PATIENT ASSESSMENT

Scene Size Up (begins upon dispatch and assess again when first on scene):

BSI/PPE	Scene Safety	Medical vs. Trauma (MOI/NOI)
Number of Patients	Need for Additional Resources	C-Spine Precautions

Primary Assessment (once the patient is encountered):

General Impression:	Life threatening injuries/illness, age, gender and "sick/not sick"
Chief Complaint:	What is the primary complaint of the patient
Mental Status:	AVPU- Alert & Oriented x # ? (person, day, time, event) or Verbal or Painful or Unresponsive
Airway:	Open & patent? Need for airway adjuncts?
Breathing:	Are they breathing and is it adequate? Need for oxygen or ventilation?
Circulation:	Pulse- Present? Rate, rhythm, quality Skin- Color, Temperature, Condition (CTC) Life threatening bleeding (blood sweep)
Disability:	Glasgow Coma Scale (GCS), neurological defecates (example: stroke, diabetic, intoxicated etc.)
Expose:	Expose injury or patient as appropriate (consider environment/ privacy) Ensure that body temperature is still maintained
Determine Transport Priority:	Examples: poor general impression, altered mental status, severe trauma/multi-trauma, shock, chest pain, respiratory distress, severe pain, complicated child birth, head injury, unconscious/unresponsive

Secondary Assessment (medical history and physical exam):

Responsive Medical	Trauma or Unresponsive Medical
SAMPLE & OPQRST	Focused or rapid physical exam (depending on patient)
Focused physical exam	Baseline vital signs
Baseline vital signs	SAMPLE & OPQRST
Transport, if not already started	Transport, if not already started
Consider detailed physical exam	Consider detailed physical exam

Ongoing Assessment (usually on the way to the hospital or if prolonged on scene time):

Repeat Primary Assessment
Repeat vital signs for trending (low priority patient: every 15 minutes, high priority patient: every 5 minutes)
Repeat Secondary Assessment (as needed)
Check interventions
Documentation

PATIENT ASSESSMENT

Mental Status Assessment (AVPU)

Alert & Oriented x ____ (up to 4 things- person, place, time, event)
Verbal stimulus- simple commands if not alert
Painful stimulus- classify only if does not react to verbal stimulus
Unresponsive- classify only if does not react to any of above stimuli

SAMPLE

Signs/**S**ymptoms
Allergies- food, medications, environmental etc.
Medications- prescribed, over the counter, illicit, herbal/alternative
Pertinent Medical History- specific to incident and includes family history
Last Oral Intact- food and drink, what, quantity, time
Events Leading Up To Incident- can be hours or days

OPQRST

Onset- "What were you doing the moment this began?"
Provokes/**P**alliation- "Does anything make it worst or better?"
Quality- "Describe what you are feeling?"
Radiation- "Where is the pain/discomfort? Does is go anywhere else?"
Severity- "On a scale of 0-10 with 0 being no pain, what number would you give it?"
Time- "What time did this start? How long is each episode? How long between episodes?"

DCAP-BTLS

Deformity
Contusions
Abrasions
Punctures/Penetrations
Burns
Tenderness
Lacerations
Swelling

Vital Signs for Normal Adult at Rest

Systolic BP: 90-140 mmHg
Diastolic BP: 60-90 mmHg
Pulse: 60-100 bpm
Respiratory Rate: 12-20 bpm
Pupils: **P**upils **E**qual **A**nd **R**ound/**R**eactive to **L**ight (PEARRL)
Skin CTC: warm, pink, dry
(Children tend to have faster pulses/respirations rates and lower blood pressures)