Press Down Firmly. You're Making 3 Copies. USE BALL POINT PEN ONLY. 578765 NCR Systemedia

MMDDYY | RUN NO 5- | AGENCY | VEH ID

AGENCY NAME

DISPATCH INFORMATION

CALL LOCATION

LOCATION CODE: CODE

MILEAGE
END
BEGIN
TOTAL

CALL REC'D
ENROUTE
AT SCENE
FROM SCENE
AT DESTINATION
IN SERVICE
IN QUARTERS

PATIENT INFORMATION

FIRST NAME | LAST NAME

ADDRESS

APPT/UNIT NUMBER | (PHO) NE -

CITY | ST | ZIP - +4

AGE | D.O.B. MM / DD / YYYY | F ○ M ○ | SS# - -

○ Residence
○ Health
○ Farm
○ Industrial
○ Other Work
○ Recreational
○ Road
○ Other

Call Received as
○ EMERGENCY
○ NON EMERGENCY
○ STANDBY

Physician

CARE IN PROGRESS ON ARRIVAL: ○ None ○ Citizen ○ PD/FD/Other First Responder ○ Other EMS ○ PAD used

MECHANISM OF INJURY
○ MVA (✓ seat belt used →) ○ Struck by vehicle ○ Fall of ______ feet ○ Unarmed assault ○ GSW ○ Knife ○ Machinery ○ ______

○ Extrication required ______ minutes

Seat belt used? ○ Yes ○ No ○ Unknown

Seat Belt Use Reported By ○ Crew ○ Police ○ Patient ○ Other

CHIEF COMPLAINT

SUBJECTIVE ASSESSMENT

PRESENTING PROBLEM
Fill in circle

○ Airway Obstructions
○ Respiratory Arrest
○ Respiratory Distress
○ Cardiac Related (Potential)
○ Cardiac Arrest
○ Allergic Reaction
○ Syncope
○ Stroke/CVA
○ General Illness/Malaise
○ Gastro-Intestinal Distress
○ Diabetic Related (Potential)
○ Pain ______
○ Unconscious/Unresp.
○ Seizure
○ Behavioral Disorder
○ Substance Abuse (Potential)
○ Poisoning (Accidental)
○ Shock
○ Head Injury
○ Spinal Injury
○ Fracture/Dislocation
○ Amputation
○ Other ______
○ Major Trauma
○ Trauma-Blunt
○ Trauma-Penetrating
○ Soft Tissue Injury
○ Bleeding/Hemorrhage
○ OB/GYN
○ Burns
Environmental
○ Heat
○ Cold
○ Hazardous Materials
○ Obvious Death

PAST MEDICAL HISTORY
○ None
○ Allergy to ______
○ Hypertension ○ Stroke
○ Seizures ○ Diabetes
○ COPD ○ Cardiac
○ Other (List) ○ Asthma

Current Medications (List)

VITAL SIGNS

TIME	RESP	PULSE	B.P.	LEVEL OF CONSCIOUSNESS	GCS	PUPILS	SKIN	STATUS
	Rate: ○ Regular ○ Shallow ○ Labored	Rate: ○ Regular ○ Irregular	/	○ Alert ○ Voice ○ Pain ○ Unresp.		○ Normal ○ Dilated ○ Constricted ○ Sluggish ○ No-Reaction ○	○ Unremarkable ○ Cool ○ Warm ○ Moist ○ Dry ○ Pale ○ Cyanotic ○ Flushed ○ Jaundiced	○ C ○ U ○ P ○ S
	Rate: ○ Regular ○ Shallow ○ Labored	Rate: ○ Regular ○ Irregular	/	○ Alert ○ Voice ○ Pain ○ Unresp.		○ Normal ○ Dilated ○ Constricted ○ Sluggish ○ No-Reaction ○	○ Unremarkable ○ Cool ○ Warm ○ Moist ○ Dry ○ Pale ○ Cyanotic ○ Flushed ○ Jaundiced	○ C ○ U ○ P ○ S
	Rate: ○ Regular ○ Shallow ○ Labored	Rate: ○ Regular ○ Irregular	/	○ Alert ○ Voice ○ Pain ○ Unresp.		○ Normal ○ Dilated ○ Constricted ○ Sluggish ○ No-Reaction ○	○ Unremarkable ○ Cool ○ Warm ○ Moist ○ Dry ○ Pale ○ Cyanotic ○ Flushed ○ Jaundiced	○ C ○ U ○ P ○ S

