South Dakota • Emergency Medical Services

Prehospital Care Report

INCIDENT/SCENE INFO

DATE | UNIT | INCIDENT NUMBER

INCIDENT ADDRESS

CITY | STATE | ZIP CODE

MILEAGE: OUT | AT SCENE | DEST. | IN

RESPONSE MODE
- TO SCENE: ☐ Emerg ☐ Non Emerg. ☐ Delayed
- FROM SCENE: ☐ Emerg ☐ Non Emerg. ☐ Delayed

TIMES: RECEIVED : | DISPATCHED : | ENROUTE : | ARRIVE SCENE : | AT PATIENT :
DEPART SCENE : | ARRIVE DEST. : | DEPART DEST. : | IN SERVICE :

INCIDENT LOCATION TYPE
- ☐ Pt. Residence ☐ Residence ☐ Highway 55+ mph ☐ Other Traffic Way ☐ Office/Business
- ☐ Bar/Restaurant ☐ Hotel/Motel ☐ Farm/Ranch ☐ Industrial/Manuf. ☐ Construction
- ☐ Jail ☐ Religious Fac. ☐ Education Fac. ☐ Leisure Fac. ☐ Swimming Pool
- ☐ Water ☐ Hospital ☐ Clinic/Dr's Office ☐ Ext. Care Fac. ☐ Other

INCIDENT TYPE
- ☐ ATV ☐ Assault ☐ Bicycle ☐ Bite/Sting ☐ Drown/Nr Drown
- ☐ Electrical ☐ Fall ☐ Fire/Burn ☐ Inter-Facility ☐ MVC
- ☐ Medical/Illness ☐ Motorcycle ☐ Pedestrian ☐ Sexual Assault ☐ Shooting
- ☐ Stabbing ☐ Standby ☐ Toxic Exposure ☐ Other ☐ Other Trauma

Work related? ☐ No ☐ Unknown ☐ Yes

OUTCOME
- ☐ Canceled
- ☐ Care Transferred to: _____
- ☐ DOA
- ☐ Direct Admit to Hosp.
- ☐ Dr's Ofc/Clinic ☐ Emerg. Dept. ☐ Ext. Care Fac. ☐ False Call ☐ Home
- ☐ No Pt. Found ☐ P.O.V. ☐ Refused ☐ Standby ☐ Treated/No Transport ☐ Other

PATIENT/BILLING INFO

PT. NAME: Last | First | M.I.

PHONE NUMBER | SOCIAL SECURITY NUMBER

ADDRESS

AGE | GENDER ☐ Female ☐ Male

RACE
- ☐ American Indian/ Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Black Hispanic
- ☐ Native Hawaiian/ Pacific Islander
- ☐ White Hispanic
- ☐ White Non-Hispanic

CITY | STATE | ZIP CODE | DATE OF BIRTH

PERSONAL PHYSICIAN | EMPLOYER | EMPLOYER PHONE NUMBER

MEDICAID # | MEDICARE # | INSURANCE # | BILL TO ☐ Same as Patient

ASSESSMENT INFO

CHIEF COMPLAINT

ALLERGIES | CURRENT MEDICATIONS

MEDICAL HISTORY
- ☐ Pt. States None
- ☐ Unknown
- ☐ Allergies
- ☐ Asthma
- ☐ Behavioral
- ☐ Cancer
- ☐ Cardiac
- ☐ COPD
- ☐ CVA
- ☐ Diabetes
- ☐ Drug/ETOH
- ☐ Hypertension
- ☐ Seizure
- ☐ Other

PT. WEIGHT ☐ lbs.

SKIN MOISTURE
- ☐ Dry
- ☐ Moist
- ☐ Normal
- ☐ Wet

SKIN COLOR
- ☐ Cyanotic
- ☐ Flushed
- ☐ Jaundiced
- ☐ Mottled
- ☐ Normal
- ☐ Pale

SKIN TEMP
- ☐ Cold
- ☐ Hot
- ☐ Normal
- ☐ Warm

CAP REFILL
- ☐ Delayed
- ☐ Normal

GLASGOW COMA SCALE

EYES first	EYES last	MOTOR first	MOTOR last	VERBAL first	VERBAL last
☐ sponT	☐	☐ obeys	☐	☐ oriented	☐
☐ voice	☐	☐ localizes	☐	☐ confused	☐
☐ pain	☐	☐ withdrwl	☐	☐ inapprop	☐
☐ none	☐	☐ flexion	☐	☐ incompr	☐
		☐ extension	☐	☐ none	☐
		☐ none	☐		

