

1. INCIDENT DATE		2. OKLAHOMA REPORT NUMBER			3. EMS AGCY #		4. VEHICLE NUMBER			5. EMS UNIT CALL SIGN			6. STATION #												
7. INCIDENT/PATIENT DISPOSITION																									
<input type="checkbox"/> Treated, Transport EMS		<input type="checkbox"/> No Patient Found		<input type="checkbox"/> Treated, Transferred Care		<input type="checkbox"/> Treated, Transported Law Enforcement			<input type="checkbox"/> Canceled			<input type="checkbox"/> Dead at Scene													
<input type="checkbox"/> No Treatment Required		<input type="checkbox"/> Pt Refused Care		<input type="checkbox"/> Treated & Released		<input type="checkbox"/> Treated, Transported Private Vehicle																			
8. INCIDENT ADDRESS				9. INCIDENT CITY				10. INCIDENT ST		11. INCIDENT ZIP		12. INCIDENT COUNTY													
13. RESPONSE MODE TO SCENE				14. FROM SCENE				Run Times				19. Unit Arrived at Scene:													
<input type="checkbox"/> Lights/Sirens				<input type="checkbox"/> No Lights/No Sirens				Use Military Time				20. Arrived at Patient:													
<input type="checkbox"/> Initial Lights/Sirens Downgraded to no Lights/Sirens				<input type="checkbox"/> Initial No Lights/Sirens Upgraded to Lights/Sirens				15. Estimated Time of Onset:				21. Unit Left Scene:													
								16. PSAP / Initial Call for Help:				22. Patient Arrived at Destination:													
								17. Unit Notified by Dispatch:				23. Unit Back in Service:													
								18. Unit Enroute:				24. Unit Back at Home Location:													
25. TYPE OF SERVICE REQUESTED				26. INCIDENT LOCATION TYPE				27. CONDITION CODE(S) <i>See reference sheet</i>																	
<input type="checkbox"/> 911 Response		<input type="checkbox"/> Medical Transport		<input type="checkbox"/> Home/residence		<input type="checkbox"/> Farm		<input type="checkbox"/> Mine/quarry		<input type="checkbox"/> Industrial place															
<input type="checkbox"/> Interfacility Transfer		<input type="checkbox"/> Intercept		<input type="checkbox"/> Sport/recreation place		<input type="checkbox"/> Street/highway		<input type="checkbox"/> Public building		<input type="checkbox"/> Trade/service															
<input type="checkbox"/> Mutual Aid		<input type="checkbox"/> Standby		<input type="checkbox"/> Health care facility		<input type="checkbox"/> Residential institution		<input type="checkbox"/> Lake/river		<input type="checkbox"/> Other															
28. COMPLAINT REPORTED BY DISPATCH (select one) <i>See Reference sheet</i>				29. EMERGENCY MEDICAL DISPATCH PERFORMED				30. CMS LEVEL OF SERVICE																	
1. _____				<input type="checkbox"/> No		<input type="checkbox"/> Yes, with pre-arrival instructions		<input type="checkbox"/> BLS, Emergency		<input type="checkbox"/> BLS															
				<input type="checkbox"/> Yes, without pre-arrival instructions		<input type="checkbox"/> Unknown		<input type="checkbox"/> N/A		<input type="checkbox"/> ALS, Level 1 Emergency		<input type="checkbox"/> ALS Lev 1													
										<input type="checkbox"/> ALS, Level 2		<input type="checkbox"/> Helicopter													
										<input type="checkbox"/> Paramedic Intercept		<input type="checkbox"/> Airplane													
										<input type="checkbox"/> Specialty Care		<input type="checkbox"/> Not Applicable													
31. NUMBER OF PATIENTS AT SCENE				32. MASS CASUALTY		33. PRIMARY ROLE OF THE UNIT																			
<input type="checkbox"/> Single		<input type="checkbox"/> None		<input type="checkbox"/> Multiple		<input type="checkbox"/> N/A		<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> N/A													
								<input type="checkbox"/> Transport		<input type="checkbox"/> Supervisor															
								<input type="checkbox"/> Non-transport		<input type="checkbox"/> Rescue															
ODOMETER READINGS				38. DEST ZIP		39. ORIG FAC ID		40. REC FAC ID		41. LATITUDE		LONGITUDE													
34. Begin		35. Arrive		36. Destination		37. End																			
42. PATIENT LAST NAME				43. PATIENT FIRST NAME				44. MI																	
45. PATIENT ADDRESS				46. <input type="checkbox"/> SAME AS INCIDENT ADDRESS				47. PATIENT CITY																	
48. STATE		49. PATIENT ZIP CODE		50. COUNTY		51. PT TELEPHONE NUMBER				52. RACE (single-choice)		53. ETHNICITY													
						Area Code		Telephone Number		<input type="checkbox"/> American Indian/Alaska Nat		<input type="checkbox"/> Hispanic													
										<input type="checkbox"/> African American/Black		<input type="checkbox"/> Not Hispanic													
