Accident No.

DIVING ACCIDENT CONSULTATION, EXAMINATION AND TREATMENT RECORD

DATE OF CALL		Time	:	PHONE	( )
NAME OF CALLER					
LOCATION OF PATIENT					

PATIENT NAME		
OCCUPATION		
SEX M F	DATE OF BIRTH	
DIVE STATUS (Qualification)	Professional	Part I/Part II/Part III/Part IV/Other
	Amateur	Novice/Sport Diver/Dive Leader/Advanced Diver/1st Class Diver/Instructor (BSAC)
Employer/Club		

DETAILS OF DIVES WITHIN LAST 72 HOURS

Date (D/M/Y)	Start Dive (Time)	Max. Depth (m)	Dive Duration (min)	Dive Profile (Mark)					Decompression Stops **D**epth (m), **T**ime (min)										Surface Interval (Hours:Minutes)
								?	D	T	D	T	D	T	D	T	D	T	

Comments about the dive(s):

TABLE USED	BSAC88 / BSAC / RNPL / RN11 / USN /SAA /NONE / OTHER (NAME)	COMPUTER USED	AladinPro / Monitor2 / Suunto / Skinny Dipper / None / OTHER (NAME)
DECOMPRESSION BY	Table Computer Instinct	LOCATION OF DIVE(S)	

HISTORY

HISTORY of the PRINCIPAL MANIFESTATIONS.

Circle the appropriate symptom(s) and note the TIME (24hr clock) and where necessary, the DATE of ONSET
Where there is no history of a manifestation or symptom, circle NONE

PAIN NONE Time and Date of ONSET

GIRDLE

JOINT PAIN

Shoulder	R	L
Elbow	R	L
Wrist	R	L
Hip	R	L
Knee	R	L
Ankle	R	L

Other (specify)

SKIN NONE Time and Date of ONSET

Itching

Redness

Marbling

Other (specify)

LYMPHATIC NONE

Lymph Node Enlarged/Painful

Swelling

NEUROLOGICAL NONE Time and Date of ONSET

Level of Consciousness

Higher Function — Aberration of thought / Loss of memory / Personality change / Dysphasia / Seizure

Special Senses — Hearing loss / Vertigo / Tinnitus / Nystagmus / Visual impairment

Strength

Sensation — Numbness / Paraesthesiae

Sphincter Function — Bladder / Bowel

PULMONARY NONE Time and Date of ONSET

Cough / SOB / Chest Pain / Haemoptysis / Cyanosis / Subcutaneous Emphysema / Voice Change / Pneumothorax

CONSTITUTIONAL NONE Time and Date of ONSET

Anorexia / Excessive Fatigue / Malaise / Headache / Vomiting

HISTORY

NARRATIVE

EVOLUTION: From the history above, summarise the significant changes in each principal manifestation PRIOR TO RECOMPRESSION. These changes may be expressed as: unchanged in intensity (STATIC); getting worse (PROGRESSIVE); SPONTANEOUSLY IMPROVING, getting worse again after a period of substantial improvement (RELAPSING); or it may have disappeared completely (RESOLVED). If no time interval is specified, it will be assumed that the evolution term used applies to the entire period prior to recompression.

Note the TIME INTERVAL (including dates where necessary) of any change.

MANIFESTATION	Time Interval	Evolution	Time Interval	Evolution	Time Interval	Evolution
Example: SKIN	*19 Aug 2000-2200*	*PR*	*19 Aug 2200-2359*	*ST*	*20 Aug 0001-0200*	*SI*

RELEVANT PAST MEDICAL HISTORY

State details of any recent medical condition

For Telephone Consultations Only

Diagnosis:

Referred to: Chamber / GP / Hospital
Details:

If reassured, advice given:

EXAMINATION

Patient examined by

GENERAL SYSTEMS EXAMINATION

ENT

Cardiovascular System

Pulmonary System

GI system

Skin

Lymphatic System

NEUROLOGICAL ASSESSMENT

Mental Status - Orientation in time / space / memory / mood / cognitive function
(If abnormal use Mini Mental State Examination shown at Appendix D of INM R97066)

