SERVICE NAME: (PLEASE PRINT)

Patient Care Report

Service #:	Unit #:	Incident #: -	Pt. Record #:	Crash #:
Date of Onset: / /	Date Unit Notified: / /		Run Report Date: / /	Trauma ID #:

Dispatched For:

TIMES (MILITARY)

Dispatch Notified: : :	Time Left Scene: : :		
Unit Notified: : :	Arrived at Destination: : :		
Unit Enroute: : :	Back In Service: : :		
Arrived at Scene: : :	Total Incident Time: : :		

Minutes For Response:

911 ☐ YES ☐ NO

Minutes At Scene:

Minutes For Transport:

Time of Injury/Illness:

PATIENT INFORMATION

(Last Name) (First) (MI)

(Street Address) (Apt. #)

(City) (State) (Zip Code)

(Phone) (Date of Birth) (Age yrs. mons)

(Gender) ☐ M 1 ☐ F 2 ☐ Unk 3

(SSN#) __ __ __ - __ __ - __ __ __ __

Ethnicity: ☐ 0 Other ☐ 1 Hispanic

Race: ☐ 0 Other, including multi racial ☐ 1 White ☐ 2 Black ☐ 3 American Indian, Eskimo or Aleut ☐ 4 Asian ☐ U Undetermined

Chief Complaint:

Injury/Illness Narrative:

Past Medical History:

Pertinent Findings on Physical Exam:

Allergies:

Patient Medications:

Emerg. Med. Care Given:

Patient Response to Emerg. Med. Care:

Provider Impression: - Select one

☐ Abdominal Pain/Problems	☐ Cardiac Rhythm Disturbance	☐ Hypothermia (Trauma)	☐ Pregnancy/OB Delivery	☐ Stings/Venomous Bites
☐ Airway Obstruction	☐ Chest Pain/Discomfort	☐ Hypovolemia	☐ Psychiatric Disorder	☐ Stroke/CVA
☐ Alleged Sexual Assault	☐ Diabetic Symptoms	☐ Inhalation Injury (Toxic Gas)	☐ Respiratory Arrest	☐ Syncope/Fainting
☐ Allergic Reaction	☐ Electrocution	☐ **Not Applicable**	☐ Respiratory Distress	☐ Traumatic Hypovolemia
☐ Altered Level of Consciousness	☐ Hyperthermia	☐ Obvious Death	☐ Seizure	☐ Traumatic Injury
☐ Behavioral Disorder	☐ Hypoglycemia	☐ Other	☐ Shock	☐ Vaginal Hemorrhage
☐ Cardiac Arrest	☐ Hypothermia (Disease)	☐ Poisoning/Drug Ingestion	☐ Smoke Inhalation	☐ Unknown

Mutual Aid	EMS Tier	Destination / Transferred To

MODE OF TRANSPORT

☐ Fixed Wing ☐ Ground ☐ **None** ☐ Other ☐ Rotor Craft

DESTINATION DETERMINATION/OUT OF HOSPITAL TRIAGE CRITERIA

☐ Closest Facility				☐ Trauma Triage (GCS, Vitals)
☐ Diversion	☐ Managed Care	☐ Other	☐ Protocol	☐ Trauma Triage (Mechanism of Injury)
☐ Family Choice	☐ **Not Applicable**	☐ Patient Choice	☐ Specialty Resource Center	☐ Trauma Triage (Risk Factors)
☐ Law Enforcement Choice	☐ On-LIne Medical Direction	☐ Patient Physician Choice	☐ Trauma Triage (Anatomy of Injury)	☐ Unknown

CLINICAL INFORMATION

Time	B/P	PULSE	RESP	TEMP	Pulse O2	Glasgow Coma Scale Eye	Verb	Motor	Total	Revised Trauma Score (RTS) Resp	BP	GCS	Total	Revised Trauma Score Pediatric Resp	BP	GCS	Total
	/																
	/																
	/																
	/																

Respiratory Effort

☐ 1 Normal ☐ N **Not Assessed** ☐ 2 Shallow/Labored ☐ U Unknown ☐ 3 Shallow/Non-Labored ☐ 4 Deep/Labored ☐ 5 Deep/Non-Labored ☐ 6 Absent ☐ 7 Labored/Fatigued

Resp. Sounds

L ☐ Clear ☐ R
L ☐ Bronchi ☐ R
L ☐ Rhales ☐ R
L ☐ Wheezes ☐ R

Skin Perfusion:

