



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:	
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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
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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:			

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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:	Dose:		Time (GMT)
Drug:			
Any other treatment given:			
Crew Member name (CAPITALS):	Staff ID:	Signature:	

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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	<input type="checkbox"/>	Patient recovered before landing	<input type="checkbox"/>	Patient walked off aided/unaided	<input type="checkbox"/>
Patient left aircraft by wheelchair	<input type="checkbox"/>	Patient left aircraft by stretcher	<input type="checkbox"/>	Patient died on aircraft	<input type="checkbox"/>

Treatment:

None	<input type="checkbox"/>	First Aid	<input type="checkbox"/>	Ground medical	<input type="checkbox"/>	GP/Appointed Dr	<input type="checkbox"/>	Hospital	<input type="checkbox"/>
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Crew:

Fit to operate	<input type="checkbox"/>	Fit to fly as passenger	<input type="checkbox"/>	Remained in hotel / hospital	<input type="checkbox"/>
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Transfer of Care to Ground Medical Services
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