

Southern Tier EMS Program Agency
BLS 12-Lead EKG Acquisition Report

Agency Name: _____

EMT Whom Acquired: _____ EMT #: _____

Date Report Completed: _____ Date of Call: _____

Patient's Age: _____ Patient's Sex: _____

Any problems with acquiring the 12-Lead? If so, please describe:

Any problems with transmitting the 12-Lead? If so, please describe:

Was this a STEMI? YES NO UNKNOWN

Was Medical Control
Contacted? YES NO

Was ALS Requested? YES NO

Receiving Physician
Name: _____

Transport Destination: _____

Please complete and either fax it to (716) 372-0614 or e-mail it as an attachment to stems@sthcs.org