OKEMSIS OKLAHOMA EMS INFORMATION SYSTEM

Prehospital Care Report

Oklahoma State Department of Health

1. INCIDENT DATE __ - __ - ____ | 2. OKLAHOMA REPORT NUMBER | 3. EMS AGCY # | 4. VEHICLE NUMBER | 5. EMS UNIT CALL SIGN | 6. STATION #

7. INCIDENT/PATIENT DISPOSITION
- ☐ Treated, Transport EMS ☐ No Patient Found ☐ Treated, Transferred Care ☐ Treated, Transported Law Enforcement ☐ Canceled
- ☐ No Treatment Required ☐ Pt Refused Care ☐ Treated & Released ☐ Treated, Transported Private Vehicle ☐ Dead at Scene

8. INCIDENT ADDRESS | 9. INCIDENT CITY | 10. INCIDENT ST | 11. INCIDENT ZIP _____ - ____ | 12. INCIDENT COUNTY

13. RESPONSE MODE TO SCENE 14. FROM SCENE
- ☐ Lights/Sirens ☐
- ☐ No Lights/No Sirens ☐
- ☐ Initial Lights/Sirens Downgraded to no Lights/Sirens ☐
- ☐ Initial No Lights/Sirens Upgraded to Lights/Sirens ☐

Run Times — Use Military Time

15. Estimated Time of Onset:		19. Unit Arrived at Scene:	
16. PSAP / Initial Call for Help:		20. Arrived at Patient:	
17. Unit Notified by Dispatch:		21. Unit Left Scene:	
18. Unit Enroute:		22. Patient Arrived at Destination:	
		23. Unit Back in Service:	
		24. Unit Back at Home Location:	

25. TYPE OF SERVICE REQUESTED
☐ 911 Response ☐ Medical Transport ☐ Interfacility Transfer ☐ Intercept ☐ Mutual Aid ☐ Standby

26. INCIDENT LOCATION TYPE ☐ N/A
☐ Home/residence ☐ Farm ☐ Mine/quarry ☐ Industrial place ☐ Sport/recreation place ☐ Street/highway ☐ Public building ☐ Trade/service ☐ Health care facility ☐ Residential institution ☐ Lake/river ☐ Other

27. CONDITION CODE(S) *See Reference Sheet*

28. COMPLAINT REPORTED BY DISPATCH (select one) *See Reference Sheet*

29. EMERGENCY MEDICAL DISPATCH PERFORMED
☐ No ☐ Yes, with pre-arrival instructions ☐ Yes, without pre-arrival instructions ☐ Unknown ☐ N/A

30. CMS LEVEL OF SERVICE
☐ BLS, Emergency ☐ BLS ☐ ALS, Level 1 Emergency ☐ ALS Lev 1 ☐ ALS, Level 2 ☐ Helicopter ☐ Paramedic Intercept ☐ Airplane ☐ Specialty Care ☐ Not Applicable

31. NUMBER OF PATIENTS AT SCENE ☐ Single ☐ None ☐ Multiple ☐ N/A

32. MASS CASUALTY ☐ Yes ☐ No ☐ N/A

33. PRIMARY ROLE OF THE UNIT ☐ Transport ☐ Supervisor ☐ Non-transport ☐ Rescue

ODOMETER READINGS 34. Begin | 35. Arrive | 36. Destination | 37. End

38. DEST ZIP | 39. ORIG FAC ID | 40. REC FAC ID | 41. LATITUDE - LONGITUDE

42. PATIENT LAST NAME | 43. PATIENT FIRST NAME | 44. M I

45. PATIENT ADDRESS | 46. ☐ SAME AS INCIDENT ADDRESS | 47. PATIENT CITY

48. STATE | 49. PATIENT ZIP CODE _____ - ____ | 50. COUNTY | 51. PT TELEPHONE NUMBER (Area Code, Telephone Number) ___ - ___ - ____

52. RACE (single-choice) ☐ American Indian/Alaska Nat ☐ African American/Black ☐ Asian ☐ Native Hawaiian/Pac Islander ☐ White ☐ Other

