Pre-Hospital Emergency Care Council

CFR REPORT

Incident Information

Date of Call: DD MM YYYY | Time Call Passed: HH MM | Time at Scene: HH MM

Time at Patient: HH MM | Time Clear: HH MM

Dispatch Classification Reference

CC | INCIDENT NUMBER

DOA Dead on Arrival

FBAO Foreign Body Airway Obstruction

INCIDENT LOCATION

☐ Home/Residence ☐ Industrial Place/Premises ☐ Recreation or Sports
☐ Street / Road ☐ Public Building ☐ Nursing home/Assisted living
☐ Educational Institution ☐ Other Places

Patient Information

☐ Name Unknown

Date of Birth: DD MM YYYY | Age | Gender: M F I U

TITLE | INDIVIDUAL HEALTH IDENTIFIER

SURNAME

FORENAME

ADDRESS

EIRCODE

Chest Pain on Arrival

☐ Yes ☐ No ☐ Unknown

Time of Chest Pain: HH MM | Time of Collapse: HH MM

Collapse Witnessed

Yes ☐ No ☐

Witnessed by: *(tick all relevant boxes)*

☐	Citizen - not dispatched by ambulance control
☐	Responder – dispatched by ambulance control
☐	Responder other – not dispatched by ambulance control
☐	Responder auxiliary/voluntary – on duty at or near the scene
☐	Practitioner - dispatched by ambulance control
☐	Doctor or off-duty practitioner – dispatched by ambulance control
☐	Doctor or off-duty practitioner – not dispatched by ambulance control
☐	Nurse
☐	Fire service*
☐	Garda

Chest Compressions

☐ Yes ☐ No | PIN/HSPI

Delivered by: *(tick all relevant boxes)*

☐	Citizen - not dispatched by ambulance control
☐	Responder – dispatched by ambulance control
☐	Responder other – not dispatched by ambulance control
☐	Responder auxiliary/voluntary – on duty at or near the scene
☐	Practitioner - dispatched by ambulance control
☐	Doctor or off-duty practitioner – dispatched by ambulance control
☐	Doctor or off-duty practitioner – not dispatched by ambulance control
☐	Nurse
☐	Fire service*
☐	Garda

Defibrillator Pads

☐ Yes ☐ No | PIN/HSPI

First applied by: *(tick relevant box)*

☐	Citizen - not dispatched by ambulance control
☐	Responder – dispatched by ambulance control
☐	Responder other – not dispatched by ambulance control
☐	Responder auxiliary/voluntary – on duty at or near the scene
☐	Practitioner - dispatched by ambulance control
☐	Doctor or off-duty practitioner – dispatched by ambulance control
☐	Doctor or off-duty practitioner – not dispatched by ambulance control
☐	Nurse
☐	Fire service*
☐	Garda

Time First Arrest Rhythm Analysis: HH MM

Initial Arrest Rhythm

☐ Shockable ☐ Unshockable

Specify: (if known)

Shock

Was shock advised ☐ Yes ☐ No | PIN/HSPI

Was shock delivered ☐ Yes ☐ No | Defibrillator Malfunction

First delivered by: *(tick relevant box)*

☐	Citizen - not dispatched by ambulance control
☐	Responder – dispatched by ambulance control
☐	Responder other – not dispatched by ambulance control
☐	Responder auxiliary/voluntary – on duty at or near the scene
☐	Practitioner - dispatched by ambulance control
☐	Doctor or off-duty practitioner – dispatched by ambulance control
☐	Doctor or off-duty practitioner – not dispatched by ambulance control
☐	Nurse
☐	Fire service*
☐	Garda

Total Shocks Delivered | Time First Shock Delivered: HH MM

Return of Spontaneous Circulation (ROSC) at any stage

☐ Yes ☐ No

Who First Achieved ROSC *(tick relevant box)*

☐	Citizen - not dispatched by ambulance control
☐	Responder – dispatched by ambulance control
☐	Responder other – not dispatched by ambulance control
☐	Responder auxiliary/voluntary – on duty at or near the scene
☐	Practitioner - dispatched by ambulance control
☐	Doctor or off-duty practitioner – dispatched by ambulance control
☐	Doctor or off-duty practitioner – not dispatched by ambulance control
☐	Nurse
☐	Fire service*
☐	Garda

Time of Return of Spontaneous Circulation: HH MM

CPR in Progress on Transfer to Hospital

☐ Yes ☐ No

Spontaneous Circulation on Arrival in Hospital (if known)

☐ Yes ☐ No

ADDITIONAL INFORMATION

Doctor in Attendance

☐ Yes ☐ No | MCRN

Medication Treatment

☐ Yes ☐ No

HH MM | MEDICATION | DOSE | ROUTE | PIN/HSPI

HH MM | MEDICATION | DOSE | ROUTE | PIN/HSPI

HH MM | MEDICATION | DOSE | ROUTE | PIN/HSPI

Care Management

☐ Oropharangeal Airway (OPA) ☐ Supraglottic Airway (SGA)
☐ Suction ☐ Positioning

FAST ASSESSMENT

F ☐ Yes ☐ No | A ☐ Yes ☐ No | S ☐ Yes ☐ No | T

Time of Onset: HH MM

ADDITIONAL INFORMATION

CFR REPORT HANDOVER

☐ Yes ☐ No

The completed CFR Report should be given to the ambulance service

Signature/PIN/HSPI

Responder Area

CFR REPORT COMPLETION GUIDE

- All entries in black ball point pen
- Date to be entered as DD/MM/YYY
- Time to be entered as 00:00 (24 hr clock)
- CC refers to licensed provider control centre code
- PIN/HSPI refers to PHECC Registered PIN/Health Services Practitioner Identifier

Incident Information: (enter appropriate information and tick box where relevant)

Date of Call
Enter date you receive call from the control centre.

