RIT / NTID / Other

Prehospital Care Report

M | D | Y — DATE OF CALL

RUN NO

4- 9244510

AGENCY CODE

VEH. ID.

Name

Address

Ph #

AGE | DOB M D Y | SEX M ☐ F ☐

Physician

Agency Name

Dispatch Information

Call Location

CHECK ONE ☐ Residence ☐ Health Facility ☐ Farm ☐ Indus. Facility ☐ Other Work Loc. ☐ Roadway ☐ Recreational ☐ Other

MILEAGE: END / BEGIN / TOTAL

LOCATION CODE

USE MILITARY TIMES

CALL REC'D

ENROUTE

ARRIVED AT SCENE

FROM SCENE

AT DESTIN

IN SERVICE

IN QUARTERS

CALL TYPE AS REC'D.
☐ Emergency
☐ Non-Emergency
☐ Stand-by

COMPLETE FOR TRANSFERS ONLY
Transferred from
☐ No Previous PCR
☐ Unknown if Previous PCR
Previous PCR Number

CARE IN PROGRESS ON ARRIVAL: ☐ None ☐ Citizen ☐ PD/FD/Other First Responder ☐ Other EMS

MECHANISM OF INJURY
☐ MVA (✓ seat belt used →) ☐ Fall of ____ feet ☐ GSW ☐ Machinery
☐ Struck by vehicle ☐ Unarmed assault ☐ Knife ☐

☐ Extrication required ____ minutes

Seat belt used? ☐ Yes ☐ No ☐ Unknown

Seat Belt Use Reported By ☐ Crew ☐ Patient ☐ Police ☐ Other

CHIEF COMPLAINT

SUBJECTIVE ASSESSMENT

PRESENTING PROBLEM
If more than one checked, circle primary

☐ Airway Obstruction
☐ Respiratory Arrest
☐ Respiratory Distress
☐ Cardiac Related (Potential)
☐ Cardiac Arrest
☐ Allergic Reaction
☐ Syncope
☐ Stroke/CVA
☐ General Illness/Malaise
☐ Gastro-Intestinal Distress
☐ Diabetic Related (Potential)
☐ Pain
☐ Unconscious/Unresp.
☐ Seizure
☐ Behavioral Disorder
☐ Substance Abuse (Potential)
☐ Poisoning (Accidental)
☐ Shock
☐ Head Injury
☐ Spinal Injury
☐ Fracture/Dislocation
☐ Amputation
☐ Other
☐ Major Trauma
☐ Trauma-Blunt
☐ Trauma-Penetrating
☐ Soft Tissue Injury
☐ Bleeding/Hemorrhage
☐ OB/GYN
☐ Burns
Environmental
☐ Heat
☐ Cold
☐ Hazardous Materials
☐ Obvious Death

PAST MEDICAL HISTORY
☐ None
☐ Allergy to
☐ Hypertension ☐ Stroke
☐ Seizures ☐ Diabetes
☐ COPD ☐ Cardiac
☐ Other (List) ☐ Asthma

Current Medications (List)

VITAL SIGNS

TIME	RESP	PULSE	B.P.	LEVEL OF CONSCIOUSNESS	GCS	R PUPILS L	SKIN	STATUS
	Rate: ☐ Regular ☐ Shallow ☐ Labored	Rate: ☐ Regular ☐ Irregular	/	☐ Alert ☐ Voice ☐ Pain ☐ Unresp.		☐ Normal ☐ ☐ Dilated ☐ ☐ Constricted ☐ ☐ Sluggish ☐ ☐ No-Reaction ☐	☐ Unremarkable ☐ Cool ☐ Pale ☐ Warm ☐ Cyanotic ☐ Moist ☐ Flushed ☐ Dry ☐ Jaundiced	☐ C ☐ U ☐ P ☐ S
	Rate: ☐ Regular ☐ Shallow ☐ Labored	Rate: ☐ Regular ☐ Irregular	/	☐ Alert ☐ Voice ☐ Pain ☐ Unresp.		☐ Normal ☐ ☐ Dilated ☐ ☐ Constricted ☐ ☐ Sluggish ☐ ☐ No-Reaction ☐	☐ Unremarkable ☐ Cool ☐ Pale ☐ Warm ☐ Cyanotic ☐ Moist ☐ Flushed ☐ Dry ☐ Jaundiced	☐ C ☐ U ☐ P ☐ S
	Rate: ☐ Regular ☐ Shallow ☐ Labored	Rate: ☐ Regular ☐ Irregular	/	☐ Alert ☐ Voice ☐ Pain ☐ Unresp.		☐ Normal ☐ ☐ Dilated ☐ ☐ Constricted ☐ ☐ Sluggish ☐ ☐ No-Reaction ☐	☐ Unremarkable ☐ Cool ☐ Pale ☐ Warm ☐ Cyanotic ☐ Moist ☐ Flushed ☐ Dry ☐ Jaundiced	☐ C ☐ U ☐ P ☐ S

