PEAK EMERGENCY RESPONSE TRAINING
A division of Peak Project Management, Inc.

POST-METHOXYFLURANE ADMINISTRATION REPORT

INCIDENT INFORMATION

RESORT, COMPANY or SAR TEAM	LOCATION OF INCIDENT	INCIDENT DATE (dd/m/m/yy)

PEAK METHOXYFLURANE CONTROL #	TIME OF INCIDENT (24 hr.)	TIME OF ADMINISTRATION (24 hr.)	EMS ARRIVAL AT SCENE (24 hr.)
PMCN - _____	_____ ☐ KNOWN ☐ ESTIMATED	_____ ☐ KNOWN ☐ ESTIMATED	_____ ☐ N/A

INJURIES DETECTED	MECHANISM OF INJURY

PATIENT INFORMATION

NAME	GENDER	DATE OF BIRTH (dd/m/m/yy)	AGE	ADDRESS
	☐ MALE ☐ FEMALE			

ADVERSE EFFECT(S) REPORTING

Were there any adverse effects or reactions reported by the patient or observed by the Provider(s)? ☐ No ☐ Yes

If YES, specify the adverse effect(s) or reaction(s) and the outcome:

_____

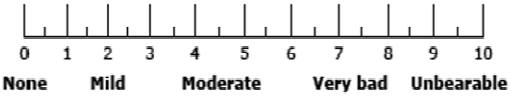
_____

_____

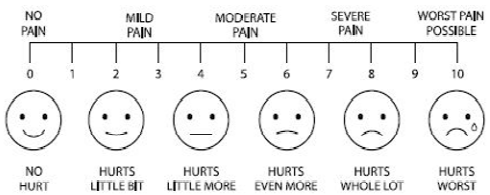
EFFICACY REPORTING

INTERVAL	TIME (24 hr.)	NPIRS NUMERIC PAIN	VPIRS VISUAL PAIN
0 min Baseline	_____ : _____		
5 min	_____ : _____		
10 min	_____ : _____		
15 min	_____ : _____		
20 min	_____ : _____		
25 min	_____ : _____		
30 min	_____ : _____		

NUMERIC PAIN INTENSITY RATING SCALE



VISUAL PAIN INTENSITY RATING SCALE



PROVIDER INFORMATION

NAME OF PROVIDER (PRINT)	PROVIDER SIGNATURE	DATE REPORT COMPLETED

FAX COMPLETED REPORT TO 604.648.8120