PATIENT REPORT FORM –SOAP NOTE

PATIENT INFORMATION	**Date:**
Name: M / F	Birthdate:
Address:	
Emergency Contact Name / Phone:	
Describe What Happened or Chief Complaint:	
INITIAL ASSESSMENT COMMENTS (ABCDE):	

SECONDARY ASSESSMENT (Subjective Assessment) **TRAUMA:** Start with Head-to-Toe Assessment or **MEDICAL**: Start with SAMPLE / HISTORY	
HEAD-TO-TOE ASSESSMENT – Palpate for DOTS Assess CSM's, EXPOSE Injury, Ask OPQRST	SAMPLE / HISTORY QUESTIONS
HEAD / NECK:	S: Signs -
SHOULDERS / CLAVICAL:	A: Allergies -
RIB CAGE:	M: Medications (Prescription & OTC & Supplements)
ABDOMEN / LUMBAR REGION:	P: Past Relevant History -
HIPS / PELVIS:	L: Last In / Out -
UPPER EXTREMITIES:	E: Events Leading Up To -
LOWER EXTREMITIES:	**Concerns:**
BACK / SPINE:	
OBSERVATIONS / CONCERNS:	**OPQRST** **In relation to injury or illness**
	O: Onset (slow, fast, time) -
	P: Provoke (what makes better or worse)-
	Q: Quality (throb, stab, sharp, etc) –
	R: Region / Radiate –
	S: Severity (scale) –
	T: Time / Timing -

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VITALS – 3x Stable Patient every 5 min; 5X Unstable Patient every 5 min (Objective Assessment)						
Norms	**AxO 3 or 4**	**12-16/min**	**60-100/m**	**SCTM**	**PEARL**	**Better? Worse?**
TIME	**LOC**	**BREATHING**	**CIRCULATION**	**SKIN**	**PUPILS**	**Comments**

Assessment & Planning		
Assessment **Current Problems Patient/Situation**	**Anticipated Problems Patient/Situation**	**Treatment Strategies**

FOCUSED SPINAL ASSESSMENT - to be done only after a complete SECONDARY ASSESSMENT			
Yes	No	Dangerous MOI?	Only do this step if you have been trained to do so. If you have not be trained in FSA you must maintain spinal precautions. **YES** to ANY question: **MAINTAIN** Spinal Motion Restrictions (SMR). **NO** to all questions: you may discontinue spinal motion restriction (SMR).
Yes	No	Over 65yrs?	
Yes	No	Abnormal CSM in extremities?	
Yes	No	Distracting injuries Or large structural injuries?	
Yes	No	Never ambulatory?	
Yes	No	Alcohol/drugs: recreational, OTC's, prescription?	
Yes	No	Immediate onset of neck or back pain?	
Yes	No	Spinal pain or tenderness upon palpation of Midline?	
Yes	No	Pain on rotation of head to 45°?	

RESCUE PLAN	Time Sent:	Time Received:
# in group:	Contact Name:	Cell Phone #:
Location Details (Lat/Long) & Terrain Concerns:		inReach / SPOT:
		Group Needs:
		Weather Concerns: