EMS NARRATIVE EXAMPLE

ID- 74 yowm height= 5'6" weight=146lbs

CC- generalized weakness

PMH- Dementia, COPD, DM, GERD, HTN, smoker 1 pack a day x 30 year, patient lives at home and has a health care aide to assist in his daily needs.

Allergies- NKDA

Medications- ASA 325mg qd, Mucinex DM(1)bid prn, Donepezil 5 mg hs, Cartia XT 180 mg qd, Colace 100 mg bid, Plavix 75mg qd, Simvastatin 20 mg qd, Zantac 150 mg bid, Atenolol 25 mg qd

HPI- Per the home health aide on scene, the patient was found this morning @ appx 0930 lying on the floor and unable to get up on his own. The patient was thought to be trying to ambulate to the bathroom and it is unknown if the patient fell or just sit down enroute. The time of the incident is also unknown but the patient was last seen the night before at approximately 2000hrs. Health Aide stated that confusion is normal with his dementia.

PE - On my arrival the patient was found still lying on the floor in wet clothes and a strong odor of urine. Patient was alert to his name and location but was confused how he ended up on the floor or how long he had been there. GCS=14, skin warm/dry, PERL, airway open, speaking full clear sentences without noted respiratory distress, mallampati=1, trachea midline, no jvd noted, chest symmetrical, BBSCTA x 4, abdomen soft non tender in all quadrants, pelvis stable without crepitus or pain on palpation. Lower extremities with good pedal pulses movement and sensation, Upper extremities with good radial pulses movement and sensation. No obvious trauma was noted on his body. Patient was able to stand up with some assistance with complaint"of feeling weak."

Rx- Initial vitals: BP=158/95, Spo2=96% on room air, Respiratory 18 BBSCTA, Pulse=98 NSR, BS=180. Patient walked to the stretcher with assistance and was transported to_____ at his request. Contact was made with the hospital inbound on hear radio with the above information. No orders were given or further questions were asked. Patient was turned over to the ED staff and placed in bed_____. A copy of our patient report along with a copy of all vitals were left with the patients RN.

Signature: Anyone Anywhere, EMTP

USE PEN ONLY - PRESS FIRMLY

Run # _____ Page 1

Date 4/22/12

Name _____ (M)/F

Street _____

City _____ State _____ Zip _____

Age 69 DOB _____

SSN _____

Call Location Residence

Squad _____ Unit # _____

☐ 1st Resp. ☐ BLS ☒ Intermed ☐ Paramedic

HOSPITAL CONTACT
Time 1633 ☒ Radio ☐ Telephone ☐ Telemetry

Phone ( ) _____

Family Dr. _____

Destination _____

RELATIVE (If a minor) _____

Twp. County/Zip _____

Med. Alert Y /(N)

Onset _____
Dispatched _____
En Route _____
On Scene _____
Left Scene _____
At Hospital _____
In Service _____

Type of Call *(Check all that apply)*
☒ Home ☐ MVC ☐ Injury
☐ Farm ☐ Industrial ☐ Acute Illness
☐ Work ☐ Nursing Home ☐ Assisted Living
☒ Fall
☐ Chronic Illness
☐ Other _____

Response to Scene
☒ Emergent

Response to Destination
☒ Code 3 ☐ Code 4 ☐ NT

LOADED MILES
Finish _____
Start _____
Total _____

On Arrival Patient Was:
☒ Conscious
☐ Unconscious
☐ Altered Mental Status
☒ Ambulatory
☒ Alert Times: 1 2 3 (4)
☒ Stretcher Required
☐ Required Restraints
☐ Combative
☐ In Custody
(CHECK ALL THAT APPLY)

Signs/Symptoms
☐ CVA ☐ Other _____
☐ MI
☐ Internal Hemorrhage
☐ Shock
☒ Diabetic
☐ Seizure
☐ CHF
☐ Head Injury
☐ General Illness
(CHECK ALL THAT APPLY)

Observations:
☐ Visable Severe Hemorraging
☐ Visable Deformity
☐ Dysphasia (Difficulty Speaking)
☐ Arm Drift
☐ Facial Droop ☐ Swelling of _____
☐ Diaphoresis
☐ Laceration ☐ Other _____
☐ Abrasion
☐ Avulson of _____
(CHECK ALL THAT APPLY)

