

AGENCY NAME
DISPATCH INFORMATION
CALL LOCATION

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

PATIENT INFORMATION
FIRST NAME
LAST NAME
ADDRESS
APPT / UNIT NUMBER
(PHONE)
CITY
ST
ZIP
AGE
D.O.B.
SEX

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
Extrication required
Seat belt used?
Seat Belt Use Reported By
Crew
Patient
Police
Other

MECHANISM OF INJURY
MVA
Struck by vehicle
Fall of feet
Unarmed assault
GSW
Knife
Machinery

CHIEF COMPLAINT
SUBJECTIVE ASSESSMENT
PRESENTING PROBLEM
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
Major Trauma
Trauma-Blunt
Trauma-Penetrating
Soft Tissue Injury
Bleeding/Hemorrhage
OB/GYN
Burns
Environmental
Heat
Cold
Hazardous Materials
Obvious Death

Table with columns: PAST MEDICAL HISTORY, VITAL SIGNS, TIME, RESP, PULSE, B.P., LEVEL OF CONSCIOUSNESS, GCS, PUPILS, SKIN, STATUS. Includes sub-sections for Allergy, Hypertension, Stroke, Diabetes, COPD, Cardiac, Asthma, and various vital signs.

OBJECTIVE PHYSICAL ASSESSMENT

COMMENTS

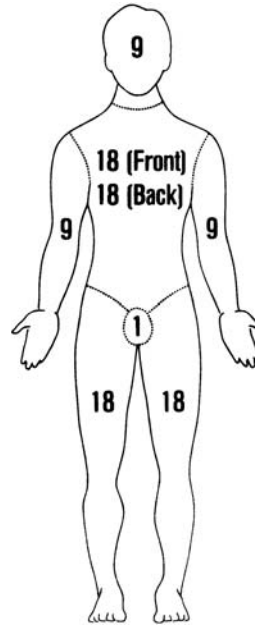
TREATMENT GIVEN
Moved to ambulance on stretcher/backboard
Moved to ambulance on stair chair
Walked to ambulance
Airway Cleared
Oral / Nasal Airway
Esophageal Obturator Airway / Esophageal Gastric Tube Airway (EOA/EGTA)
EndoTracheal Tube (E/T)
Oxygen Administered @
Suction Used
Artificial Ventilation Method
C.P.R. in progress on arrival by: Citizen PD/FD/Other First Responder Other
C.P.R. Started @ Time
EKG Monitored (Attach Tracing) [Rhythm(s)]
Defibrillation/Cardioversion No. Times
Manual Semi-automatic
Medication Administered (Use Continuation Form)
IV Established Fluid
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
CREW
IN CHARGE
DRIVER'S NAME
NAME
NAME
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	Patient's Best Verbal Response Arouse patient with voice or painful stimulus.
	To Voice	3	
	To Pain	2	
	None	1	
Verbal Response	Oriented	5	Patient's Best Motor Response Response to command or painful stimulus.
	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	

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: _____