WFR - PATIENT ASSESSMENT

▶1. OPEN A CAN OF CALM

▶2. SCENE SIZE-UP

1. I'm Number One (Scene Safety)
2. What Happened to You?
3. None on Me (BSI / Gloves)
4. Any More?
5. How Alive?

▶3. LIFE THREATS - ABCDE (INITIAL ASSESSMENT)

- Identify Self
- Get Permission to Help *[ASK: "I've got some first aid training, can I help?]*
- Airway - *look in mouth*
- Breathing - *two breaths, expose chest injuries*
- Circulation - *assess pulse - do a blood sweep - control life-threatening injuries*
- Decision About Disability - MOI for spine injury? *[ASK: What Happened?]*
- Expose Injured Areas - *treat life threatening injuries*

▶4. HEAD TO TOE (SECONDARY ASSESSMENT)

- *Complete head to toe assessment: look, listen, and feel / CHECK BACK & CSMs!*

BSI = Body Substance Isolation
CSMs = Circulation, Sensation, Motion
FSA= Focused Spine Assessment
MOI = Mechanism of Injury
HPI = History of Present Illness
S/S = Signs & Symptoms
Tx = Treatment

NORMAL ADULT VITAL SIGNS
LOR: A+Ox4 | HR: 50-100/regular/strong | RR: 12-20/regular/strong
SCTM: pink/warm/dry | BP: Less than 120/80 | P: PERRL | T: 98.6F (37C)

▶5. VITAL SIGNS (Qualifiers Below the Table)

TIME			
Levels of Resp. (LOR)			
Heart Rate (HR)			
Respiratory Rate (RR)			
Skin (SCTM)			
Blood Pressure (BP)			
Pupils (P)			
Temperature (T)			

LOR = Awake & Oriented A+Ox4 = Person, Place, Time, Event.
V=Unresponsive Verbal / P =Unresponsive Pain / U=Unresponsive
HR = Rythm: regular/irregular. Quality: strong/weak/bounding
RR = Rythm: regular/irregular. Effort easy/shallow/labored/deep
SCTM = Color/Temp/Moisture: pink/pale/ashen, warm/cool , dry/moist
BP = if no cuff palpate pulse, if detected write, "strong radial pulse"
P = PERRL Equal, round and reactive to light

ABOUT:
The infosheet was created for personal use while completing several NOLS Wilderness Medicine WFR courses. It is offered freely to WFR students & WFRs who might need some additional help after opening that "can of calm." This is not intended to be a substitute for professional training - get WFR certified. Send any suggestions or corrections to mark@letsgoexploring.com.

▶6. PATIENT HISTORY - CHIEF COMPLAINT [CC]

*ASK: Where does it hurt the most?*______________________________

____

Patient Name: __________________________Age _____Sex (M/F)____

-Onset: *How fast did this pain come on?*

-Provokes: *What makes pain worse / better?*

-Quality: *What words describe the pain?*

-Radiates/Region: *Where is the pain? Is it distracting from other areas of pain?*

-Severity: (Find their ten for pain) *How does this rate on a scale of 1-10?*

-Time: *How long has this been going on?*

▶7. PATIENT HISTORY - MOI/HPI [SAMPLE]

Symptoms: *Headache? Dizziness? Nausea? Cold? Hot? Stress?*

Allergies: *Allergies to Medications? Foods? Insects? Pollens? Exposure?*

Medications: *Over the Counter? Prescriptions? Alcohol / Drugs? Herbal? Any ED meds?*

Pertinent Medical History: *Diabetes? Asthma? Seizures? Heart Issues?*

Last Intake/ Output? *(quality and quantity) Food? Water? 1 & 2 (color/odor) Vomiting?*

Events Leading Up to Incident? *(Relevant to Cause of MOI)*

▶ 8. FOCUSED SPINE ASSESSMENT (FSA) - *[WITH MOI & WITHOUT S/S of SPINE INJURY]*

NA+Ox3 or 4 | SOBER | NOT DISTRACTED | NORMAL CSMs (ALL 4 EXTREMITIES) | PALPATE SPINE (& PATIENT DENIES PAIN)

If ALL criteria are met, and patient agrees, OK to release spine. Ask patient that if they later have tingling/numbness in extremities or head pain to let you know.

▶9. MAKE EVACUATION DECISION

▶10. MONITOR YOUR PATIENT IF STAYING PUT *(keep checking vitals and CSMs)*