



SURF LIFE SAVING AUSTRALIA INCIDENT REPORT LOG

Form no: 161/07

Name of Club / Service: _____

State: _____

Date: ____/____/____ Time: _____ am / pm
 Location (beach/suburb): _____
 Name of Victim: _____
 Age: _____ DOB: ____/____/____ M / F
 Address if known: _____

Conditions at time of incident (if relevant):

Wind: Calm Slight Moderate
 Weather: Fine Overcast Rain
 Seas: Small Medium Large
 Water Surface: No Chop Avg Chop Large Chop
 Wave Type: Surging Spilling Plunging

Type of incident:
 (may choose more than one)

Major First Aid Minor First Aid
 Major Rescue Search & Rec.
 Member Injury Employee Injury
 Carnival Incident Complaint
 Drowning Near Drowning
 Other _____

Patient is:

Public SLSC Member
 Employee Other _____

Type of activity at time of incident:

Swimming/wading Body boarding
 Walking/playing near water
 Riding other craft
 Rock fishing Other fishing
 Using a motorised water craft (rec)
 Water skiing
 SCUBA/skin diving
 Wind/kite surfing Sailing
 Rock walking Suspect suicide
 Patrolling: IRB PWC
 Beach 4WD JRB/ORB
 Attempting a rescue
 Training for (please be very specific) _____

Carnival official doing _____
 Competition in _____

IRB Competition: Driver Patient
 Crew Patient
 Surf boat crew position: _____
 Administrative Fundraising
 Water safety Junior activities
 Other club activity _____
 Other _____
 Unknown

Experience in activity:

3 years + 1-3 years
 1 year No experience

Other contributing factors:

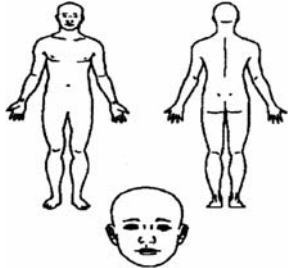
Negotiating the break
 Returning to shore
 Dumped Shore break
 Lost control of own craft
 Other person lost control of craft
 Freak wave Sand bank
 Pot hole Slippery rocks
 Suspected alcohol Suspect drugs
 Rip type _____
 Slip / trip / fall Assault
 Collision with _____
 Mechanical malfunction
 Other _____
 Unknown

Description of incident:
 (please use back if needed)

Nature of injury:

Marine sting, type _____
 Abrasion / graze Blisters
 Open wound / laceration / cut
 Bruise / contusion
 Inflammation / swelling
 Fracture (including suspected)
 Dislocation / subluxation
 Sprain Sprain
 Overuse injury Concussion
 Cardiac problem
 Respiratory problem
 Loss of consciousness
 Heat stroke / Heat exhaustion
 Hypothermia Sunburn
 Suspected spinal Deceased
 Other _____
 Unknown

Body region injured (please circle):



Initial treatment:

None given – not required
 None given – patient refused
 None given – referred elsewhere
 RICE ICE
 Cleaned
 Dressed (incl. bandage)
 Sling / splint
 Spinal collar
 Massage / stretching
 Strapping / taping only
 Stitches
 Medication
 Prescription written

Resuscitation
 (please fill in other side of form)

Rescue breathing CPR
 Oxygen therapy Oxygen airbag
 Defibrillation (defib)
 Other _____

Mechanism of incident:
 (what went wrong?)

Location of incident:

In water On beach
 On rocks Other _____

and...

In flags
 Outside but near flags
 < 1km from patrolled area
 1 - 5km from patrolled area
 > 5km from patrolled area

Who first sighted the rescue/incident:
 (e.g. public) _____

Who conducted the rescue/incident:
 (e.g. lifesaver) _____

Main language spoken:
 _____ Or English
 Non-English Speaking Unknown

Referral:

No referral Medical practitioner
 Physiotherapist
 Ambulance transport to _____
 Hospital X-ray
 Peer counselling Pro. counselling

Other services:

Fire/Rescue Police
 JRB / ORB Helicopter
 Investigation required
 Worker Compensation required
 Other _____

Treating person:

Medical practitioner Nurse
 Ambulance Physio
 Chiropractor First Aid Off.
 Lifesaving Lifeguard
 Other _____

Person completing form:

Name: _____
 Position: _____
 Phone: _____
 Email: _____
 Signature: _____

Enter this form into the Incident Reporting Database



INCIDENT REPORT LOG

PART B: Resuscitation Report

<p>1) Patient's condition when first observed:</p> <input type="checkbox"/> Conscious <input type="checkbox"/> Unconscious <input type="checkbox"/> Not Breathing <input type="checkbox"/> Pulse Absent <p>2) Colour of patient when first observed:</p> <input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Blue <input type="checkbox"/> Grey <input type="checkbox"/> Unknown <p>3) Patient's colour changed during resuscitation:</p> <input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Blue <input type="checkbox"/> Grey <input type="checkbox"/> Unknown <p>4) Airway of the patient was obstructed when first observed by:</p> <input type="checkbox"/> Vomit <input type="checkbox"/> Seaweed <input type="checkbox"/> Dentures <input type="checkbox"/> Clenched jaw <input type="checkbox"/> Airway was clear <input type="checkbox"/> Unknown <p>5) How long was it, from when the incident was first reported to the time of the first artificial breaths?</p> <input type="checkbox"/> 0-1 min <input type="checkbox"/> 1-3 min <input type="checkbox"/> 3-5 min <input type="checkbox"/> 5-10 min <input type="checkbox"/> 10-20 min <input type="checkbox"/> Other <p>6) Which method was used?</p> <input type="checkbox"/> Mouth to mask <input type="checkbox"/> Mouth to mouth <input type="checkbox"/> Mouth to nose <input type="checkbox"/> Bag valve mask <input type="checkbox"/> Combination <p>7) What oxygen equipment was used:</p> <input type="checkbox"/> Oxygen therapy <input type="checkbox"/> Air bag resuscitator <input type="checkbox"/> Both <input type="checkbox"/> None <p>8) How long was oxygen administered for?</p> <input type="checkbox"/> 0-1 min <input type="checkbox"/> 1-3 min <input type="checkbox"/> 3-5 min <input type="checkbox"/> 5-10 min <input type="checkbox"/> 10-20 min <input type="checkbox"/> Other	<p>9) The patient regurgitated / vomited due to:</p> <input type="checkbox"/> Mechanical device <input type="checkbox"/> Blocked airway <input type="checkbox"/> Revival <input type="checkbox"/> Did not vomit <p>10) Which airway was inserted: (type)</p> <input type="checkbox"/> OP Airway <input type="checkbox"/> Combitube <input type="checkbox"/> LMA mask <input type="checkbox"/> Other <input type="checkbox"/> None <p>11) How long was it, from when the incident was first reported to the time an airway was inserted?</p> <input type="checkbox"/> 0-1 min <input type="checkbox"/> 1-3 min <input type="checkbox"/> 3-5 min <input type="checkbox"/> 5-10 min <input type="checkbox"/> 10-20 min <input type="checkbox"/> Other <p>12) How long was CPR carried out?</p> <input type="checkbox"/> 0-1 min <input type="checkbox"/> 1-3 min <input type="checkbox"/> 3-5 min <input type="checkbox"/> 5-10 min <input type="checkbox"/> 10-20 min <input type="checkbox"/> Other <p>13) A defibrillator was used by:</p> <input type="checkbox"/> Lifesaver <input type="checkbox"/> Lifeguard <input type="checkbox"/> Ambulance <input type="checkbox"/> Doctor <input type="checkbox"/> Unknown <p>14) How long was it, from when the incident was first reported to the time the defibrillator was applied?</p> <input type="checkbox"/> 0-1 min <input type="checkbox"/> 1-3 min <input type="checkbox"/> 3-5 min <input type="checkbox"/> 5-10 min <input type="checkbox"/> 10-20 min <input type="checkbox"/> Other <p>15) How many times was a shock delivered?</p> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Other <p>16) Did the patient regain consciousness?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>17) How long was it, after calling for assistance, before the ambulance arrived?</p> <input type="checkbox"/> 0-1 min <input type="checkbox"/> 1-3 min <input type="checkbox"/> 3-5 min <input type="checkbox"/> 5-10 min <input type="checkbox"/> 10-20 min <input type="checkbox"/> Other <p>18) The patient was conveyed to hospital by:</p> <input type="checkbox"/> Ambulance <input type="checkbox"/> Helicopter <input type="checkbox"/> Private vehicle <input type="checkbox"/> Other <input type="checkbox"/> Unknown <p>19) Which hospital was the patient conveyed to?</p> <p>_____</p> <p>20) What condition was the patient in when in transport?</p> <input type="checkbox"/> Conscious <input type="checkbox"/> Unconscious <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown <p>21) Condition on discharge from hospital (if known):</p> <input type="checkbox"/> Full recovery <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown <p>22) Was trauma counselling arranged for the rescuer(s)?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>23) Was a carry used?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>24) If yes, what kind?</p> <p>_____</p> <p>Person completing form: (if different from the other side of the form) Name: _____ Position: _____ Phone: _____ Email: _____ Signature: _____</p>
<p>Please provide brief details of the incident including any recommendations:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>		