										<input type="checkbox"/> Asian															
										<input type="checkbox"/> Native Hawaiian/Pac Islander															
										<input type="checkbox"/> White															
										<input type="checkbox"/> Other															
55. AGE		56. AGE UNITS		57. DATE OF BIRTH		58. SOCIAL SECURITY NUMBER				54. GENDER															
		<input type="checkbox"/> Hours <input type="checkbox"/> Days								<input type="checkbox"/> Female															
		<input type="checkbox"/> Months <input type="checkbox"/> Years								<input type="checkbox"/> Male															
59. PRIMARY PAYMENT METHOD																									
<input type="checkbox"/> Not Billed		<input type="checkbox"/> Unknown		<input type="checkbox"/> Workers Comp		<input type="checkbox"/> Medicare		<input type="checkbox"/> Other Government		Medicare #: _____		Insurance1 #: _____													
<input type="checkbox"/> Self Pay		<input type="checkbox"/> Not Available		<input type="checkbox"/> Insurance		<input type="checkbox"/> Medicaid		<input type="checkbox"/> Not Applicable		Medicaid #: _____		Insurance2 #: _____													
60. CHIEF COMPLAINT																									
PATIENT MEDICAL HISTORY				PATIENT MEDICATION HISTORY				61. PATIENT MEDICATION ALLERGIES																	
62. NARRATIVE:																									
Receiving Facility: _____ I received a verbal & written report on the care of this patient: _____																									
INITIAL & FINAL VITAL SIGNS <input type="checkbox"/> Not applicable										GLASGOW COMA SCALE <input type="checkbox"/> Not applicable															
63. Time		64. Pulse		65. Resp		66. SBP		67. DBP		68. Method BP		69. LOC		70. O2 Sat		71. EKG		72. Eyes		73. Verbal		74. Motor		75. GCS Score	
Initial:		:								<input type="checkbox"/> Arterial Line		<input type="checkbox"/> A				<i>See reference sheet</i>		<input type="checkbox"/> 4 Spon		<input type="checkbox"/> 5 Oriented		<input type="checkbox"/> 6 Obeys			
										<input type="checkbox"/> Auto Cuff		<input type="checkbox"/> V						<input type="checkbox"/> 3 Speech		<input type="checkbox"/> 4 Confused		<input type="checkbox"/> 5 Localizes			
										<input type="checkbox"/> Manual Cuff		<input type="checkbox"/> P						<input type="checkbox"/> 2 Pain		<input type="checkbox"/> 3 Inapprop		<input type="checkbox"/> 4 W/draws			
										<input type="checkbox"/> Palpate Cuff		<input type="checkbox"/> U						<input type="checkbox"/> 1 None		<input type="checkbox"/> 2 Garbled		<input type="checkbox"/> 3 Flexion			
										<input type="checkbox"/> Venous Line								<input type="checkbox"/> 1 None		<input type="checkbox"/> 1 None		<input type="checkbox"/> 2 Extent			
																		<input type="checkbox"/> 1 None		<input type="checkbox"/> 1 None		<input type="checkbox"/> 3 Extent			
																		<input type="checkbox"/> 1 None		<input type="checkbox"/> 1 None		<input type="checkbox"/> 1 None			
MEDITATIONS <input type="checkbox"/> None <input type="checkbox"/> Not applicable														80. Medication Authorization											
76. Time		77. Medication Given <i>See reference sheet</i>		78. Meds Administered By:		79. Med Complications <i>See reference sheet</i>				<input type="checkbox"/> Protocol (Standing Order)		<input type="checkbox"/> On-Line													
				<input type="checkbox"/> CM 1 <input type="checkbox"/> CM 2 <input type="checkbox"/> CM 3						<input type="checkbox"/> Written Orders (Patient Specific)		<input type="checkbox"/> On-Scene		<input type="checkbox"/> Not Applicable											
				<input type="checkbox"/> CM 1 <input type="checkbox"/> CM 2 <input type="checkbox"/> CM 3						<input type="checkbox"/> Protocol (Standing Order)		<input type="checkbox"/> On-Line													
				<input type="checkbox"/> CM 1 <input type="checkbox"/> CM 2 <input type="checkbox"/> CM 3						<input type="checkbox"/> Written Orders (Patient Specific)		<input type="checkbox"/> On-Scene		<input type="checkbox"/> Not Applicable											
				<input type="checkbox"/> CM 1 <input type="checkbox"/> CM 2 <input type="checkbox"/> CM 3						<input type="checkbox"/> Protocol (Standing Order)		<input type="checkbox"/> On-Line													
				<input type="checkbox"/> CM 1 <input type="checkbox"/> CM 2 <input type="checkbox"/> CM 3						<input type="checkbox"/> Written Orders (Patient Specific)		<input type="checkbox"/> On-Scene		<input type="checkbox"/> Not Applicable											
PROCEDURES <input type="checkbox"/> None <input type="checkbox"/> Not applicable																									
