WorkSafe
WORKERS' COMPENSATION BOARD OF BC

OCCUPATIONAL FIRST AID PATIENT ASSESSMENT

Certification Services — Program Design Division

DATE AND TIME OF ILLNESS / INJURY AM / PM	DATE AND TIME REPORTED TO FIRST AID AM / PM
TIME OF ARRIVAL AT FIRST AID (WALK IN) AM / PM	TIME ON SCENE (IF APPLICABLE) AM / PM

EMPLOYEE NAME DATE OF BIRTH D M Y	EMPLOYER NAME EMPLOYER PHONE NUMBER
EMPLOYEE'S DOCTOR	CONTACT PERSON

GLASGOW COMA SCALE

EYE OPENING RESPONSE	BEST VERBAL RESPONSE	BEST MOTOR RESPONSE
4 SPONTANEOUSLY	5 ORIENTED	6 OBEYS COMMANDS
3 SPEECH	4 CONFUSED	5 LOCALIZES PAIN
2 TO PAIN	3 INAPPROPRIATE WORDS	4 WITHDRAWS FROM PAIN
1 NO RESPONSE	2 INCOMPREHENSIBLE SOUNDS	3 FLEX TO PAIN (DECORTICATE)
	1 NO RESPONSE	2 EXTENDS TO PAIN (DECEREBRATE)
		1 NO RESPONSE

PATIENTS CHIEF COMPLAINT

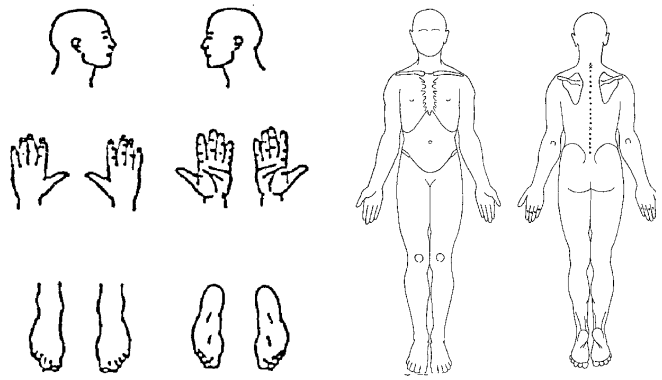
MECHANISM OF INJURY / HISTORY OF ILLNESS

PHYSICAL FINDINGS

VITAL SIGNS	TIME	TIME	TIME	TIME
RESPIRATIONS				
PULSE				
LOC / GCS	E V M TOTAL	E V M TOTAL	E V M TOTAL	E V M TOTAL
PUPIL SIZE & REACTION + / -	L R	L R	L R	L R
SKIN				

ALLERGIES

PLEASE MARK INJURED OR EXPOSED AREA



MEDICATIONS

INTERVENTIONS (PLEASE CHECK)

❒ AIRWAY CLEARED ❒ MAINTAINED ❒ OROPHARYNGEAL AIRWAY
❒ VENTILATED ❒ PKT. MASK ❒ BVM
❒ CONTROLLED BLEEDING ❒ OXYGEN ADMINISTERED LPM_____

DEFINITIVE TREATMENTS (PLEASE CHECK)

❒ TRACTION ❒ SPLINTED ❒ IMMOBILIZED
❒ SPINAL IMMOBILIZATION ❒ ADDITIONAL TREATMENTS (PLEASE EXPLAIN)

RECOMMENDATIONS

❒ RETURN TO WORK ❒ FIRST AID FOLLOW UP ❒ MEDICAL AID

TRANSPORTED BY (PLEASE CHECK)

❒ ETV ❒ INDUSTRIAL AMBULANCE ❒ B.C. AMBULANCE SERVICE
❒ AIR EVACUATION ❒ OTHER (PLEASE EXPLAIN)

CHANGES IN PATIENTS CONDITION (PLEASE EXPLAIN)

F.A.A. NAME (PLEASE PRINT)	F.A.A. SIGNATURE	OFA CERTIFICATE #	OFA LEVEL
			❒ 1 ❒ TE ❒ 2 ❒ 3

NAME OF WITNESSES (PLEASE PRINT)	EMPLOYER MAILING ADDRESS STREET / AVENUE
EMPLOYEE SIGNATURE	CITY / TOWN POSTAL CODE

WHITE COPY – Work Site

CANARY COPY – Medical Aid