Complaints:
☐ SOB
☐ Chest Pain
☐ Nausea
☒ Weakness
☐ Vertigo
☐ Laceration
☐ Paralysis of _____
☐ Level of Pain 1 2 3 4 5 6 7 8 9 10
☒ Feeling Faint Location of pain _____
☐ Other _____
(CHECK ALL THAT APPLY)

Law Enforcement on Scene
Yes ☒ No ☐ Unit # _____

FEES
Base _____
Mileage _____
Total _____

VITAL SIGNS

	By:	By:	By
Times	1620	1625	1633
B/P	130/88	127/87	137/94
Pulse	134	123	107
Respiration	18	18	19
O2 Saturation	90	91	96%
Cap. Refill Child Only			
Temperature			

Breath Sounds
RIGHT / LEFT
☒ Present ☒
☐ Diminished ☐
☐ Absent ☐
☐ Crackels ☐
☐ Wheezing ☐
☐ Rhonchi ☐
☒ Equal
ON SCENE

Breath Sounds
RIGHT / LEFT
☒ Present ☒
☐ Diminished ☐
☐ Absent ☐
☐ Crackels ☐
☐ Wheezing ☐
☐ Rhonchi ☐
☒ Equal
ENROUTE

Oxygen 4 L/min via NC Time 1626 By _____ OP/NP
Airway Suction _____ Yankauer Cath FR _____ OT/NT
ETT Size _____ ETT Marker Line _____ Combi/PTL
Intubated By _____ # of Attempts _____ # of Successes _____
IO/IV Cath Size 20 Location (R) Hand ASPETIC TECH (Y) N
By _____ Time 1634 # of Attempts 1 # of Successes 1
Amount Infused 50 cc INT Placement By _____
Blood Draw Time _____ By _____
Solution: ☒ 0.9 N/S
Cardiac Monitor (Y) N Interp. Sinus Tach By _____ Time 1626
Defib. ☐ AED ☐ Manual
By _____
Glucoscan High mg/dl Time 1627 By _____
Restrained: Seatbelt: Lap/Shoulder Airbag Childseat Helmet
Ejected _____ Feet Driver / Passenger
Skin condition Warm Skin color Pink Pupils E/R

Dressing / Bandages / Wound Care

Fracture Immobilization:
Sager / Back Board CFO
Vacuum / Hare / PASG
Other: _____

Spinal Immobilization:
LSB / KED / CID
Other: _____

Extrication:
Auto / Home
Other _____
Extrication Time: _____
By: _____

NARRATIVE

Called to scene of male pt. who fainted and was found lying in the yard. Pt. states he was out in barn and was attempting to walk back to house when he began to feel faint and passed out. Pt. has hx of CVA approximately a year ago and is a diabetic. Upon arrival found pt inside sitting at kitchen table. Pt. is a/o x4, Skin PWD. Pt. denies any pain. Pt (-) for SOB and Chest Pains. Pt. denies any nausea or vomiting. Pt vitals assessed as noted. Cardiac Monitor applied showing sinus tach. O2 applied at 4LPM via NC. IV established in (R) hand with 20 gauge

cont. →

Narrative Continue: Accucheck attempted x2 with a reading of High. Pt. placed in semi-fowlers for comfort. Pt. transported Code III to . Upon arrival pt. placed in Exam 5 and care transferred to ER. Staff.

Meds	Dosage	Route	Time	Given By	Order EB/SO
O_2	4Lpm	NC	1626		SO
.9% NACL	50cc	IV	1634		SO

Morphine Sulfate Security Bag ID Number:

EYE OPENI	INIT.	ONGOING
Spontaneous	4 ✓	✓
To Voice	3	
To Pain	2	
None	1	
VERBAL RESPONSE		
Oriented	5 ✓	✓
Confused	4	
Inapprop. Words	3	
Incompreh. Words	2	
None	1	
MOTOR RESPONSE		
Obey Command	6 ✓	✓
Locate Pain	5	
Withdraw	4	
Flexion Pain	3	
Extension	2	
None	1	
TOTAL	15	15

Revised Trauma Score
TOTAL
(Score on Back)

Patient Race: ☑ White, non-Hispanic ☐ White, Hispanic ☐ Black, non-Hispanic ☐ Black, Hispanic ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander

Chronic Illness: Diabetes, CVA

Present Medications: On File

Allergies: NKDA ☐ Sulfa ☐ ASA ☐ PCN ☐ Nitro ☐ Morphine

1) Reporter 2) Driver ☐ DNRCC ☐ DNR Arrest

3) 4) 5 6)

Patient Received By: Attending Physician:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY BENEFITS PAYABLE TO THIS SERVICE. I ALSO REQUEST PAYMENT OF GOVERNMENT AND / OR INSURANCE BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT OR MYSELF. I HAVE RECEIVED A COPY OF THE SERVICE'S NOTICE OF PRIVACY POLICY.

