

Handout for the Rescue Team

Name:	Birthday/Civil registration number:	Date:	Name of ship:	Port of call:
The medical officer's name:	Medication :	Drug intolerance/Which:		
Next of kin:	Telephone number:	Informed <input type="checkbox"/>	Not informed <input type="checkbox"/>	

What happened– describe the situation:

A: Airway

Action	Guidance			
Secure clear airway	Oxygen	6 l/min <input type="checkbox"/>	9 l/min <input type="checkbox"/>	Unconsciousness, tongue depressor <input type="checkbox"/>
Fixate head	Is a cervical collar placed <input type="checkbox"/>			
Neck/back	No sympt. <input type="checkbox"/>	Pain <input type="checkbox"/>	Lesion <input type="checkbox"/>	*See the back

B: Breathing

Action	Guidance			
Breathing frequency	Normal <input type="checkbox"/>	Laboured <input type="checkbox"/>	Shallow <input type="checkbox"/>	None <input type="checkbox"/>
Chest	No sympt. <input type="checkbox"/>	Pain <input type="checkbox"/>	Lesion <input type="checkbox"/>	*See the back
Action in case of cardiac arrest:	Have you provided cardio-pulmonary resuscitation:			Yes <input type="checkbox"/> No <input type="checkbox"/>
Starting time: _____	Have you used a heart starter:			Yes <input type="checkbox"/> No <input type="checkbox"/>

C: Circulation

Action	Guidance			
Pulse	Pulse is detectable on wrist – Yes <input type="checkbox"/> No <input type="checkbox"/> On the neck Yes <input type="checkbox"/> No <input type="checkbox"/>			
Quality of pulse	Rapid <input type="checkbox"/>	Slow <input type="checkbox"/>	Regular <input type="checkbox"/>	Irregular <input type="checkbox"/>
Skin colour	Normal <input type="checkbox"/>	Pale <input type="checkbox"/>	Bluish <input type="checkbox"/>	Reddish <input type="checkbox"/>
Skin feels:	Warm and dry <input type="checkbox"/>	Cool and dry <input type="checkbox"/>	Warm and clammy <input type="checkbox"/>	Cool and clammy <input type="checkbox"/>
Capillary response	Under 2 seconds <input type="checkbox"/>		More than 2 seconds <input type="checkbox"/>	
Examine if there are any haemorrhages	Haemorrhage stopped <input type="checkbox"/>		Where? *See the back	
	Access Vein needle	yes <input type="checkbox"/> no <input type="checkbox"/>	Sodium chloride	yes <input type="checkbox"/> time ____ no <input type="checkbox"/>

D: Disability

Action	Guidance			
Level of consciousness	Awake <input type="checkbox"/>	Responsive to speech <input type="checkbox"/>	Responsive to pain <input type="checkbox"/>	No response: <input type="checkbox"/>
Examine pupil reaction	Normal reaction to light <input type="checkbox"/>		Abnormal: Describe	
Action	Examine if there are other injuries			
Abdomen	No sympt. <input type="checkbox"/>	Pain: <input type="checkbox"/>	Lesion: <input type="checkbox"/>	*See the back
Pelvis	No sympt. <input type="checkbox"/>	Pain: <input type="checkbox"/>	Lesion: <input type="checkbox"/>	*See the back
Arms/legs	No sympt. <input type="checkbox"/>	Pain: <input type="checkbox"/>	Fracture: <input type="checkbox"/>	*See the back

Patient current values

	Time:	Time:	Time:
Breathing frequency/min.			
Pulse/min.			
Capillary response >2sec.			
Level of consciousness			
Oxygen saturation			
Blood pressure			
Oxygen l/min.			
Sodium chloride drip/min			

Has medicine been administered– yes no

Which medicine: _____ amount: _____ How: tbl. im sc iv time: _____

Other : _____ amount: _____ How: tbl. im sc iv time: _____

Other : _____ amount: _____ How: tbl. im sc iv time: _____

Mark down any injuries here:

Normal body values

Breathing frequency

Age	Breathing frequency/min.
0 – 6 weeks	30 - 50
7 weeks– 6 years	20 – 30
6 – 13 years	(12 – 20) - 30
13 – 16 years	12 - 20
Over 16 years	12- 16
Oxygen saturation Children/adults	> 95%

Pulse

Age	Pulse
0 – 6 weeks	120 – 160
7 weeks – 1 year	80 – 140
1 – 16 years	60 - 120
Over 16 years	60 - 80

Blood pressure

Age	Blood pressure
0 – 6 years	75 – 100/ 50 -68
6 – 16 years	105 – 125/65–80
Over 16 years	Below 120-140/ 60-80

