FIRST RESPONSE 1077584 EMS

First Responder Service | Arrival Time | Service #

Prior Care by: ☐ First Responder ☐ MD/RN ☐ Fire ☐ Police ☐ Bystander
Aid Given: ☐ Moved Patient ☐ CPR ☐ Other:

TYPE OF AMBULANCE RESPONSE

TO Scene: ☐ Emergency ☐ Mutual Aid ☐ Non-Emergency ☐ Cancelled En Route
FROM Scene: ☐ Transport ☐ Transfer ☐ No Transport ☐ Care Refused

TYPE OF CALL

- ☐ Allergic Reaction
- ☐ Behavioral
- ☐ Cardiovascular
- ☐ Diabetic
- ☐ Gastrointestinal
- ☐ Heat/Hyperthermia
- ☐ Hypothermia/Frostbite
- ☐ Neurological
- ☐ Ob/Gyn
- ☐ Poisoning/Overdose
- ☐ Respiratory
- ☐ Toxic Exposure
- ☐ Trauma
- ☐ Urinary Tract
- ☐ Vascular
- ☐ OTHER:

MECHANISM OF INJURY

- ☐ Vehicle *Type:*
  - ☐ Air Bag Inflated
  - ☐ Restraint used
  - ☐ Child restraint
  - ☐ Helmet used
- ☐ Drowning/Suffocation
- ☐ Electrical
- ☐ Fall
- ☐ Fire
- ☐ Organized Sports
- ☐ Stab/Gunshot
- ☐ Tool/Object: *Specify*
- ☐ OTHER:

SCENE

- ☐ Farm
- ☐ Home
- ☐ Industrial
- ☐ Logging
- ☐ Medical Facility
- ☐ Public Building/Place
- ☐ Recreational
- ☐ School
- ☐ Street/Highway
- ☐ OTHER:
- ☐ AT WORK
- ☐ Hazardous Materials
- ☐ Mass Casualty

CARE GIVEN PATIENT

- ☐ AIRWAY Opened
  - ☐ Manually Cleared
  - ☐ Nasopharyngeal
  - ☐ Oropharyngeal
  - ☐ EOA ☐ successful
  - ☐ ET ☐ successful
  - ☐ NTT ☐ successful
  - ☐ Suction
  - ☐ Cricothyroid Needle Puncture
- ☐ OXYGEN Administered
  - ☐ Cannula _____ L/m
  - ☐ Simple Mask _____ L/m
  - ☐ Non-rebreather _____ L/m
- ☐ BREATHING Assisted
  - ☐ Bag Valve Mask
  - ☐ Demand Valve
  - ☐ Pocket Mask
- ☐ BLEEDING Controlled
  - ☐ Bandage/Dressing Applied
- ☐ Intraosseous infusion
- ☐ IV attempted ☐ successful

MAST inflated: ☐ Legs ☐ Abdomen

CARDIAC Care

- ☐ CPR
- ☐ Cardioversion X _____
- ☐ Defibrillation X _____
- ☐ Monitoring
- ☐ Pacing
- ☐ Drug Administration

TRAUMA Care

- ☐ Extrication
- ☐ Cervical Immobilization
- ☐ Short Board
- ☐ Long Board
- ☐ Burn Care
- ☐ Chest Decompression
- ☐ Sling/Swathe
- ☐ Splint, type: _____
- ☐ Splint, traction
- ☐ OB/GYN Care/Childbirth
- ☐ Restraint applied
- ☐ OTHER CARE:

ODOMETER MILEAGE

START | SCENE | DESTINATION | LOADED MILES

SIGNS and SYMPTOMS by SITE

(Mark boxes that apply with an X)

	AMPUTATION	BLEEDING	BLUNT/CRUSH	BURN	DEFORMITY/SWELLING	LOSS OF SENSATION	NUMBNESS/TINGLING	PAIN	PARALYSIS	WOUND/SOFT TISSUE
HEAD										
FACE / EYE / EAR										
NECK / THROAT										
CHEST										
BACK										
ABDOMEN										
UPPER ARM / SHOULDER										
LOWER ARM / ELBOW / HAND										
UPPER LEG / HIP										
LOWER LEG / KNEE / FOOT										

SIGNS and SYMPTOMS

- ☐ Altered Mental Status
- ☐ Apparent Death
- ☐ Breathing Difficulty
- ☐ Cardiac Arrest
- ☐ Cold/Shivering
- ☐ Dizziness/Fainting
- ☐ Hot/Feverish
- ☐ Nausea/Vomiting
- ☐ Respiratory Arrest
- ☐ Vision Impaired
- ☐ OTHER:

GLASGOW COMA SCALE

Eye Opening Response	SPONTANEOUS	4
	TO VOICE	3
	TO PAIN	2
	NONE	1
Best Verbal Response	ORIENTED	5
	CONFUSED	4
	INAPPROPRIATE WORDS	3
	INCOMPREHENSIBLE SOUNDS	2
	NONE	1
Best Motor Response	OBEYS COMMANDS	6
	LOCALIZES PAIN	5
	WITHDRAWS (PAIN)	4
	FLEXION (PAIN)	3
	EXTENSION (PAIN)	2
	NONE	1
Total GCS Points	*Apply this score to the GCS portion of Trauma Score at right*	

REVISED TRAUMA SCORE

GLASGOW COMA SCALE (GCS) (Total points from left)	13-15	4
	9-12	3
	6-8	2
	4-5	1
	3	0
Systolic Blood Pressure	> 89 mm HG	4
	76-89 mm HG	3
	50-75 mm HG	2
	1-49 mm HG	1
	No Pulse	0
Respiratory Rate	10-29/min	4
	> 29.min	3
	6-9/min	2
	1-5/min	1
	None	0
TOTAL TRAUMA SCORE:		

BILLING INFORMATION

Guarantor's Name | Relationship

Address | Phone #

City | State | Zip

SPECIAL BILLING INSTRUCTIONS: (Social Security #. Other Insurance, etc.)

☐ Medicare ☐ Medicaid ☐ Workman's Comp.
☐ Private Insurance ☐ Private No Insurance ☐ VA ☐ Other

HOSPITAL DATA LINKAGE

Receiving Hospital: _____ Inpatient Record# _____

Initial VITAL SIGNALS: B/P: _____ PULSE _____ RESP. _____ TEMP. _____ (°C)

PATIENT DISPOSITION:
☐ ADMITTED ICU/CCU ☐ ADMITTED MED/SURG ☐ ADMITTED TO SURGERY ☐ DISCHARGED Other:
☐ DISCHARGED HOME ☐ DOA ☐ DIED ☐ TRANSFERRED TO:

SIGNATURE OF PERSON RECEIVING PATIENT: _____ ☐ Trauma Team Activated

NEW HAMPSHIRE *EMS* Patient Record

1077584

SERVICE NH Lic # **DATE** Mo. / Day / Year Call #

DISPATCHED TO Medical Facility or Street City/Town State

PATIENT NAME Last First M.I. Phone #

Address City/Town State ZIP

D.O.B. Mo. / Day / Year **AGE** ☐ F ☐ M Sex Weight 1 - 2 - 3 - 4 Patient Status Trauma Score

Trauma Team ☐ ACTIVATED

NOTIFY: Relationship Phone #

CHIEF COMPLAINT

Hx PRESENT ILLNESS/ MECHANISM OF INJURY

PAST MEDICAL HISTORY

Allergies

Meds Rx:

Pertinent Med/Surg. Hx:

Medical I.D. for:

Patient's MD

EMS RESPONSE TIMES

DISPATCH RESPONDING ARRIVE SCENE

LEAVE SCENE AT HOSPITAL IN SERVICE

TIME (24 Hour)	L.O.C.	PULSE	BP	RESPIRATIONS	LUNG SOUNDS	PUPILS	SKIN	TEMPERATURE
	AV / PU	☐ Regular ☐ Irreg ☐ Strong ☐ Weak	/	☐ Normal ☐ Abnormal ☐ Labored ☐ Shallow	L R SOUNDS: Clear, Absent, Stridor, Rales, Rhonchi, Wheezes	L R: Reactive, Unreactive, Constricted, Dilated, ☐ Unequal, ☐ Disconjugate L__mm R__mm	☐ Normal ☐ Cyanotic ☐ Moist ☐ Flushed ☐ Pale	☐ Normal ☐ Warm/Hot ☐ Cool/Cold °C/F 1 3 5 7 9
	AV / PU	☐ Regular ☐ Irreg ☐ Strong ☐ Weak	/	☐ Normal ☐ Abnormal ☐ Labored ☐ Shallow				
	AV / PU	☐ Regular ☐ Irreg ☐ Strong ☐ Weak	/	☐ Normal ☐ Abnormal ☐ Labored ☐ Shallow				
	AV / PU	☐ Regular ☐ Irreg ☐ Strong ☐ Weak	/	☐ Normal ☐ Abnormal ☐ Labored ☐ Shallow				

***NARRATIVE** should include a complete chronological flow of events including times, patient condition, each procedure and its effect upon the patient's condition.*

Time	Treatment	Results/Observations	NH ALS#

MEDICAL CONTROL Name of Physician: Name of Hospital: Verbal Order ☐ Standing Order ☐

AMBULANCE CREW and LICENSE #:

Signature, Primary Care Attendent

Original - Service WHITE COPY - HOSPITAL Yellow Copy - EMS Green Copy - EMS Hosp Coor