

# Wyoming EMS 2008

## Patient Care Report



RECORD #:

PATIENT INFORMATION					
LAST NAME	FIRST NAME	MIDDLE INITIAL	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	RACE / ETHNICITY	
Pt's Address, City			AGENCY INFORMATION		
PATIENT'S HOME ZIP: Age <input type="checkbox"/> Months (1-23) <input type="checkbox"/> Years <input type="checkbox"/> Days (1-31) <input type="checkbox"/> Hours (1-23) DOB / /			INCIDENT DATE: / / 200		INCIDENT #:
			EMS AGENCY & NUMBER:		EMS UNIT CALL SIGN "MS#" <input type="checkbox"/> If Fire Unit

INCIDENT INFORMATION						
INCIDENT ADDRESS			TYPE OF DELAY(S):		TIME LOG (Military Time 0000-2359)	
INCIDENT CITY	INCIDENT ZIP	DAY OF WEEK: <input type="checkbox"/> Sun <input type="checkbox"/> Wed <input type="checkbox"/> Mon <input type="checkbox"/> Thu <input type="checkbox"/> Tue <input type="checkbox"/> Fri <input type="checkbox"/> Sat	<input type="checkbox"/> Dispatch	<input type="checkbox"/> Response		PUBLIC SAFETY ACCESS POINT <small>First phone ring - 911 center</small>
INCIDENT COUNTY	INCIDENT STATE <input type="checkbox"/> WY, or:		<input type="checkbox"/> None - Not App <input type="checkbox"/> Not Known <input type="checkbox"/> Caller (uncooperative)	<input type="checkbox"/> Scene <input type="checkbox"/> Transport		( Dispatch Notified ) <small>Only if separate dispatch center from above</small>
INCIDENT LOCATION TYPE (Check 1 Only) <input type="checkbox"/> Not Applicable (cancelled) <input type="checkbox"/> Farm <input type="checkbox"/> Health Care Facility (clinic, hospital, nursing home, etc.) <input type="checkbox"/> Home/Residence <input type="checkbox"/> Industrial Place and Premises <input type="checkbox"/> Lake, River, Ocean <input type="checkbox"/> Mine or Quarry <input type="checkbox"/> Place of Recreation or Sport <input type="checkbox"/> Other: _____			<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"/> High Call Volume <input type="checkbox"/> Language Barrier <input type="checkbox"/> Location (Inability To Obtain) <input type="checkbox"/> No Units Available <input type="checkbox"/> Road Conditions <input type="checkbox"/> Safety "Conditions" <input type="checkbox"/> Staff Delay <input type="checkbox"/> Technical Failure <input type="checkbox"/> Traffic <input type="checkbox"/> Vehicle Crash <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> Weather <input type="checkbox"/> Wilderness <input type="checkbox"/> Other:			UNIT NOTIFIED <small>Required Time Entry</small>
INCIDENT / PATIENT DISPOSITION (Check 1 Only) <input type="checkbox"/> Treated, Transport EMS <input type="checkbox"/> Cancelled <input type="checkbox"/> Treated & Released <input type="checkbox"/> No Patient Found <input type="checkbox"/> No Treatment Required <input type="checkbox"/> Not Applicable			SCENE TEMP <input type="radio"/> O <input type="radio"/> F		UNIT EN ROUTE <small>Required Time Entry</small>	
<input type="checkbox"/> Unknown <input type="checkbox"/> Pt Refused Care <input type="checkbox"/> Dead At Scene <input type="checkbox"/> Treated, Transferred Care <input type="checkbox"/> Treated, Transported Law Enforcement <input type="checkbox"/> Treated, Transported Private Vehicle					ARRIVE ON SCENE	
PRIMARY ROLE OF THE UNIT (Check 1 Only) <input type="checkbox"/> Transport (if vehicle has cot, role is transport) <input type="checkbox"/> Non-Transport (Fire, 1st Resp)			TYPE OF SERVICE REQUEST (Check 1 Only) <input type="checkbox"/> 911 Response (scene) <input type="checkbox"/> Interfacility Transfer <input type="checkbox"/> Medical Transport <input type="checkbox"/> Standby <input type="checkbox"/> Intercept <input type="checkbox"/> Mutual aid		ARRIVED AT PT.	
DISPATCHED BY 911 CTR <input type="checkbox"/> Yes <input type="checkbox"/> No			RESPONSE MODE <input type="checkbox"/> ← Lights / Sirens → <input type="checkbox"/> ← No Lights / No Sirens → <input type="checkbox"/> { Initial Lights / Sirens, Downgraded To No Lights / Sirens } <input type="checkbox"/> { Initial No Lights / Sirens, Upgraded To Lights / Sirens }		TRANSFER OF PATIENT CARE	
ALCOHOL/DRUG USE INDICATORS <input type="checkbox"/> None <input type="checkbox"/> Smell of Alcohol (beverage) on Breath <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 <input type="checkbox"/> Not Applicable			TRANSPORT MODE <input type="checkbox"/> ODOMETER or <input type="checkbox"/> MILEAGE TO		UNIT LEFT SCENE	
EMERGENCY MEDICAL DISPATCH PERFORMED <input type="checkbox"/> Not Reported <input type="checkbox"/> Yes, w/pre-arrival instructions <input type="checkbox"/> Not Available <input type="checkbox"/> Yes, w/out pre-arrival instructions			AGENCY SCENE ASSISTANCE BY: <input type="checkbox"/> None <input type="checkbox"/> WHP <input type="checkbox"/> FD <input type="checkbox"/> Lay person <input type="checkbox"/> PD <input type="checkbox"/> EMS Provider <input type="checkbox"/> SO <input type="checkbox"/> Other		Beginning Odometer	
POSSIBLE INJURY <b>Check 1 only</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <small>If yes, complete Trauma Section</small> <input type="checkbox"/> Not Applicable Ex: Refusal Standby, etc.			PRIOR AID: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known <input type="checkbox"/> Not Applicable		On Scene	
COMPLAINT REPORTED BY DISPATCH (Check 1 Only) <input type="checkbox"/> Not Applicable <input type="checkbox"/> Not Known <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Allergies <input type="checkbox"/> Animal Bite <input type="checkbox"/> Assault <input type="checkbox"/> Back Pain <input type="checkbox"/> Breathing Problem <input type="checkbox"/> Burns			PRIOR AID PERFORMED BY: <input type="checkbox"/> EMS Provider <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Lay person <input type="checkbox"/> Other Healthcare Provider		Patient Destination	
			# OF PATIENTS AT SCENE: <input type="checkbox"/> Single <input type="checkbox"/> Multiple <input type="checkbox"/> None <input type="checkbox"/> Not Applicable		Ending Odometer	
			<input type="checkbox"/> Fall Victim <input type="checkbox"/> Headache <input type="checkbox"/> Heart Problems <input type="checkbox"/> Heat/Cold Exposure <input type="checkbox"/> Hemorrhage/Laceration <input type="checkbox"/> Industrial Accident <input type="checkbox"/> Ingestion/Poisoning <input type="checkbox"/> Pregnancy/Childbirth <input type="checkbox"/> Psychiatric Problem		Do Not Use For Mileage	
TRAUMA - Complete this Section if Possible Injury = YES			TRAUMA - TEAM ACTIVATION CRITERIA			

