



**SURF LIFE SAVING
INCIDENT REPORT LOG**

Name of Club or Service: _____

State: _____ Local Government Area: _____

<p>Details of Incident</p> <p>Date: ____/____/____ Time: ____ am / pm</p> <p>Location of Incident: _____</p> <p>Name of Victim: _____</p> <p>Age: ____ DOB: ____/____/____ M / F</p> <p>Address: _____ Postcode: _____</p>	<p>Venue Conditions at Time of incident: (if relevant)</p> <p>Wind conditions: <input type="checkbox"/> Calm <input type="checkbox"/> Slight <input type="checkbox"/> Mod <input type="checkbox"/> Strong</p> <p>Weather conditions: <input type="checkbox"/> Fine <input type="checkbox"/> Overcast <input type="checkbox"/> Rain</p> <p>Sea conditions: <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large</p> <p>Water surface: <input type="checkbox"/> No chop <input type="checkbox"/> Avg chop <input type="checkbox"/> Large chop</p> <p>Wave type: <input type="checkbox"/> Surging <input type="checkbox"/> Spilling <input type="checkbox"/> Plunging</p> <p>Rip Type: <input type="checkbox"/> Permanent <input type="checkbox"/> Fixed <input type="checkbox"/> Flash <input type="checkbox"/> Traveling</p>
---	---

<p>Patient Declaration - I acknowledge that the information disclosed in this incident report form has been disclosed to SLSA and other Surf Life Saving organisations for the purposes of fulfilling the Surf Life Saving organisations' objectives.</p>	<p>Signature: _____</p>
---	-------------------------

Please fill in the below relating to the victim:

