



PATIENT CARE REPORT

RESPONSE #
DATE OF EVALUATION (MM / DD / YYYY)
TIME CALL DISPATCH _____
TIME AT SCENE _____
TIME TO HOSPITAL _____
TIME AT HOSPITAL _____
TIME CLEAR _____

PATIENT NAME	AGE	DOCTOR
CHIEF COMPLAINT / DESCRIPTION OF INCIDENT		ATTENDANT NAME
MECHANISM OF INJURY / HISTORY OF ILLNESS		DRIVER NAME
RELEVANT PAST MEDICAL HISTORY		LEVEL APPLIED FOR
MEDITATIONS		TRAINING INSTITUTION
ALLERGIES		PHYSICAL EXAM

CARE GIVEN	AIRWAY	OXYGEN	PAIN ASSESSMENT	FRONT	BACK	PUPILS																					
<input type="checkbox"/> CONTROL BLEEDING <input type="checkbox"/> DRESS WOUND <input type="checkbox"/> CPR <input type="checkbox"/> AED <input type="checkbox"/> SPINAL IMMOBILIZATION <input type="checkbox"/> IV THERAPY <input type="checkbox"/> PATIENT COMFORT/ REASSURANCE <input type="checkbox"/> FRACTURE MGMT	<input type="checkbox"/> CLEARED <input type="checkbox"/> POSITIONED <input type="checkbox"/> SUCTIONED <input type="checkbox"/> ASSISTED <input type="checkbox"/> ORAL AIRWAY	<input type="checkbox"/> MASK <input type="checkbox"/> NON-REBREATHER <input type="checkbox"/> BVM <input type="checkbox"/> POCKET MASK <input type="checkbox"/> NASAL CANNULA _____ OXYGEN LPM				<table border="0"> <tr><td>R</td><td>L</td><td>EQUAL</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>REACT</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>DILAT.</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>CONST.</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>RT. LG.</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>LT. LG.</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>OTHER</td></tr> </table>	R	L	EQUAL	<input type="checkbox"/>	<input type="checkbox"/>	REACT	<input type="checkbox"/>	<input type="checkbox"/>	DILAT.	<input type="checkbox"/>	<input type="checkbox"/>	CONST.	<input type="checkbox"/>	<input type="checkbox"/>	RT. LG.	<input type="checkbox"/>	<input type="checkbox"/>	LT. LG.	<input type="checkbox"/>	<input type="checkbox"/>	OTHER
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TIME	GCS				VITAL SIGNS				SKIN	PROTOCOLS
	E	V	M	TOTAL	PULSE	RESP.	SpO ₂	BP		
								/		
								/		
								/		
								/		
								/		
								/		
								/		
								/		
								/		

ADDITIONAL TREATMENTS AND COMMENTS

PATIENT ASSESSMENT GUIDE

RESCUE SCENE EVALUATION

- Personal Protective Equipment
- Environment
- Hazards
- Mechanism of Injury

PRIMARY SURVEY

- LOC
- Delicate Spine
- Airway
- Breathing
- Circulation
- Rapid Body Survey
- O₂

SECONDARY SURVEY

HISTORY

- Chief Complaint
- History of Chief Complaint
- Relevant Medical History
- Medications
- Allergies

VITAL SIGNS

- LOC
- Respiration
- Pulse
- Skin
- BP

HEAD-TO-TOE ASSESSMENT

- Head
- Neck
- Chest
- Breath Sounds
- Bowel Sounds
- Abdomen
- Hips/Pelvis
- Back
- Lower Extremities
- Upper Extremities

HAND-OFF REPORT

- Age
- Chief Complaint
- History of Chief Complaint
- Medical History
- Medications
- Vital Signs
- Allergies
- Relevant Physical Findings
- Treatments/Protocols

FUNCTIONAL INQUIRY

- General
- CNS
- Respiratory
- Cardiac
- GI/GU
- Endocrine
- Muscular/Skeletal

DOCUMENTATION INFORMATION AND COMMON ABBREVIATIONS

GLASGOW COMA SCALE: TOTAL SCORE = /15

Eyes Open	Best Verbal Response	Best Motor Response
4 Spontaneously	5 Oriented	6 Obeys commands
3 To Speech	4 Confused	5 Localizes to pain
2 To Pain	3 Inappropriate words	4 Withdraws from pain
1 No Response	2 Incomprehensible sounds	3 Flexion to pain (decorticate)
	1 No Response	2 Extension to pain (decerebrate)
A Alert		1 No Response
V Verbal		
P Pain		
U Unresponsive		

PAIN ASSESSMENT

P Position	L Location
Q Quality	O Onset
R Radiation	T Type of pain
S Severity	A Associated/Aggravated symptoms
T Timing	R Relieving/Radiating
	P Precipitating event

MEDICAL ASSESSMENT

S Signs & Symptoms
A Allergies
M Medications
P Previous Hx
L Last Oral Intake
E Events Precipitating

Abdomen	Abd	Left Upper Quadrant	LUQ
Abdomen pain	Abd pn	Less than	<
As needed	prn	Level of Consciousness	LOC
Automatic External Defibrillator	AED	Male	♂
Alcohol	ETOH	Mass Casualty Incident	MCI
Bag-Valve-Mask	BVM	Medications	Med
Basic Life Support	BLS	Motor Vehicle Accident	MVA
Blood Pressure	BP	More than	>
Body Surface Area	BSA	Non-insulin dependent diabetes mellitus	NIDDM
Cardiopulmonary Resuscitation	CPR	Nonrebreather mask	NRM
Cardiovascular	CV	Nothing by mouth	NPO
Central Nervous System	CNS	Obstetrical/gynaecological	OB/GYN
Chief Complaint	CC	Oropharyngeal airway	OPA
Chest Pain	CP	Overdose	OD
Complains of	c/o	Oxygen	O ₂
Chronic Obstructive Pulmonary Disease	COPD	Pain	pn
Congestive Heart Failure	CHF	Palpation	Palp
Coronary Artery Disease	CAD	Patient	Pt
Dead on Arrival	DOA	Pulse	P
Decreased	↓	Range of Motion	ROM
Delirium Tremens	DTs	Respirations	R
Ear, Nose, and Throat	ENT	Right Lower Quadrant	RLQ
Equal	=	Right Upper Quadrant	RUQ
Estimated time of arrival	ETA	Rule Out	R/O
Female	♀	Short of Breath	SOB
Foreign body obstruction	FBO	Signs and Symptoms	S/S
Gastrointestinal	GI	Temperature	T
Gunshot Wound	GSW	Transient Ischemic Attack	TIA
History	Hx	Treatment	Tx
Hypertension	HTN	Times	X
Immediately	Stat	Unconscious	unc
Increased	↑	Vital Signs	VS
Insulin Dependent Diabetic Mellitus	IDDM	Year-old	y/o
Left Lower Quadrant	LLQ		