PUPILS

L	R	
☐	☐	Constricted
☐	☐	Dilated
☐	☐	Normal
☐	☐	Non-Reactive
☐	☐	Prosthetic

INJURY CRITERIA
- ☐ Flail Chest
- ☐ Burns >20%/Face
- ☐ Fall >20 feet
- ☐ Paralysis
- ☐ Speed of 40+ mph
- ☐ Deformity of 20+ in.
- ☐ Intrusion of 12+ in.
- ☐ Rollover
- ☐ Ejection
- ☐ Death Same MV
- ☐ Motorcycle 20+ mph
- ☐ Ped. vs. MV >5 mph

MEDICAL ILLNESS/SYMPTOM

P	S		P	S	
☐	☐	Abdominal Pain	☐	☐	Hypo/Hyperglycemia
☐	☐	Airway Obstruction	☐	☐	Hypo/Hyperthermia
☐	☐	Allergic Reaction	☐	☐	Nausea/Vomiting
☐	☐	Behavioral	☐	☐	Obstetrical
☐	☐	Breathing Difficulty	☐	☐	Overdose
☐	☐	Cardiac Arrest	☐	☐	Paralysis
☐	☐	Cardiac Symptoms	☐	☐	Poisoning/Ingestion
☐	☐	Chest Pain	☐	☐	Respiratory Arrest
☐	☐	CVA	☐	☐	Seizure
☐	☐	Dehydration	☐	☐	Shock
☐	☐	Dizziness	☐	☐	Unconscious
☐	☐	Gynecological	☐	☐	Weakness
☐	☐	Hypertension	☐	☐	Other

INJURY SITE/TYPE

	Amputate	Burn/Elec	Frac/Disloc	Pain	Paralysis	Penetrate	Soft-Open	Soft-Closed
Head	☐	☐	☐	☐	☐	☐	☐	☐
Face		☐	☐	☐	☐	☐	☐	☐
Eye		☐	☐	☐	☐	☐	☐	☐
Neck		☐	☐	☐	☐	☐	☐	☐
Chest		☐	☐	☐	☐	☐	☐	☐
Back		☐	☐	☐	☐	☐	☐	☐
Abdomen		☐	☐	☐	☐	☐	☐	☐
Pelvis/Genitals	☐	☐	☐	☐	☐	☐	☐	☐
Upper Ext.	☐	☐	☐	☐	☐	☐	☐	☐
Lower Ext.	☐	☐	☐	☐	☐	☐	☐	☐

CONTRIBUTING FACTORS
- ☐ Alcohol
- ☐ Substances
- ☐ Delay in Detection
- ☐ Delay in EMS Access
- ☐ Extric. Time >15 min.
- ☐ Equipment
- ☐ HAZMAT
- ☐ Pt. Abused
- ☐ Self-Infliction
- ☐ Sports
- ☐ Terrain
- ☐ Weather

PT PROTECTION
- ☐ Shoulder/Lap Belt
- ☐ Shoulder Belt
- ☐ Lap Belt
- ☐ Air Bag Deployed
- ☐ Safety Seat
- ☐ Helmet
- ☐ Personal Flot. Device
- ☐ Goggles/Safety Glasses
- ☐ Padding/Protect. Clothing

PT LOCATION
- ☐ Driver ☐ Rear
- ☐ Front ☐ Truck Bed

RESCUE/EXT. EQUIP.
- ☐ Come Along
- ☐ Hydraulic Spreader
- ☐ Air Chisel
- ☐ Air Bags
- ☐ Jaws of Life
- ☐ Other

ASSIST

	Bystander	1st Responder	Fire	Police
Extricate/Moved	☐	☐	☐	☐
CPR	☐	☐	☐	☐
Wound Mgmt.	☐	☐	☐	☐
Airway	☐	☐	☐	☐
Defib	☐	☐	☐	☐

ARREST/CPR — Minutes

	< 4	4–8	> 8	Unk
Arrest to CPR	☐	☐	☐	☐
Arrest to Defib	☐	☐	☐	☐
Arrest to ALS	☐	☐	☐	☐