<p>Type of incident: (may cross more than one)</p> <p><input type="checkbox"/> ¹Major First Aid <input type="checkbox"/> ²Minor F.A.</p> <p><input type="checkbox"/> ³Major Rescue <input type="checkbox"/> ⁴Search and Res</p> <p><input type="checkbox"/> ⁵Member Injury <input type="checkbox"/> ⁶Employee Injury</p> <p><input type="checkbox"/> ⁷Minor Sting <input type="checkbox"/> ⁸Major Sting</p> <p><input type="checkbox"/> ⁹Drowning <input type="checkbox"/> ¹⁰Complaint</p> <p><input type="checkbox"/> ¹¹Other _____</p> <p>Victim is:</p> <p><input type="checkbox"/> ¹Public <input type="checkbox"/> ²SLS Club Member</p> <p><input type="checkbox"/> ³Employee <input type="checkbox"/> ⁴Other _____</p> <p>Nationality (victim)</p> <p><input type="checkbox"/> ¹Australian</p> <p><input type="checkbox"/> ²Other _____</p> <p><input type="checkbox"/> ^{2a}Tourist <input type="checkbox"/> ^{2b}Immigrant <input type="checkbox"/> ³Unknown</p> <p>Type of activity at time of incident:</p> <p><input type="checkbox"/> ¹Swimming/wading <input type="checkbox"/> ²Body board</p> <p><input type="checkbox"/> ³Walking playing near water</p> <p><input type="checkbox"/> ⁴Riding other craft</p> <p><input type="checkbox"/> ⁵Rock Fishing <input type="checkbox"/> ⁶Other fishing</p> <p><input type="checkbox"/> ⁷Using a motorised water craft (Rec)</p> <p><input type="checkbox"/> ⁸Water skiing</p> <p><input type="checkbox"/> ⁹SCUBA/skin diving</p> <p><input type="checkbox"/> ¹⁰Wind/kite surfing <input type="checkbox"/> ¹¹Sailing</p> <p><input type="checkbox"/> ¹²Rock walking</p> <p><input type="checkbox"/> ¹³Suspected suicide</p> <p><input type="checkbox"/> ¹⁴Patrolling in - <input type="checkbox"/> ¹⁵IRB, <input type="checkbox"/> ¹⁶PWC</p> <p><input type="checkbox"/> ¹⁷Beach, <input type="checkbox"/> ¹⁸4WD <input type="checkbox"/> ¹⁹JRB/ORB</p> <p><input type="checkbox"/> ²⁰Attempting a rescue</p> <p><input type="checkbox"/> ²¹Training for (please be very specific _____)</p> <p><input type="checkbox"/> ²²Carnival Official doing _____</p> <p><input type="checkbox"/> ²³Competition in _____</p> <p><input type="checkbox"/> ²⁴Driver <input type="checkbox"/> ²⁵Crew <input type="checkbox"/> ²⁶Patient</p> <p><input type="checkbox"/> ²⁷Surf Boat Crew Position: _____</p> <p><input type="checkbox"/> ²⁸Administrative <input type="checkbox"/> ²⁹Fundraising</p> <p><input type="checkbox"/> ³⁰Water safety <input type="checkbox"/> ³¹Junior activities</p> <p><input type="checkbox"/> ³²Other club activity _____</p> <p><input type="checkbox"/> ³³Other _____</p> <p>Experience in activity</p> <p><input type="checkbox"/> ¹3 years or greater <input type="checkbox"/> ²1-3 Years</p> <p><input type="checkbox"/> ³1 year or less <input type="checkbox"/> ⁴No experience</p> <p><input type="checkbox"/> ⁵Unknown</p> <p>Other contributing factors:</p> <p><input type="checkbox"/> ¹Negotiating the break</p> <p><input type="checkbox"/> ²Returning to shore</p> <p><input type="checkbox"/> ³Dumped <input type="checkbox"/> ⁴Shore break</p> <p><input type="checkbox"/> ⁵Lost control of own craft</p> <p><input type="checkbox"/> ⁶Other person lost control of craft</p> <p><input type="checkbox"/> ⁷Freak wave <input type="checkbox"/> ⁸Sand bank</p> <p><input type="checkbox"/> ⁹Pot hole <input type="checkbox"/> ¹⁰Slippery rocks</p> <p><input type="checkbox"/> ¹¹Suspected Alcohol <input type="checkbox"/> ¹²Suspect Drugs</p> <p><input type="checkbox"/> ¹³Rip type _____ <input type="checkbox"/> ¹⁴Shark/ Croc</p> <p><input type="checkbox"/> ¹⁵Slip/ trip/ fall <input type="checkbox"/> ¹⁶Assault</p> <p><input type="checkbox"/> ¹⁷Collision with _____</p> <p><input type="checkbox"/> ¹⁸Mechanical Malfunction _____</p> <p><input type="checkbox"/> ¹⁹Other _____</p>	<p>Description of incident and cause – (please use the reverse if needed) _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Nature of injury</p> <p><input type="checkbox"/> ¹Marine Sting, type _____</p> <p><input type="checkbox"/> ²Abrasion / graze <input type="checkbox"/> ³Blisters</p> <p><input type="checkbox"/> ⁴Open wound /laceration / cut</p> <p><input type="checkbox"/> ⁵Bruise / contusion</p> <p><input type="checkbox"/> ⁶Inflammation / swelling</p> <p><input type="checkbox"/> ⁷Fracture (including suspected)</p> <p><input type="checkbox"/> ⁸Dislocation/subluxation</p> <p><input type="checkbox"/> ⁹Sprain <input type="checkbox"/> ¹⁰Strain</p> <p><input type="checkbox"/> ¹¹Overuse injury <input type="checkbox"/> ¹²Concussion</p> <p><input type="checkbox"/> ¹³Cardiac problem</p> <p><input type="checkbox"/> ¹⁴Respiratory problem</p> <p><input type="checkbox"/> ¹⁵Asthma</p> <p><input type="checkbox"/> ¹⁶Loss of consciousness</p> <p><input type="checkbox"/> ¹⁷Heat stroke / Heat exhaustion</p> <p><input type="checkbox"/> ¹⁸Hypothermia <input type="checkbox"/> ¹⁹Sunburn</p> <p><input type="checkbox"/> ²⁰Suspected spinal</p> <p><input type="checkbox"/> ²¹Other _____</p> <p>Body region injured: (Please Circle)</p> <div style="text-align: center;"> </div> <p>Description _____</p> <p>Initial treatment:</p> <p><input type="checkbox"/> ¹None given – not required</p> <p><input type="checkbox"/> ²None given – patient refused</p> <p><input type="checkbox"/> ³None given – referred elsewhere</p> <p><input type="checkbox"/> ⁴RICE <input type="checkbox"/> ⁴ ICE</p> <p><input type="checkbox"/> ⁵Cleaned</p> <p><input type="checkbox"/> ⁶Dressed (incl. Bandage)</p> <p><input type="checkbox"/> ⁷Sling/ Splint</p> <p><input type="checkbox"/> ⁸Spinal collar</p> <p><input type="checkbox"/> ⁹Massage/ Stretching</p> <p><input type="checkbox"/> ¹⁰Strapping/Taping only</p> <p><input type="checkbox"/> ¹¹Stitches</p> <p><input type="checkbox"/> ¹²Medication</p> <p><input type="checkbox"/> ¹³Prescription written</p> <p>CPR/Defib/Oxygen (Fill in reverse of form)</p> <p><input type="checkbox"/> ¹⁴CPR <input type="checkbox"/> ¹⁵Oxygen therapy</p> <p><input type="checkbox"/> ¹⁶Oxygen airbag <input type="checkbox"/> ¹⁷Defibrillation</p> <p><input type="checkbox"/> ¹⁸Other _____</p>	<p>Location of incident?</p> <p><input type="checkbox"/> ¹In water <input type="checkbox"/> ²On Beach</p> <p><input type="checkbox"/> ³On rocks/cliff <input type="checkbox"/> ⁴Other _____</p> <p>and...</p> <p><input type="checkbox"/> ¹In flags</p> <p><input type="checkbox"/> ²Outside but near flags (within 50m)</p> <p><input type="checkbox"/> ³<1km from patrolled area</p> <p><input type="checkbox"/> ⁴1 to 5 km from patrolled area</p> <p><input type="checkbox"/> ⁵> 5 km from patrolled area</p> <p>Who first sighted the rescue/ incident? e.g. public _____</p> <p>Who conducted the rescue/ incident? e.g. lifesaver _____</p> <p>Main language spoken: _____ Or <input type="checkbox"/> English</p> <p><input type="checkbox"/> Non English speaking <input type="checkbox"/> Don't know</p> <p>Referral:</p> <p><input type="checkbox"/> ¹No referral</p> <p><input type="checkbox"/> ²Medical Practitioner</p> <p><input type="checkbox"/> ³Physiotherapist</p> <p><input type="checkbox"/> ⁴Ambulance transport to _____</p> <p><input type="checkbox"/> ⁵Hospital <input type="checkbox"/> ⁶Xray</p> <p><input type="checkbox"/> ⁷Peer Counselling</p> <p><input type="checkbox"/> ⁸Professional Counselling</p> <p>Other services:</p> <p><input type="checkbox"/> ¹Fire/ Rescue <input type="checkbox"/> ²Police</p> <p><input type="checkbox"/> ³JRB/ ORB <input type="checkbox"/> ⁴Helicopter</p> <p><input type="checkbox"/> ⁵Investigation required</p> <p><input type="checkbox"/> ⁶Worker Compensation required (fill in State form requirements)</p> <p><input type="checkbox"/> ⁷Other _____</p> <p>Treating person:</p> <p><input type="checkbox"/> ¹Medical Practitioner <input type="checkbox"/> ²Nurse</p> <p><input type="checkbox"/> ³Ambulance <input type="checkbox"/> ⁴Physiotherapist</p> <p><input type="checkbox"/> ⁵Chiropractor <input type="checkbox"/> ⁶First Aid Officer</p> <p><input type="checkbox"/> ⁷Lifesaving <input type="checkbox"/> ⁸Lifeguard</p> <p><input type="checkbox"/> ⁹Other _____</p> <p>What condition was the patient in when transport?</p> <p><input type="checkbox"/> ¹Conscious <input type="checkbox"/> ²Unconscious</p> <p><input type="checkbox"/> ³Deceased</p> <p><input type="checkbox"/> ⁴Unknown</p> <p>Person completing from: Name: _____</p> <p>Position: _____</p> <p>Phone: _____</p> <p>Email: _____</p> <p>Signature: _____</p>
--	---	--

