

Patient Care Report

SERVICE NAME: (PLEASE PRINT)																	
Service #:		Unit #:		Incident #:		Pt. Record #:		Crash #:									
Date of Onset: / /			Date Unit Notified: / /			Run Report Date: / /			Trauma ID #:								
Dispatched For:																	
TIMES (MILITARY)					PATIENT INFORMATION												
Dispatch Notified:		Time Left Scene:		(Last Name)			(First) (MI)										
Unit Notified:		Arrived at Destination:		(Street Address)			(Apt. #)										
Unit Enroute:		Back In Service:		(City)			(State) (Zip Code)										
Arrived at Scene:		Total Incident Time:		(Phone)			(Date of Birth) (Age yrs. mons)										
Minutes For Response:		911 <input type="checkbox"/> YES <input type="checkbox"/> NO		Time of Injury/Illness:		(Gender) <input type="checkbox"/> M 1 <input type="checkbox"/> F 2 <input type="checkbox"/> Unk 3		(SSN#)									
Minutes At Scene:				Ethnicity		Race		<input type="checkbox"/> 0 Other, including multi racial <input type="checkbox"/> 3 American Indian, Eskimo or Aleut <input type="checkbox"/> 1 Hispanic <input type="checkbox"/> 1 White <input type="checkbox"/> 4 Asian <input type="checkbox"/> 2 Black <input type="checkbox"/> U Undetermined									
Chief Complaint:					Injury/Illness Narrative:												
Past Medical History:					Pertinent Findings on Physical Exam:												
Allergies:					Patient Medications:												
Emerg. Med. Care Given:					Patient Response to Emerg. Med. Care:												
Provider Impression: - Select one <input type="checkbox"/> Abdominal Pain/Problems <input type="checkbox"/> Cardiac Rhythm Disturbance <input type="checkbox"/> Hypothermia (Trauma) <input type="checkbox"/> Pregnancy/OB Delivery <input type="checkbox"/> Stings/Venomous Bites <input type="checkbox"/> Airway Obstruction <input type="checkbox"/> Chest Pain/Discomfort <input type="checkbox"/> Hypovolemia <input type="checkbox"/> Psychiatric Disorder <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Alleged Sexual Assault <input type="checkbox"/> Diabetic Symptoms <input type="checkbox"/> Inhalation Injury (Toxic Gas) <input type="checkbox"/> Respiratory Arrest <input type="checkbox"/> Syncope/Fainting <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Electrocution <input type="checkbox"/> Not Applicable <input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Traumatic Hypovolemia <input type="checkbox"/> Altered Level of Consciousness <input type="checkbox"/> Hyperthermia <input type="checkbox"/> Obvious Death <input type="checkbox"/> Seizure <input type="checkbox"/> Traumatic Injury <input type="checkbox"/> Behavioral Disorder <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Other <input type="checkbox"/> Shock <input type="checkbox"/> Vaginal Hemorrhage <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Hypothermia (Disease) <input type="checkbox"/> Poisoning/Drug Ingestion <input type="checkbox"/> Smoke Inhalation <input type="checkbox"/> Unknown																	
Mutual Aid		EMS Tier		Destination / Transferred To		MODE OF TRANSPORT											
						<input type="checkbox"/> Fixed Wing <input type="checkbox"/> Ground <input type="checkbox"/> None <input type="checkbox"/> Other <input type="checkbox"/> Rotor Craft											