53. ETHNICITY ☐ Hispanic ☐ Not Hispanic

55. AGE | 56. AGE UNITS ☐ Hours ☐ Days ☐ Months ☐ Years | 57. DATE OF BIRTH __ - __ - ____ | 58. SOCIAL SECURITY NUMBER ___ - __ - ____

54. GENDER ☐ Female ☐ Male

59. PRIMARY PAYMENT METHOD
☐ Not Billed ☐ Unknown ☐ Workers Comp ☐ Medicare ☐ Other Government ☐ Self Pay ☐ Not Available ☐ Insurance ☐ Medicaid ☐ Not Applicable

Medicare #: ________ Insurance1 #: ________
Medicaid #: ________ Insurance2 #: ________

60. CHIEF COMPLAINT

61. PATIENT MEDICAL HISTORY | 62. PATIENT MEDICATION HISTORY | 63. PATIENT MEDICATION ALLERGIES

64. NARRATIVE:

Receiving Facility: ________ I received a verbal & written report on the care of this patient: ________

INITIAL & FINAL VITAL SIGNS ☐ Not Applicable — **GLASGOW COMA SCALE** ☐ Not Applicable

65. Time	66. Pulse	67. Resp	68. SBP	69. DBP	70. Method BP	71. LOC	72. O2 Sat	73. EKG	74. Skin	75. Pupils	76. Eyes	77. Verbal	78. Motor	79. GCS Score
					☐ Arterial Line ☐ Auto Cuff ☐ Manual Cuff ☐ Palpate Cuff ☐ Venous Line	☐ A ☐ V ☐ P ☐ U		See Reference sheet	☐ Warm ☐ Pale ☐ Cool ☐ Pink ☐ Dry ☐ Moist ☐ Cyanotic ☐ Diaphoretic	Left / Right: ☐ Normal ☐ ☐ Constricted ☐ ☐ Dilated ☐ ☐ Non-Reactive ☐	☐ 4 Spon ☐ 3 Speech ☐ 2 Pain ☐ 1 None	☐ 5 Oriented ☐ 4 Confused ☐ 3 Inapprop ☐ 2 Garbled ☐ 1 None	☐ 6 Obeys ☐ 5 Localizes ☐ 4 W/draws ☐ 3 Flexion ☐ 2 Extent ☐ 1 None	
					☐ Arterial Line ☐ Auto Cuff ☐ Manual Cuff ☐ Palpate Cuff ☐ Venous Line	☐ A ☐ V ☐ P ☐ U		See Reference sheet	☐ Warm ☐ Pale ☐ Cool ☐ Pink ☐ Dry ☐ Moist ☐ Cyanotic ☐ Diaphoretic	Left / Right: ☐ Normal ☐ ☐ Constricted ☐ ☐ Dilated ☐ ☐ Non-Reactive ☐	☐ 4 Spon ☐ 3 Speech ☐ 2 Pain ☐ 1 None	☐ 5 Oriented ☐ 4 Confused ☐ 3 Inapprop ☐ 2 Garbled ☐ 1 None	☐ 6 Obeys ☐ 5 Localizes ☐ 4 W/draws ☐ 3 Flexion ☐ 2 Extent ☐ 1 None	

MEDICATIONS ☐ None ☐ Not applicable

80. Time	81. Medication Given *See Reference Sheet*	82. Meds Administered By:	83. Med Complications *See Reference Sheet*	84. Medication Authorization
:		☐ CM 1 ☐ CM 2 ☐ CM 3		☐ Protocol (Standing Order) ☐ On-Line ☐ Written Orders (Patient Specific) ☐ On-Scene ☐ Not Applicable
:		☐ CM 1 ☐ CM 2 ☐ CM 3		☐ Protocol (Standing Order) ☐ On-Line ☐ Written Orders (Patient Specific) ☐ On-Scene ☐ Not Applicable
:		☐ CM 1 ☐ CM 2 ☐ CM 3		☐ Protocol (Standing Order) ☐ On-Line ☐ Written Orders (Patient Specific) ☐ On-Scene ☐ Not Applicable

PROCEDURES ☐ None ☐ Not applicable

85. Time	86. Procedure *See Rreference Sheet*	87. # Attempts	88. Successful	89. Done By:	90. Procedure Complications *See Reference Sheet*
:			☐ YES ☐ NO ☐ NA	☐ CM 1 ☐ CM 2 ☐ CM 3	
:			☐ YES ☐ NO ☐ NA	☐ CM 1 ☐ CM 2 ☐ CM 3	
:			☐ YES ☐ NO ☐ NA	☐ CM 1 ☐ CM 2 ☐ CM 3	

☐ **I have been given notice of HIPAA Privacy Practices.**

☐ This is to certify that **I am refusing treatment/transport.** I have been informed of the risk(s) involved, and thereby release the ambulance service, its attendants, and its affiliates from responsibility that may result from this action.

☐ **Patient Authorization & Release:** I, the undersigned, hereby authorize ____________________(“Provider”) to provide me with emergency or non-emergency transportation and/or any medical treatment or services it deems necessary. I acknowledge that I am responsible for paying for all charges based on Providers current billing rates, regardless of whether or not I personally requested emergency medical services (EMS) originally. I hereby assign to Provider all my insurance and third party agency benefits for EMS and authorize such benefits to be paid to Provider. I authorize the release of any medical, hospital, or other records or information about me, or my dependents to my insurance carriers in order to determine insurance or other third party benefits for EMS to which my dependents or I may be entitled.

Witness ________ Date / Time ________ Patient / Guardian ________ Date / Time ________

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OKLAHOMA EMS INFORMATION SYSTEM

Prehospital Care Report Number:

Oklahoma State Department of Health

SYMPTOMS 91. P=PRIMARY (pick one) ☐ Not applicable
92. A =ASSOCIATED (multi) ☐ Not applicable

P A
☐ ☐ Transport Only
☐ ☐ None
☐ ☐ Bleeding
☐ ☐ Breathing
☐ ☐ Changes in Responsiveness
☐ ☐ Choking
☐ ☐ Death
☐ ☐ Device/Equip Problem
☐ ☐ Diarrhea
☐ ☐ Drainage/Discharge
☐ ☐ Fever
☐ ☐ Malaise
☐ ☐ Mass/Lesion
☐ ☐ Mental/Psych
☐ ☐ Nausea/Vomiting
☐ ☐ Pain
☐ ☐ Palpitations
☐ ☐ Rash/Itching
☐ ☐ Swelling
☐ ☐ Weakness
☐ ☐ Wound

PROVIDER IMPRESSION
93. P= PRIMARY (pick one) ☐ Not applicable
94. S=SECONDARY (pick one) ☐ Not applicable

P S
☐ ☐ Abdominal pain
☐ ☐ Airway obstruct
☐ ☐ Allergic reaction
☐ ☐ Altered LOC
☐ ☐ Behavior/psych
☐ ☐ Cardiac arrest
☐ ☐ Cardiac arrhythmia
☐ ☐ Chest pain
☐ ☐ CHF
☐ ☐ COPD
☐ ☐ Diabetic
☐ ☐ Electrocution
☐ ☐ Hyperthermia
☐ ☐ Hypothermia
☐ ☐ Hypovolemia/shock
☐ ☐ Inhalation injury/toxic gas
☐ ☐ Inhalation/smoke
☐ ☐ Obvious Death
☐ ☐ Poisoning/drug OD
☐ ☐ Pregnancy/OB delivery
☐ ☐ Respiratory arrest
☐ ☐ Respiratory distress
☐ ☐ Seizure
☐ ☐ Sexual assault/rape
☐ ☐ Stings/venomous bites
☐ ☐ Stroke/CVA
☐ ☐ Syncope/fainting
☐ ☐ Traumatic injury
☐ ☐ Vaginal hemorrhage

95. **ALCOHOL/DRUG USE INDICATORS** (multi-choice)
☐ Not applicable
☐ None
☐ Smell of alcohol ***present***
☐ Pt admits to alcohol use
☐ Pt admits to drug use
☐ Alcohol and/or drug paraphernalia at scene

96. **CHIEF COMPLAINT ANATOMIC LOCATION** ☐ Not applicable
☐ Abdomen ☐ Back ☐ Chest ☐ Extremity Lower ☐ Extremity Upper ☐ General/Global ☐ Genitalia ☐ Head ☐ Neck

97. **CHIEF COMPLAINT ORGAN SYSTEM**
☐ Not applicable ☐ Cardiovascular ☐ CNS/Neuro ☐ Endocrine/Metabolic ☐ GI ☐ Global ☐ Musculoskeletal ☐ OB/GYN ☐ Psych ☐ Pulmonary ☐ Renal ☐ Skin

98. **Incident Work-Related**
☐ Yes ☐ No ☐ Unknown ☐ Not applicable

99. **CARDIAC ARREST**
☐ Not applicable
☐ Yes, Prior to Arrival
☐ Yes, After Arrival
☐ No

100. **RESUSCITATION** (multi)
☐ Not applicable
☐ Defibrillation ☐ None-DOA
☐ Ventilation ☐ None-DNR/***DNAR***
☐ Chest Comp ☐ None-Signs of life

101. **TIME OF ARREST** (mins)
☐ Not applicable
☐ 0-2 ☐ 2-4
☐ 4-6 ☐ 6-8
☐ 8-10 ☐ 10-15
☐ 15-20 ☐ >20

102. **ARREST WITNESSED BY:**
☐ Not applicable Lay
☐ Person Healthcare
☐ Provider
☐ Not Witnessed

103. **CAUSE OF ARREST**
☐ Not applicable ☐ Drowning
☐ Unknown ☐ Respiratory
☐ Presumed Cardiac ☐ Electrocution
☐ Trauma ☐ Other

STEMI ☐ Not applicable
104. 12-Lead EKG used: ☐ Yes Yes ☐ No No
105. Transmitted for interpretation: ☐ Paramedic ☐ Physician
106. Interpreter (indicate all): ☐ ☐ ☐ Computer Program
107. STEMI probable: ☐ Yes ☐ No ☐ Inconclusive

108. **Stroke Scale**
☐ Not applicable ☐ Not available ☐ Not known
☐ Cincinnati Stroke Scale Negative ☐ LA Stroke Scale Negative
☐ Cincinnati Stroke Scale Non-conclusive ☐ LA Stroke Scale Non-conclusive
☐ Cincinnati Stroke Scale Positive ☐ LA Stroke Scale Positive

PRIOR AID RECEIVED PRIOR TO ARRIVAL OF UNIT See Reference Sheet

109. PRIOR AID PERFORMED BY:
110. PRIOR AID (Use PROCEDURES List and/or MEDICATIONS List)

☐ EMS Provider ☐ Other Health Care Provider
☐ Law Enforcement ☐ Lay Person ☐ Unknown
☐ EMS Provider ☐ Other Health Care Provider
☐ Law Enforcement ☐ Lay Person ☐ Unknown
☐ EMS Provider ☐ Other Health Care Provider
☐ Law Enforcement ☐ Lay Person ☐ Unknown
☐ EMS Provider ☐ Other Health Care Provider
☐ Law Enforcement ☐ Lay Person ☐ Unknown

111. **OUTCOME OF PRIOR AID**
☐ Improved ☐ Unchanged ☐ Worse ☐ Unknown

112. **BARRIERS TO EFFECTIVE CARE** [multi-choice]
☐ Not applicable
☐ Developmentally Impaired
☐ Unattended/Unsupervised
☐ Hearing Impaired
☐ Language
☐ Unattended or unsupervised (including minors)
☐ Physically Impaired
☐ Physically Restrained
☐ Speech Impaired
☐ Unconscious
☐ None

113. **TRAUMA PRESENT**
☐ Not applicable
☐ Yes
☐ No

114. **CAUSE OF INJURY**
☐ Not applicable
See Ref. Sheet

115. **MECHANISM OF INJURY**
☐ Not applicable
☐ Blunt ☐ Penetrating
☐ Burn ☐ Not Known

