

Patient Care Report

SERVICE NAME: (PLEASE PRINT)											
Service #:		Unit #:		Incident #: -							
Date of Onset: / /		Date Unit Notified: / /		Pt. Record #:							
Dispatched For:		Run Report Date: / /		Crash #:							
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 <input type="checkbox"/> 0 Other <input type="checkbox"/> 1 Hispanic		Race <input type="checkbox"/> 0 Other, including multi racial <input type="checkbox"/> 1 White <input type="checkbox"/> 2 Black <input type="checkbox"/> 3 American Indian, Eskimo or Aleut <input type="checkbox"/> 4 Asian <input type="checkbox"/> U Undetermined							
Minutes For Transport:		Chief Complaint:		Injury/Illness Narrative:							
Past Medical History:		Allergies:		Pertinent Findings on Physical Exam:							
Emerg. Med. Care Given:		Patient Medications:		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							
<input type="checkbox"/> Closest Facility <input type="checkbox"/> Division <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							
<input type="checkbox"/> Fixed Wing		<input type="checkbox"/> Ground		<input type="checkbox"/> None <input type="checkbox"/> Other <input type="checkbox"/> Rotor Craft							
DESTINATION DETERMINATION/OUT OF HOSPITAL TRIAGE CRITERIA											
<input type="checkbox"/> Protocol <input type="checkbox"/> Specialty Resource Center <input type="checkbox"/> Trauma Triage (Anatomy of Injury)		<input type="checkbox"/> Trauma Triage (GCS, Vitals) <input type="checkbox"/> Trauma Triage (Mechanism of Injury) <input type="checkbox"/> Trauma Triage (Risk Factors) <input type="checkbox"/> Unknown									
CLINICAL INFORMATION											
Time	B/P	PULSE	RESP	TEMP	Pulse O2	Glasgow Coma Scale (GCS) Values	Motor Component	Revised Trauma Score (RTS)	Revised Trauma Score Pediatric	Respiratory Effort	Resp. Sounds
/	/	/	/	/	/					<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	<input type="checkbox"/> Clear (R) <input type="checkbox"/> Bronchi (R) <input type="checkbox"/> Rhales (R) <input type="checkbox"/> Wheezes (R)
Glasgow Coma Scale (GCS) Values For patients >5 years: 1 None 2 Grunts 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 Excessive 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						Motor Component For patients >5 years: 1 None 2 Excessive 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 Excessive 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		Revised Trauma Score (RTS) Values Resp. Rate: 10-29 4 >29 3 6-9 2 1-5 1 None 0 Systolic B.P.: >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		Skin Perfusion: <input type="checkbox"/> 1 Normal <input type="checkbox"/> 2 Decreased <input type="checkbox"/> 3 Not Assessed Pupils: <input type="checkbox"/> Normal (R) <input type="checkbox"/> Constricted (R) <input type="checkbox"/> Dilated (R) <input type="checkbox"/> No react (R)	
Cardiac Arrest Information											
Cardiac Arrest: Y N		Bystander CPR: Y N		Arrest Time: Min.							
Witnessed Arrest: Y N		Pulse Restored: Y N		Arrest to CPR: Min.							
Trauma Arrest: Y N		Number of Shocks:		Arrest to DEFIB. Min.							
Arrest to Meds. Min.											
Cardiac Rhythm: I = Initial D = Destination PLEASE NOTE: ANY CHANGES IN CARDIAC RHYTHM SHOULD BE NOTED BELOW BY (↓ TIME COLUMNS)											
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
											ST Elevation/Abnormal SVT
											Vent. Fibrillation
											Vent. Tachycardia
											Other
Date: _____ Signature: _____											