Airline logo

SAMPLE MEDICAL INCIDENT REPORT

(To be completed for all incidents)

COMPLETED FORM TO BE RETURNED TO:	
NAME OF PERSON COMPLETING FORM:	Staff ID:

SECTION 1

Date:	/ /	Flight No:		From:		To:	

PATIENT DETAILS *(Complete as applicable)*

Name:							
Sex:	M / F	Age:		Seat No:		Frequent flyer member?	Y/N
Home Address:							

DETAILS OF ILLNESS / ACCIDENT

Time/Date of Onset (GMT):	: hrs. / /	Location:	
Describe events leading up to incident:			

SYMPTOMS & SIGNS *(tick, circle or complete all appropriate boxes)*

PAIN:	Site(s):		Severity:	Mild / Moderate / Severe
	Character:	Sharp / Cramping / Aching / Throbbing	Pattern:	Constant / Variable

BLEEDING	Site(s):		Severity:	Mild / Moderate / Severe

Nausea		Vomiting		Diarrhoea		Cough		Breathless or wheezy	
Faint		Pale		Blue		Flushed		Clammy/Sweating	
Hot/feverish		Cold		Dizzy		Weakness		Fit/Convulsion	
Anxious		Confused		Aggressive		Intoxicated			
Rash/spots		Where:							
Other (specify):									

INJURY *(tick appropriate box/boxes):*

Abrasion		Amputation		Fracture		Bruising		Burn	
Concussion		Cut		Dislocation		Sprain		Foreign Body	

Body Part

Head/neck		Eye		Ear		Torso		Back	
Arm		Hand		Finger		Leg		Foot/toe	

OBSERVATIONS:	Pulse: / minute	Blood Pressure: mm/Hg
	Temperature:	Respiration: / minute
	Other observations:	

cut-off-portion

TRANSFER OF CARE TO GROUND MEDICAL SERVICES			
Name of Casualty:		Date and time of onset:	
Brief Details of Incident:			
Oxygen given:	YES / NO	If yes, did condition improve?	YES / NO
Was casualty unconscious at any time?	YES / NO		
Defibrillator applied?	YES / NO	If yes, were any shocks given?	YES / NO
MEDICATION ADMINISTERED: Drug:	Dose:	Time (GMT)	
Any other treatment given:			
Crew Member name (CAPITALS):	Staff ID:	Signature:	

SAMPLE MEDICAL INCIDENT REPORT

(To be completed for all incidents)

PATIENT'S MEDICAL HISTORY

		DETAILS
Had this problem before?	YES / NO	
Taking **any** medication?	YES / NO	
Any allergies?	YES / NO	
Any recent illnesses or operations?	YES / NO	
Currently pregnant?	YES / NO	If yes how many months?

CABIN CREW ACTION *(circle or complete as indicated)*

Oxygen given?	YES / NO	If yes, did patient's condition improve?	YES / NO
Medication given? (specify)			
Was own medication or from other passenger used? (specify)			
Defibrillator used?	YES / NO	If yes, were any shocks administered?	YES / NO
Other onboard medical equipment used (specify)			

Was Cardiopulmonary Resuscitation (CPR) performed?	Pulse restored?	Respiration restored?	Consciousness regained?
YES / NO	YES / NO	YES / NO	YES / NO

Use of ground medical control	YES / NO	Successful / unsuccessful	
Assistance of on-board Dr or Health Professional		YES / NO	Successful / unsuccessful
Attempt to contact company doctor:		YES / NO	Successful / unsuccessful
Port Health Authority advised:		YES / NO	

Further information/comments:

OUTCOME *(tick):*

Diversion		Patient recovered before landing		Patient walked off aided/unaided	
Patient left aircraft by wheelchair		Patient left aircraft by stretcher		Patient died on aircraft	

Treatment:

None		First Aid		Ground medical		GP/Appointed Dr		Hospital	

Crew:

Fit to operate		Fit to fly as passenger		Remained in hotel / hospital	

cut-off-portion

Transfer of Care to Ground Medical Services

Sample Medical Incident Report