ROCK MEDICINE
P.O. Box 756
Roseville, CA 95661-9998
(415) 646-5474

Show: _____
Date: _____
Venue: _____
Time In: _____
Intake Completed By: _____

Arrived:
- ☐ Alone
- ☐ Companion
- ☐ RockMed
- ☐ Security

Mode:
- ☐ Ambulatory
- ☐ Assisted
- ☐ Wheelchair
- ☐ Gurney/Stretcher
- ☐ C-Spine

Condition:
- ☐ Alert
- ☐ Agitated
- ☐ Disoriented
- ☐ Combative
- ☐ Comatose

Name: _____ Age: _____ Sex: _____ Race: _____
Address: _____ City: _____ Zip: _____
Phone: _____

Allergies: _____ Last Tetanus: _____
Rx Medications: _____
Chronic/Serious Illnesses in past year: _____
Alcohol/Drugs used in past 24 hours: _____

Circumstances of Incident: _____
_____
When? _____ Where in Venue? _____
Witness to Incident: _____ Phone: _____
Address: _____ City: _____ Zip: _____

I hereby give consent and authorization for treatment deemed necessary by the attending physician:

Patient Signature ✕ _____ Witness _____

TIME						
TEMP						
PULSE						
RESP.						
B/P						

Chief Complaint:

Physical Exam:

Diagnosis:

Treatment:

Medications Administered:

Discharge
Condition: _____
☐Ambulatory ☐Wheelchair
☐Friends/Family ☐Security
☐Via Ambulance # _____
Destination: _____

I have received and understand post-injury instructions.

Patient Signature: ✕ _____

Attending Staff: _____ **Time Out:** _____

Attending Physician: _____

I have been offered free medical care, have refused, and understand the possible consequences.

Patient Signature: _____ Witness: _____

Incident
Minor

Staff Incident
Intake # _____