81. Time		82. Procedure <i>See reference sheet</i>		83. # Attempts		84. Successful		85. Done By:		86. Procedure Complications <i>See reference sheet</i>															
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA		<input type="checkbox"/> CM 1 <input type="checkbox"/> CM 2 <input type="checkbox"/> CM 3																	
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA		<input type="checkbox"/> CM 1 <input type="checkbox"/> CM 2 <input type="checkbox"/> CM 3																	
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA		<input type="checkbox"/> CM 1 <input type="checkbox"/> CM 2 <input type="checkbox"/> CM 3																	
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA		<input type="checkbox"/> CM 1 <input type="checkbox"/> CM 2 <input type="checkbox"/> CM 3																	
<input type="checkbox"/> I have been given notice of HIPAA Privacy Practices. <input type="checkbox"/> 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. <input type="checkbox"/> 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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SYMPTOMS 87. P=PRIMARY (pick one) <input type="checkbox"/> Not applicable 88. A =ASSOCIATED (multi) <input type="checkbox"/> Not applicable <table border="0"> <tr> <td>P</td><td>A</td><td>P</td><td>A</td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>Transport Only</td><td>Fever</td><td>None</td><td>Malaise</td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>Bleeding</td><td>Mass/Lesion</td><td>Breathing</td><td>Mental/Psych</td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>Changes in Responsiveness</td><td>Nausea/Vomiting</td><td>CHF</td><td>Pain</td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>Choking</td><td>Palpitations</td><td>COPD</td><td>Rash/Itching</td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>Death</td><td>Swelling</td><td>Device/Equip Problem</td><td>Weakness</td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>Diarrhea</td><td>Wound</td><td>Drainage/Discharge</td><td></td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> </table>		P	A	P	A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transport Only	Fever	None	Malaise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	Mass/Lesion	Breathing	Mental/Psych	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Changes in Responsiveness	Nausea/Vomiting	CHF	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Choking	Palpitations	COPD	Rash/Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Death	Swelling	Device/Equip Problem	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	Wound	Drainage/Discharge		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		PROVIDER IMPRESSION 89. 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ALCOHOL/DRUG USE INDICATORS (multi-choice) <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Smell of alcohol present <input type="checkbox"/> Pt admits to alcohol use <input type="checkbox"/> Pt admits to drug use <input type="checkbox"/> Alcohol and/or drug paraphernalia at scene
P	A	P	A																																																																																																																																									
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																										

92. CHIEF COMPLAINT ANATOMIC LOCATION <input type="checkbox"/> Not applicable <input type="checkbox"/> Abdomen <input type="checkbox"/> Extremity Lower <input type="checkbox"/> Genitalia <input type="checkbox"/> Back <input type="checkbox"/> Extremity Upper <input type="checkbox"/> Head <input type="checkbox"/> Chest <input type="checkbox"/> General/Global <input type="checkbox"/> Neck	93. CHIEF COMPLAINT ORGAN SYSTEM <input type="checkbox"/> Not applicable <input type="checkbox"/> Endocrine/Metabolic <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Pulmonary <input type="checkbox"/> Cardiovascular <input type="checkbox"/> GI <input type="checkbox"/> OB/GYN <input type="checkbox"/> Renal <input type="checkbox"/> CNS/Neuro <input type="checkbox"/> Global <input type="checkbox"/> Psych <input type="checkbox"/> Skin	94 Incident Work-Related <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable
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95. CARDIAC ARREST <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes, Prior to Arrival <input type="checkbox"/> Yes, After Arrival <input type="checkbox"/> No	96. RESUSCITATION (multi) <input type="checkbox"/> Not applicable <input type="checkbox"/> None-DOA <input type="checkbox"/> Defibrillation <input type="checkbox"/> None-DNR/DNAR <input type="checkbox"/> Ventilation <input type="checkbox"/> Chest Comp <input type="checkbox"/> None-DOA <input type="checkbox"/> None-DNR/DNAR <input type="checkbox"/> None-Signs of life	97. TIME OF ARREST (mins) <input type="checkbox"/> Not applicable <input type="checkbox"/> 0-2 <input type="checkbox"/> 2-4 <input type="checkbox"/> 4-6 <input type="checkbox"/> 6-8 <input type="checkbox"/> 8-10 <input type="checkbox"/> 10-15 <input type="checkbox"/> 15-20 <input type="checkbox"/> >20	98. ARREST WITNESSED BY: <input type="checkbox"/> Not applicable <input type="checkbox"/> Lay Person <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Not Witnessed	99. CAUSE OF ARREST <input type="checkbox"/> Not applicable <input type="checkbox"/> Drowning <input type="checkbox"/> Unknown <input type="checkbox"/> Respiratory <input type="checkbox"/> Presumed Cardiac <input type="checkbox"/> Electrocutation <input type="checkbox"/> Trauma <input type="checkbox"/> Other
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STEMI 100. 12-Lead EKG used: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable 101. Transmitted for interpretation: <input type="checkbox"/> Yes <input type="checkbox"/> No 102. Interpreter (indicate all): <input type="checkbox"/> Paramedic <input type="checkbox"/> Physician <input type="checkbox"/> Computer Program 103. STEMI probable: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inconclusive	104. Stroke Scale <input type="checkbox"/> Not applicable <input type="checkbox"/> Not available <input type="checkbox"/> Not known <input type="checkbox"/> Cincinnati Stroke Scale Negative <input type="checkbox"/> LA Stroke Scale Negative <input type="checkbox"/> Cincinnati Stroke Scale Non-conclusive <input type="checkbox"/> LA Stroke Scale Non-conclusive <input type="checkbox"/> Cincinnati Stroke Scale Positive <input type="checkbox"/> LA Stroke Scale Positive
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PRIOR AID RECEIVED PRIOR TO ARRIVAL OF UNIT See Ref. Sheet 105. PRIOR AID PERFORMED BY: <input type="checkbox"/> EMS Provider <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Lay Person <input type="checkbox"/> Unknown	106. PRIOR AID (Use PROCEDURES List and/or MEDICATIONS List) 107. TIME	108. OUTCOME OF PRIOR AID <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Worse <input type="checkbox"/> Unknown
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<input type="checkbox"/> EMS Provider <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Lay Person <input type="checkbox"/> Unknown <input type="checkbox"/> EMS Provider <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Lay Person <input type="checkbox"/> Unknown <input type="checkbox"/> EMS Provider <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Lay Person <input type="checkbox"/> Unknown <input type="checkbox"/> EMS Provider <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Lay Person <input type="checkbox"/> Unknown	109. BARRIERS TO EFFECTIVE CARE [multi-choice] <input type="checkbox"/> Not applicable <input type="checkbox"/> Physically Impaired <input type="checkbox"/> Developmentally Impaired <input type="checkbox"/> Physically Restrained <input type="checkbox"/> Unattended/Unsupervised <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Unconscious <input type="checkbox"/> Language <input type="checkbox"/> None <input type="checkbox"/> Unattended or unsupervised (including minors)
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110. TRAUMA PRESENT <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes <input type="checkbox"/> No	111. CAUSE OF INJURY <input type="checkbox"/> Not applicable See Ref. Sheet	112. MECHANISM OF INJURY <input type="checkbox"/> Not applicable <input type="checkbox"/> Blunt <input type="checkbox"/> Penetrating <input type="checkbox"/> Burn <input type="checkbox"/> Not Known	113. Other Trauma Mechanism <input type="checkbox"/> Not applicable <input type="checkbox"/> Explosion <input type="checkbox"/> Assault <input type="checkbox"/> Electrical <input type="checkbox"/> ATV <input type="checkbox"/> Other Trauma	114. HOSPITAL TEAM NOTIFIED <input type="checkbox"/> Not applicable <input type="checkbox"/> Trauma <input type="checkbox"/> Yes <input type="checkbox"/> Stroke <input type="checkbox"/> No <input type="checkbox"/> STEMI	115. TIME HOSPITAL TRAUMA TEAM NOTIFIED See Ref. Sheet	116. Trauma Triage Level <input type="checkbox"/> Not applicable <input type="checkbox"/> Priority 1 <input type="checkbox"/> Priority 2 <input type="checkbox"/> Priority 3
