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APPENDIX C

Nr	Date	Time	M/F	Age	Brouht in by
1	2006/01/01	07h30	M	20	Family

AMPLE History

Nr	Allergies	Medications	Past m	Last meal	Event ti	T/M	Event	Amb record
1	Unkown	Depress tabs	None	Unknown	06h40	Trauma	MVA	None

Vital signs

Nr	Time	RR	Pulse	B/P	Temp	Sats	AVPU	Glucos	Urine	Peakflow
1	07h40	12	110	159/83	36	96	A	7.8		

Examination

Nr	Time	Doctor	Genera	CVS	Resp	Abd	GCS	Pupils	ENT	Spine	Limbs	Other
1	07h40	i	Normal	Normal	Normal	Normal	15	Normal		Normal	Tender R leg	Abrasions

Nr	ECG	Results	ABG	Time	pH	CO2	O2	Lact	Hct	HCO3	BE	Sats	Bloods	Results	Xrays	Results	Scan	Results
1	Yes	Sinus tachy	Yes	07h50	7.4	35	83	1.2	35	11	2.5	98	FBC	Hb 10	CXR, neck, pelvis, R t	Femur #	No	

Nr	O2	IV Infusion	Oral	IMI	IVI	Rectal	Inhalatic	POP	Suture	Stomach	Woundcare	Reduction	Other
1	R/B mask	Ringers			Morpine 2 mg 07h50, 4 mg 08h00								

Nr	Catheter	NGT	ET Tub	Reason	Splints	CVP	Art line	Ventilat	Rate	Tidal	PEEP	O2	Airway	Mode
1	Yes	No	No		Trac 3	No	No							

Nr	Diagnosis	Dead	RGL	Mortuary	Admit, ti	Ward	High Ca	ICU	Other	Specialist	Conf letter	Seen again
1	Femur # right				Yes, Unkown			F2		Orthopod	No	No