PART B: CPR / OXYGEN REPORT FORM

<p>1. Patients condition when first observed:</p> <p><input type="checkbox"/> ¹Conscious <input type="checkbox"/> ²Unconscious <input type="checkbox"/> ³Breathing <input type="checkbox"/> ⁴Not Breathing <input type="checkbox"/> ⁵No Signs of Life</p> <p>2. Colour of patient when first observed:</p> <p><input type="checkbox"/> ¹Normal <input type="checkbox"/> ²Pale <input type="checkbox"/> ³Blue <input type="checkbox"/> ⁴Grey <input type="checkbox"/> ⁵Unknown</p> <p>3. Patients colour changed during resuscitation</p> <p><input type="checkbox"/> ¹Normal <input type="checkbox"/> ²Pale <input type="checkbox"/> ³Blue <input type="checkbox"/> ⁴Grey <input type="checkbox"/> ⁵Unknown</p> <p>4. Airway of the patient was obstructed when first observed by:</p> <p><input type="checkbox"/> ¹Vomit <input type="checkbox"/> ²Seaweed <input type="checkbox"/> ³Dentures <input type="checkbox"/> ⁴Clenched jaw <input type="checkbox"/> ⁵Airway was clear <input type="checkbox"/> ⁶Unknown</p> <p>5. How long was it, from when the incident was first reported to the time of the first artificial breaths:</p> <p><input type="checkbox"/> ¹0-1 min <input type="checkbox"/> ²1-3 min <input type="checkbox"/> ³3-5 min <input type="checkbox"/> ⁴5-10 min <input type="checkbox"/> ⁵10-20 min <input type="checkbox"/> ⁶Other</p> <p>6. How long was CPR carried out for:</p> <p><input type="checkbox"/> ¹0-1 min <input type="checkbox"/> ²1-3 min <input type="checkbox"/> ³3-5 min <input type="checkbox"/> ⁴5-10 min <input type="checkbox"/> ⁵10-20 min <input type="checkbox"/> ⁶Other</p> <p>7. Which method was used for Rescue Breaths?</p> <p><input type="checkbox"/> ¹Mouth to Mask <input type="checkbox"/> ²Mouth to Mouth <input type="checkbox"/> ³Mouth to Nose <input type="checkbox"/> ⁴Bag valve mask</p> <p>8. What oxygen equipment was used:</p> <p><input type="checkbox"/> ¹Oxygen Therapy <input type="checkbox"/> ²Air Bag Resuscitator</p>	<p>9. How long was oxygen administered for:</p> <p><input type="checkbox"/> ¹0-1 min <input type="checkbox"/> ²1-3 min <input type="checkbox"/> ³3-5 min <input type="checkbox"/> ⁴5-10 min <input type="checkbox"/> ⁵10-20 min <input type="checkbox"/> ⁶Other</p> <p>10. The patient regurgitated / vomited due to:</p> <p><input type="checkbox"/> ¹Mechanical Device <input type="checkbox"/> ²Blocked Airway <input type="checkbox"/> ³Revival</p> <p>11. An Airway was Inserted: (type)</p> <p><input type="checkbox"/> ¹OP Airway <input type="checkbox"/> ²Combitube <input type="checkbox"/> ³LMA Mask <input type="checkbox"/> ⁴Other</p> <p>12. How long was it, from when the incident was first reported to the time an airway was inserted?</p> <p><input type="checkbox"/> ¹0-1 min <input type="checkbox"/> ²1-3 min <input type="checkbox"/> ³3-5 min <input type="checkbox"/> ⁴5-10 min <input type="checkbox"/> ⁵10-20 min <input type="checkbox"/> ⁶Other</p> <p>13. A defibrillator was used by:</p> <p><input type="checkbox"/> ¹Lifesaver <input type="checkbox"/> ²Lifeguard <input type="checkbox"/> ³Ambulance <input type="checkbox"/> ⁴Doctor</p> <p>14. How long was it, from the incident was first reported to the time the defibrillator was applied?</p> <p><input type="checkbox"/> ¹0-1 min <input type="checkbox"/> ²1-3 min <input type="checkbox"/> ³3-5 min <input type="checkbox"/> ⁴5-10 min <input type="checkbox"/> ⁵10-20 min <input type="checkbox"/> ⁶Other</p> <p>15. How many times was a shock delivered?</p> <p><input type="checkbox"/> ¹1 <input type="checkbox"/> ²2 <input type="checkbox"/> ³3 <input type="checkbox"/> ⁴4 <input type="checkbox"/> ⁵5 <input type="checkbox"/> ⁶Other</p> <p>16. Did the patient regain consciousness?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>17. How long was it, after calling for assistance, that the ambulance arrived?</p> <p><input type="checkbox"/> ¹0-1 min <input type="checkbox"/> ²1-3 min <input type="checkbox"/> ³3-5 min <input type="checkbox"/> ⁴5-10min <input type="checkbox"/> ⁵10-20 min <input type="checkbox"/> ⁶Other</p> <p>18. The patient conveyed to hospital by?</p> <p><input type="checkbox"/> ¹Ambulance <input type="checkbox"/> ²Helicopter <input type="checkbox"/> ³Private vehicle <input type="checkbox"/> ⁴Other</p> <p>19. Which hospital was the patient conveyed to?</p> <p>_____</p> <p>20. What condition was the patient in when transport?</p> <p><input type="checkbox"/> ¹Conscious <input type="checkbox"/> ²Unconscious <input type="checkbox"/> ³Deceased <input type="checkbox"/> ⁴Unknown</p> <p>21. Condition on discharge from hospital (if known)</p> <p><input type="checkbox"/> ¹Full recovery <input type="checkbox"/> ²Deceased <input type="checkbox"/> ³Unknown</p> <p>22. Trauma counselling was arranged for the rescuer/s</p> <p><input type="checkbox"/> ¹Yes <input type="checkbox"/> ²No</p> <p>24. Was a carry used:</p> <p><input type="checkbox"/> ¹Yes <input type="checkbox"/> ²No</p> <p>If yes, what kind? _____</p> <p>Name of person completing form: (If different from other side of form)</p> <p>_____</p> <p>Position: _____</p> <p>Phone: _____</p> <p>e-mail: _____</p> <p>Signature: _____</p>
--	---	--

Please provide brief details of the incident including any recommendations: