RADIO MEDICAL RECORD

for use in ships in cases of
illness and accident

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INSTRUCTIONS

THE RECORDS

In cases of illnesses and accidents, records must be kept in accordance with the following guidelines:

In the ship's log, general information is recorded, such as "NN ill. See records".

The records are kept confidentially in a locked cupboard and are only accessible to the captain and person treating the illness.

The patient has the right to see the records.

RADIO MEDICAL RECORDS

Radio Medical records are divided into three types of health situations:

1. Minor ailments (colour code green)
2. Accidents (colour code red)
3. Illnesses (colour code blue)

Minor ailments:
Minor ailments are considered to be cases where it is not thought necessary to consult Radio Medical for advice. It could be a case of seasickness, slight tenderness in a foot, or something similar, but it could also be the start of an actual and more severe illness, where the records must later be expanded.

Accidents:
The term "accidents" is used in cases where external influences cause harm to the patient's health. The records should, as a minimum, include the information in these instructions.

Illnesses:
Illnesses constitute the remainder.

The instructions for accidents and illnesses are divided into to sub-categories, the *case history* and the *objective examination.*

The case history	The patient's presentation of the case from the questions he is asked. The main questions which should always be asked are emphasised by bold type. Supplementary questions are only asked if a main question indicates elaboration.
Objective investigation	The result of the investigation of the patient.

RADIO MEDICAL

Treatment of the ill and injured should be carried out in collaboration with Radio Medical. Call Radio Medical as early as possible in the course of an illness. Use of Radio Medical is free. Telecommunication via VHF, HF and MF is also free, while the ship (company) itself pa the costs of telecommunication via INMARSA

Radio Medical has 24-hour coverage. You ca therefore always contact a doctor. If possible, try to restrict *non-acute* calls to the period 08.00-12.00 UTC.

In the case of illness and accident onboard a ship, there should be a close collaboration between Radio Medical and the person treating the illness onboard.

The division of responsibilities is as follows

1. The person treating the illness begins inde pendent life-saving first aid in the case of a sudden occurrence of a dangerous condition.
2. The person treating the illness completes t Radio Medical records.
3. The records are communicated to the doctors at Radio Medical.
4. The doctors make a diagnosis, advise on treatment, and advise on possible evacuation.
5. The person treating the illness carries out the treatment.
6. In collaboration, it is decided how often Ra dio Medical should be updated during the course of an illness, and when the case ca be considered closed.

You can consult Radio Medical in *all* questior on health matters. There is *no* lower limit for minor ailments. This also applies if a doctor i foreign port has expressed an opinion on the condition of a crew-member, and you want a second opinion. You can (and should) thus u Radio Medical as a kind of "medical emerger centre".

It can be difficult to assess how severe an illness must be before you should consult Rad Medical. In the case of certain minor ailment is easy to decide: seasickness, a slight head ache or a minor cut will hardly be cause for consulting Radio Medical. On the other hanc apparently minor cases, such as sinusitis, ca be more dangerous than you think.

Advice should be sought from Radio Medica the case of the following conditions:

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- All abnormal mental conditions.
- All cases affecting consciousness, respiration, pulse or blood pressure.
- Fevers if the temperature is 39° or over, and if the illness lasts more than 2-3 days.
- All cases with pains in the chest or abdomen.
- Before giving drugs if, in *Inventory, control document and user instructions for the contents of the ship's medicine chest*, it is stated "Consult Radio Medical".
- Before the following procedures: injections of drugs and infusions of fluids, suturing wounds, treatment of fractures and major injuries, and emptying the bladder.

Address:
The Danish Radio Medical is located at the Intensive Care Unit at the Central Hospital in Esbjerg. Calls are answered by a duty doctor there, if necessary with the assistance of other specialist doctors.

In rare instances, there may be a short waiting period before you can speak to the doctor. In these cases, an experienced nurse from the intensive care unit will take the first details about the type of case and its severity.

Calls via telephone, fax and telex to Radio Medical can be made direct. You can also call Lyngby Radio, who will transfer you to Radio Medical.

In the case of the evacuation of a patient, either Radio Medical or a sea rescue centre (Maritime Rescue Co-ordination Centre or MRCC) can be called.

Radio Medical:
Direct telephone: +45 75 45 67 66
Direct telefax: +45 75 45 67 50

Postal address:
Radio Medical
Intensive Care Unit 241
Central Hospital
Østergade 80
DK-6700 Esbjerg

THE CASE HISTORY

1.	What is the patient's problem? What has happened?

8.	ALLERGIES
8.1	Is the patient allergic to any drugs?
	If so:
8.1.1	Which drugs can the patient not tolerate?
8.1.2	What symptoms occur when the patient takes the drug?
8.1.3	Does the patient develop a red, itching rash?
8.1.4	Does the patient's face swell?
8.1.5	Does the patient experience difficulty in breathing?
8.1.6	Does the patient suffer from allergic shock?

OBJECTIVE EXAMINATION

Z.	Describe the treatment carried ou

ACCIDENTS

THE CASE HISTORY

1. **What has happened?**
   Describe the circumstances of the accident:
   What external influences caused the accident, and
   What happened in the course of the accident?
3. **What symptoms does the casualty have?**

6. DRUGS
6.1 **Is the patient currently taking any drugs?**
If so:
6.1.1 Trade name of the drug.
6.1.2 Drug's active ingredients.
6.1.3 Drug's strength.
6.1.4 Drug's dosage.
6.1.5 Time drug was last taken.

8. ALLERGY
8.1 **Is the patient allergic to any drugs?**
If so:
8.1.1 To what drugs is the patient allergic?
8.1.2 What symptoms arise when he takes that drug?
8.1.3 Does the patient develop a red, itching rash?
8.1.4 Does the patient's face swell?
8.1.5 Does the patient experience difficulty in breathing?
8.1.6 Does the patient suffer allergic shock?

OBJECTIVE EXAMINATION

A. GENERAL CONDITION
A.1 **The patient appears slightly ill.**
A.2 **The patient appears ill.**
A.3 **The patient appears very ill.**
A.4 **The patient is in a life-threatening condition.**

B. CONSCIOUSNESS
The patient is:
B.1 **Awake, clear and well-oriented.**
B.2 **Awareness affected, but reacts to speech.**
B.3 **Unconscious but reacts to pain stimuli.**
B.4 **Unconscious and does not react to pain stimuli.**

C. THE SKIN
C.1 **The colour of the skin is:**
C.1.1 Normal light pink.
C.1.2 Flushed red.
C.1.3 Blue violet.
C.1.4 Pale.
C.1.5 Yellowish.

C.3 **The temperature of the skin is described, compared with that of your hand.**
C.3.1 The temperature of the skin feels normal.
C.3.2 The skin feels warm.
C.3.3 The skin feels cool.

C.4 **The dampness of the skin:**
C.4.1 The skin feels dry.
C.4.2 The skin feels clammy.

OBJECTIVE EXAMINATION

D. TAKING THE PULSE

D.1 The rate: number of beats per minute.

D.3 Is the strength of the pulse the same as your own?

If not:

D.3.1 The pulse feels very strong.

D.3.2 The pulse feels weak.

E. BLOOD PRESSURE

Blood pressure: Systolic/diastolic, e.g. 140/60 mm Hg.

H. RESPIRATION

H.1 Rate:

Number of breaths per minute.

H.4 Is there breathlessness?

If so:

(Listen to the lungs with a stethoscope:)

H.4.1 Is there a rattle from secretion, which disappears or lessens on coughing?

H.4.2 Is there a wet, seething and boiling sound, which is unchanged on coughing?

H.4.3 Is there a whistling and wheezing sound, which is unchanged on coughing?

OBJECTIVE EXAMINATION

Y. Describe the injury.

Z. Describe what treatment has been given until now.

ILLNESS

THE CASE HISTORY

1.	What is the matter? What is wrong with the patient? What has happened?
2.	When did the patient begin to feel ill?
3.	What symptoms were there at the start of the illness?
4.	Previous history.
4.1	Has the patient suffered from a similar condition before?
4.2	Has the patient previously suffered from a serious illness or been admitted to hospital?
5.	Are there others onboard with similar symptoms?

6.	DRUGS
6.1	Is the patient currently taking any drugs?
	If so:
6.1.1	Trade name of the drug.
6.1.2	Drug's active ingredients.
6.1.3	Drug's strength.
6.1.4	Drug's dosage.
6.1.5	Time drug was last taken.
6.2	Has the patient previously taken any drugs?
	If so:
6.2.1	What type of drugs?
6.2.2	For which illness?
6.3	Does the patient have a fever?
	If so:
6.3.1	Has the patient been in an area with malaria?
6.3.2	Did the patient take preventive drugs?

THE CASE HISTORY

7.	ALCOHOL
7.1	Does the patient drink alcohol every day?
	If so:
7.1.1	How many units a day?
7.2	Is the patient currently under the influence of alcohol?

8.	ALLERGY
8.1	Is the patient allergic to any drugs?
	If so:
8.1.1	To which drugs is the patient allergic?
8.1.2	What symptoms arise when he takes that drug?
8.1.3	Does the patient develop a red, itching rash?
8.1.4	Does the patient's face swell?
8.1.5	Does the patient experience difficulty in breathing?
8.1.6	Does the patient suffer allergic shock?

9.	HEAD, SENSES AND NERVOUS SYSTEM
9.1	Is there pain in the head?
	If so:
9.1.1	Is there slight pain, pain or severe pain?
9.1.2	Where in the head is the pain?
9.1.3	Does the pain radiate? If so: From where and to where?
9.1.4	Is the pain constant?
9.1.5	Is the pain aggravated by light or noise?
9.1.6	Is the pain aggravated when the the head is bent forward?
9.1.7	Is there pain on swallowing?
9.2.	Are the senses functioning normally?
9.2.1	Can be patient see normally?
9.2.2	Can the patient hear normally?
9.2.3	Are senses of taste and smell normal?

THE CASE HISTORY

9.2.4 Is skin sensitivity normal?
If no to points 9.2.1 to 9.2.4:
Ask the patient to describe the abnormality.

9.3 The nervous system
Do muscles function normally?
9.3.1 In the face?
9.3.2 In arms, hands and fingers?
9.3.3 In legs, feet and toes?
If no to points 9.3.1 to 9.3.3:
Ask the patient to describe the abnormality.

10. THE CHEST
10.1 Does the patient have pain in the chest?
If so:
10.1.1 Is there slight pain, pain or severe pain?
10.1.2 Where in the chest is the pain?
10.1.3 Does the pain radiate? If so:
From where and to where?
10.1.4 Is the pain constant?
10.1.5 Is there less pain while resting?
10.1.6 Is the pain induced by exertion, cold or smoking?
10.1.7 Is the pain aggravated by deep breathing?
10.1.8 Is the pain less when the patient holds his
breath?

10.2 Does the patient have difficulty in breathing? If so:
10.2.1 Is there breathlessness on physical activity?
10.2.2 Is there breathlessness while resting.

10.3 Is there a cough
If so:
10.3.1 Is there phlegm?
10.3.2 Is the phlegm yellow or clear or bloody?

11. STOMACH AND INTESTINES
11.1 Is the appetite normal?
If not:
11.1.1 Is it reduced?
11.1.2 Is it increased?

THE CASE HISTORY

11.2 Is there nausea?

11.3 Is there vomiting?
If so:
11.3.1 When did vomiting start?
11.3.2 How many times has vomiting occurred?
11.3.3 When did vomiting last occur?
11.3.4 Did the vomit contain normal food, fresh blood, black blood, or yellowish/green bile?

11.4 Is there heartburn or burning behir the breastbone?
If so:
11.4.1 Is it aggravated by tobacco, alcohol, coffee or tea?
11.4.2 Is it reduced by biscuits, bread or mil

11.5 Is the pain in the abdominal area?
If so:
11.5.1 Is there slight pain, pain or severe pain?
11.5.2 Where in the abdomen is the pain?
11.5.3 Does the pain radiate? If so:
from where and to where?
11.5.4 Is the pain constant?
11.5.5 Is it worse in bouts (colic)?
11.5.6 Does the pain lessen if the patient lie still?
11.5.7 Does pain occur on eating fatty or smoked foods?