116. **HOSPITAL TEAM NOTIFIED**
☐ Not applicable ☐ Trauma
☐ Yes ☐ Stroke
☐ No ☐ STEMI

117. **TIME HOSPITAL TEAM NOTIFIED**

118. **Trauma Triage Level**
☐ Not applicable ☐ Priority 2
☐ Priority 1 ☐ Priority 3

119. **TRAUMA TRIAGE CRITERIA**
☐ Not applicable
☐ GCS <=13
☐ GCS improving
☐ Resp compromise resulting from trauma
☐ Hemodynamic compromise from trauma
☐ Blunt trauma/no hemodynamic trauma
☐ Penetrating injury to trunk-neck-head
☐ Penetrating injuries to extremities
☐ Amputation proximal to wrist or ankle
☐ Paralysis resulting from trauma
☐ Flail chest
☐ Two or more proximal long bone fractures
☐ Open or depressed skull fracture
☐ Unstable pelvis
☐ PTS <= 8
☐ BSA >= 10%
☐ BSA < 10%
☐ Other single system injury
☐ Minor injuries

Intercept:
120. TIME REQUESTED: 121. TIME ARRIVED:
122. TIME OF CARE TRANSFER: 123. REC AGENCY:

124. **TRAUMA REFERRAL CENTER (TreC) NOTIFIED**
☐ Yes ☐ No ☐ N/A

125. **TreC TRACKING #:** ☐ N/A
126. **TIME TReC NOTIFIED:** ☐ N/A

127. **VEHICULAR INJURY INDICATORS** ☐ Not applicable
☐ Dash Deformity | Fire | Space Intrusion >1 foot
☐ DOA Same Vehicle | Rollover/Roof Deformity | Windshield Spider/Star
☐ Ejection | Side Post Deformity | Steering Wheel Deformity

128. **USE OF SAFETY EQUIPMENT [multi]** ☐ Not applicable ☐ None
Child Restraint | Lap Belt | Protective Gear
Eye Protection | Pers Flotation Device | Shoulder Belt
☐ Helmet Worn | Protective Clothing | Other (Airbag)

129. **AIRBAG DEPLOYMENT** ☐ Not applicable
☐ Airbag Deployed Front | Airbag Deployed Other | No Airbag Present
☐ Airbag Deployed Side | Airbag Not Deployed | Unknown

130. **PATIENT POSITION** ☐ Not applicable ☐ Unknown
☐ Driver ☐ Left (non-driver) Middle ☐ Right ☐ Other

131. **TYPE OF DESTINATION**
☐ Home
☐ Medical Office/Clinic
☐ Nursing Home
☐ Other EMS (ground)
☐ Other
☐ Hospital
☐ Morgue
☐ Other EMS (air)
☐ Police/Jail
☐ Not applicable

132. **REASON FOR CHOOSING DESTINATION**
☐ Closest
☐ Diversion
☐ Family Choice
☐ Insurance
☐ Law Enforcement Choice
☐ Specialty Resource Center
☐ On-line Med Control
☐ Other
☐ Pt Choice
☐ Pt Physician's Choice
☐ Protocol
☐ Not applicable

133. **ED DISPOSITION**
☐ Admit-floor
☐ Admit-ICU
☐ Death
☐ Not Applicable
☐ Released
☐ Transferred
☐ Unknown

134. **HOSPITAL DISPOSITION**
☐ Death
☐ Discharge ☐ Not applicable
☐ Transfer-other hosp
☐ Transfer-nursing home
☐ Transfer-other
☐ Transfer-rehab
☐ Unknown

135. **TYPE OF DELAY(S)** (select all) **DISPATCHER**
☐ Not applicable
☐ None
☐ Caller Uncooperative
☐ High Call Volume
☐ Language Barrier
☐ Location (Inability to obtain)
☐ No Unit Available
☐ Safety Conditions
☐ Technical Failure
☐ Other