OBJECTIVE PHYSICAL ASSESSMENT

COMMENTS

TREATMENT GIVEN
☐ Moved to ambulance on stretcher/backboard
☐ Moved to ambulance on stair chair
☐ Walked to ambulance
☐ Airway Cleared
☐ Oral/Nasal Airway
☐ Esophageal Obturator Airway/Esophageal Gastric Tube Airway (EOA/EGTA)
☐ EndoTracheal Tube (E/T)
☐ Oxygen Administered @ ____ L.P.M., Method ____
☐ Suction Used
☐ Artificial Ventilation Method ____
☐ C.P.R. in progress on arrival by: ☐ Citizen ☐ PD/FD/Other First Responder ☐ Other
☐ C.P.R. Started @ Time ▶ ____ Time from Arrest Until C.P.R. ▶ ____ Minutes
☐ EKG Monitored (Attach Tracing) [Rhythm(s) ____]
☐ Defibrillation/Cardioversion No. Times ____ ☐ Manual ☐ Semi-automatic
☐ Medication Administered (Use Continuation Form)
☐ IV Established Fluid ____ Cath. Gauge ____
☐ Mast Inflated @ Time ____)
☐ Bleeding/Hemorrhage Controlled (Method Used: ____)
☐ Spinal Immobilization Neck and Back
☐ Limb Immobilized by ☐ Fixation ☐ Traction
☐ (Heat) or (Cold) Applied
☐ Vomiting Induced @ Time ____ Method ____
☐ Restraints Applied, Type ____
☐ Baby Delivered @ Time ____ In County ____
☐ Alive ☐ Stillborn ☐ Male ☐ Female
☐ Transported in Trendelenburg position
☐ Transported in left lateral recumbent position
☐ Transported with head elevated
☐ Other ____

DISPOSITION (See list) **DISP. CODE** **CONTINUATION FORM USED** YES ←

CREW	IN CHARGE	DRIVER'S NAME	NAME	NAME
	☐ EMT ☐ AEMT #	☐ CFR ☐ EMT ☐ AEMT #	☐ CFR ☐ EMT ☐ AEMT #	☐ CFR ☐ EMT ☐ AEMT #

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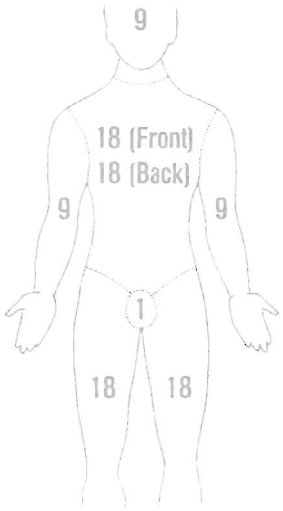
AGENCY COPY/WHITE RESEARCH COPY/YELLOW HOSPITAL PATIENT RECORD COPY/PINK

NON-HOSPITAL DISPOSITION CODES:

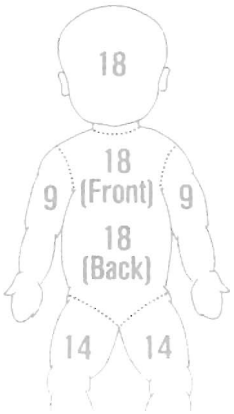
NURSING HOME	001
OTHER MEDICAL FACILITY	002
RESIDENCE	003
TREATED BY THIS UNIT, TRANSPORTED BY ANOTHER UNIT	004
REFUSED MEDICAL AID OR TRANSPORT	005
CALL CANCELLED	006
STANDBY ONLY (NO PATIENT)	007
NO PATIENT FOUND	008
OTHER	010

THE RULE OF NINES

Estimation of Burned Body Surface (PERCENT)



ADULT



INFANT

Hospital Receiving Agent

(IF REQUIRED)

COMPLETE ON WHITE (AGENCY) COPY ONLY

SIGNATURE

REFUSAL OF TREATMENT/TRANSPORTATION

NEGATIVA A RECIBIR TRATAMIENTO/SER TRASLADADO

RELEASE

EXONERACION DE RESPONSABILIDADES

COMPLETE ON WHITE (AGENCY) COPY ONLY
LLENE UNICAMENTE LA COPIA BLANCA (DE LA AGENCIA)

I hereby refuse (treatment/transport to a hospital) and I acknowledge that such treatment/transportation was advised by the ambulance crew or physician. I hereby release such persons from liability for respecting and following my express wishes.

Mediante la presente declaro que me niego a aceptar el tratamiento/traslado a un hospital y reconozco asimismo que el medico o el personal de la ambulancia recomendaron ese tratamiento/traslado. Consiguientemente, eximo a dichas personas de toda responsabilidad por haber respetado y cumplido mis deseos expresos.

Signed: _____
Firma:

Witness: _____
Testigo:

Glasgow Coma Scale

Eye Opening	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
Verbal Response	Oriented	5
	Confused	4
	Inappropriate Words	3
	Incomprehensible Sounds	2
	None	1
Motor Response	Obeys Command	6
	Localizes Pain	5
	Withdraw (pain)	4
	Flexion (pain)	3
	Extension (pain)	2
	None	1

Patient's Best Verbal Response
Arouse patient with voice or painful stimulus.

Patient's Best Motor Response
Response to command or painful stimulus.

Total GCS Score :3-15

ICD DIAGNOSTIC CODE

INSURANCE ID#

CARRIER

1 ☐ MEDICARE 2 ☐ MEDICAID 3 ☐ BLUE CROSS 4 ☐ COMMERCIAL INSURANCE 5 ☐ SELF PAY

WAS THIS A WORKERS' COMPENSATION INJURY: ☐ YES ☐ NO INSURANCE CODE _____

PATIENT'S EMPLOYER: _____ PHONE (_____) _____

EMPLOYER'S ADDRESS _____

RESPONSIBLE PARTY _____ PHONE (_____) _____

ADDRESS _____ (ZIP _____) RELATION _____

Prehospital Care Report

CONTINUATION FORM

USE BALL POINT PEN ONLY | **PRESS DOWN FIRMLY: PRINT NEATLY**

DATE M	D	Y	AGENCY NAME	Enter PCR ID# Top Center of PCR

PATIENTS NAME	RECEIVING HOSPITAL	RECEIVING HOSP ID	MEDICAL CONTROL ID	Pt's Approx Weight in kgs

TIME	RESP	BREATH SOUNDS	PULSE	EKG	B.P.	G.C.S.	MEDICATIONS	DOSE	ROUTE
	RATE: ☐ REGULAR ☐ SHALLOW ☐ LABORED	R ☐ NORMAL ☐ L, ☐ DECREASED ☐, ☐ ABSENT ☐, ☐ RALES ☐, ☐ RONCHI ☐, ☐ WHEEZES ☐	RATE: ☐ REGULAR ☐ IRREGULAR	☐ DEFIB @ ____ J	/	EO, V, M, Tot	☐ Adenosine ☐ Diazepam ☐ Lidocaine ☐ Albuterol ☐ Epinephrine ☐ Morphine ☐ Atropine ☐ Furosemide ☐ Nitroglyc. ☐ Dextrose ☐ Other________		
	RATE: ☐ REGULAR ☐ SHALLOW ☐ LABORED	R ☐ NORMAL ☐ L, ☐ DECREASED ☐, ☐ ABSENT ☐, ☐ RALES ☐, ☐ RONCHI ☐, ☐ WHEEZES ☐	RATE: ☐ REGULAR ☐ IRREGULAR	☐ DEFIB @ ____ J	/	EO, V, M, Tot	☐ Adenosine ☐ Diazepam ☐ Lidocaine ☐ Albuterol ☐ Epinephrine ☐ Morphine ☐ Atropine ☐ Furosemide ☐ Nitroglyc. ☐ Dextrose ☐ Other________		
	RATE: ☐ REGULAR ☐ SHALLOW ☐ LABORED	R ☐ NORMAL ☐ L, ☐ DECREASED ☐, ☐ ABSENT ☐, ☐ RALES ☐, ☐ RONCHI ☐, ☐ WHEEZES ☐	RATE: ☐ REGULAR ☐ IRREGULAR	☐ DEFIB @ ____ J	/	EO, V, M, Tot	☐ Adenosine ☐ Diazepam ☐ Lidocaine ☐ Albuterol ☐ Epinephrine ☐ Morphine ☐ Atropine ☐ Furosemide ☐ Nitroglyc. ☐ Dextrose ☐ Other________		

NARRATIVE:

MEDICAL CONTROL RECORD	MEDICAL CONTROL FACILITY		ON-LINE MED CTRL PHYSICIAN: PRINT NAME	MD ID#	SIGNATURE (OPTIONAL)
Controlled Substance Destroyed	DRUG	QTY	DATE	DRUG DESTROYED WITNESS: PRINT NAME	SIGNATURE / LICENSE #
INDIVIDUAL ADMINISTERING MEDICATION and/or IN CHARGE - PLEASE PRINT -			SIGNATURE	EMT/AEMT CERT NUMBER	

DOH-3411 (2/96)

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EMS 100A

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