

Times Military Format Please

Call Rec'd

Dispatched

Responding

On

Tran **Pg 1**

At Hospital

In Service

Dispatched As Response Emergency Routine

Location of Call **Pg 1**

Village/Twp County

Incident Site Residence Farm Unknown Other:
 Recreational Facility Mine/Quarry Public/Commercial Bldg.
 Residential Institution Street/Highway Educational Site

Disposition Transporter Arrived at Scene Refused Transport
 Cancelled Nothing Found Standby Only

Determination for Destination Protocol/CI Physician Preference Other (List in Narr.)
 Patient/Family Choice Diversion

Unit Num **Pg 1**

Transport Emergency Routine

Hospital

Mileage

Ending

Starting

Total

Other **Pg 1** Miles

Factors Affecting Delivery of Care

Adverse Weather/Road Haz-Mat Prolonged Extrict **Pg 2** Unsafe Scene Not Applicable Other:

Patient Info

Name Phone

Address Age DOB

City **Patient Pg** Zip Sex Male Female

SSN Race Ethnicity Hispanic/Latino Non-Hispanic

Protective Devices None Mild

A **Pg 2**

H

Other

Pt. Vehicle Damage

CHIEF Complaint or PRIMARY Injury **Pg 2**

Reported Chemical Abuse

Alc **Pg 2**

Dr

PRESENTING PROBLEM (Check All That Apply)

Unconscious Allergic Reaction General Illness/Malaise Disease Head Injury Cold

Airway Obst Respiratory Respiratory Cardiac Related (potential) Cardiac Arrest

General Weakness Behavior Disorder Poisoning (accidental) Substance Abuse (potential) Suicide (potential)

Fracture/Dislo Shock OB/GYN DOA Multiple Trauma Heat

Injury Injury Injury Heat

Haz-Mat Pain (where?) Other

02 **Pg 8**

NC Aerosol Tx

Airway

Injury Description **Pg 2** Burns Blast Exposure Unknown Other:

Mechanism of Injury:

Pg 4 Pg 8

Intubation

Oral **Pg 8**

Nasal

Pertinent Medical History

Family Physician

COPD Cancr Diabr Other Histr

Patient Pg

Medication

Vital Signs Unable To Obtain (Document)

Time	Pulse	Resp	BP	Pulse Ox	Glucometer Check	Temp

Lung/Resp. 1st ✓ 2nd ✓

Reg./Normal	R	L	R	L
Shall				
Apne				
Rhor				
Rale				
Whe				

Pupils

1	2	3	4	5	6

Pg 3

Skin

Temp.	Moist	Color
<input type="checkbox"/> Ho	<input type="checkbox"/>	<input type="checkbox"/> Normal
<input type="checkbox"/> Wt	<input type="checkbox"/>	<input type="checkbox"/> Pale
<input type="checkbox"/> Cc	<input type="checkbox"/>	<input type="checkbox"/> Cyanotic
<input type="checkbox"/> Cr	<input type="checkbox"/>	<input type="checkbox"/> Flushed
		<input type="checkbox"/> Jaundice

Pg 5

Glasgow Coma Scale

Eye Opening		Best Motor Response	
4	<input type="checkbox"/> Spontan	<input type="checkbox"/> Obeys Command	
3	<input type="checkbox"/> To Voice	<input type="checkbox"/> Localizes Pain	
2	<input type="checkbox"/> To Pain	<input type="checkbox"/> Withdraws	
1	<input type="checkbox"/> No Res	<input type="checkbox"/> Flexion	
		<input type="checkbox"/> Extension	
		<input type="checkbox"/> No Response	

Pg 3

Best Verbal R

5	<input type="checkbox"/> Orient	
4	<input type="checkbox"/> Confu	
3	<input type="checkbox"/> Inappropriate	
2	<input type="checkbox"/> Incomprehensible	
1	<input type="checkbox"/> No Response	

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GCS = 1st / 2nd

IV/IO

Time	Solution	Rate	Cannula	Attempts	Name	Blood Drawn

Pg 8

Cardiac

Arrest Witnessed Y/N By

CPR initiated by Time

CPR Discontinued Y/N Auth **Pg 2**

Defib/Cardioversion Y/N

Spontaneous Circulation Y/N

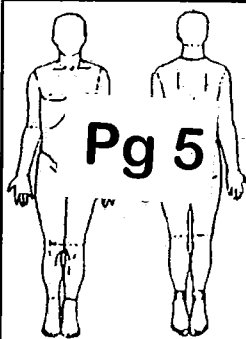
Rhythm at Hospital

EKG Rhythm Time 12 Lead Y N Other

Sinus	Atrial	Heart Blocks
<input type="checkbox"/> NSR	<input type="checkbox"/> Fib/Flt	<input type="checkbox"/> 1st Degree
<input type="checkbox"/> Tachycardia	<input type="checkbox"/> PAC	<input type="checkbox"/> 2nd Degree Type I
<input type="checkbox"/> Bradycardia	<input type="checkbox"/> SVT/Psvt	<input type="checkbox"/> 2nd Degree Type II
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Asystole	<input type="checkbox"/> 3rd Degree
<input type="checkbox"/> PEA	<input type="checkbox"/> Paced Rhythm	
	<input type="checkbox"/> PVC's	

Pg 8

Observations



Letter Injury Location

L-Laceration

G-Gunshot A-Abrasion

P-Pain D-Deformity

B-Burns C-Discoloration

Pg 5

SENECA COUNTY EMS PATIENT CARE REPORT

Patient	Date
Narrative	

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Time	Event	Just.	Medical Refusal Form
			<p>The grave nature of my illness and/or injury have been explained to me and I understand that my refusal of treatment and/or transport is against my medical advice and may endanger my life. The undersigned hereby releases this department and Seneca County EMS, its officers, agents and employees from any and all claims and damages resulting directly or indirectly in connection with the undersignee's refusal.</p> <p>Please be advised, if you receive treatment for your condition you may be billed even though you were not transported. This may not be covered under your insurance or by Medicare or Medicaid.</p> <p>Patient Signature _____ Date _____</p> <p>Witness Signature _____</p>
	Pg 8		

Crew Members and Training Level		
Print	Sign	Level
1. Driver		
2.		
3.		
4.		
5.		

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