

The Diving Medical Advisory Committee

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Aide Mémoire for Recording and Transmission of Medical Data to Shore

DMAC 01 – 1984

C O N F I D E N T I A L

This form has been designed in three parts to make it easier to use.

Part 1 is an aide mémoire to obtain essential information for transmission ashore in event of a medical emergency. This information will enable the onshore doctor to advise on immediate management of the casualty.

Part 2 collects more detailed information to provide a permanent record of the incident and to assist in accident analysis. Obviously in urgent cases **there must be no delay** in contacting medical assistance with the information in Part 1. Part 2 should be completed later.

The onshore doctor will frequently ask for some further examination to be carried out.

Part 3 provides a form for recording this information.

It is recognised that it will not be necessary to complete the form fully in most cases, and where a question (or section) is not applicable, 'N/A' should be entered. If you are uncertain of the meaning of a question, do not attempt to answer it, but ring the question number.

Essential Information For Transmission Ashore In Event Of An Emergency

Part I – Section A

GENERAL INFORMATION

1 Patient surname:..... Christian name:.....

2 Company:.....

3 Worksite:.....

4 Date of incident:..... Time:.....

5 Type of incident:.....

6 Is the general condition of the patient:

Good	<input type="checkbox"/>
Fair	<input type="checkbox"/>
Critical	<input type="checkbox"/>

INFORMATION ABOUT THE DIVE RELATED TO THE INCIDENT

(If the illness is not related to diving, skip to Section E)

7	Method:	Scuba	<input type="checkbox"/>	Bell bounce	<input type="checkbox"/>
		Surface supplied	<input type="checkbox"/>	Saturation	<input type="checkbox"/>
		Wet bell	<input type="checkbox"/>		
8	Air mixture:	Air	<input type="checkbox"/>	Nitrox	<input type="checkbox"/>
		Heliox	<input type="checkbox"/>	Trimix	<input type="checkbox"/>
9	Job:	Diver	<input type="checkbox"/>	Other	<input type="checkbox"/>
		Bellman	<input type="checkbox"/>	Specify .....	|
10	Working depth:				.....metres
11	Bell depth:				.....metres
12	Storage depth (where relevant):				.....metres
13	Time spent at working depth:				..... minutes
14	Decompression table selected:	.....		
	Depth selected:				.....metres
	Bottom time selected:				.....metres
	Surface interval selected (repetitive dives):			..... hours	..... minutes
15	Type of work performed:	.....		
				
				
				
16	Adverse conditions, if any (e.g. sea state, tidal stream, temperature, fouling, disorderly ascent, hard work, etc.):	.....		
				
				
17	Did the incident begin:	in the water	<input type="checkbox"/>	in the deck chamber	<input type="checkbox"/>
		in the bell	<input type="checkbox"/>	other?	<input type="checkbox"/>
				Specify?	
18	At the onset of symptoms, was the patient:				
		descending	<input type="checkbox"/>	ascending	<input type="checkbox"/>
		on the bottom	<input type="checkbox"/>	on the surface	<input type="checkbox"/>

COMPRESSION/DECOMPRESSION INCIDENT

(If the illness is not related to diving, skip to Section E)

19 Incident during or immediately following compression: YES NO

20 Incident during normal decompression: YES NO

21 Incident after surfacing following normal decompression: YES NO

End of decompression at: hours minutes

22 Incident following excursion from saturation: YES NO

Time of outset after decompression: hours minutes

23 Incident following blow-up/drop in pressure YES NO

From: depth:metres time:hours minutes

To: depth:metres time:hours minutes

24 In other circumstances: YES NO

Specify:.....

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25 Onset of first symptom at:

depth:metres time:hours minutes

26 Niggles: YES NO

27 Pain in joints: YES NO

State location:.....

28 Pain in muscles: YES NO

State location:.....

29 Pins and needles: YES NO

State location:.....

30 Patches of numbness or tingling, or altered sensation: YES NO

State location:.....

31 Muscle weakness or paralysis: YES NO

State location:.....