☐ 1 Normal ☐ 2 Decreased ☐ 3 **Not Assessed**

Pupils:

L ☐ Normal ☐ R
L ☐ Constricted ☐ R
L ☐ Dilated ☐ R
L ☐ No react. ☐ R

Eye Opening Component

0 Not applicable
1 None
2 Responds to Pain
3 Responds to Speech
4 Spontaneous Opening

Verbal Component

For patients >5 years:
1 None
2 Non-specific sounds
3 Inappropriate words
4 Confused conversation or speech
5 Oriented and appropriate speech
9 Unknown

Glasgow Coma Scale (GCS) Values

For patients 2-5 years:
1 None
2 Grunts
3 Cries and/or screams
4 Inappropriate words
5 Appropriate words
9 Not assessed

For patients 0-23 months:
1 None
2 Persistent cry, grunting
3 Inappropriate cry
4 Cries, inconsolable
5 Smiles, coos, cries appropriately
9 Not assessed

Motor Component

For patients >5
1 None
2 Extensor posturing in response to painful stimulation
3 Flexor posturing in response to painful stimulation
4 General withdrawal in response to painful stimulation
5 Localization of painful stimulation
6 Obeys commands with appropriate motor response
9 Unknown

For patients up to 5 years
1 None
2 Extensor posturing in response to painful stimulation
3 Flexor posturing in response to painful stimulation
4 General withdrawal in response to painful stimulation
5 Localization of painful stimulation
6 Spontaneous
9 Not assessed

Revised Trauma Score (RTS) Values

Resp. Rate		Systolic B.P.		GCS Total	
10-29	4	BP>89	4	13-15	4
>29	3	76-89	3	9-12	3
6-9	2	50-75	2	6-8	2
1-5	1	1-49	1	4-5	1
None	0	None	0	< 4	0

Cardiac Arrest Information

Cardiac Arrest:	Y	N	**Bystander CPR:**	Y	N
Witnessed Arrest:	Y	N	**Pulse Restored:**	Y	N
Trauma Arrest:	Y	N	**Number of Shocks:**		

Cardio Pulmonary Arrest Time: _____

Min.	<4	<8	<12	>12	Unk.
Arrest to CPR:					
Arrest to DEFIB.					
Arrest to Meds.					

Cardiac Rhythm: I = Initial D = Destination **PLEASE NOTE: ANY CHANGES IN CARDIAC RHYTHM SHOULD BE NOTED BELOW BY (↓ TIME COLUMNS)**

I	D	↓ Time rhythm observed	I	D	↓ Time rhythm observed	I	D	↓ Time rhythm observed	I	D	↓ Time rhythm observed	I	D	↓ Time rhythm observed
		Not Applicable			AV Block - 1st			PEA (EMD)			PVCs			ST Elevation/Abnormal
		Unable to Identify			AV Block -2nd, Type I			Idioventricular			Sinus Bradycardia			SVT
		Asystole			AV Block -2nd, Type II			Junctional			Sinus Rhythm			Vent. Fibrillation
		Atrial Fibrillation			AV Block - 3rd			Pacemaker			Sinus Tachycardia			Vent. Tachycardia
														Other

Date: Signature _____

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SERVICE NAME: (PLEASE PRINT)

Service #:	Unit #:	Incident #: -	Pt. Record #:	Crash #:
Date of Onset: / /	Date Unit Notified: / /		Run Report Date: / /	Trauma ID #:

INJURY

INJURY MATRIX Select one

	Abrasion	Amputation	Blunt Injury	Burn	Crushing Injury	Dislocation/Fracture	Gunshot Wound	Laceration	Pain	Puncture/Stab	Tissue Swelling
Head											
Face											
Neck											
Chest											
Back											
Abdomen											
Pelvic / Genitalia											
Upper Extremity											
Lower Extremity											

