description of Involvement |
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**If section is not applicable, tick box □**

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| Did the patient recover?  □ Yes □ No | If ‘Yes’ did they recover before medical assistance arrived?  □ Yes □ No |
| If ‘Yes’, what hospital / medical institution was the patient transported to? | |
| How were they transported? □ Ambulance □ Police Vehicle □ Private Vehicle | |
| Has contact been made with the injured person or their family? □ Yes □ No  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| List any updated information: | |

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| Was counselling arranged for staff / personnel involved? □ Yes □ No |
| If ‘Yes’ who was contacted: □ PPC (1300 361 008) □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Who will be attending: |

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| Casualty Acknowledgement:  I understand that the treatment provided and detailed above, was first aid only and not a substitute for professional medical attention. Accordingly, I understand that the YMCA recommends I see a further examination by a medical professional as a matter of precaution. | |
| Signed: | Date: |

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| --- |
| Name of Patient:  Name of Parent or Guardian:  Note – Parent/guardian to sign if casualty is a child (under 16 years of age) |
| If casualty is a child, has parent notification letter been given? □ Yes □ No |

PRIVACY DISCLAIMER:

The YMCA acknowledges and respects privacy of individuals. The information that is being collected on this form is for the purposes of providing and recording first aid rendered to you while in a YMCA facility. The intended recipients of this information are the YMCA, its staff, insurers, and medical professionals (Ambulance Services), hospital, doctor & nurses, council or building owners.

You have the right to access and alter personal information concerning yourself in accordance with the Privacy Act 1988 and YMCA Privacy Policy. If you do not wish to have your information disclosed to a third party please tick the "OPT OUT" box below. It is important to note that if you choose to opt to not have your personal information transferred to medical professionals, your first aid treatment may be restricted. OPT OUT □

|  |  |
| --- | --- |
| Form Completed By: | Signature: |
| Duty Manager Name: | Signature: |
| Manager Name: | Signature: |
| Area Warden Name: | Chief Warden Name: |