Glasgow Coma Scale Score -		6	5	4	3	2	1
Total	**Best Motor Response**	Carries out request	Localises to pain	Withdraws to pain	Flexor response to pain	Extensor response to pain	No response to pain
	Best Verbal Response		Orientated	Confused	Inappropriate speech	Incomprehensible speech	None
	Eye opening			Spontaneous	In response to speech	In response to pain	None

COORDINATION

Gait	Finger/nose
Heel-to-toe Walk	Rapid movement
Heel shin slide	Romberg

REFLEXES (Normal, Brisk, Sluggish, Absent)

Biceps	R	L	Knee	R	L
Triceps	R	L	Ankle	R	L
Supinator	R	L	Plantar	R	L
Abdominal	R	L	Cremaster	R	L

CRANIAL NERVES

II	Vision / Visual Fields	**VIII**	Hearing
III,IV,VI	Pupils / Eye Movements / Nystagmus	**IX**	Mouth /Throat Sensation
V	Facial Sensation	**X**	Gag / Palate Movement
	Corneal Reflex	**XI**	Shoulder/Neck
VII	Facial Expression	**XII**	Tongue

POWER

JOINT	R/L	MOVEMENTS (see key)	POWER (see scale) Record Tone as appropriate
Shoulder			
Elbow			
Wrist			
Fingers			
Hip			
Knee			
Ankle			
Toes			

MOVEMENT KEY

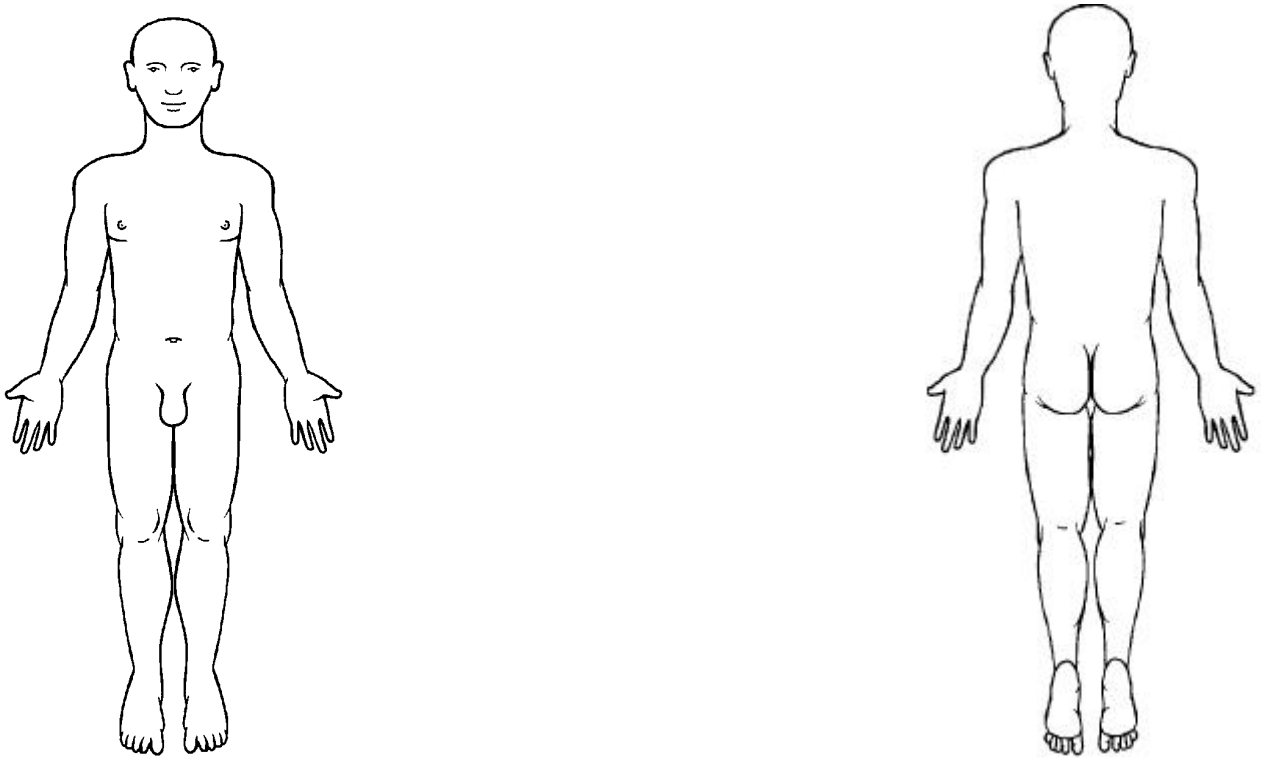
FLexion
EXtension
ABduction
ADduction
ROtation