Cause of Injury - Select one

- ☐ Accidental Chemical Poisoning
- ☐ Accidental Drug Poisoning
- ☐ Accidental Falls
- ☐ Aircraft Related Accident
- ☐ Alleged Sexual Assault
- ☐ Bicycle
- ☐ Bicycle Accident
- ☐ Bites
- ☐ Child Battering
- ☐ Drowning
- ☐ Electrocution (Non-lightning)
- ☐ Excessive Cold
- ☐ Excessive Heat
- ☐ Fire and Flames
- ☐ Firearm Assault
- ☐ Firearm Injury (Accidental)
- ☐ Firearm Self-inflicted (Intentional)
- ☐ Lightning
- ☐ Machinery Accidents
- ☐ Motor Vehicle Non-traffic Crash
- ☐ Mechanical Suffocation
- ☐ Vehicle
- ☐ Motorcycle
- ☐ Motorcycle/Vehicle
- ☐ **Not Applicable**
- ☐ Radiation Exposure
- ☐ Smoke Inhalation
- ☐ Snowmobile
- ☐ Stabbing Assault
- ☐ Vehicle/Bicycle
- ☐ Vehicle/Fixed Object
- ☐ Vehicle/Pedestrian
- ☐ Vehicle/Train
- ☐ Vehicle/Vehicle
- ☐ Venomous stings (plants, animals)
- ☐ Water transport accident
- ☐ Unknown

PROCEDURES

S = Successful U = Unsuccessful

Time	# of Attempts	Staff ID	Staff ID	S/U
	Assisted Ventilation (Positive Pressure)			
	Bleeding Controlled			
	Burn Care			
	Cardiopulmonary Resuscitation			
	Cervical Immobilization			
	Combination Airway/EOA			
	Combination Airway/ET			
	Cricothyrotomy			
	ECG Monitoring			
	Endotracheal Intubation			
	Esophageal Airway			

Time	# of Attempts	Staff ID	Staff ID	S/U
	External Cardiac Pacing			
	External Defibrillation (includes auto)			
	Glucometer			
	Intraosseous Catheter			
	Intravenous Catheter			
	Intravenous Fluids			
	Long Spineboard			
	MAST (PASG)			
	Monitoring a Medicated IV			
	Nasogastric Tube Insertion			
	Nasopharyngeal Airway Insertion			

Time	# of Attempts	Staff ID	Staff ID	S/U
	Needle Thoracotomy			
	Obstetrical Care (Delivery)			
	Oropharyngeal Airway Insertion			
	Other			
	Oxygen by Cannula			
	Oxygen by Mask			
	Pulse/Oximeter			
	Short Spine Board (KED)			
	Suction			
	Splint of Extremity			
	Traction Splint			

MEDICATIONS

Medication:	Time:	Dosage:	Route:	Staff ID:	Comments/ Response:

SCENE INFORMATION

Scene Address: Apt. #:

Scene City: | Scene State: | Scene Zip: | Scene County: | Scene Township:

Location Type:
- ☐ **Not Applicable**
- ☐ Other
- ☐ Unknown

Medical Facilities
- ☐ Doctor's Office/Clinic
- ☐ Hospital
- ☐ Nursing Home
- ☐ Other Medical Facility

Residences
- ☐ City Residence
- ☐ Farm Residence
- ☐ Other Residence

Road/Highway Areas
- ☐ Freeway
- ☐ Gravel Road
- ☐ Highway (County)
- ☐ Highway (State)
- ☐ Interstate (55 mph)
- ☐ Interstate (65 mph)
- ☐ Other Roadway
- ☐ Street

Job/Construction Site
- ☐ Construction Site
- ☐ Farm
- ☐ Manufacturing Facility
- ☐ Office Building
- ☐ Other Job Site

Water/Waterways
- ☐ Lake/Pond
- ☐ Other Water Area
- ☐ Quarry/Pit
- ☐ River/Stream
- ☐ Swimming Pool

Public Places
- ☐ Government Building
- ☐ Other Public Place
- ☐ Recreation Area
- ☐ Shopping Center

Educational Institutions
- ☐ College/University
- ☐ Grade School
- ☐ High School
- ☐ Jr. High/Middle School
- ☐ Other School
- ☐ Preschool/Daycare

Factors Affecting EMS:
- ☐ Adverse Road Conditions
- ☐ Adverse Weather
- ☐ Crowd Control
- ☐ Hazardous Material
- ☐ Language Barrier
- ☐ **None**
- ☐ **Not Applicable**
- ☐ Other
- ☐ Prolonged Extrication (>20 min)
- ☐ Unsafe Scene
- ☐ Vehicle Problems

Lights & Siren:

To Scene	From Scene	To Scene	From Scene	To Scene	From Scene
☐ Initial non-emergent, upgraded to Lights or Siren	☐	☐ Non emergent, No Lights or Siren	☐	☐ Initial emergent, downgraded to no Lights or Siren	☐
		☐ Emergent, with Lights or Siren	☐	☐ **Not Applicable**	☐

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SERVICE NAME: (PLEASE PRINT)

Service #:	Unit #:	Incident #: -	Pt. Record #:	Crash #:
Date of Onset: / /	Date Unit Notified: / /		Run Report Date: / /	Trauma ID #:

TREATMENT AUTHORIZATION

- ☐ **None**
- ☐ **Not Applicable**
- ☐ On-Line Designee
- ☐ On-Line Physician
- ☐ Other
- ☐ Physician at Scene
- ☐ Protocols
- ☐ Unable to Contact
- ☐ Unknown
- ☐ Written Orders

PRIOR AID

- ☐ **None**
- ☐ **Not Applicable**
- ☐ Other
- ☐ Unknown

Citizen/Bystander

- ☐ Bystander
- ☐ Family
- ☐ Other Citizen
- ☐ Patient

EMS Agency/Fire Dept

- ☐ Ambulance Service
- ☐ First Responder Service
- ☐ Fixed Wing Service
- ☐ Helicopter Service
- ☐ Other Agency/Fire Dept
- ☐ Rescue Service

Health Care Professional

- ☐ EMT
- ☐ First Responder
- ☐ Other Medical Professional
- ☐ Physician
- ☐ RN/LPN

Medical Facility

- ☐ Doctor's Office/Clinic
- ☐ Hospital
- ☐ Nursing Home
- ☐ Other Medical Facility

Law Enforcement

- ☐ Local Police
- ☐ Other Law Enforcement
- ☐ Sheriff
- ☐ State Patrol

SAFETY EQUIPMENT

- ☐ Airbag, Child Safety Seat Used
- ☐ Airbag Deployed, Lap Belt Used
- ☐ Airbag Deployed, No Lap Belt
- ☐ Airbag, Lap and Shoulder Belt Used
- ☐ Child Safety Seat
- ☐ Eye Protection
- ☐ Helmet
- ☐ Lap Belt Only
- ☐ **None Used**
- ☐ **Not Applicable**
- ☐ Personal Flotation Dev.
- ☐ Protective Clothing
- ☐ Protective Clothing/Gear
- ☐ Shoulder and Lap Belt
- ☐ Shoulder Belt Only
- ☐ Unknown

HUMAN FACTORS

- ☐ Asleep
- ☐ **None**
- ☐ Physically disabled
- ☐ Physically restrained
- ☐ Possibly impaired by alcohol
- ☐ Possibly impaired by other drug or chemical
- ☐ Possibly mentally disabled
- ☐ Unattended or unsupervised person
- ☐ Unconscious

INJURY INTENT

- ☐ Intentional, Self
- ☐ Intentional, Other
- ☐ Unintentional
- ☐ **Not Applicable**
- ☐ Unknown

SIGNIFICANT EXPOSURE

- ☐ Airborne Exposure
- ☐ Blood to Eyes
- ☐ Blood to Mouth
- ☐ Blood to Open Wound
- ☐ Mouth to Mouth
- ☐ Multiple Exposures
- ☐ Needlestick
- ☐ **Not Applicable**
- ☐ Other
- ☐ Other Body Fluids
- ☐ Saliva to Eyes
- ☐ Saliva to Mouth
- ☐ Unknown

EXPOSURE PRECAUTIONS

- ☐ All Precautions
- ☐ Gloves
- ☐ Gloves/Mask
- ☐ Gloves/Mask/Gown
- ☐ Goggles
- ☐ Goggles/Gown
- ☐ Gown
- ☐ Hepafilter
- ☐ Mask
- ☐ Mask/Goggles
- ☐ Mask/Goggles/Gown
- ☐ **None**
- ☐ **Not Applicable**
- ☐ Other
- ☐ Unknown

BILLING INFORMATION

Insurance - Primary:	Number:	Insurance - Secondary:	Number:
Responsible Party:			
(Last Name)	(First)	(MI)	
(Address)			
(City)	(State)	(Zip)	(Phone)

MILEAGE

Beg:

End:

Total:

INSURANCE TYPE

- ☐ No Insurance
- ☐ Private Pay
- ☐ Private Insurance
- ☐ Medicare
- ☐ Medicaid - Title XIX
- ☐ Medicare/Medicaid
- ☐ VA Insurance
- ☐ Unknown
- ☐ **Not Applicable**