CAUSE OF INJURY (select from list):		TRAUMA INJURY MATRIX										FULL ACTIVATION		MECHANISMS TO CONSIDER	
INTENT OF INJURY: <input type="checkbox"/> Intentional, other <input type="checkbox"/> Unintentional <input type="checkbox"/> Intentional, self <input type="checkbox"/> N/A / Unknown		Mark Corresponding Injury Box with an "X"		Head	Face	Neck	Thorax	Abdomen	Spine	Pelvis	U-extrem	L-extrem	<input type="checkbox"/> GCS < 12 or	High Risk MVC	
MECHANISM OF INJURY <input type="checkbox"/> Blunt <input type="checkbox"/> Other <input type="checkbox"/> Not Applicable <input type="checkbox"/> Burn <input type="checkbox"/> Penetrate <input type="checkbox"/> Not Known		Amputation		10	20	30	40	50	60	70	80	90	<input type="checkbox"/> Systolic BP <90 or	<input type="checkbox"/> > 12 Inches Intrusion Occupant	
USE OF SAFETY EQUIP <input type="checkbox"/> Not Applicable <input type="checkbox"/> Not Known <input type="checkbox"/> None <input type="checkbox"/> Child Restraint <input type="checkbox"/> Shoulder Belt <input type="checkbox"/> Eye Protection <input type="checkbox"/> Helmet Worn <input type="checkbox"/> Protective Clothing <input type="checkbox"/> Lap Belt <input type="checkbox"/> Personal Flotation Device <input type="checkbox"/> Other <input type="checkbox"/> Protective Non-Clothing Gear		Bleeding Cntrl		11	21	31	41	51	61	71	81	91	<input type="checkbox"/> Resp Rate <10 or >30	<input type="checkbox"/> > 18 Inches into Vehicle (any site)	
		Bleeding Un-Cntrl		11U	21U	31U	41U	51U	61U	71U	81U	91U	<input type="checkbox"/> Penetrating Trauma Head/Neck/Torso/Groin	<input type="checkbox"/> Ejection (Partial or Complete)	
		Burn		12	22	32	42	52	62	72	82	92	<input type="checkbox"/> Partial Activation	<input type="checkbox"/> Death In Compartment	
		Crush		13	23	33	43	53	63	73	83	93	<input type="checkbox"/> Amputation(s)	<input type="checkbox"/> Falls: 2 X Patient's Height	
		Dislocation- Fx		14	24	34	44	54	64	74	84	94	<input type="checkbox"/> Crush, Mangled Extrem	<input type="checkbox"/> Auto vs. Ped/Bike, Thrown, Run Over or with significant Impact > 20 mph	
		Gunshot		15	25	35	45	55	65	75	85	95	<input type="checkbox"/> Flail Chest	<input type="checkbox"/> Motorcycle/Bike >20mph	
		Laceration		16	26	36	46	56	66	76	86	96	<input type="checkbox"/> Traumatic Paralysis	<input type="checkbox"/> Recreational Vehicle: ATV, etc.	
		Pain W/O Swelling-Brusing		17	27	37	47	57	67	77	87	97	<input type="checkbox"/> 2 or More Proximal Long Bone Fractures	<input type="checkbox"/> Burns > 10%	
		Puncture-Stab		18	28	38	48	58	68	78	88	98	<input type="checkbox"/> Pelvic Fracture	OTHER CONSIDERATIONS	
		Soft Tissue Swelling/Brusing		19	29	39	49	59	69	79	89	99	<input type="checkbox"/> Skull Fracture Open or Depressed	<input type="checkbox"/> Age: Geriatric - Pediatric	
												<input type="checkbox"/> Pregnancy >20 weeks		<input type="checkbox"/> EMS Provider Judgment	

