UNIVERSITY OF MASSACHUSETTS LOWELL
EMERGENCY MEDICAL SERVICES

BLS DOCUMENTATION

			RUN #	DISPATCH TIME
PATIENT I.D. # (MEDICAL RECORD #)	DATE	DAY	MILEAGE @ SCENE	SCENE ARRIVAL TIME
AMBULANCE DISPATCHED TO:	STREET AND NUMBER	CITY/TOWN	TIME:	
			MILEAGE AT HOSP.	SCENE DEPART TIME
PATIENT NAME	PHONE			HOSPITAL ARRIVAL TIME
ADDRESS STREET & NO.	CITY	ZIP	RECEIVING HOSPITAL:	

ALSO RESPONDING: ☐ POLICE ☐ ALS ☐ BLS ☐ FIRE

AGE	D.O.B.	SEX	SOCIAL SECURITY NUMBER

CHIEF COMPLAINT

VITAL SIGNS: ☐ UNABLE TO OBTAIN ☐ NOT ATTEMPTED

REASON: _____

TIME	BP	PULSE	CAPIL RETURN	RESPIRATIONS RATE/EFFORT

PHYSICAL EXAM

NEURO STATUS

EYE OPENING:	☐ SPONTANEOUS	☐ TO PAIN
	☐ TO VOICE	☐ NONE
VERBAL RESPONSE:	☐ ORIENTED	☐ INCOMPREHENSIBLE
	☐ CONFUSED	
	☐ INAPPROPRIATE	☐ NONE
MOTOR RESPONSE:	☐ OBEDIENCE	☐ FLEXION
	☐ PURPOSEFUL	☐ EXTENSION
	☐ WITHDRAWAL	☐ NONE

SKIN CONDITION

☐ NORMAL
☐ COOL
☐ HOT ☐ WARM
☐ PALE ☐ DRY
☐ FLU: HED
☐ CYANOTIC
☐ DIAPHORETIC

PAST MEDICAL HISTORY

CURRENT MEDS: ☐ NONE
BROUGHT WITH PATIENT: ☐ YES ☐ NO ☐ UNKNOWN

ALLERGIES: ☐ NONE ☐ UNKNOWN

EMERGENCY CARE: ☐ CPR ☐ SPLINTING ☐ EXTRICATION

☐ BLEEDING CONTROL ☐ BANDAGING ☐ BACKBOARD ☐ C-SPINE
☐ O_2 / VENTILATION RATE _____ ROUTE _____
☐ AIRWAY ORAL/NASAL ☐ SUCTIONING
☐ MAST ☐ LEGS TIME _____ ☐ ABD TIME _____
☐ MEDICAL CONTROL MD _____

SUSPECTED PROBLEM ☐ CHRONIC ☐ ACUTE

☐ MAJOR TRAUMA	☐ ACUTE MEDICAL	☐ CARDIAC ARREST	
☐ MINOR TRAUMA	☐ MINOR MEDICAL	☐ CARDIAC DISORDER	
☐ SOFT TISSUE INJ.	☐ OB-GYN	☐ SHOCK	
☐ BURNS	☐ ETOH	☐ SEIZURES	☐ NEURO
☐ ORTHO	☐ OD/POISON	☐ PSYCH	☐ NEONATE
☐ RESP			

CARDIAC ARREST TREATMENT

☐ WITNESSED ☐ UNWITNESSED TIME _____

CPR STARTED BY: ☐ FAMILY ☐ BYSTANDER ☐ POLICE
☐ FIRE ☐ EMT ☐ OTHER TIME: _____

DEFIBRILLATION BY: ☐ BLS EMT ☐ ALS ☐ NOT INDICATED

OF DEFIBRILLATIONS _____

EMT DEFIB NAME _____

CMED INCIDENT # _____

CC/HPI/EXAM/MANAGEMENT:

I, _____ of my own free will do hereby refuse treatment by the U. Mass. - Lowell emergency medical service and do hereby waive any claims against University of Mass - Lowell and its employees for any injury caused to me by the refusal of treatment or transportation to a medical facility.

_____
SIGNED

_____
DATE

BLS EMT #1 Name: _____

BLS EMT #2 Name: _____

White - Hospital Record Yellow - Ambulance Record Pink - Regional Record