Santa Barbara County Medical Reserve Corps

Patient Treatment Form

DATE:___/___/____

TIME: ____________

PRIMARY IMPRESSION:

____

____

NATURE OF INJURY/ILLNESS

____

____

CHIEF COMPLAINT:

____

INCIDENT LOCATION

____

____

DISPOSITION:

☐ **TRANSFERRED CARE** (*OVER*)

☐ **TREAT & RELEASE**

NAME:________________________

PHONE: ________________

Gender: M F

WEIGHT: ______ AGE: _____

D.O.B: ____/___/____

NOTES: ____

____

____

TREATED BY: ________________________________

TITLE/OCCUPATION: ________________________

911 Call

☐ **911 called**

☐ **Law Enforcement**

S ____________________________

____

A ____________________________

____

M ____________________________

____

P ____________________________

____

L ____________________________

____

E ____________________________

____

First Aid/CPR _______________

Care provided _____________________

Notes: ____

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