

PATIENT ENCOUNTER FORM

Event : _____

DATE & TIME (24HR) _____

Last Name : _____

First Name : _____

Phone : _____

Age : _____ ☐ Female ☐ Male

DOB : _____

Family Physician : _____

PATIENT CATEGORY _____

Amblyopic, In Event Staff, In Performance, In Expectation, In Unknown

PARTICIPANT ID _____

(Race/BI Number)

TRIANGLE ACUTY SCALE**

☐ Black ☐ Red ☐ Yellow ☐ Red ☐ Green ☐ White

PRESENTING COMPLAINT _____

HISTORY _____

Past History _____

Medications _____

Allergies _____

Level of Consciousness
(AVPU)



PHYSICAL FINDINGS

VITAL SIGNS

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

CLINICAL IMPRESSION OF CARE PROVIDER

Abrasional/thermal hypothermia

☐ Blister ☐ Dislocation ☐ Intoxication

☐ Chest Pain ☐ Disinfect ☐ Laceration

☐ Concussion ☐ Fracture ☐ Sprain/Strain

☐ Contusion ☐ Hyperthermia

Other _____

MEDICATION or IV GIVEN

Time :	Medication/IV	Provider Name :
_____	_____	_____
_____	_____	_____
_____	_____	_____

TREATMENT & SERVICES PROVIDED

☐ Antacid ☐ Splint/Taping/Tensor

☐ Counseling ☐ Stretching

☐ Ibuprofen ☐ Tylenol

☐ Immobilization ☐ Vaseline

☐ R.I.C.E. ☐ Wound Management

☐ Sling ☐ Other _____

☐ Other _____ ☐ Other _____

DISCHARGE ACUTY SCALE**

☐ Black ☐ Red ☐ Yellow ☐ Red ☐ 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 medic

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 _____

**DOB, Race, Family Physician (Optional)

PARTICIPANT ID:

**Triangle/Discharge Acuity Scale Level

Black/Deceased-obvious, non-conscious injury

Red/Severe injury-Critical, no action, Chest Pain, Collapse

Yellow/Injury-injury, no ABC complaints, DOB

Green/Minor injury-injury, no action, no complaints, DOB

White/No injury-injury, no action, no complaints, DOB

RA ID :

**Level of Training of Care Provider

PCR, EMT, CMA, EMT, LPN, RN, NP, NVC, Chiropractor, etc.

Encounter Forms For Family Practice

Michael Rajnik



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