32 Difficulty in urinating: YES NO

33 Pain in the lumbar region, around waist, or in the abdomen: YES NO

34 Standing upright difficult or impossible: YES NO

35 Nausea: YES NO

36	Vomiting:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
37	Vertigo, loss of balance:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
38	Deafness, hearing problems:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
39	Speech problems:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
40	Visual problems:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
41	Drowsiness, confusion:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Specify:.....		
42	Loss of consciousness:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
43	Paleness, anxiety, sweating, collapse:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Specify:.....		
44	Cyanosis, blue skin:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
45	Breathlessness, painful breathing, chokes:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Specify:.....		
46	Blood-stained froth in airways:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
47	Respiratory distress worsening with decompression:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
42	Others (specify below):	<input type="checkbox"/> YES	<input type="checkbox"/> NO
		
		
		

Part I – Section D
PREVIOUS DIVE

(If ended less than 24 hours before the accident)

49 Method: Scuba Bell bounce
 Surface supplied Saturation
 Wet bell Excursion from saturation

50 Air mixture: Air Nitrox
 Heliox Trimix

51 Depth:metres

52 Bottom time (where relevant): minutes

53 Table selected:.....
 Depth selected:metres
 Time selected:metres

54 Normal decompression: YES NO

55 End of decompression:
 Date:/..... time:hours minutes

56 If saturation, back to storage depth from last working dive:
 Date:/..... time:hours minutes

ACCIDENT OR ILLNESS NOT RELATED TO DECOMPRESSION

57 Nature of Accident or Illness:
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58 Does he have difficulty or pain with breathing? YES NO

59 Is he bleeding? YES NO

60 If yes, is bleeding controlled? YES NO

61 State of consciousness:

Fully alert and orientated	<input type="checkbox"/>
Drowsy	<input type="checkbox"/>
Confused	<input type="checkbox"/>
Unconscious but responds to stimuli	<input type="checkbox"/>
Unconscious and unresponsive	<input type="checkbox"/>

62 Details symptoms:.....
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63 Treatment given:.....
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Additional Information for Record Purposes

NB Do **not** delay transmission of Part 1 in order to complete this part of the form

Part 2 – Section A

GENERAL INFORMATION

- 1 Name of patient:
- 2 Date of birth:
- 3 Date of last medical examination:
- 4 Where medical records are held:.....
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- 5 Details of previous decompression sickness:.....
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- 6 Any significant past or recent medical history:.....
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.....
- 7 Name of diving supervisor:
- 8 Name of medical attendant:.....
- 9 Time of transmission of Part 1:..... GMT Date.....
- 10 Addressee:.....
.....
- 11 Copied to:.....
.....
- 12 Telex confirmation sent at:..... GMT Date.....
- 13 Time message acknowledged: GMT Date.....
- 14 Reason for contacting shore doctor:
 - Assistance required urgently
 - Assistance required as soon as possible
 - Assistance required when practicable
 - Assistance required when patient gets ashore
 - For information only

Part 2 – Section B

Brief statement of the problem:

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Part 2 – Section C

Summary of advice/instructions received from ashore:

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Part 2 – Section D

Details of treatment given (including therapeutic tables by number as well as depth, duration and gases, and all supplementary therapy). State also times of implementation:

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Part 2 – Section E

Record of progress. Summary of history of the condition, times of significant changes:

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Part 2 – Section F

Final outcome (e.g. fully recovered, transferred ashore under pressure, etc.):

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Record of Medical Examination

All or part of this examination may be carried out at the request of the onshore doctor. Results should be recorded in the appropriate section and the questions which are not relevant to the particular incident left blank.

Part 3 – Section A

EXAMINATION/GENERAL

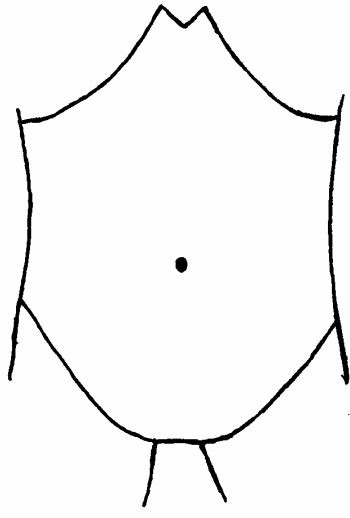
- 1 Is the patient in pain? YES NO
 If 'yes', specify site, intensity and any factors which exacerbate or relieve it:

- 2 Has he any major injury? YES NO
 If 'yes', name the site and describe briefly. If there is bleeding give an estimate of blood loss:

- 3 What is his temperature?°C
- 4 Has he any skin rashes? YES NO
 If 'yes', describe appearance and site:

Part 3 – Section C
ABDOMEN

16 Does the patient have abdominal pain? YES NO
 If 'yes', specify site by writing I 6 on chart, and character:



17 Does the patient have diarrhoea? YES NO
 18 Has the patient vomited? YES NO
 If 'yes', specify:
 a) When did the patient last vomit?..... GMT
 b) If he is still vomiting, specify frequency and character:

19 Has he vomited blood?? YES NO

20 Can the patient pass urine without difficulty? YES NO

21 Is the urine clear or blood stained

22 Is urinating painful? YES NO

23 Is the abdomen soft to palpation? YES NO
 If 'no', specify the site by writing 23 on chart

24 Are there any swellings in the abdomen? YES NO
 If 'yes', specify site (by writing 24 on chart), size and consistency:

25 Can you hear bowel sounds? YES NO

Part 3 – Section D
NERVOUS SYSTEM

26 Has he any visual disturbance? YES NO

If 'yes', specify:

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27 Has he a headache? YES NO

28 State of consciousness:

Fully alert and orientated	<input type="checkbox"/>
Confused	<input type="checkbox"/>
Drowsy	<input type="checkbox"/>
Unconscious but responds to stimuli	<input type="checkbox"/>
Unconscious and unresponsive	<input type="checkbox"/>

29 Are pupils equal and normal in response to light? YES NO

If 'no', amplify:

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30 Is the corneal (blink) reflex normal? YES NO

31 Does the patient have vertigo (dizziness)? YES NO

32 Does the patient have nystagmus (eye flickering)? YES NO

33 Is hearing equal and normal in both ears? YES NO

If 'no', specify:

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34 Are the remainder of the cranial nerves normal?

Eye movements	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Swallowing reflex	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Facial sensation	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tongue movement	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Facial movements	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Soft palate movement	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Shrugging of shoulders	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

35 Can the patient voluntarily move his:

R. Shoulder	<input type="checkbox"/> YES	<input type="checkbox"/> NO	L. Shoulder	<input type="checkbox"/> YES	<input type="checkbox"/> NO
R. Elbow	<input type="checkbox"/> YES	<input type="checkbox"/> NO	L. Elbow	<input type="checkbox"/> YES	<input type="checkbox"/> NO
R. Wrist	<input type="checkbox"/> YES	<input type="checkbox"/> NO	L. Wrist	<input type="checkbox"/> YES	<input type="checkbox"/> NO
R. Fingers	<input type="checkbox"/> YES	<input type="checkbox"/> NO	L. Fingers	<input type="checkbox"/> YES	<input type="checkbox"/> NO
R. Hip	<input type="checkbox"/> YES	<input type="checkbox"/> NO	L. Hip	<input type="checkbox"/> YES	<input type="checkbox"/> NO
R. Knee	<input type="checkbox"/> YES	<input type="checkbox"/> NO	L. Knee	<input type="checkbox"/> YES	<input type="checkbox"/> NO
R. Ankle	<input type="checkbox"/> YES	<input type="checkbox"/> NO	L. Ankle	<input type="checkbox"/> YES	<input type="checkbox"/> NO
R. Toes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	L. Toes	<input type="checkbox"/> YES	<input type="checkbox"/> NO

36 Has he any weakness? YES NO

If 'yes', specify:

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37	Are reflexes (tendon jerks)		Normal	Increased	Absent	?
	Triceps:	R.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		L.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Biceps:	R.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		L.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Knee	R.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		L.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ankle:	R.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		L.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

38 Is the plantar response:

		↑ R.	<input type="checkbox"/>	↑ L.	<input type="checkbox"/>
	OR	↓ R.	<input type="checkbox"/>	↓ L.	<input type="checkbox"/>
	or not clear	R.	<input type="checkbox"/>	L.	<input type="checkbox"/>

39 Does he have 'pins and needles'? YES NO

If 'yes', specify:

.....

40 Is there a normal sensory response to pinprick? YES NO

If 'no', specify:

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Can you detect a level of sensory change? YES NO

41 Can he pass urine? YES NO

ANY OTHER RELEVANT FINDINGS NOT LISTED ABOVE

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