Appendix H: Stop the Bleed Post-Use Form

Instructions: This form should be completed on-site as thoroughly as possible by the Stop the Bleed responder or professional responders after using a Stop the Bleed kit. Once completed, promptly contact the EH&S Stop the Bleed Program Coordinator at ehsocchealth@ucr.edu or call 951-827-5528 to arrange pick-up within 24 hours and ensure notification to the regulatory body for this program.

Name: _____

Department: _____

Email: _____ **Phone:** _____

Were you the primary responder who used the Stop the Bleed kit? ☐ Yes ☐ No

If not, name the person who used the Stop the Bleed Kit: _____

Individual's Name (Optional): _____

Individual's Age: _____ **Gender:** _____

How was the Individual Found? _____

Date of Incident and Time of Incident: _____

Location of Incident (Address and Precise Location): _____

Additional Comments: _____

Other: _____

Responding EMS Service: _____

Individual's Outcome (if known):

☐ Discharged Alive ☐ DOA at ER ☐ Died in ER ☐ Died within 24hrs ☐ Died After 24hrs

Estimated Response Time: _____ ☐ AM ☐ PM

Receiving Hospital (if known): _____

Additional observations: _____

Name of responder: _____ **Date:** _____

Signature of responder: _____