POWER SCALE

0 No movement possible
1 A flicker of movement
2 Muscle contracts but can't overcome gravity
3 Can overcome gravity but not the examiner
4 Slight weakness
5 Normal

EXAMINATION

Use the diagram to record location of sensory abnormalities – light touch, pin-prick, temperature sensation, vibration, proprioception etc.



ADDITIONAL EXAMINATION NOTES

DIAGNOSIS(ES)

TREATMENT

TREATMENT PRIOR TO RECOMPRESSION

Fluids: None | IV | Oral — Volume: ml — Type:

Oxygen: None — Duration: min — Inspired pO_2: % — Flow: l/min

Means of Delivery: Oronasal Mask / Nasal Cannulae /Demand System / ET Tube / Other

Drugs: Name, Dose, Route:

Transport to Chamber: Air | Road | Sea — Date/Time of Arrival at Chamber:

Chamber Used:

RECOMPRESSION (Record ALL Recompression Treatments for this incident)

Date	Start Time	Table Description / Profile	Outcome
		RN62 / RN61 / Other (Specify) Extensions 18m x0 x1 x2 Max Depth Duration 9m x0 x1 x2	Recovered / Improved / Unchanged / Worse / Dead
		RN62 / RN61 / Other (Specify) Extensions 18m x0 x1 x2 Max Depth Duration 9m x0 x1 x2	Recovered / Improved / Unchanged / Worse / Dead
		RN62 / RN61 / Other (Specify) Extensions 18m x0 x1 x2 Max Depth Duration 9m x0 x1 x2	Recovered / Improved / Unchanged / Worse / Dead
			Recovered / Improved / Unchanged / Worse / Dead
			Recovered / Improved / Unchanged / Worse / Dead
			Recovered / Improved / Unchanged / Worse / Dead
			Recovered / Improved / Unchanged / Worse / Dead

FLUID BALANCE

Fluid Given	Route	Date/ Time	Volume (ml)	Running Total	Fluid Out	Date / Time	Volume (ml)	Running Total
TOTAL IN					TOTAL OUT			

MEDICATION

Drug Name	Dose	Route	Date/Time	Signed

TREATMENT

TREATMENT NARRATIVE

Include time to relief of symptoms / signs and whether complete or partial; any problems during treatment, including details of any transfer to alternative tables; the patient's condition at the end of the initial treatment and progress during anyretreatment.

SUMMARY

INVESTIGATIONS

This space is to be used for reporting the results of any investigations

PATIENT DISCHARGED TO

HOME/HOSPITAL/OTHER

PATIENT'S HOME ADDRESS

POST CODE PHONE

PATIENT'S GENERAL PRACTITIONER

NAME Unknown

ADDRESS

POST CODE

LETTER SENT TO GP: NO YES DATE SENT:

FINAL DIAGNOSIS(ES)

NAME OF DOCTOR	SIGNATURE	DATE

REVIEW

This space should be used for reporting the patient's condition at subsequent review.