136. **TYPE OF DELAY(S)** (select all) **RESPONSE**
☐ Not applicable
☐ None
☐ Crowd
☐ Directions
☐ Distance
☐ Diversion
☐ HazMat
☐ Safety Conditions
☐ Staff Delay
☐ Traffic
☐ Vehicle Crash
☐ Vehicle Failure
☐ Weather
☐ Other

137. **TYPE OF DELAY(S) SCENE** (select all)
☐ Not applicable
☐ None
☐ Crowd
☐ Directions
☐ Distance
☐ Diversion
☐ Extrication>20 Min
☐ HazMat
☐ Language Barrier
☐ Safety Conditions
☐ Staff Delay
☐ Traffic
☐ Vehicle Crash
☐ Vehicle Failure
☐ Weather
☐ Other

138. **TYPE OF DELAY(S) TRANSPORT** (select all)
☐ Not applicable
☐ None
☐ Crowd
☐ Directions
☐ Distance
☐ Diversion
☐ HazMat
☐ Safety Conditions
☐ Staff Delay
☐ Traffic
☐ Vehicle Crash
☐ Vehicle Failure
☐ Weather
☐ Other

139. **TYPE OF DELAY(S)** (select all) **RETURN**
☐ Not applicable
☐ None Clean up
☐ Decontamination
☐ Documentation
☐ ED Overcrowding
☐ Equipment Failure
☐ Equipment Replenishment
☐ Staff Delay
☐ Vehicle Failure
☐ Other
☐

Enter CREW MEMBER Information for: 140. **CREW MEMBER ID NUMBER** 141. **LEVEL OF SERVICE** 142. **CREW MEMBER ROLE**

CREW MEMBER 1 ID NUMBER

Crew Member1 Signature

o B o I o P o EMR o Physician o Nurse O Student O Other

CREW MEMBER 1 ROLE
☐ Primary Patient Caregiver ☐ Driver
☐ Secondary Patient Caregiver ☐ Other
☐ Third Patient Caregiver

CREW MEMBER 2 ID NUMBER

Crew Member2 Signature

o B o I o P o EMR o Physician o Nurse O Student O Other

CREW MEMBER 2 ROLE
☐ Primary Patient Caregiver ☐ Driver
☐ Secondary Patient Caregiver ☐ Other
☐ Third Patient Caregiver

CREW MEMBER 3 ID NUMBER

Crew Member3 Signature

o B o I o P o EMR o Physician o Nurse O Student O Other

CREW MEMBER 3 ROLE
☐ Primary Patient Caregiver ☐ Driver
☐ Secondary Patient Caregiver ☐ Other
☐ Third Patient Caregiver

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OKLAHOMA EMS INFORMATION SYSTEM

Prehospital Care Report

SUPPLEMENTAL PAGE

Oklahoma State Department of Health

Oklahoma Report Number from 1st page:	PATIENT LAST NAME from 1st page:	INCIDENT DATE from 1st page:
		- -

Additional PATIENT MEDICAL HISTORY from 1st page:	Additional PATIENT MEDICATION HISTORY from 1st page:	Additional PATIENT ALLERGIES from 1st page:

Additional NARRATIVE from 1st page:

Report Given to: ______________________; Narrative page ___of ___pages

Necessity For Service

Upon arrival, Patient Found in:
- ☐ Ambulating
- ☐ Geri Cardiac Chair
- ☐ Recliner
- ☐ Wheelchair
- ☐ Bed
- ☐ Gurney/exam table
- ☐ Floor
- ☐ Other ________

Was stretcher necessary?
- ☐ Unable to sit upright
- ☐ Unable to balance in sitting position
- ☐ Unconscious/shock
- ☐ Req. physical restraints
- ☐ Severe hemorrhage
- ☐ Bed Confined
- ☐ Fetal position ☐ Contractures ☐ Paralyzed
- ☐ MI
- ☐ Unset or poss fracture
- ☐ Acute stroke
- ☐ MVC
- ☐ Other ________