X _____

I UNDERSTAND THAT MEDICARE/MEDICAID/and MANY INSURANCE COMPANIES PAY ONLY FOR SERVICES WHEN THEY ARE REASONABLE AND NECESSARY, SEE FOR EXAMPLE SECTION 1862 (A)(1) OF THE MEDICARE LAW. IF IT IS DETERMINED THAT A PARTICULAR SERVICE IS NOT REASONABLE AND NECESSARY UNDER MEDICARE/MEDICAID PROGRAM STANDARDS, MEDICARE/MEDICAID OR THAT MY INSURANCE COMPANY WILL DENY OR NOT FULLY PAY FOR THIS SERVICE, I AGREE TO PAY ALL REASONABLE CHARGES ASSOCIATED WITH THE AMBULANCE TRANSPORT TOGETHER WITH COSTS OF COLLECTION IF NOT PAID WHEN DUE. THIS SIGNATURE WILL ALLOW SUBMISSION TO MEDICARE FOR THIS AND FUTURE AMBULANCE TRANSPORTS.

X _____

I, THE UNDERSIGNED, WITNESS THAT THE PATIENT IDENTIFIED ABOVE, IS NOT ABLE TO SIGN ON HIS OR HER BEHALF, BECAUSE OF A PHYSICAL OR MENTAL IMPAIRMENT.

X _____

REASON: _____ **RELATIONSHIP:** _____ **DATE:** _____

Medicaid Number _____ Medicare Number _____

White - EMS FILE Yellow - EMS BILLING Pink - SQUAD HOUSE Gold - HOSPITAL

USE PEN ONLY - PRESS FIRMLY

Run # 11- Page 1

Date 8/24/11

Name M (F) Squad Unit #

Street Twp. ☐ 1st Resp. ☐ BLS ☐ Intermed ☒ Paramedic

City State Zip HOSPITAL CONTACT Time 0627 ☒ Radio ☐ Telephone ☐ Telemetry

Age 95 DOB Phone ( ) Destination

SSN Family Dr. RELATIVE (If a minor)

Call Location Twp. County/Zip Med. Alert Y / N

Onset Dispatched En Route On Scene Left Scene At Hospital In Service

Type of Call *(Check all that apply)*

☒ Home ☐ MVC ☒ Injury ☒ Fall ☐ Chronic Illness

☐ Farm ☐ Industrial ☐ Acute Illness ☐ Other

☐ Work ☐ Nursing Home ☐ Assisted Living

Response to Scene ☒ Emergent

Response to Destination ☒ Code 3 ☐ Code 4 ☐ NT

LOADED MILES Finish Start Total

On Arrival Patient Was:

☒ Conscious
☐ Unconscious
☐ Altered Mental Status
☐ Ambulatory
☒ Alert Times: 1 2 (3) 4
☒ Stretcher Required
☐ Required Restraints
☐ Combative
☐ In Custody
(CHECK ALL THAT APPLY)

Signs/Symptoms

☐ CVA ☐ Other
☐ MI
☐ Int
☐ Sho
☐ Diat
☐ Seizu
☐ CHF
☐ Head Injury
☐ General Illness
(CHECK ALL THAT APPLY)

Observations:

☐ Visible
norraging
Speaking)
elling of
☐ Diaphoresis
☐ Laceration ☐ Other
☐ Abrasion
☐ Avulson of
(CHECK ALL THAT APPLY)

Complaints:

☐ SOB
☐ Chest Pain
☐ Nausea
☐ Weakness
☐ Vertigo
☐ Laceration
☐ Paralysis of
☒ Level of Pain 1 2 3 4 5 6 7 8 9 (10) severe
☐ Feeling Faint Location of pain
☐ Other
(CHECK ALL THAT APPLY)

Law Enforcement on Scene Yes ☐ No ☒ Unit #

FEES Base Mileage Total

VITAL SIGNS

	By:	By:	By:
Times	0620	0640	
B/P	160/P	154/P	/
Pulse	78	82	
Respiration	22	20	
O2 Saturation	97%	98%	
Cap. Refill Child Only			
Temperature			

