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|--|---|-------------|--|---------------|---|---|---|---|--|--|--|---------------------------------|--|--|--|--|---|
| Unit Information | Date | | Agency Name | | | Agency Number | | | Preliminary Report* Revision 2 | | Type of Service Requested | | | | | | |
| | Transport Unit # | Call Sign # | EMT B / I / P | EMT B / I / P | PCR # | <input type="checkbox"/> 911 Resp. (Scene) <input type="checkbox"/> Interfacility Trans. <input type="checkbox"/> Medical Trans. <input type="checkbox"/> Standby <input type="checkbox"/> Intercept <input type="checkbox"/> Mutual Aid | | | | | | | | | | | |
| | Patient Name | | | | | Age | Date of Birth | Sex | Phone Number | Work Related/Occup. | | | | | | | |
| | Patient Address | | | | | City | State | Zipcode | Race/Eth. | Social Security Number | | | | | | | |
| Situation | Location / Address of Call or Incident | | | | | | Other Agencies | | | | | | | | | | |
| | <input type="checkbox"/> Same as Above Response Mode to Scene <input type="checkbox"/> Lights and Sirens <input type="checkbox"/> No Lights and Sirens <input type="checkbox"/> Downgraded to No L&S <input type="checkbox"/> Upgraded to L&S | | | | | | Dispatch Complaint | | | EMD Performed <input type="checkbox"/> | | EMD Card # | | | | | |
| | CPR AED On Scene Prior to EMS Yes No Prior to Arrival Time Started Yes No | | Arrest Witnessed By EMS/1st R/PD Family Bystander Unknown | | Downtime < 5 minutes 5-10 minutes 10-15 minutes Unknown | | Performed By: EMS/1st R PD Family Bystander | | Mechanism of Injury <input type="checkbox"/> Steering Wheel Deformity <input type="checkbox"/> Windshield Spider <input type="checkbox"/> Dash Deformity <input type="checkbox"/> Lap Seat Belt <input type="checkbox"/> Side Post Deformity <input type="checkbox"/> Shoulder Belt <input type="checkbox"/> Ejection <input type="checkbox"/> Helmet <input type="checkbox"/> DOA Same Vehicle <input type="checkbox"/> Infant Carseat <input type="checkbox"/> Rollover <input type="checkbox"/> Airbag <input type="checkbox"/> Space Intrusion > 1 ft. <input type="checkbox"/> Fire <input type="text"/> Extraction Time (min) <input type="text"/> Fall (ft) | | | PSAP Call Date/Time | | | | | |
| | Chief Complaint | | | | | | Unit Notified by Dispatch Date/Time | | | | | Unit En Route Date/Time | | | | | |
| Duration | | | | | | Severity (1-10) | | | | | | Unit Arrived on Scene Date/Time | | | | | |
| Other Complaints | | | | | | Severity (1-10) | | | | | | Arrived at Patient Date/Time | | | | | |
| Vital Signs | Duration | | Min | Hrs | Days | Severity (1-10) | | DATES and TIMES Unit Left Scene Date/Time Patient Arrived at Destination Date/Time Unit Back in Service Date/Time Unit Back at Home Location Date/Time | | | | | | | | | |
| | Time | BP | HR | RR | Glucose | CO2 | SaO2 | | | | | Temp. | | | | | |
| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| Past History | Evidence of Alcohol Ingestion? | | Yes | No | DNR/MOST Form <input type="checkbox"/> | | Living Will <input type="checkbox"/> | | ODOMETER Beginning Odometer On-Scene Odometer Destination Odometer Loaded Mileage | | | | | | | | |
| | Allergies | | | | | | | | | | | | | | | | |
| | Denies | | | | | | | | | | | | | | | | |
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| Patient Survey | Narrative | | | | | | | | | | | | | | | | |
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| Procedures & Medications | Skin | | HEENT / Neck | | Chest | | Heart | | Abdomen | | Pelvis / Gen. | | Extremities | | Back | | |