<input type="checkbox"/> Closest Facility <input type="checkbox"/> Diversion <input type="checkbox"/> Family Choice <input type="checkbox"/> Law Enforcement Choice		<input type="checkbox"/> Managed Care <input type="checkbox"/> Not Applicable <input type="checkbox"/> On-Line Medical Direction		<input type="checkbox"/> Other <input type="checkbox"/> Patient Choice <input type="checkbox"/> Patient Physician Choice		DESTINATION DETERMINATION/OUT OF HOSPITAL TRIAGE CRITERIA <input type="checkbox"/> Protocol <input type="checkbox"/> Trauma Triage (GCS, Vitals) <input type="checkbox"/> Specialty Resource Center <input type="checkbox"/> Trauma Triage (Mechanism of Injury) <input type="checkbox"/> Trauma Triage (Anatomy of Injury) <input type="checkbox"/> Trauma Triage (Risk Factors) <input type="checkbox"/> Unknown											
CLINICAL INFORMATION																	
Time	B/P	PULSE	RESP	TEMP	Pulse O ₂	Glasgow Coma Scale Eye Verb Motor Total	Revised Trauma Score (RTS) Resp BP GCS Total	Revised Trauma Score Pediatric Resp BP GCS Total	Respiratory Effort <input type="checkbox"/> 1 Normal <input type="checkbox"/> N Net Assessed <input type="checkbox"/> 2 Shallow/Labored <input type="checkbox"/> U Unknown <input type="checkbox"/> 3 Shallow/Non-Labored <input type="checkbox"/> 4 Deep/Labored <input type="checkbox"/> 5 Deep/Non-Labored <input type="checkbox"/> 6 Absent <input type="checkbox"/> 7 Labored/Fatigued	Resp. Sounds <input type="checkbox"/> Clear (R) <input type="checkbox"/> Bronchi (R) <input type="checkbox"/> Rhales (R) <input type="checkbox"/> Wheezes (R)							
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Eye Opening Component		Verbal Component		Glasgow Coma Scale (GCS) Values				Motor Component		Revised Trauma Score (RTS) Values							
0 Not applicable 1 None 2 Responds to Pain 3 Responds to Speech 4 Spontaneous Opening		For patients >5 years: 1 None 2 Non-specific sounds 3 Inappropriate words 4 Confused conversation or speech 5 Oriented and appropriate speech 9 Unknown		For patients 2-5 years: 1 None 2 Grunts 3 Cries and/or screams 4 Inappropriate words 5 Appropriate words 9 Not assessed				For patients 0-23 months: 1 None 2 Extensor posturing in response to painful stimulation 3 Flexor posturing in response to painful stimulation 4 General withdrawal in response to painful stimulation 5 Localization of painful stimulation 6 Obeys commands with appropriate motor response 9 Unknown		For patients up to 5 years 1 None 2 Extensor posturing in response to painful stimulation 3 Flexor posturing in response to painful stimulation 4 General withdrawal in response to painful stimulation 5 Localization of painful stimulation 6 Spontaneous 9 Not assessed		Resp. Rate 10-29 4 >29 3 6-9 2 1-5 1 None 0		Systolic B.P. BP>89 4 76-89 3 50-75 2 1-49 1 None 0		GCS Total 13-15 4 9-12 3 6-8 2 4-5 1 <4 0	
Cardiac Arrest Information					Cardio Pulmonary Arrest Time:												
Cardiac Arrest: Y N		Bystander CPR: Y N		Witnessed Arrest: Y N		Pulse Restored: Y N		Trauma Arrest: Y N		Number of Shocks:							
PLEASE NOTE: ANY CHANGES IN CARDIAC RHYTHM SHOULD BE NOTED BELOW BY (↓ TIME COLUMNS)																	
Cardiac Rhythm: I = Initial D = Destination																	
I	D	↓ Time rhythm observed	I	D	↓ Time rhythm observed	I	D	↓ Time rhythm observed	I	D	↓ Time rhythm observed						
		Not Applicable			AV Block - 1st			PEA (EMD)			PVCs						
		Unable to identify			AV Block -2nd, Type I			Junctional			Sinus Bradycardia						
		Asystole			AV Block -2nd, Type II			Pacemaker			Sinus Rhythm						
		Atrial Fibrillation			AV Block -3rd						Sinus Tachycardia						
Date:										Signature:							