PATIENT DISPOSITION

- ☐ Allowed Treatment, Refused Transport
- ☐ Canceled by EMS
- ☐ Canceled by Fire Department
- ☐ Canceled by First Response
- ☐ Canceled by Law Enforcement
- ☐ Dead at Scene
- ☐ No Patient Found
- ☐ No Treatment Required
- ☐ Non-Emergency, Alternate Transport
- ☐ **Not Applicable**
- ☐ Refused Treatment, Allowed Transport
- ☐ Refused Treatment, Refused Transport
- ☐ Treated and Released
- ☐ Treated, Transferred Care
- ☐ Treated, Transported by EMS, Improved
- ☐ Treated, Transported by EMS, No Change
- ☐ Treated, Transported by EMS, Worsened
- ☐ Treated, Transported by Private Vehicle
- ☐ Unknown

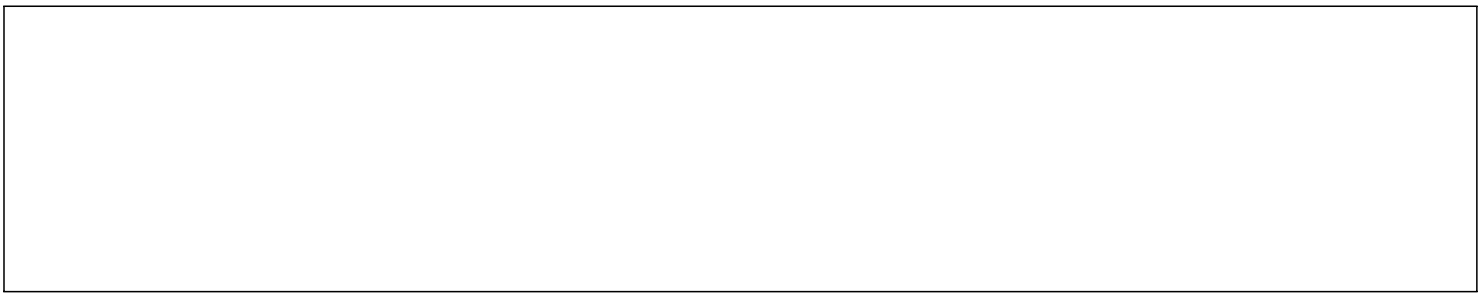
TIME	NARRATIVE
	Turned care over to:

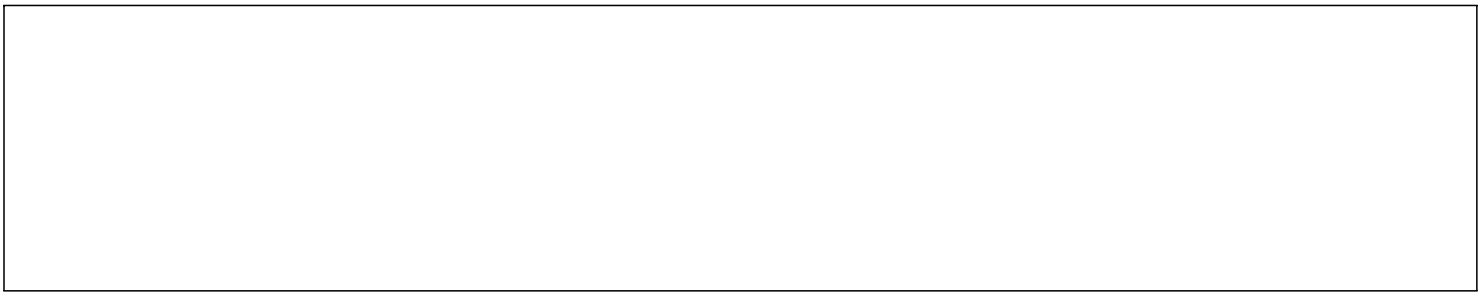
	CREW BOX	Staff ID	Driver		Level
Crew Memb 1:			Y	N	
Crew Memb 2:			Y	N	
Crew Memb 3:			Y	N	
Crew Memb 4:			Y	N	

