Boston University Emergency Medical Services Patient Care Report Form

Date	☐**Student** ☐**Employee** ☐**Visitor**	**ID# or SS#**	**Building**	**Location**
Name *First Last*		**Phone**	**Age** / **DOB**	**Sex**
Address *Street Apt./Box# City State Zip*			**If Under 18, Name & Phone of Legal Guardian**	

Activity
☐Family Rec _____
☐Intramural _____
☐Recreation _____
☐Club _____
☐Summer Camp _____
☐Non-Credit Class _____
☐PE Class _____
☐Other _____

Past Medical History

Patient Medications

Allergies

Chief Complaint/Mechanism of Injury

Times
Time of Injury _____
Time on Scene _____
Transport Called
Y☐ N☐
If Yes: Time called _____
Arrived _____
Patient Departed _____

Disposition
Patient transported to:
☐Home ☐SHS ☐Hospital ER: _____ ☐Other _____
Transported by:
☐Private Vehicle ☐Taxi ☐Ambulance (Company/#_____) ☐Other _____

Vitals	**Set 1**	**Set 2**	**Set 3**
Time			
Pulse/min	N W B | R I	N W B | R I	N W B | R I
Blood Pressure	/	/	/
Respirations/min	N S D | R I	N S D | R I	N S D | R I
Capillary Refill	<2 sec >2 sec	<2 sec >2 sec	<2 sec >2 sec
Skin Color			
Temperature			
Moisture			

L.O.C.
Responsiveness
1|2|3
☐☐☐ *A*-Alert
Orientated to
☐☐☐Person
☐☐☐Place
☐☐☐Time
☐☐☐Event
Reduced Responses
☐☐☐*V*-Verbal Stimuli
☐☐☐*P*-Painful Stimuli
☐☐☐*U*-Unresponsive

Chest
Breath Sounds
L☐ R☐ Present
L☐ R☐ Absent
L☐ R☐ Diminished
Lung Sounds
L☐ R☐ Clear
L☐ R☐ Rales
L☐ R☐ Rhonchi
L☐ R☐ Wheeze
L☐ R☐ Stridor

Pupillary Response
1|2|3 1|2|3
L☐☐☐ R☐☐☐ N
L☐☐☐ R☐☐☐ D
L☐☐☐ R☐☐☐ C
N-Normal Size
D-Dilated
C-Constricted
L☐☐☐ R☐☐☐ R
L☐☐☐ R☐☐☐ S
L☐☐☐ R☐☐☐ U
R-Reactive
S-Sluggish
U-Unreactive

Airway
☐Patent
☐Partially obstructed
☐Fully obstructed

Pulse/Resp. Codes:
N-Normal
W-Weak B-Bounding
S-Shallow D-Deep
R-Regular I-Irregular

Equipment Used
_____
_____
_____
_____

Trachea
☐Midline
☐Tugging L☐ R☐
☐Deviated L☐ R☐

C-Spine
☐Normal
☐Deformed

JVD
☐Y ☐N

Abdomen *Quadrant*

Rigid	Y☐ N☐	_____
Distended	Y☐ N☐	_____
Tender	Y☐ N☐	_____
Palpable Mass	Y☐ N☐	_____
Guarding	Y☐ N☐	_____

Extremities ☐+CSMs

Reduced/Absent:

Distal Pulse	☐LU	☐RU	☐LL	☐RL
Cap-Refill	☐LU	☐RU	☐LL	☐RL
Sensation	☐LU	☐RU	☐LL	☐RL
Motion	☐LU	☐RU	☐LL	☐RL

Extremities ☐Atraumatic

Present:

Deformity	☐LU	☐RU	☐LL	☐RL
Ecchymosis	☐LU	☐RU	☐LL	☐RL
Swelling	☐LU	☐RU	☐LL	☐RL
Crepitus	☐LU	☐RU	☐LL	☐RL

Initial Assessment _____

Focused Assessment/Patient Interview _____

Physical Examination _____

Treatment/Ongoing Assessment _____

I_____ hereby refuse ☐treatment / ☐transport to a hospital via ambulance and acknowledge that the above mentioned treatment/transportation was offered and advised by the Emergency Medical Service Provider, Boston University Police, and/or Student Health Services. I hereby release any such persons, The Department of Physical Education, Recreation, and Dance, and Boston University from liability for respecting and following my expressed wishes. Patient Signature_____ Witness Signature_____
Patient Name (print)_____ Witness Name (print)_____

EMS Provider Name (Print)_____ EMS Provider Signature_____
EMT Certification #_____ Date_____