

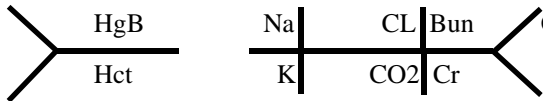
Commonwealth of Dominica



Office of the Maritime Administrator

***INJURY AND ILLNESS MEDICAL RECORD
(CONFIDENTIAL)***

1. Vessel: _____		2. Voyage #: _____		3. Cabin/Crew #: _____	
4. Status: <input type="checkbox"/> PAX <input type="checkbox"/> Crew <input type="checkbox"/> Other (Describe): _____					
5. Name (FIRST, LAST, MIDDLE): _____					
6. Address (CITY, STATE, ZIP CODE): _____					
7. Nationality: _____					
8. Birth Date: _____			11. Date: _____		
9. Social Security #: _____			12. Time: _____		
10. Home Phone #: _____					
HISTORY PRESENT ILLNESS/INJURY			VITAL SIGNS		
Age: _____			BP (Sys./Dia.): _____		
Gender: _____			Pulse (BPM): _____		
CC: _____			Temperature (F or C): _____		
Medications: _____					
Allergies: _____					
Past History: _____					
LMP: _____			Tetanus: _____		
Medical Tests:		<input type="checkbox"/> Urine/Dipstick		Medical Treatment:	
<input type="checkbox"/> CBC	<input type="checkbox"/> Platelets	<input type="checkbox"/> Amylase/Lipase	<input type="checkbox"/> Liver Profile	<input type="checkbox"/> dT 0.5cc IM	<input type="checkbox"/> Hypertet 250 UI IM
<input type="checkbox"/> Electrolytes	<input type="checkbox"/> Bun	<input type="checkbox"/> KUB	<input type="checkbox"/> Flat/Erect Abdomen	<input type="checkbox"/> IV Type / Rate:	<input type="checkbox"/> O2
<input type="checkbox"/> Creatine	<input type="checkbox"/> Glucose	<input type="checkbox"/> CXR	<input type="checkbox"/> ABGFiO2: _____ %	<input type="checkbox"/> Monitor / Tele	<input type="checkbox"/> Pulse Oximetry
<input type="checkbox"/> CPK and CPK-MB	<input type="checkbox"/> Troponin	<input type="checkbox"/> EKG	<input type="checkbox"/> BHCG	<input type="checkbox"/> Inhaler Treatment	<input type="checkbox"/> _____
<input type="checkbox"/> PT/PTT	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
PHYSICAL EXAM					
BP: _____	P: _____	RR: _____	Temp: _____	Pulse Oxy: _____	

GENERAL: Well developed, nourished, in _____distress <input type="checkbox"/> YES <input type="checkbox"/> NO					
HEENT:		<input type="checkbox"/> Head atraumatic	<input type="checkbox"/> TM's Clear	<input type="checkbox"/> Nystagmus	<input type="checkbox"/> Anicteric
		<input type="checkbox"/> Sharp Discs	<input type="checkbox"/> Throat Clear	<input type="checkbox"/> PERRL EOM's intake	
Mucosa:		<input type="checkbox"/> Moist	<input type="checkbox"/> Dry	<input type="checkbox"/> Pink	<input type="checkbox"/> Pale
NECK:		<input type="checkbox"/> Supple	<input type="checkbox"/> Kernigs	<input type="checkbox"/> Brudzinski	<input type="checkbox"/> JVD
					<input type="checkbox"/> Stridor
CHEST:		<input type="checkbox"/> Clear Breath Sounds		<input type="checkbox"/> Normal Expansion	<input type="checkbox"/> No Wheezing Rale
CV:		<input type="checkbox"/> PMII 4 th ICS MCL		<input type="checkbox"/> No Gallops, murmurs	<input type="checkbox"/> Regular Rhythm
ABD:		<input type="checkbox"/> Non-distended	<input type="checkbox"/> Bowel Sounds: _____	<input type="checkbox"/> Soft	<input type="checkbox"/> Rovsing
		<input type="checkbox"/> Rebound	<input type="checkbox"/> Organomegaly: _____	<input type="checkbox"/> Guarding	<input type="checkbox"/> Tenderness: _____
GU/GYN:		Plank pain: <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> None		Hernias: <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> None	
		Normal Genitalia. Testes Descended/Tender		Hemmoct Stool: <input type="checkbox"/> Pos <input type="checkbox"/> Neg Color: _____	
EXT:		<input type="checkbox"/> Cyanosis	<input type="checkbox"/> Clubbing	<input type="checkbox"/> Edema	<input type="checkbox"/> Deformities
NEURO:		<input type="checkbox"/> Alert	<input type="checkbox"/> Attentive	<input type="checkbox"/> Cooperative	<input type="checkbox"/> DTS's symmetric
Goal-oriented conversation		Clear Speech	Coordinates Well	Moves face and four extremities symmetrically	
SKIN:		<input type="checkbox"/> Good turgor	<input type="checkbox"/> No rashes	<input type="checkbox"/> Diaphoretic	<input type="checkbox"/> Warm <input type="checkbox"/> Dry
LAB RESULTS:					
		pH _____ O2 _____ CO2 _____ FiO2 _____%		Interpretation: Amy/Lapse CK/MB/Troponin Other:	
ACCUCHECK:		PULSE OXYMETRY:		U/A	
EKG:		Rhythm: _____	Rate: _____	Impression: _____	
X-RAY:					
TELEMEDICAL ADVICE RECEIVED:					
FINAL DIAGNOSIS:					
MAY RETURN TO DUTY:					
INSTRUCTIONS/REFERRAL:					
<input type="checkbox"/> Return ASAP if worsening in your condition.					
PHYSICIAN SIGNATURE: _____				DATE: _____	
PATIENT SIGNATURE: _____				DATE: _____	