Breath Sounds ON SCENE	RIGHT	LEFT
	☐	☒
Present	☐	☐
Diminished	☐	☐
Absent	☐	☐
Crackels	☐	☐
Wheezing	☐	☐
Rhonchi	☐	☐
	☒	
Equal		

Breath Sounds ENROUTE	RIGHT	LEFT
Present	☐	☐
Diminished	☐	☐
Absent	☐	☐
Crackels	☐	☐
Wheezing	☐	☐
Rhonchi	☐	☐
Equal		

Oxygen 2 L/min via N.C Time 0626 By OP/NP

Airway Suction Yankauer Cath FR OT/NT

ETT Size ETT Marker Line Combi/PTL

Intubated By # of Attempts # of Successes

IO (N) Cath Size 25 Location (L) Hand ASEPTIC TECH Y/N

By Time 0622 # of Attempts 1 # of Successes 1

Amount Infused T.Ko INT Placement By

Blood Draw Time By

Solution: ☒ 0.9 N/S

Cardiac Monitor (Y) / N Interp. Sinus By Time 0622

Defib ☐ AED ☐ Manual

By

Glucoscan mg/dl Time By

Restrained: Seatbelt: Lap/Shoulder Airbag Childseat Helmet

Ejected Feet Driver / Passenger

Skin condition Warm & Dry Skin color Pink Pupils

Dressing / Bandages / Wound Care

Fracture Immobilization: Sager / Back Board CFO Vacuum / Hare / PASG Other:

Spinal Immobilization: LSB / KED / CID Other:

Extrication: Auto / Home Other:

Extrication Time: By:

NARRATIVE

CC - Fall

Hx. Pt had an unwitnessed fall to a carpeted floor. Pt. had just Awoke & when she got out of bed, family members heard her fall.

Patient Name | Run # 11- | Date: 8/24/11

Narrative Continued:

Ax- Found Pt lying on her (R) side AFOX 3 (Normal) complaining of Lower back Pain, NO deformity noted, upon exam increased Pain in (L) hip Area. Pt. difficult to talk to due to hearing loss. Pt. Secured to a vacuum mattress in Position found (R) side fetal Position

Rx- IV - 22g of .9% NS @ TKO

O2 - 2 L/min via NC

Monitor - NSR, , Vacuum Splint as found

Meds	Dosage	Route	Time	Given By	Order ER/SO
Morphine	2 mg	IVP	0638		SO
Tx- Contacted E.R for an order to give Morphine					
E.R said it was OK					

GLASGOW SCALE

EYE OPENING		INIT.	ONGOING
Spontaneous	4		
To Voice	3	X	X
To Pain	2		
None	1		
VERBAL RESPONSE			
Oriented	5	X	X
Confused	4		
Inapprop. Words	3		
Incomprehen. Words	2		
None	1		
MOTOR RESPONSE			
Obey Command	6	X	X
Locate Pain	5		
Withdraw	4		
Flexion Pain	3		
Extension	2		
None	1		
TOTAL		14	14

Revised Trauma Score

TOTAL

Morphine Sulfate Security Bag ID Number: AB00 546 0cc

Patient Race: ☒ White, non-Hispanic ☐ White, Hispanic ☐ Black, non-Hispanic ☐ Black, Hispanic ☐

Chronic Illness: hypertension, thyroid

Present Medications: with Pt, vitamin C

Allergies: Sulfa

☒ Sulfa ☐ ASA ☐ PCN ☐ Nitro ☐ Morphine

1) Reporte 2) Driver ☐ DNRCC ☐ DNR Arrest

3) 4) 5 6)

Patient Received By: Attending Physician:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY BENEFITS PAYABLE TO THIS SERVICE. I ALSO REQUEST PAYMENT OF GOVERNMENT AND / OR INSURANCE BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT OR MYSELF. I HAVE RECEIVED A COPY OF SERVICE'S NOTICE OF PRIVACY POLICY.