11.6 Was the last bowel movement nor mal and at the regular time?
If not:
11.6.1 When was the last bowel movement (date and time of day)?
11.6.2 Were the last faeces lumpy, normal, soft or watery?
11.6.3 Were the faeces of normal colour, w light red blood, black, like the water i which rice has been cooked, or light putty coloured?
11.6.4 Is wind passed?

THE CASE HISTORY

12.	**Urinary tract, bladder and lower abdomen**
12.1	**Is the amount of urine passed normal?**
	If not:
12.1.1	Is there more or less than normal?
12.2	**Is there an urge to urinate?**
12.3	**Is the urine dark yellow, yellow or totally clear?**
12.4	**Is the urine clear or cloudy?**
12.5	**Is there blood or a dark/black colour in the urine?**
12.6	**Is there a discharge from the urethra?**
	If so:
12.6.1	Is the discharge yellowish or clear?
12.6.2	Is there a burning sensation in the urethra?
12.7	**Is there pain in the lower abdomen?**
	If so?
12.7.1	Is there slight pain, pain or severe pain?
12.7.2	Where in the lower abdomen is the pain?
12.7.3	Does the pain radiate? If so: from where and to where?
12.7.4	Is the pain constant?
12.7.5	Is it worse in bouts?
12.7.6	Does the pain lessen if the patient lies still?

THE CASE HISTORY

13.	**Women's diseases in the lower abdomen**
13.1	**Are the patient's periods normal?**
	If so:
13.1.1	What date was the last period?
13.1.2	Did she bleed for the same number of days as usual?
13.1.3	Was there about the same amount of blood as usual?
13.2	**Does the patient take birth-control pills?**
	If so:
13.2.1	Were the pills taken as prescribed during the past three months?
	If not:
13.2.2	When were they taken irregularly?
13.3	**Is there bleeding now?**
	If so:
13.3.1	Is there heavier bleeding than usual?
13.3.2	Are there "lumps" in the blood?
13.4	**Could the patient be pregnant?**

14.	MUSCLES, JOINTS AND BONES
14.1	**Is there pain in joints, muscles or bones?**
	If so:
14.1.1	Is there slight pain, pain or severe pain?
14.1.2	Where does it hurt?
14.1.3	Does the pain radiate? If so: from where and to where?
14.1.4	Is the pain constant?
14.1.5	Is the pain aggravated by pressure on the site?
14.1.6	Is the pain less while resting?

OBJECTIVE INVESTIGATION

A.	GENERAL CONDITION
A.1	The patient appears slightly ill.
A.2	The patient appears ill.
A.3	The patient appears very ill.
A.4	The patient is in a life-threatening condition.
B.	CONSCIOUSNESS
	The patient is:
B.1	Awake, clear and well-oriented.
B.2	Awareness affected, but reacts to speech.
B.3	Unconscious but reacts to pain stimuli.
B.4	Unconscious and does not react to pain stimuli.
C.	THE SKIN
C.1	The colour of the skin is:
C.1.1	Normal light pink.
C.1.2	Flushed red.
C.1.3	Blue violet.
C.1.4	Pale.
C.1.5	Yellowish.
C.3	Are there red patches on the skin?
	If so:
C.3.1	Where are there red patches?
C.3.2	How large are the patches?
C.3.3	Does the skin turn white when pressed?
C.3	The temperature of the skin is described, compared with that of your hand.
C.3.1	The temperature of the skin feels normal.
C.3.2	The skin feels warm.
C.3.3	The skin feels cool.
C.4	The dampness of the skin:
C.4.1	The skin feels dry.
C.4.2	The skin feels clammy.

