MOTORSPORT SOUTH AFRICA NPC

Reg. No 1995/005605/08

PATIENT REPORT FORM - PRIORITY 1 & 2 PATIENTS *for 2021*

This form is to be completed for all Competitors, related team members and Officials seen at MSA events.
The completed forms must be submitted to MSA along with the completed MSA Accident Report Form

Event **Name:**	Medical **Service Provider**:
Event **Venue:**	CMO / CMC **Name**:
Event **Date:**	CMO / CMC **HPCSA No**: **MSA Lic:**
Event **Category:** **INTL / NATIONAL / REGIONAL / CLUB**	CMO / CMC **Contact No**:

Patient Information

First Name:	**Surname**:	**DOB**:	**Age**:	Female	Male
ID Number:	**Contact Number:**				

Type: Competitor ☐ Team member ☐ Official ☐ Other ☐

Competitor details: MSA Licence # ☐ Start number ☐ Category ☐

Next of Kin:	**Contact details:**

Accident Information

Place of accident: Paddock ☐ Pit lane ☐ Turn # ☐ Stage # ☐

Date / time of accident: Date ☐ Time ☐

Description of accident (as reported by the injured person):

Primary care at site of accident:

Doctor:	
ALS:	
ILS:	
BLS:	

No primary care		Drugs / Other:
Oxygen		
Intubation		
IV-line		
Immobilisation		

At Medical Centre / secondary place of treatment:

Time of arrival:
Doctor:
ALS:

Transportation:

Self		Ambulance	
Medical car		Helicopter	

Patient Assessment

Level of consciousness:
Airway:
Breathing:
Circulation:
Disability:

Vital Signs:

BP systolic:		GCS initial:	
BP diastolic:		Sat O^2:	
HR:		HGT:	
RR:			

Apparent Injuries

A = skin abrasion / **W** = wound / **C** = contusion / **H** = haematoma / **S** = sprain / **F** = fracture / **D** = dislocation

Upper limb	right	left	**Lower limb**	right	left	**Spine**		**Other region**	
Clavicle			Pelvis			Cervical		Abdomen	
Shoulder			Hip			Thoracic spine		Chest/ribs	
Humerus			Femur			Lumbar spine		Head	
Upper arm			Thigh			Sacrum		Face	
Elbow			Knee			Coccyx		Eye	
Ulna			Calf			**Other:**			
Radius			Tibia						
Forearm			Fibula						
Wrist			Lower leg						
Thumb			Ankle						
Scaphoid			Foot						
Hand/digits			Digits						

PATIENTS NAME:

Secondary Survey Notes

Differential Diagnosis

1.		4.	
2.		5.	
3.		6.	

Treatment

Jaw thrust		Suction		OP Tube		ET tube size		cm at teeth
Oxygen mask	%	Flow rate	Lpm	BVM ventilation		Ventilator		
IV line	gg	Site				IV fluid & rate		

Medications:

Time:	Medication administered:	Dosage, route & rate:

Treatment notes:

Discharge / Transfer

Time of discharge / transfer:

Discharged: No follow-ups required ☐ Return on *date/time*

Self-discharged against medical advice ☐

Transfer to Hospital: Self ☐ Ambulance ☐ Helicopter ☐

Medical Expense Coverage: MSA Insurance ☐ Medical Aid ☐ Private ☐

Name of hospital: Attending Doctor:

Final Assessment & Follow Up

I = inpatient treatment / **O** = outpatient treatment / **U** = treatment unknown / **N** = no treatment / **F** = death

Assessment ☐ Fit to Race? **YES** **NO** (Circle One) If unfit, reported to CoC (time)

Completed by

Name: Address:

HPCSA registration #:

NOTE: Please attach additional notes if areas above are insufficient

Date and signature of CMO / CMC