X

I UNDERSTAND THAT MEDICARE/MEDICAID/and MANY INSURANCE COMPANIES PAY ONLY FOR SERVICES WHEN THEY ARE REASONABLE AND NECESSARY, SEE FOR EXAMPLE SECTION 1862 (A)(1) OF THE MEDICARE LAW. IF IT IS DETERMINED THAT A PARTICULAR SERVICE IS NOT REASONABLE AND NECESSARY UNDER MEDICARE/MEDICAID PROGRAM STANDARDS, MEDICARE/MEDICAID OR THAT MY INSURANCE COMPANY WILL DENY OR NOT FULLY PAY FOR THIS SERVICE, I AGREE TO PAY ALL REASONABLE CHARGES ASSOCIATED WITH THE AMBULANCE TRANSPORT TOGETHER WITH COSTS OF COLLECTION IF NOT PAID WHEN DUE. THIS SIGNATURE WILL ALLOW SUBMISSION TO MEDICARE FOR THIS AND FUTURE AMBULANCE TRANSPORTS.

X

I, THE UNDERSIGNED, WITNESS THAT THE PATIENT IDENTIFIED ABOVE, IS NOT ABLE TO SIGN ON HIS OR HER BEHALF, BECAUSE OF A PHYSICAL OR MENTAL IMPAIRMENT.

X

REASON: RELATIONSHIP: DATE:

Medicaid Number Medicare Number

White - EMS FILE Yellow - EMS BILLING Pink - SQUAD HOUSE Gold - HOSPITAL

MEDIC UNIT

NAME: | DATE: 2/11/12 | RESPON. PARTY: SelF

ADDRESS: | DOL | AGE: 75 | ADDRESS: Sand

CITY: | STATE: | SEX: M (F)

COUNTY. | ZIP: | MC#:

LOCATION: Residents | HS#:

PHYSICIAN: | S.S.#.

DESTINATION. | INS.:

RECEIVED	AT SCENE	ENROUTE	DESTINATION	CLEAR
1824	1848	1904	1913	

CHIEF COMPLAINT:

weakness, dehydrated, pain all over

VITAL SIGNS:

TIME	B/P	PULSE	RESP.	TEMP.
1908	160/95	116	16	-

EKG RHYTHM & DEFIBRILLATION

TIME	RHYTHM
1908	A-F.D

ASSESSMENT: ☑ CONSCIOUS ☐ DISORIENTED ☐ UNCONSCIOUS ☐ UNRULY ☐ DAS

SKIN COLOR: ☑ NORMAL ☐ CYANOTIC ☐ PALE, ASHEN ☐ FLUSHED ☐ JAUNDICED

SKIN COND.: ☐ HOT ☐ COOL ☑ WARM ☐ MOIST ☑ DRY

PUPILS: ☑ RESPONSIVE ☐ UNEQUAL ☐ DILATED ☐ CONSTRICTED ☐ NON-REACTIVE

BLANCHING: ☐ GOOD ☐ POOR

TURGOR: ☐ GOOD ☑ FAIR ☐ POOR

TREATMENT:

- ☐ AIRWAY ORAL NASAL
- ☐ OXYGEN
- ☐ SUCTION AIRWAY
- ☐ CPR
- ☐ VENTILATION
- ☐ ENDOTRACHAEL TUBE SIZE
- ☐ NASOGASTRIC TUBE SIZE
- ☐ BLEEDING CONTROL
- ☐ BANDAGING
- ☐ FRACTURE IMMOBILIZATION
- ☐ SPINAL IMMOBILIZATION
- ☐ TRACTION SPLINT
- ☐ DELIVERY: INFANT VIABLE YES ___ NO ___ TIME ___
- ☑ ALLERGIES: Morphine
- ☑ GLASGOW COMA SCALE 15
- ☑ I.V. FLUIDS
- ☑ BLOOD DRAWN
- ☐ BLOOD GLUCOSE LEVEL
- ☑ CARDIAC MONITOR
- ☐ TRANSPORT ONLY

DRUGS

TIME	DRUG/S	ORD. BY
1905	NS	3

OXYGEN ADMINISTRATION:

TIME	ADJUNCT	LPM	02 SAT %
1908	Ø	RH	96

MEDIC ALERT TAG: YES (NO)

SEAT BELT HELMET WORN

AIR BAG CHILD SEAT

ORDERED BY: 1. ER 2. AT

EQUIPMENT LEFT

HOSPITAL NOTIFIED

1910

SIGNATURE AND TITLE OF PATIENT AND/OR EQ

075Y F
MED 02/11/2012
ADM:
REF:
DOB

75y/o F has C/O weakness, dehydration and pain all over. Per family member this is over a 2 week period. Good general impression. Hx x 4 I/C S assessment. Pt moved to EMS cot by sheet lift. 20g IV to (R) hand 2nd attempt. Blood draw. Cardiac monitor and vitals as noted. Pt transported W/O incident or complications. Verbal report and Pt care turned over to ER staff.