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117. TRAUMA TRIAGE CRITERIA <input type="checkbox"/> Not applicable <input type="checkbox"/> GCS <=13 <input type="checkbox"/> GCS improving <input type="checkbox"/> Resp compromise resulting from trauma <input type="checkbox"/> Hemodynamic compromise from trauma <input type="checkbox"/> Blunt trauma/no hemodynamic trauma <input type="checkbox"/> Penetrating injury to trunk-neck-head <input type="checkbox"/> Penetrating injuries to extremities <input type="checkbox"/> Amputation proximal to wrist or ankle <input type="checkbox"/> Paralysis resulting from trauma <input type="checkbox"/> Flail chest <input type="checkbox"/> Two or more proximal long bone fractures <input type="checkbox"/> Open or depressed skull fracture <input type="checkbox"/> Unstable pelvis <input type="checkbox"/> PTS <= 8 <input type="checkbox"/> BSA >= 10% <input type="checkbox"/> BSA < 10% <input type="checkbox"/> Other single system injury <input type="checkbox"/> Minor injuries	118. ALS INTERCEPT <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes <input type="checkbox"/> No	119. TIME ALS REQUESTED: <input type="checkbox"/> N/A <input type="text"/> / <input type="text"/> 120. TIME ALS ARRIVED: <input type="text"/> / <input type="text"/> 121. TIME OF CARE TRANSFER: <input type="checkbox"/> N/A <input type="text"/> / <input type="text"/> 122. REC AGENCY: <input type="text"/> / <input type="text"/> 123. AIR INTERCEPT <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes <input type="checkbox"/> No	124. TIME AIR REQUESTED: <input type="checkbox"/> N/A <input type="text"/> / <input type="text"/> 125. TIME AIR ARRIVED: <input type="text"/> / <input type="text"/> 126. TIME OF AIR TRANSFER: <input type="checkbox"/> N/A <input type="text"/> / <input type="text"/> 127. REC AGENCY: <input type="text"/> / <input type="text"/>	128. TRAUMA REFERRAL CENTER (TrEC) NOTIFIED <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A 129. TrEC TRACKING #: <input type="text"/> 130. TIME TrEC NOTIFIED: <input type="text"/>
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131. VEHICULAR INJURY INDICATORS <input type="checkbox"/> Dash Deformity <input type="checkbox"/> Fire <input type="checkbox"/> DOA Same Vehicle <input type="checkbox"/> Rollover/Roof Deformity <input type="checkbox"/> Ejection <input type="checkbox"/> Side Post Deformity <input type="checkbox"/> Not applicable <input type="checkbox"/> Space Intrusion >1 foot <input type="checkbox"/> Windshield Spider/Star <input type="checkbox"/> Steering Wheel Deformity	132. USE OF SAFETY EQUIPMENT [multi] <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Child Restraint <input type="checkbox"/> Lap Belt <input type="checkbox"/> Protective Gear <input type="checkbox"/> Eye Protection <input type="checkbox"/> Pers Flotation Device <input type="checkbox"/> Shoulder Belt <input type="checkbox"/> Helmet Worn <input type="checkbox"/> Protective Clothing <input type="checkbox"/> Other (Airbag)
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133. AIRBAG DEPLOYMENT <input type="checkbox"/> Airbag Deployed Front <input type="checkbox"/> Airbag Deployed Other <input type="checkbox"/> Airbag Deployed Side <input type="checkbox"/> Airbag Not Deployed <input type="checkbox"/> Not applicable <input type="checkbox"/> No Airbag Present <input type="checkbox"/> Unknown	134. PATIENT POSITION <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown <input type="checkbox"/> Driver <input type="checkbox"/> Left (non-driver) <input type="checkbox"/> Middle <input type="checkbox"/> Right <input type="checkbox"/> Other
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135. TYPE OF DESTINATION <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Medical Office/Clinic <input type="checkbox"/> Morgue <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other EMS (air) <input type="checkbox"/> Other EMS (ground) <input type="checkbox"/> Police/Jail <input type="checkbox"/> Other <input type="checkbox"/> Not applicable	136. REASON FOR CHOOSING DESTINATION <input type="checkbox"/> Closest <input type="checkbox"/> On-line Med Control <input type="checkbox"/> Diversion <input type="checkbox"/> Other <input type="checkbox"/> Family Choice <input type="checkbox"/> Pt Choice <input type="checkbox"/> Insurance <input type="checkbox"/> Pt Physician's Choice <input type="checkbox"/> Law Enforcement Choice <input type="checkbox"/> Protocol <input type="checkbox"/> Specialty Resource Center <input type="checkbox"/> Not applicable	137. ED DISPOSITION <input type="checkbox"/> Admit-floor <input type="checkbox"/> Admit-ICU <input type="checkbox"/> Death <input type="checkbox"/> Not Applicable <input type="checkbox"/> Released <input type="checkbox"/> Transferred <input type="checkbox"/> Unknown	138. HOSPITAL DISPOSITION <input type="checkbox"/> Death <input type="checkbox"/> Discharge <input type="checkbox"/> Not applicable <input type="checkbox"/> Transfer-other hosp <input type="checkbox"/> Transfer-nursing home <input type="checkbox"/> Transfer-other <input type="checkbox"/> Transfer-rehab <input type="checkbox"/> Unknown