PROCEDURES (Check Off Procedures Performed)			
BLS PROCEDURES:		EMT I & P PROCEDURES:	
<input type="checkbox"/> None	<input type="checkbox"/> Defibrillation AED	<input type="checkbox"/> None	<input type="checkbox"/> Cardioversion (Synchronized)
<input type="checkbox"/> Airway Cleared	<input type="checkbox"/> Defibrillation - AED Placement of Pads NO Shock	<input type="checkbox"/> ALS Assessment	<input type="checkbox"/> Chest Decompression
<input type="checkbox"/> Airway Oral	<input type="checkbox"/> Extrication	<input type="checkbox"/> 12 Lead ECG	<input type="checkbox"/> Defibrillation Manual
<input type="checkbox"/> Airway Bagged	<input type="checkbox"/> Rescue	<input type="checkbox"/> 12 Lead Cellular Transmittal	<input type="checkbox"/> External Cardiac Pacing
<input type="checkbox"/> Airway Nasal	<input type="checkbox"/> Restraints Physical	<input type="checkbox"/> Airway Combutube	<input type="checkbox"/> Qualitative Rhythm Interpretation
<input type="checkbox"/> Airway Suctioning	<input type="checkbox"/> Spinal Immobilization	<input type="checkbox"/> Airway Intub Confirm Co2	<b>Venous Access:</b>
<input type="checkbox"/> Blood Glucose Analysis	<input type="checkbox"/> Splinting	<input type="checkbox"/> Ary Intub Confirm Esophageal Bulb	<input type="checkbox"/> Blood Draw
<input type="checkbox"/> Childbirth	<input type="checkbox"/> Splinting Pelvic	<input type="checkbox"/> Airway Nebulizer Treatment	<input type="checkbox"/> External Jugular
<input type="checkbox"/> CPR	<input type="checkbox"/> Splinting Traction	<input type="checkbox"/> Airway Orotracheal Intub	<input type="checkbox"/> Extremity
<input type="checkbox"/> Other (not O2/Vitals)	<input type="checkbox"/> Wound Care	<input type="checkbox"/> Capnography	<input type="checkbox"/> Intraosseous Adult
		<input type="checkbox"/> Cardiac Monitor	<input type="checkbox"/> Intraosseous Ped

PUBLIC ACCESS DEFIBRILLATION		EMT P PROCEDURES ONLY:	
<input type="checkbox"/> None	<input type="checkbox"/> PAD No Shock Advised	<input type="checkbox"/> Airway Nasotracheal Intub	<input type="checkbox"/> Airway Needle Cricothyrotomy
<input type="checkbox"/> PAD Shocked		<input type="checkbox"/> Cardioversion	<input type="checkbox"/> Nasogastric Tube Insertion
		<input type="checkbox"/> Urinary Catheterization	