CREW ☒ ☐ ☐

☒ COMPLETING REPORT ☐ ☐

REFUSAL OF SERVICE THE UNDERSIGNED HEREBY RELEASES THIS DEPARTMENT AND ITS PERSONNEL FROM ANY AND ALL CLAIMS IN CONNECTION WITH THE UNDERSIGNEE'S REFUSAL TO ACCEPT TRANSPORTATION AND/OR MEDICAL SERVICE ON ___

SIGNATURE: ___ WITNESS SIGNATURE: ___

MED 02/11/2012 075Y F
211 -01
ZOLL Medical Corporation
8000-0300
ZOLL Medical Corporation
Recorder P/N: 8000-0300
HR= 1099

SQUAD _____ Nurse Sign _____

DATE 4/11/12 RUN # _____ RUN SHEET Time 10[illegible]

Name _____ Phone _____

Address _____ County of Residence _____

City _____ State _____ Zip _____

Age 74 Birth Date _____ sex (M) F Race W SS # _____

Location of Call _____ City / Zip _____

Twp / County _____ Factors Affecting Care DEMENTIA

Destination _____ Family Physician _____

Hospital Code _____ ER Doctor _____

TIME DISP RECD	0948
TIME PAGED	0948
TO SCENE	0950
AT SECNE	1002
TO HOSP	1011
AT HOSP	1027
TO QRTS	1045
IN QRTS	1103
START MILES	67411.2
END MILES	67473.2
TOTAL MILES	11.0

Hosp Contact : ☑ Radio ☐ Cell Phone / Phone ☐ Dispatch Responding Unit : ☑ ALS ☐ BLS ☐ First Responder

Type of Run : ☑ Emergency ☐ Non- Emergency ☐ Scheduled ☐ Hospital Transfer ☐ Transport Only

Type of Call : ☑ Home ☐ Farm ☐ Industrial ☐ Traffic ☐ Other _____

Transport Vehicle Type : ☑ Ground ☐ Air ☐ Other _____

Severity of Condition: ☐ Stable ☐ Unstable ☐ Minor ☐ Serious ☐ Critical ☐ DOA ☐ DNR ☐ DNR / CC ☐ DNR/CC/A

Onset Date 4/11/12 Onset Time _____ Allergies : ☑ NKA ☐ PCN ☐ SULFA ☐ Other _____

Chronic Illness Dementia **Present Medications** PLAVIX CARTIA

PACLOTONE

TIME	Drug/Sol	Dose	Route	Defib/Card	Watt/Sec	Rhythm	Given By
	Oxygen	lpm					

	B/P	PULSE	RESP	SPO2	TEMP
1006	158/90	98	18	96%	—
1016	134/70	96	18	97%	
1026	121/74	96	18	98%	

PUPILS L R
☑ Respond
☐ Unequal
☐ Dilated
☐ Constrict
☐ No React

LUNG SOUNDS L R
☑ Clear
☐ Rales
☐ Rhonchi
☐ Wheezes
☐ Dimished
☐ Absent

LOC
☑ Alert
☐ Verbal
☐ Painful
☐ Unresponsive
☐ Other

Skin Color
☑ Normal
☐ Flushed
☐ Pale /Ashen
☐ Cyanotic
☐ Jaundice

Skin Condition
☐ Cool
☑ Warm
☐ Moist
☐ Diaphoretic
☑ Dry

SUSPECTED NATURE OF PROBLEM

☐ Abd Pain
☐ Alcohol Related
☐ Allergic reaction
☐ Anxiety
☐ Assaults
☐ Behavior Disorder
☐ Bleeding
☐ Burns
☐ Cardiac
☐ Diabetic
☐ Fever
☐ Fracture Sprain
☐ Head Injury
☐ Multiple Complaints
☐ N & V
☐ Multiple trauma ☐ Blunt ☐ Penetrating
☐ OB / Gyn
☐ Overdose
☐ Poisoning
☐ Respiratory
☐ Seizure
☐ Shooting
☐ Spinal Cord
☐ Stabbing
☐ Stroke
☐ Suicide Attempt
☐ Unconscious
☑ Other Weakness