Arrest Witnessed? ☐ Yes ☐ No

Pulse/Rhythm Restored? ☐ Yes ☐ No

South Dakota

TREATMENT/NARRATIVE

VITAL SIGNS/TREATMENT

TIME	B/P	PALP.	RESP.	PULSE	EKG	PEA	PVC	OXYGEN	TREATMENT	CM	COMMENTS
		☐	☐ Irr.	☐ Irr.		☐	☐				
		☐	☐ Irr.	☐ Irr.		☐	☐				
		☐	☐ Irr.	☐ Irr.		☐	☐				
		☐	☐ Irr.	☐ Irr.		☐	☐				

BLS PROCEDURES

	Driver	CM 1	CM 2
Assessment	☐	☐	☐
Airway Clear	☐	☐	☐
Abdominal Thrust	☐	☐	☐
Assist Meds	☐	☐	☐
Back Blows	☐	☐	☐
Bleeding Control	☐	☐	☐
CPR	☐	☐	☐
Defib-Auto	☐	☐	☐
Extrication	☐	☐	☐
Glucometer	☐	☐	☐
MAST	☐	☐	☐
OB Delivery	☐	☐	☐
Oxygen	☐	☐	☐
Pulse Ox	☐	☐	☐
Restraints	☐	☐	☐
Spinal Immob.	☐	☐	☐
Splint Extremity	☐	☐	☐
Suction	☐	☐	☐
Ventilation	☐	☐	☐
Other BLS	☐	☐	☐

ALS PROCEDURES

	Driver	CM 1	CM 2
Blood Draw	☐	☐	☐
Cardiac Monitor	☐	☐	☐
Cardiac Pacing	☐	☐	☐
Cardioversion	☐	☐	☐
Defib-Manual	☐	☐	☐
Cricothyrotomy	☐	☐	☐
Combitube	☐	☐	☐
Glucometer	☐	☐	☐
Intubation-Nasal	☐	☐	☐
Intubation-Oral	☐	☐	☐
IV-Ext. Jugular	☐	☐	☐
IV-Intraosseous	☐	☐	☐
IV-Peripheral	☐	☐	☐
Med. Admin.	☐	☐	☐
Needle Thoracostomy	☐	☐	☐

IV TYPES & RATES

LINE 1	Bolus	TKO	Pump	Wide
D5W	☐	☐	☐	☐
LR	☐	☐	☐	☐
NS	☐	☐	☐	☐
Other	☐	☐	☐	☐

LINE 2	Bolus	TKO	Pump	Wide
D5W	☐	☐	☐	☐
LR	☐	☐	☐	☐
NS	☐	☐	☐	☐
Other	☐	☐	☐	☐

LINE 3	Bolus	TKO	Pump	Wide
D5W	☐	☐	☐	☐
LR	☐	☐	☐	☐
NS	☐	☐	☐	☐
Other	☐	☐	☐	☐

LINE 4	Bolus	TKO	Pump	Wide
D5W	☐	☐	☐	☐
LR	☐	☐	☐	☐
NS	☐	☐	☐	☐
Other	☐	☐	☐	☐

NARRATIVE

DESTINATION/CREW SIGNATURES

RECEIPT OF SERVICES

I acknowledge receipt of the EMS services listed in this document and accept full responsibility for all charges. I authorize payment of medical benefits from my insurance company to the provider of such services and authorize the provider to release medical and other necessary information to my insurance company for that purpose.

Patient Signature **Date/Time**

REFUSAL OF SERVICES

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

Patient Signature **Date/Time**

NAME OF RECEIVING FACILITY

CHOSEN BY
☐ Family ☐ Health Prof. ☐ Patient ☐ Protocol ☐ Other

SIGNATURE OF PERSON RECEIVING PATIENT **Date/Time**

MEDICAL CONTROL PHYSICIAN **Date/Time**

MEDICAL CONTROL
☐ Individual Protocol ☐ On-Line ☐ Off-Line

ATTEMPTS

	1	2	3+	Unable
Defib	☐	☐	☐	☐
Intraoss	☐	☐	☐	☐
Intub	☐	☐	☐	☐
IV	☐	☐	☐	☐

DRIVER **CM ID#** ☐ RPT

CREW MEMBER #1 **CM ID#** ☐ RPT

CREW MEMBER #2 **CM ID#** ☐ RPT