OBJECTIVE PHYSICAL ASSESSMENT

COMMENTS

TREATMENT GIVEN *FILL IN CIRCLE*

○ Moved to ambulance on stretcher/backboard
○ Moved to ambulance on stair chair
○ Walked to ambulance
○ Airway Cleared
○ Oral / Nasal Airway
○ Esophageal Obturator Airway / Esophageal Gastric Tube Airway (EOA/EGTA)
○ EndoTracheal Tube (E/T)
○ Oxygen Administered @ ______ L.P.M., Method ______
○ Suction Used
○ Artificial Ventilation Method ______
○ C.P.R. in progress on arrival by: ○ Citizen ○ PD/FD/Other First Responder ○ Other
○ C.P.R. Started @ Time ▶ ______ Time from Arrest Until C.P.R. ▶ ______ Minutes
○ EKG Monitored (Attach Tracing) [Rhythm(s) ______]
○ Defibrillation/Cardioversion No. Times ______ ○ Manual ○ Semi-automatic

○ Medication Administered (Use Continuation Form)
○ IV Established Fluid ______ Cath. Gauge ______
○ Mast Inflated @ Time ______)
○ Bleeding / Hemorrhage Controlled (Method Used: ______)
○ Spinal Immobilization Neck and Back
○ Limb Immobilized by ○ Fixation ○ Traction
○ (Heat) or (Cold) Applied
○ Vomiting Induced @ Time ______ Method ______
○ Restraints Applied, Type ______
○ Baby Delivered @ Time ______ In County ______
○ Alive ○ Stillborn ○ Male ○ Female
○ Transported in Trendelenburg position
○ Transported in left lateral recumbent position
○ Transported with head elevated
○ Other: ______

DISPOSITION (See List) | **DISP. CODE** | **CONTINUATION FORM USED** YES ←

CREW

IN CHARGE	DRIVER'S NAME	NAME	NAME
○ EMT ○ AEMT #	○ CFR ○ EMT ○ AEMT #	○ CFR ○ EMT ○ AEMT #	○ CFR ○ EMT ○ AEMT #

NON-HOSPITAL DISPOSITION CODES:

NURSING HOME	001
OTHER MEDICAL FACILITY	002
RESIDENCE	003
TREATED BY THIS UNIT, TRANSPORTED BY ANOTHER UNIT	004
REFUSED MEDICAL AID OR TRANSPORT	005
CALL CANCELLED	006
STANDBY ONLY (NO PATIENT)	007
NO PATIENT FOUND	008
OTHER	010

THE RULE OF NINES
Estimation of Burned Body Surface (PERCENT)

ADULT

INFANT

Hospital Receiving Agent

(IF REQUIRED)

COMPLETE ON WHITE (AGENCY) COPY ONLY

SIGNATURE

REFUSAL OF TREATMENT/TRANSPORTATION

NEGATIVA A RECIBIR TRATAMIENTO/SER TRASLADADO

RELEASE

EXONERACION DE RESPONSABILIDADES

COMPLETE ON WHITE (AGENCY) COPY ONLY
LLENE UNICAMENTE LA COPIA BLANCA (DE LA AGENCIA)

I hereby refuse (treatment/transport to a hospital) and I acknowledge that such treatment/transportation was advised by the ambulance crew or physician. I hereby release such persons from liability for respecting and following my express wishes.

Mediante la presente declaro que me niego a aceptar el tratamiento/traslado a un hospital y reconozco asimismo que el medico o el personal de la ambulancia recomendaron ese tratamiento/traslado. Consiguientemente, eximo a dichas personas de toda responsabilidad por haber respetado y cumplido mid deseos expresos.

Signed: _____
Firma:

Witness: _____
Testigo:

Glasgow Coma Scale

Eye Opening	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
Verbal Response	Oriented	5
	Confused	4
	Inappropriate Words	3
	Incomprehensible Sounds	2
	None	1
Motor Response	Obeys Command	6
	Localizes Pain	5
	Withdraw (pain)	4
	Flexion (pain)	3
	Extension (pain)	2
	None	1

Patient's Best Verbal Response
Arouse patient with voice or painful stimulus.

Patient's Best Motor Response
Response to command or painful stimulus.

Total GCS Score :3-15

ICD DIAGNOSTIC CODE

INSURANCE ID #

CARRIER

1 ☐ MEDICARE 2 ☐ MEDICAID 3 ☐ BLUE CROSS 4 ☐ COMMERCIAL INSURANCE 5 ☐ SELF PAY

WAS THIS A WORKER'S COMPENSATION INJURY: ☐ YES ☐ NO INSURANCE CODE _____

PATIENT'S EMPLOYER: _____ PHONE (_____) _____

EMPLOYER'S ADDRESS: _____

RESPONSIBLE PARTY: _____ PHONE (_____) _____

ADDRESS: _____ (ZIP: _____) RELATION: _____