TREATMENT GIVEN

☐ Airway
☐ Oral Size _____
☐ Nasal size _____
☐ Cannula
☐ Mask
☐ Bandaging
☐ Burn Care
☐ By Stander CPR started _____
☐ CPR-squad started _____
Time Stopped _____
☐ Cardiac Monitor

☐ Extrication ☐ > 20 min.
☐ Ice Pack
☐ Immobilization
☐ Cervical Collar
☐ Other _____
☐ Spinal
☐ Backboard
☐ Other _____

☐ Extremity ☐ Vacuum ☐ Board ☐ Hager ☐ Sager ☐ Other _____
☐ Infant delivery
☐ Intubation tube Size _____
attempts _____
☐ No gastric sounds
☐ Bilat sounds

☐ IV Therapy # attempts _____
☑ Psych First Aid
☐ Suction ☐ Nasal ☐ Oral ☐ Tracheal

Cap Refill : ☐ < 2 sec ☐ > 2 sec ☐ Not Assessed

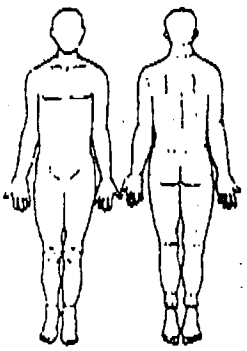
Glasgow Coma Scale : On Scene / En Route:

	EYES	MOTOR	VERBAL	TOTAL
On Scene	4	5	1	15
En Route				

Trauma Scale : On scene / En Route

	Resp Rate	Systolic B/P
On scene		
En Route		

Date 4-11-12 Run # _____



D - Deformities
C - Contusions
A - Abrasions
P - Puncture
B - Burns
T - Tenderness
L - Lacerations
S - Swelling
IV Site

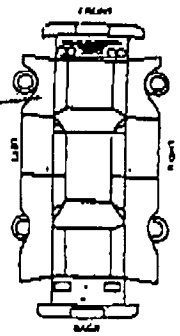
Seatbelts in Use : ☐ Yes - on upon arrival ☐ Yes - per patient ☐ Not Used

Type Used : ☐ Lap Only ☐ Shoulder Only ☐ Lap & Shoulder

Airbag Deployed : ☐ Yes ☐ No ☐ Disengaged ☐ Not Equipped

Approximate Rate of Speed _____

☐ Per patient ☐ Per Law Enforcement ☐ By Stander ☐ Other _____



Chief Complaint / Mechanism of Injury C/o: LOWBACK WEAKNESS H/x: N/A FOUND

Assessment / Treatment PT LYING ON FLOOR THIS AM PT INITIALLY RESTED R/A + T/A. EMS REQUESTED WHEN PT COULD NOT AMBULATE TO BATHROOM A/P ON ARRIVAL FOUND PT SEATED ON COUCH CALMLY SKIN W-D, W/S CLAIMS PT HAS NO C/O W/S R/A: PT ABLE TO GO TO WASH FOR EVAL OF ~~WEAKNESS~~ WEAKNESS PT DID AMBULATE W/I ASSIST TO CAR W/S T/A: 90 FOR FURTHER EVAL

Drug / Alcohol Use ☐ Per Patient ☐ N/A ☐ Observed _____

Medical Direction ☑ Protocol ☐ On-line (radio / phone) ☐ Other _____

I understand that I am financially responsible for the services provided to me by the _____ regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to the above ambulance service. I authorize and direct any holder of medical information or documentation about me to release to the centers of Medicare and Medicaid Services and its carriers and agents, as well as the ambulance service and its billing agents and any other payers or insurers, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by the squad of record, now or in the future. I agree to immediately remit to the squad of record , any payments that I receive directly from any source for the services provided to me and I assign all rights to such payments to the squad of record.

_____ **I have received a copy of the Privacy Policy for the squad of record.**

_____ Date _____

Patient Signature

Patient Representative Signature _____ Relationship to Patient _____

Patient unable to sign because: _____

Refusal of treatment / transport - The nature of my illness / injury has been explained to me and I understand that my refusal of treatment and /or transport is against medical advise and may endanger my life. I hereby release the rescue squad , its officers and employee's from any and all claims and damages resulting directly with my refusal of treatment and / or transport.

Signature _____ Date _____ Witness _____

Report written by _____

Crew Members (B= EMT I= Intermediate P = Paramedic D= Driver O=Other)

See Continuation Paper - page 3 ☐

Law Enforcement on Scene : ☐ Yes _____ ☑ No

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____