MM DD YY | 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 ○ Patient ○ Police ○ Other

CHIEF COMPLAINT

SUBJECTIVE ASSESSMENT

PRESENTING PROBLEM

Fill in circle

01 ○ Airway Obstructions
02 ○ Respiratory Arrest
03 ○ Respiratory Distress
04 ○ Cardiac Related (Potential)
05 ○ Cardiac Arrest
06 ○ Allergic Reaction
07 ○ Syncope
08 ○ Stroke/CVA
09 ○ General Illness/Malaise
10 ○ Gastro-Intestinal Distress
11 ○ Diabetic Related (Potential)
12 ○ Pain ______
34 ○ Unconscious/Unresp.
13 ○ Seizure
15 ○ Behavioral Disorder
16 ○ Substance Abuse (Potential)
17 ○ Poisoning (Accidental)
18 ○ Shock
19 ○ Head Injury
20 ○ Spinal Injury
21 ○ Fracture/Dislocation
22 ○ Amputation
23 Other ______
24 ○ Major Trauma
25 ○ Trauma-Blunt
26 ○ Trauma-Penetrating
27 ○ Soft Tissue Injury
28 ○ Bleeding/Hemorrhage
14 ○ OB/GYN
29 ○ Burns
Environmental
30 ○ Heat
31 ○ Cold
32 ○ Hazardous Materials
33 ○ 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 ○ Pale ○ Warm ○ Cyanotic ○ Moist ○ Flushed ○ Dry ○ Jaundiced	○ C ○ U ○ P ○ S
	Rate: ○ Regular ○ Shallow ○ Labored	Rate: ○ Regular ○ Irregular	/	○ Alert ○ Voice ○ Pain ○ Unresp.		○ Normal ○ / ○ Dilated ○ / ○ Constricted ○ / ○ Sluggish ○ / ○ No-Reaction ○	○ Unremarkable ○ Cool ○ Pale ○ Warm ○ Cyanotic ○ Moist ○ Flushed ○ Dry ○ Jaundiced	○ C ○ U ○ P ○ S
	Rate: ○ Regular ○ Shallow ○ Labored	Rate: ○ Regular ○ Irregular	/	○ Alert ○ Voice ○ Pain ○ Unresp.		○ Normal ○ / ○ Dilated ○ / ○ Constricted ○ / ○ Sluggish ○ / ○ No-Reaction ○	○ Unremarkable ○ Cool ○ Pale ○ Warm ○ Cyanotic ○ Moist ○ Flushed ○ Dry ○ 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 #

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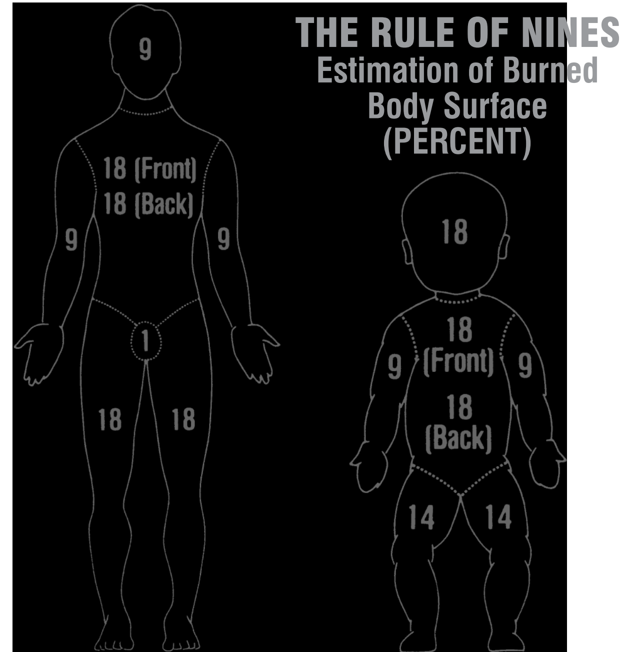
NON-HOSPITAL DISPOSITION CODES:

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



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	**Patient's Best Verbal Response**
	Inappropriate Words	3	Arouse patient with voice or painful stimulus.
	Incomprehensible Sounds	2	
	None	1	
Motor Response	Obeys Command	6	
	Localizes Pain	5	
	Withdraw (pain)	4	**Patient's Best Motor Response**
	Flexion (pain)	3	Response to command or painful stimulus.
	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: ______