

EMS SERVICE REPORT



State of New Mexico
 Department of Health
 Public Health Division
 Injury Prevention and EMS Bureau

Multi-Patient
 ___ of ___ Patients



				/ /
Service Number	Service Name	Unit Number	Run/Incident	Mo/Day/Year

Patient Name (Last, First, MI) _____ SSN _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age _____	DOB _____/_____/____
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Billing/Mailing Address _____ City, State, Zip _____ County _____ Phone # _____	Prescribed Medications _____ Allergies _____
If Minor, Name of Parent or Guardian _____	_____

Dispatch Call Received _____ Service Dispatched _____ Date _____ Date _____ Time _____ Time _____	Non-Emergency/Emergency Time Responded _____ Mode: To Scene: <input type="checkbox"/> Emergent <input type="checkbox"/> <input type="checkbox"/> Non-Emergent <input type="checkbox"/> <input type="checkbox"/> Up/Downgraded <input type="checkbox"/> From Scene: _____ On Scene _____ Depart Scene _____ At Hospital/Transfer _____ In Service _____	Response/Disposition Cancelled <input type="checkbox"/> Emergency <input type="checkbox"/> Non-Emergency <input type="checkbox"/> Transfer <input type="checkbox"/> Mutual Aid <input type="checkbox"/> Stand by <input type="checkbox"/> Unk _____ <input type="checkbox"/>	Pre-Arrival Aid CPR <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A AED <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A First Aid <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Provided by: _____
Incident Address/Location _____ _____ City _____, NM County _____	Mileage Beginning _____ On Scene _____ At Hosp. _____ Ending _____	Transport/Transfer Facility _____ Unit/Service _____	Type of Incident Medical <input type="checkbox"/> MVC <input type="checkbox"/> Violence <input type="checkbox"/> Fall <input type="checkbox"/> Employment <input type="checkbox"/> Other _____

Primary Category/Prehospital Care Summary <input type="checkbox"/> Medical <input type="checkbox"/> Cardiac <input type="checkbox"/> OB <input type="checkbox"/> Pediatric <input type="checkbox"/> Behavioral <input type="checkbox"/> Poison <input type="checkbox"/> Other <input type="checkbox"/> Trauma <input type="checkbox"/> MVC <input type="checkbox"/> Burn <input type="checkbox"/> Fall <input type="checkbox"/> Head/Spine <input type="checkbox"/> Violence <input type="checkbox"/> Firearm/GSW <input type="checkbox"/> Other	BLS <input type="checkbox"/> Extrication est. min _____ <input type="checkbox"/> Assessment <input type="checkbox"/> Airway Management <input type="checkbox"/> Oxygen <input type="checkbox"/> Nasal/Oral Airway <input type="checkbox"/> Combitube <input type="checkbox"/> BVM <input type="checkbox"/> CPR <input type="checkbox"/> Defibrillation <input type="checkbox"/> Wound Care <input type="checkbox"/> Control bleeding <input type="checkbox"/> Limb Splinting <input type="checkbox"/> Spinal Immobilization <input type="checkbox"/> OB Delivery <input type="checkbox"/> Other _____	ALS <input type="checkbox"/> IV <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> Chest Decompression <input type="checkbox"/> Cricothyrotomy <input type="checkbox"/> Other _____ Intubation <input type="checkbox"/> Medication <input type="checkbox"/> IV Site <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Arm <input type="checkbox"/> Leg <input type="checkbox"/> Hand <input type="checkbox"/> I/O <input type="checkbox"/> EJ Outcome <input type="checkbox"/> Improved <input type="checkbox"/> No change <input type="checkbox"/> Worsened <input type="checkbox"/> Cardiac Resuscitation <input type="checkbox"/> Expired	Disposition Treatment <input type="checkbox"/> refused <input type="checkbox"/> not needed Transport <input type="checkbox"/> refused <input type="checkbox"/> not needed <input type="checkbox"/> Transported by private car <input type="checkbox"/> Other service transported <input type="checkbox"/> Cancelled <input type="checkbox"/> False alarm <input type="checkbox"/> Divert <input type="checkbox"/> Closest hospital <input type="checkbox"/> Re-route <input type="checkbox"/> Protocol <input type="checkbox"/> Physician request <input type="checkbox"/> Patient request <input type="checkbox"/> Dead at scene <input type="checkbox"/> Other _____
Suspected <input type="checkbox"/> Drug <input type="checkbox"/> Alcohol Seatbelt Use <input type="checkbox"/> Yes <input type="checkbox"/> No	Helmet Use <input type="checkbox"/> Yes <input type="checkbox"/> No Infant Seat Use <input type="checkbox"/> Yes <input type="checkbox"/> No		

Time →							
GCS							
Pulse Rate							
Respiratory Rate							
Blood Pressure	/	/	/	/	/	/	/
O2 Sat/ETCO2	/	/	/	/	/	/	/
BGL							
Oxygen							
Medications							

