

ADVANCED PROTOCOL INITIATION REPORT (PIR)

INCIDENT INFORMATION					
RESORT or SAR TEAM NAME	RESPONDER(s) NAME(s)	INCIDENT DATE	*INCIDENT TIME	ACTIVITY	CWSAA REPORT # <input type="checkbox"/> N/A

PATIENT INFORMATION				
NAME	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	AGE	CHIEF COMPLAINT

HISTORY of CHIEF COMPLAINT (Mechanism of Injury / Nature of Illness) _____

PAST MEDICAL HISTORY <input type="checkbox"/> UNKNOWN	PREVIOUS CARDIAC HISTORY? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNKNOWN
MEDICATIONS <input type="checkbox"/> UNKNOWN	ALLERGIES <input type="checkbox"/> UNKNOWN

*TIME	VITAL SIGNS					DIAGNOSTIC SIGNS			
	LOR (GCS)	RESP	PULSE	TEMP / SKIN	BP	CMS	PUPILS	SPO ₂	
							<input type="checkbox"/> REACTIVE <input type="checkbox"/> NON-REACTIVE	<input type="checkbox"/> EQUAL <input type="checkbox"/> UNEQUAL	
							<input type="checkbox"/> REACTIVE <input type="checkbox"/> NON-REACTIVE	<input type="checkbox"/> EQUAL <input type="checkbox"/> UNEQUAL	
							<input type="checkbox"/> REACTIVE <input type="checkbox"/> NON-REACTIVE	<input type="checkbox"/> EQUAL <input type="checkbox"/> UNEQUAL	

PROTOCOL SPECIFIC REPORTING							
NITROUS OXIDE	START PSI	END PSI	ADVANCED PROCEDURE? <input type="checkbox"/> No <input type="checkbox"/> Yes	CHEST AUSCULTATED? <input type="checkbox"/> No <input type="checkbox"/> Yes	ADVERSE EFFECTS (specify): _____ <input type="checkbox"/> N/A	SEVERITY SCALE (1-10) PRE-TX POST-TX	
SAGER TRACTION	FOOTWEAR REMOVED? <input type="checkbox"/> No <input type="checkbox"/> Yes	APPLIED ON-SCENE? <input type="checkbox"/> No <input type="checkbox"/> Yes	LBS. TRACTION APPLIED _____	CIRCULATION, MOBILITY, SENSATION PRE-APPLICATION POST-APPLICATION		RESULT	
MEDICATION - ASSIST <input type="checkbox"/> NITROGLYCERIN <input type="checkbox"/> SALBUTAMOL	*TIME - 1 ST DOSE	EFFECT	*TIME - 2 ND DOSE	EFFECT	*TIME - 3 RD DOSE	OVERALL RESULT	
MEDICATION <input type="checkbox"/> ASPIRIN <input type="checkbox"/> DIPHENHYDRAMINE <input type="checkbox"/> EPINEPHRINE <input type="checkbox"/> METHOXYFLURANE <input type="checkbox"/> NALOXONE	*TIME - 1 ST DOSE	EFFECT	*TIME - 2 ND DOSE	EFFECT	*TIME - 3 RD DOSE	OVERALL RESULT	
AED	*TIME AED APPLIED	BYSTANDER CPR? <input type="checkbox"/> No <input type="checkbox"/> Yes	EFFECTIVE CPR? <input type="checkbox"/> No <input type="checkbox"/> Yes	# OF SHOCKS DELIVERED _____	RETURN OF SPONTANEOUS CIRCULATION? BREATHING? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes		POST AED INCIDENT REPORT COMPLETED? <input type="checkbox"/> No <input type="checkbox"/> Yes
KING LT-D	*TIME OF INSERTION	TUBE SIZE	AMT. CUFF INFLATION	CHEST AUSCULTATED? <input type="checkbox"/> No <input type="checkbox"/> Yes	PRE-INSERTION GASTRIC DISTENTION? <input type="checkbox"/> No <input type="checkbox"/> Yes		RESULT

PATIENT TRANSPORTATION		
MODE OF TRANSPORTATION <input type="checkbox"/> T-BOG <input type="checkbox"/> LITTER <input type="checkbox"/> SNOWMOBILE <input type="checkbox"/> WALKING	POSITION OF PATIENT <input type="checkbox"/> SUPINE <input type="checkbox"/> SEMI-RECUMBENT <input type="checkbox"/> SUP/LATERAL <input type="checkbox"/> 3/4 PRONE	PATIENT'S HEAD POSITION <input type="checkbox"/> HEAD-UP HILL <input type="checkbox"/> HEAD-DOWN HILL

PROTOCOL REPORTING CONTROL	
DATE FAXED	FAXED BY - INITIALS
<input type="checkbox"/> HOME/HOTEL <input type="checkbox"/> REFUSED <input type="checkbox"/> BCAS <input type="checkbox"/> MORGUE <input type="checkbox"/> HOSP/CLINIC _____	

* All times must be recorded in 24 hour format.