OBJECTIVE INVESTIGATION

D.	TAKING THE PULSE
D.1	The rate: number of beats per minute.
D.2	Is the pulse beating regularly?
	If not:
D.2.1	The pulse is slightly irregular.
D.2.2	The pulse misses a beat.
D.2.3	The pulse gives an extra beat.
D.3	Is the strength of the pulse the sam as your own?
	If not:
D.3.1	The pulse feels very strong.
D.3.2	The pulse feels weak.
E.	BLOOD PRESSURE
	Blood pressure: Systolic/diastolic, e.g. 140/60 mm Hg.
F.	CAPILLARY RESPONSE
F.1	Normal blood circulation:
	The skin turns white when pressed and pink when released.
F.2	The area is constantly white, both when pressed and when released.
F.3	The area is unchanged blue violet.
H.	RESPIRATION
H.1	Rate:
	Number of breaths per minute.
H.2	Note whether breathing is shallow normal or deep.
H.3	Note whether breathing is difficult easy.
H.4	Listen to the lungs with a stethoscope:
H.4.1	Is there a rattle from secretion, which disappears or lessens on coughing?
H.4.2	Is there a wet, seething and boiling sound, which is unchanged on coughing?
H.4.3	Is there a whistling and wheezing sound, which is unchanged on coughing?

OBJECTIVE INVESTIGATION

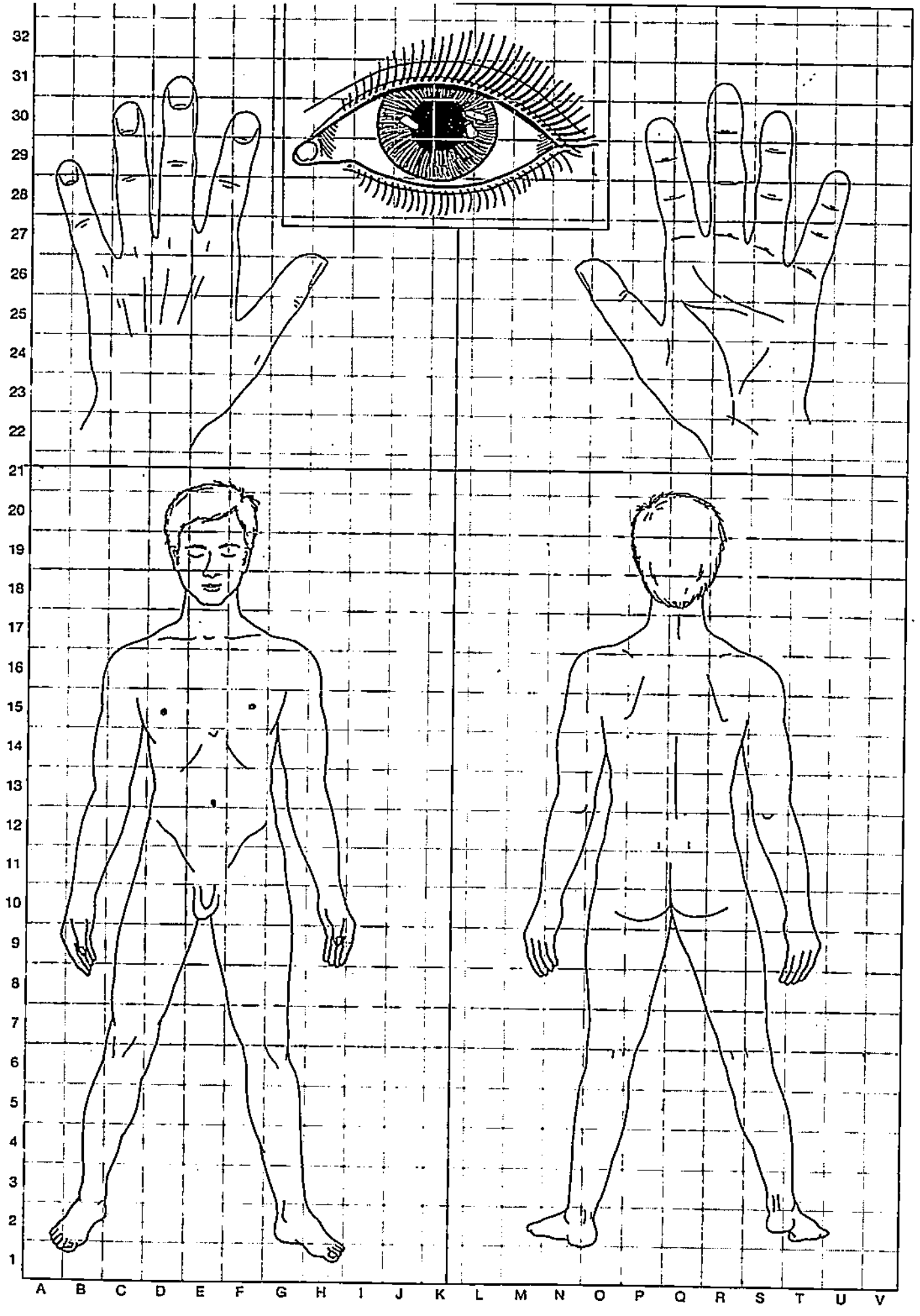
I.	THE SKULL AND NECK
I.1	Does the patient have a fever?
	If so:
I.1.1	Is there resistance on bending the neck?
	If so:
I.1.2	Is there resistance on straightening the lower leg?
K.	THE EYES
K.1	Are the membranes in the eyelids pink all over?
	If not:
K.1.1	Are the membranes pale?
K.1.2	Are the membranes bloodshot?
K.1.3	Are there small pinpricks of bleeding on the membrane?
K.2	Is the cornea white all over?
	If not:
K.2.1	Is the cornea bloodshot?
K.2.2	Is the cornea yellowish?
K.2.3	Is there a clearly defined blood-red area?
K.3	Do the pupils contract uniformly?
	If not:
K.3.1	Is there a reaction to light?
K.3.2	Is the reaction to light the same on both sides?
K.3.3	Are the pupils round?
L.	THE NOSE, MOUTH AND THROAT
L.1	Is there snot in the nose?
L.2	Are the membranes in the cheeks light red?
	If not:
L.2.1	Are the membranes pale?
L.2.2	Are the membranes very red?
L.2.3	Is there a coating?
L.3	Are the tonsils swollen?
	If so:
L.3.1	Are the tonsils very red?
L.3.2	Are there yellow or white spots on the tonsils?