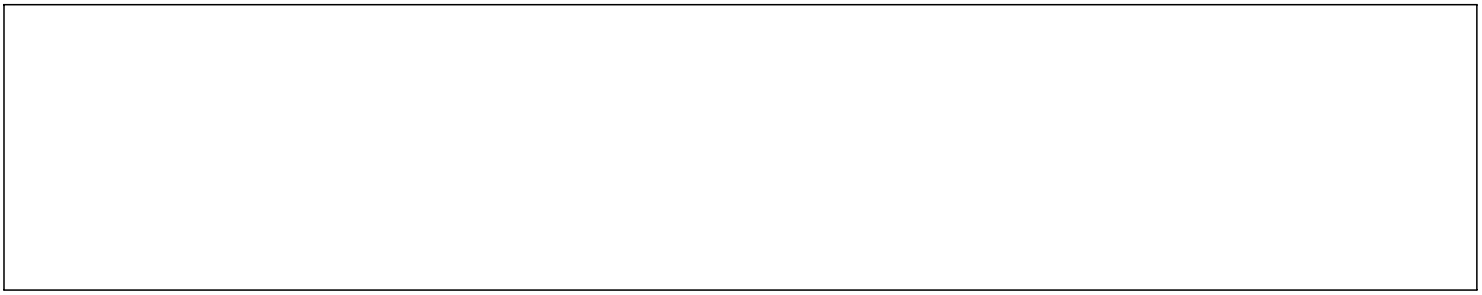
Date:

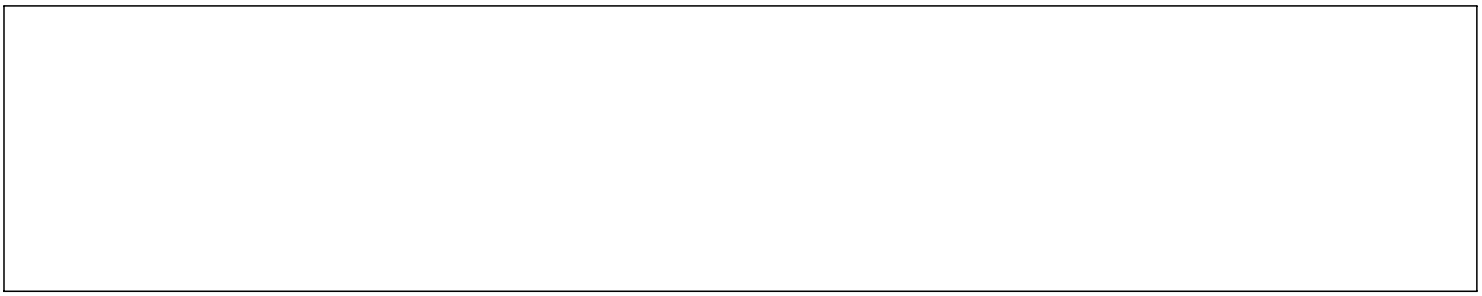
Signature _____

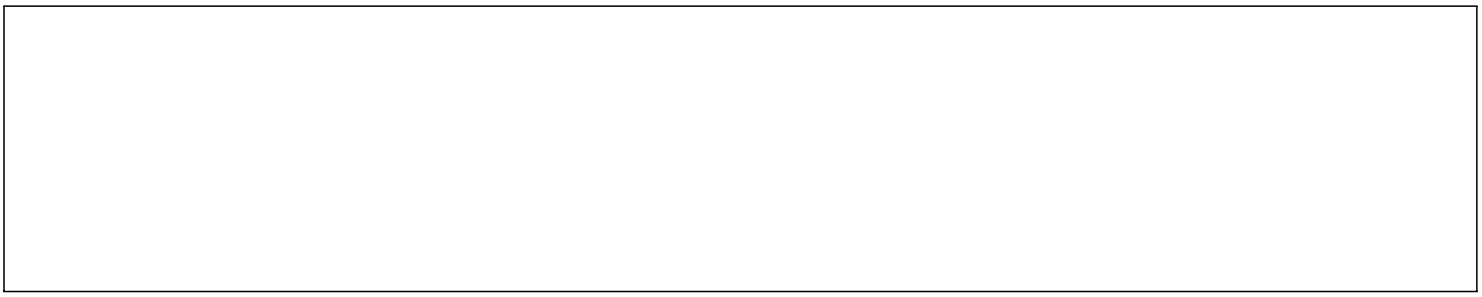
EKG STRIPS











Service Name:	Run Report Date:
Patient Name:	Page _____ of _____