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139. TYPE OF DELAY(S) (select all) DISPATCHER <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Caller Uncooperative <input type="checkbox"/> High Call Volume <input type="checkbox"/> Language Barrier <input type="checkbox"/> Location (Inability to obtain) <input type="checkbox"/> No Unit Available <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Technical Failure <input type="checkbox"/> Other	140. TYPE OF DELAY(S) (select all) RESPONSE <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Crowd <input type="checkbox"/> Directions <input type="checkbox"/> Distance <input type="checkbox"/> Diversion <input type="checkbox"/> HazMat <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Staff Delay <input type="checkbox"/> Traffic <input type="checkbox"/> Vehicle Crash <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> Weather <input type="checkbox"/> Other	141. TYPE OF DELAY(S) (select all) SCENE <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Crowd <input type="checkbox"/> Directions <input type="checkbox"/> Distance <input type="checkbox"/> Diversion <input type="checkbox"/> Extrication>20 Min <input type="checkbox"/> HazMat <input type="checkbox"/> Language Barrier <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Staff Delay <input type="checkbox"/> Traffic <input type="checkbox"/> Vehicle Crash <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> Weather <input type="checkbox"/> Other	142. TYPE OF DELAY(S) (select all) TRANSPORT <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Crowd <input type="checkbox"/> Directions <input type="checkbox"/> Distance <input type="checkbox"/> Diversion <input type="checkbox"/> HazMat <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Staff Delay <input type="checkbox"/> Traffic <input type="checkbox"/> Vehicle Crash <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> Weather <input type="checkbox"/> Other	143. TYPE OF DELAY(S) (select all) RETURN <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Clean up <input type="checkbox"/> Decontamination <input type="checkbox"/> Documentation <input type="checkbox"/> ED Overcrowding <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Equipment Replenishment <input type="checkbox"/> Staff Delay <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> Other
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Enter CREW MEMBER Information for: 144. CREW MEMBER ID NUMBER 145. LEVEL OF SERVICE 146. CREW MEMBER ROLE

CREW MEMBER 1 ID NUMBER <input type="text"/> Crew Member1 Signature <input type="checkbox"/> B <input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> EMR <input type="checkbox"/> Physician <input type="checkbox"/> Nurse	CREW MEMBER 2 ID NUMBER <input type="text"/> Crew Member2 Signature <input type="checkbox"/> B <input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> EMR <input type="checkbox"/> Physician <input type="checkbox"/> Nurse	CREW MEMBER 3 ID NUMBER <input type="text"/> Crew Member3 Signature <input type="checkbox"/> B <input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> EMR <input type="checkbox"/> Physician <input type="checkbox"/> Nurse
CREW MEMBER 1 ROLE <input type="checkbox"/> Primary Patient Caregiver <input type="checkbox"/> Driver <input type="checkbox"/> Secondary Patient Caregiver <input type="checkbox"/> Other <input type="checkbox"/> Third Patient Caregiver	CREW MEMBER 2 ROLE <input type="checkbox"/> Primary Patient Caregiver <input type="checkbox"/> Driver <input type="checkbox"/> Secondary Patient Caregiver <input type="checkbox"/> Other <input type="checkbox"/> Third Patient Caregiver	CREW MEMBER 3 ROLE <input type="checkbox"/> Primary Patient Caregiver <input type="checkbox"/> Driver <input type="checkbox"/> Secondary Patient Caregiver <input type="checkbox"/> Other <input type="checkbox"/> Third Patient Caregiver