Patient moved to Stretcher via
- ☐ Total lift
- ☐ Draw sheet
- ☐ Other ________

Did patient
- ☐ Vomit
- ☐ Complain of nausea
- ☐ Complain of pain

Was patient
- ☐ Incontinent
- ☐ Combative
- ☐ Confused/lethargic
- ☐ Dizzy
- ☐ Weak
- ☐ Other ______

Did patient require
- ☐ IV
- ☐ Saline hep lock
- ☐ Drug therapy
- ☐ Oxygen
- ☐ Intubation
- ☐ Ventilator
- ☐ EKG monitor
- ☐ Chemstrip
- ☐ Other ______

Patient placed in
- ☐ Ambulating
- ☐ Geri Cardiac Chair
- ☐ Recliner
- ☐ Wheelchair
- ☐ Bed
- ☐ Gurn/exam table
- ☐ Other _____

Additional VITAL SIGNS & Glasgow Coma Scale from 1st page: Glasgow Coma Scale — Pediatric Trauma Score: Age 12 and under

Time	Pulse	Resp	SBP	DBP	Method BP	LOC	O2 Sat	EKG	Eyes	Verbal	Motor	GCS Score	Weight	Airway	CNS	BP	Wounds	Skeletal	143. PT Score
					☐Arterial Line ☐Auto Cuff ☐Manual Cuff ☐Palpate Cuff ☐Venous Line	☐ A ☐ V ☐ P ☐ U		See Ref Sheet	☐4 Spon ☐3 Speech ☐2 Pain ☐1 None	☐5 Oriented ☐4 Confuse ☐3 Inapprop ☐2 Garbled ☐1 None	☐6 Obeys ☐5 Localizes ☐4 W/draws ☐3 Flexion ☐2 Extent ☐1 None		Initial: ☐>20:+2 ☐ 10-20: 1 ☐<10:-1	Initial: ☐Normal:+2 ☐Maint:+1 ☐Unmaint:-1	Initial: ☐Awake:+2 ☐Obtund:+1 ☐Coma:-1	Initial: ☐>90:+2 ☐90-50: 1 ☐<50:-1	Initial: ☐ None: +2 ☐ Minor: 1 ☐ Major:-1	Initial: ☐None:+2 ☐Closed fx:+1 ☐Open:-1	Initial: _____
					☐Arterial Line ☐Auto Cuff ☐Manual Cuff ☐Palpate Cuff ☐Venous Line	☐ A ☐ V ☐ P ☐ U		See Ref Sheet	☐4 Spon ☐3 Speech ☐2 Pain ☐1 None	☐5 Oriented ☐4 Confuse ☐3 Inapprop ☐2 Garbled ☐1 None	☐6 Obeys ☐5 Localizes ☐4 W/draws ☐3 Flexion ☐2 Extent ☐1 None		Final: ☐>20:+2 ☐ 10-20: 1 ☐<10:-1	Final: ☐Normal:+2 ☐Maint:+1 ☐Unmaint:-1	Final: ☐Awake:+2 ☐Obtund:+1 ☐Coma:-1	Final: ☐>90:+2 ☐90-50: 1 ☐<50:-1	Final: ☐ None: +2 ☐ Minor: 1 ☐ Major:-1	Final: ☐None:+2 ☐Closed fx:+1 ☐Open:-1	
					☐Arterial Line ☐Auto Cuff ☐Manual Cuff ☐Palpate Cuff ☐Venous Line	☐ A ☐ V ☐ P ☐ U		See Ref Sheet	☐4 Spon ☐3 Speech ☐2 Pain ☐1 None	☐5 Oriented ☐4 Confuse ☐3 Inapprop ☐2 Garbled ☐1 None	☐6 Obeys ☐5 Localizes ☐4 W/draws ☐3 Flexion ☐2 Extent ☐1 None		☐>20:+2 ☐ 10-20: 1 ☐<10:-1	☐Normal:+2 ☐Maint:+1 ☐Unmaint:-1	☐Awake:+2 ☐Obtund:+1 ☐Coma:-1	☐>90:+2 ☐90-50: 1 ☐<50:-1	☐ None: +2 ☐ Minor: 1 ☐ Major:-1	☐None:+2 ☐Closed fx:+1 ☐Open:-1	
					☐Arterial Line ☐Auto Cuff ☐Manual Cuff ☐Palpate Cuff ☐Venous Line	☐ A ☐ V ☐ P ☐ U		See Ref Sheet	☐4 Spon ☐3 Speech ☐2 Pain ☐1 None	☐5 Oriented ☐4 Confuse ☐3 Inapprop ☐2 Garbled ☐1 None	☐6 Obeys ☐5 Localizes ☐4 W/draws ☐3 Flexion ☐2 Extent ☐1 None		☐>20:+2 ☐ 10-20: 1 ☐<10:-1	☐Normal:+2 ☐Maint:+1 ☐Unmaint:-1	☐Awake:+2 ☐Obtund:+1 ☐Coma:-1	☐>90:+2 ☐90-50: 1 ☐<50:-1	☐ None: +2 ☐ Minor: 1 ☐ Major:-1	☐None:+2 ☐Closed fx:+1 ☐Open:-1	Final: _____

