



# SAMPLE PATIENT CARE REPORT

## Basic Life Support PRACTICAL EXAMINATION

Call Location \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Years/Months Sex \_\_\_\_\_ Race \_\_\_\_\_

Time	LOC	Pulse	Respirations	BP	Perfusion	Pupils	GCS Score
	<input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresp	Rate:  <input type="checkbox"/> Not Obtained <input type="checkbox"/> Unable to	Rate: <input type="checkbox"/> Normal  <input type="checkbox"/> Labored <input type="checkbox"/> Increased not OR <input type="checkbox"/> Increased/Labored  <input type="checkbox"/> Decreased/Fatigued  <input type="checkbox"/> Not Obtained <input type="checkbox"/> Absent <input type="checkbox"/> Unable to	 <input type="checkbox"/> Palpated  <input type="checkbox"/> Not Obtained <input type="checkbox"/> Unable to	<input type="checkbox"/> Normal  <input type="checkbox"/> Decreased  <input type="checkbox"/> Not Obtained <input type="checkbox"/> Not Obtained <input type="checkbox"/> UNREACT	<input type="checkbox"/> PERL <input type="checkbox"/> R > L <input type="checkbox"/> L > R <input type="checkbox"/> DIL <input type="checkbox"/> CON <input type="checkbox"/> UNREACT	EYE: VERBAL MOTOR TOTAL
	<input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresp	Rate:  <input type="checkbox"/> Not Obtained <input type="checkbox"/> Unable to	Rate: <input type="checkbox"/> Normal  <input type="checkbox"/> Labored <input type="checkbox"/> Increased not OR <input type="checkbox"/> Increased/Labored  <input type="checkbox"/> Decreased/Fatigued  <input type="checkbox"/> Not Obtained <input type="checkbox"/> Absent <input type="checkbox"/> Unable to	 <input type="checkbox"/> Palpated  <input type="checkbox"/> Not Obtained <input type="checkbox"/> Unable to	<input type="checkbox"/> Normal  <input type="checkbox"/> Decreased  <input type="checkbox"/> Not Obtained <input type="checkbox"/> Not Obtained <input type="checkbox"/> UNREACT	<input type="checkbox"/> PERL <input type="checkbox"/> R > L <input type="checkbox"/> L > R <input type="checkbox"/> DIL <input type="checkbox"/> CON <input type="checkbox"/> UNREACT	EYE: VERBAL MOTOR TOTAL

Assessment Findings \_\_\_\_\_

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Treatment Performed \_\_\_\_\_

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Lead Name \_\_\_\_\_ Assist Name \_\_\_\_\_

**ALL INFORMATION MUST BE LEGIBLE TO BE COUNTED**