OBJECTIVE INVESTIGATION

M.	THE GLANDS
M.1	Are there swollen glands?
	If so:
M.1.1	Under the jaw?
M.1.2	Along the neck muscles?
M.1.3	In the armpits?
M.1.4	In the groin?
N.	THE ABDOMEN
N.1.	Does the abdomen look relaxed?
	If not:
N.1.1	Is the skin on the abdomen flat and tight?
N.1.2	Is the skin on the abdomen swollen and tight?
N.2	Listen to the abdomen with a stethoscope.
N.2.1	Is there a gentle, gurgling sound?
	If not:
N.2.2	Is it totally silent?
N.2.3	Are the sounds from the intestines ringing with metallic sounds?
N.3.	Is the abdomen hard or soft?
N.4	Is the abdomen tender to the touch?
	If so:
N.4.1	Where in the abdomen does it hurt?
O.	THE NERVOUS SYSTEM
O.1	Is the sense of feeling intact on the right and left side?
	If not:
O.1.1	Where is there abnormality?
O.2	Is there a knee reflex on both sides?
O.3	Is the knee reflex the same on both sides?
O.4	Do both big toes move towards the nose in the reflex on the sole of the foot?

OBJECTIVE INVESTIGATION

P.	THE SKELETON
P.1	**Is there an accumulation of fluid at the ankles or top of the foot?**
Q.	THE URINE
Q.1	**Is the urine a normal colour?**
	If not:
Q.1.1	Is the urine a strong yellow?
Q.1.2	Is the urine unusually dark?
Q.1.3	Is the urine reddish?
Q.2	**How much urine is passed per day?**
Q.3	**Reading a urine test strip:**
Q.3.1	Are there signs of sugar (glucose)?
Q.3.2	Are there signs of protein (albumen)?
Q.3.3	Are there signs of blood (haemoglobin/erythrocytes)?
Q.3.4	Are there signs of nitrite?
Q.3.5	Are there signs of leukocytes?
Q.4	**Pregnancy test**
Q.4.1	Is the urine test positive?
Z.	**Describe the treatment carried out until now**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