

# PATIENT HANDOVER FORM



Location of Incident: \_\_\_\_\_  
 Time:            AM / PM            Date:    /    /

Age/DOB: \_\_\_\_\_            Gender: Male / Female  
 Patient's Name: \_\_\_\_\_  
 Patient's Address: \_\_\_\_\_

Vital Signs	Initial Assessment Time ____ AM / PM	Second Assessment Time ____ AM / PM
Consciousness		
Breathing Rate		
Skin Colour		
Bleeding		
Pulse Rate		

**Mechanism of Injury:** (What body part sustained injury and how did the incident occur?) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medical History:** (Tick and specify)  
 Existing Conditions/Allergies: \_\_\_\_\_  
 Medications: \_\_\_\_\_

**Treatment Administered:** (Including approx timing, equipment used)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Treating Person Name:** \_\_\_\_\_  
**Treating Person Phone:** \_\_\_\_\_  
**Club / Service:** \_\_\_\_\_

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