MEDICATIONS Continued from 1st page

Time	Medication Given See Reference Sheet	Medication Administered By:	Reactions See Reference Sheet	Medication Authorization
		☐ CM 1 ☐ CM 2 ☐ CM 3		☐ Protocol (Standing Order) ☐ Written Orders (Patient Specific) ☐ On-Line ☐ On-Scene ☐ Not applic
		☐ CM 1 ☐ CM 2 ☐ CM 3		☐ Protocol (Standing Order) ☐ Written Orders (Patient Specific) ☐ On-Line ☐ On-Scene ☐ Not applic
		☐ CM 1 ☐ CM 2 ☐ CM 3		☐ Protocol (Standing Order) ☐ Written Orders (Patient Specific) ☐ On-Line ☐ On-Scene ☐ Not applic
		☐ CM 1 ☐ CM 2 ☐ CM 3		☐ Protocol (Standing Order) ☐ Written Orders (Patient Specific) ☐ On-Line ☐ On-Scene ☐ Not applic
		☐ CM 1 ☐ CM 2 ☐ CM 3		☐ Protocol (Standing Order) ☐ Written Orders (Patient Specific) ☐ On-Line ☐ On-Scene ☐ Not applic

PROCEDURES Continued from 1st page

Time	Procedure	# Attempts	Successful	Done By:	Complications See Reference. Sheet
			☐ YES ☐ NO ☐ NA	☐ CM 1 ☐ CM 2 ☐ CM3	
			☐ YES ☐ NO ☐ NA	☐ CM 1 ☐ CM 2 ☐ CM3	
			☐ YES ☐ NO ☐ NA	☐ CM 1 ☐ CM 2 ☐ CM3	
			☐ YES ☐ NO ☐ NA	☐ CM 1 ☐ CM 2 ☐ CM3	
			☐ YES ☐ NO ☐ NA	☐ CM 1 ☐ CM 2 ☐ CM3	

CREW MEMBER 4 ID NUMBER	CREW MEMBER 5 ID NUMBER	CREW MEMBER 6 ID NUMBER
Crew Member4 Signature	Crew Member5 Signature	Crew Member6 Signature
O B O I O P O EMR O Physician O Nurse O Student O Other	O B O I O P O EMR O Physician O Nurse O Student O Other	O B O I O P O EMR O Physician O Nurse O Student O Other

CREW MEMBER 4 ROLE	CREW MEMBER 5 ROLE	CREW MEMBER 6 ROLE
☐ Primary Patient Caregiver ☐ Driver	☐ Primary Patient Caregiver ☐ Driver	☐ Primary Patient Caregiver ☐ Driver
☐ Secondary Patient Caregiver ☐ Other	☐ Secondary Patient Caregiver ☐ Other	☐ Secondary Patient Caregiver ☐ Other
☐ Third Patient Caregiver	☐ Third Patient Caregiver	☐ Third Patient Caregiver