Time Call Passed
Enter time you receive call from the control centre.

Time at Scene
Enter time you arrived at the scene.

Time at Patient
Enter time of arrival of the first appropriate emergency response at the patient.

Time Clear
Enter time ambulance/vehicle, crew and equipment available to respond to another incident.

Dispatch Classification Reference
Enter appropriate call classification – e.g. 09 E 01 A as advised by the control centre.

CC and Incident number
Enter the control centre number assigned by the licensed provider.
Incident Number:
Enter incident number as given to you by the control centre.

DOA If patient dead on arrival tick box.

FBAO If foreign body airway obstruction tick box.

Incident Location
Enter incident location address.
Tick incident location box as appropriate.

Eircode
Enter location code comprising of routing key and unique identifier.

Patient Information: (enter appropriate information and tick box where relevant)

If name unknown, tick box.

Enter date of birth, age and gender: male, female, intersex etc. as stated.

Enter title (a prefix added to the name: Dr/Ms/Mr/Mrs/Prof.).

Enter Surname/Forename
Family name, surname, last name or marital name followed by forename.

Enter IHI
Individual Health Identifier Code as given to you by the patient, if it is available.

Enter address and eircode.

Chest Pain on Arrival

Determine if patient has chest pain and tick box as appropriate.

Enter time chest pain commenced.

If patient collapsed determine time of collapse and enter time.

Collapse Witnessed

If you witness the patient collapsing tick Yes.

If you do not witness the collapse tick No.

Tick all relevant boxes for person who witnessed collapse.

Record in additional information if there is no option available to you.

* If Fire service present which is not Dublin Fire Brigade (DFB) tick this box.

Chest Compressions

If chest compressions were delivered to the patient tick Yes.

If chest compressions were not delivered tick No.

Tick all relevant boxes for person who delivered chest compressions.

* If Fire service present which is not Dublin Fire Brigade (DFB) tick this box.

Defibrillator Pads

If defibrillator pads were applied to the patient tick Yes.

If defibrillator pads were not applied tick No.

Tick relevant box for person who first applied pads.

* If Fire service present which is not Dublin Fire Brigade (DFB) tick this box.

Initial Arrest Rhythm

Tick Shockable/Unshockable as appropriate.

Record time of first rhythm analysis.

Record rhythm if known.

Shock

If shock was advised when defibrillator pads applied tick Yes and record PIN/HSPI if applies.

If shock was not advised when defibrillator pads applied tick No.

If shock was delivered tick Yes.

If shock was not delivered tick No.

Enter total number of shocks delivered and the time the first shock was delivered at.

Tick relevant box for person who first delivered shock.

* If Fire service present which is not Dublin Fire Brigade (DFB) tick this box.

Return of Spontaneous Circulation (ROSC) at any stage

Did patient have return of spontaneous circulation (ROSC) at any stage during the event? Tick yes or no as appropriate.

Tick relevant box for person who first achieved return of spontaneous circulation.

* If Fire service present which is not Dublin Fire Brigade (DFB) tick this box.

Record time of return of spontaneous circulation.

If the following is known to you please select as appropriate:

- CPR in Progress on Transfer to Hospital.
- Spontaneous Circulation on Arrival in Hospital.

Doctor in Attendance

Record as appropriate and Medical Council Registration Number (MCRN) if available.

Medication Treatment

Enter name of medication, time administered, dose, route and PIN/HSPI/Other who administered the medication.

Care Management

Tick as appropriate and use additional space if required.

FAST ASSESSMENT

FAST Assessment will assist in early diagnosis of a stroke.

The definition of FAST is as follows:

F acial weakness: can the patient smile? have the eyes/face dropped?

A rm weakness: can the patient raise both arms and maintain for 5 seconds?

S peech: can the patient speak clearly and understand what you say?

T ime to call 112/999. Enter Time of Onset of symptoms.

CFR Report Handover

The completed CFR Report must be handed over to the ambulance service. Tick Yes or No as appropriate. Record signature/PIN/HSPI as appropriate and name of Community Responder Area.

Pre-Hospital Emergency Care Council

RECOGNITION OF DEATH

DEATH CONFIRMED BY DOCTOR/ADVANCED PARAMEDIC/PARAMEDIC:

	MCRN/PIN/HSPI

CONTACT NUMBER:

	HH	MM

OR

IT IS INAPPROPRIATE TO COMMENCE RESUSCITATION WHEN THE FOLLOWING INDICATORS OF DEATH ARE PRESENT:

1	DECOMPOSITION	❑
2	RIGOR MORTIS	❑
3	INCINERATION	❑
4	DECAPITATION	❑
5	POOLING	❑
6	OTHER INJURIES TOTALL Y INCOMPATIBLE WITH LIFE **Document with one 10 sec. rhythm strip (where appropriate).** PLEASE SPECIFY NATURE OF INJURIES	❑
7	UNWITNESSED CARDIAC ARREST FOLLOWING BLUNT TRAUMA	❑