| | Normal Pale Cyanotic Clammy Jaundiced Cold Warm Diaphoretic | | Normal JVD Tracheal Dev. SQ Air Stridor Lac. / Lesion | | Normal BS Decreased BS Tenderness Acc. Muscles Flail Segment Rhonchi / Wheezing Rales Lac. / Lesion | | Normal Decreased Sounds Murrur Monitor/ECG/FHT'S | | Normal Distention Tenderness Guarding Mass Lac./Lesions R L UQ LQ | | Normal Tender Unstable Genital Injury Crowning Lac./Lesions | | Normal Tenderness | | Normal Tender Sp. Process No C T L Tender Paraspinous No C T L Pain to ROM No C T L Lac./Lesions | | |
| | Neuro Pupils L: React. Dil __ mm Nonreact. Blind R: React. Dil __ mm Nonreact. Blind | | Findings Normal Confused Unresponsive Nonreact. Blind Combative Hallucinations | | Seizures Post-ictal | | Obtunded Tremors | | Deficit Dysphasia Hemiplegia: R L | | Stroke Screen <input type="checkbox"/> Positive <input type="checkbox"/> Negative | | | | | | |
| | Glasgow Coma Scale Eyes Spontaneous 4 To Voice 3 To Pain 2 None 1 | | Verbal Oriented 5 Confused 4 Inappropriate Sounds 3 Incomprehensible Sounds 2 None 1 | | Motor Obeys Commands 6 Localizes to Pain 5 Withdraws (Pain) 4 Flexion (Pain) 3 Extension (Pain) 2 None 1 | | Total GCS Score <input style="width: 20px; height: 20px; border: 1px solid red;" type="text"/> | | Adult Trauma Score Resp. Rate 10 - 29 = 4 > 29 = 3 6 - 9 = 2 1 - 5 = 1 None = 0 | | Systolic BP > 89 = 4 76 - 89 = 3 50 - 75 = 2 1 - 49 = 1 None = 0 | | GCS Points 13 - 15 = 4 9 - 12 = 3 6 - 8 = 2 4 - 5 = 1 3 = 0 | | Total Adult Trauma Score <input style="width: 20px; height: 20px;" type="text"/> | | Reperfusion Check Sheet <input type="checkbox"/> No Contraindicators <input type="checkbox"/> Contraindicators |
| Time | Procedure | | Size | Tech State ID | Success | Time | Medication | | Dose/Route | Tech State ID | | | | | | | |
| | | | | | Y N | | | | | | | | | | | | |
| | | | | | Y N | | | | | | | | | | | | |
| | | | | | Y N | | | | | | | | | | | | |
| | | | | | Y N | | | | | | | | | | | | |
| Disposition | ETT Confirmation and Signature at Destination | | | | | | Cardiac Rhythm or 12 Lead Interpretation | | | | | | | | | | |
| | Transport Mode from Scene | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Lights and Sirens <input type="checkbox"/> No Lights and Sirens <input type="checkbox"/> Downgraded to No L&S <input type="checkbox"/> Upgraded to L&S | | | | | | Patient's Condition on Arrival | | | Reason for Choosing Destination (circle) | | Treatment Authorized by MD MICN | | | | | |
| | Transport <input type="checkbox"/> Refused <input type="checkbox"/> Cancelled | | Moved to Ambulance <input type="checkbox"/> Walk <input type="checkbox"/> Stretcher <input type="checkbox"/> Carry <input type="checkbox"/> Stairchair | | Transport Position <input type="checkbox"/> Prone <input type="checkbox"/> L. Lateral <input type="checkbox"/> Trendelenberg <input type="checkbox"/> Fowlers <input type="checkbox"/> Supine <input type="checkbox"/> Sitting <input type="checkbox"/> Head Elevated | | Safety <input type="checkbox"/> Gloves <input type="checkbox"/> Mask <input type="checkbox"/> Gown <input type="checkbox"/> Eyewear | | <input type="checkbox"/> Improved <input type="checkbox"/> Same <input type="checkbox"/> Worse | | Diversion Insurance Status On-Line Medical Direction Patient Choice Protocol | | Closest Facility Family Choice Law Enforcement Choice Patient's Physician Choice Specialty Resource Center | | Patient Received by | | |
| Destination Name and/or Address | | | | | | EMT Signature | | EMT-P State ID | | Medical Control Signature | | | | | | | |
| * This is a preliminary document. This is not the final EMS Patient Care Report. | | | | | | | | | | | | | | | | | |

