

Wyoming EMS 2009 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		
			INCIDENT DATE: / / 200	INCIDENT #:	
PATIENT'S HOME ZIP:	Age <input type="checkbox"/> Years	<input type="checkbox"/> Months (1-23) <input type="checkbox"/> Days (1-31) <input type="checkbox"/> Hours (1-23)	DOB / /	EMS AGENCY & NUMBER:	
				EMS UNIT CALL SIGN "MS#" <input type="checkbox"/> If Fire Unit	

INCIDENT INFORMATION					
INCIDENT ADDRESS			TYPE OF DELAY(s): <input type="checkbox"/> Dispatch <input type="checkbox"/> None - Not App <input type="checkbox"/> Not Known <input type="checkbox"/> Caller (uncooperative) Crowd <input type="checkbox"/> <input type="checkbox"/> Directions <input type="checkbox"/> <input type="checkbox"/> Distance <input type="checkbox"/> <input type="checkbox"/> Diversion <input type="checkbox"/> <input type="checkbox"/> Extrication >20 Min <input type="checkbox"/> <input type="checkbox"/> Hazmat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Call Volume <input type="checkbox"/> Language Barrier <input type="checkbox"/> Location (Inability To Obtain) <input type="checkbox"/> No Units Available Road Conditions <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Safety "Conditions" Staff Delay <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Technical Failure Traffic <input type="checkbox"/> <input type="checkbox"/> Vehicle Crash <input type="checkbox"/> <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> <input type="checkbox"/> Weather <input type="checkbox"/> <input type="checkbox"/> Wilderness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other: <input type="checkbox"/> <input type="checkbox"/>		TIME LOG (Military Time 0000-2359) PUBLIC SAFETY ACCESS POINT <i>First phone ring - 911 center</i> : (Dispatch Notified) <i>Only if separate dispatch center from above</i> : UNIT NOTIFIED <i>Required Time Entry</i> : UNIT EN ROUTE <i>Required Time Entry</i> : ARRIVE ON SCENE : ARRIVED AT PT. : TRANSFER OF PATIENT CARE : UNIT LEFT SCENE : PATIENT ARRIVED AT DESTINATION : BACK IN SERVICE : UNIT CANCELLED : AT HOME LOCATION <i>Required Time Entry</i> :
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"/> Sat			
INCIDENT COUNTY	INCIDENT STATE <input type="checkbox"/> WY, or:				
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"/> Public Building (schools, government offices) <input type="checkbox"/> Residential Institution (Nursing Home, jail/prison, etc.) <input type="checkbox"/> Street or Highway <input type="checkbox"/> Trade or Service (business, bars, restaurants, etc)		
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 O F		
<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					

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	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 }	TRANSPORT MODE <input type="checkbox"/> ODOMETER or <input type="checkbox"/> MILEAGE TO
DISPATCHED BY 911 CTR <input type="checkbox"/> Yes <input type="checkbox"/> No	Beginning Odometer: Do Not Use For Mileage On Scene: Mileage To Scene Patient Destination: Mileage To Pt Destination Ending Odometer: Destination To Home		

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	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	PRIOR AID: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known <input type="checkbox"/> Not Applicable	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	# OF PATIENTS AT SCENE: <input type="checkbox"/> Single <input type="checkbox"/> Mass Casualty Incident <input type="checkbox"/> Multiple <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
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POSSIBLE INJURY <i>Check 1 only</i> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, complete Injury and Trauma Section if Appropriate <input type="checkbox"/> Not Applicable Ex: Refusal Standby, etc.	COMPLAINT REPORTED BY DISPATCH (Check 1 Only) <input type="checkbox"/> Not Applicable <input type="checkbox"/> CO Poisoning/Hazmat <input type="checkbox"/> Not Known <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Chest Pain <input type="checkbox"/> Allergies <input type="checkbox"/> Choking <input type="checkbox"/> Animal Bite <input type="checkbox"/> Convulsions/Seizure <input type="checkbox"/> Assault <input type="checkbox"/> Diabetic Problem <input type="checkbox"/> Back Pain <input type="checkbox"/> Drowning <input type="checkbox"/> Breathing Problem <input type="checkbox"/> Electrocutation <input type="checkbox"/> Burns <input type="checkbox"/> Eye Problem			<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	<input type="checkbox"/> Sick Person <input type="checkbox"/> Stab/Gunshot Wound <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Traffic Accident <input type="checkbox"/> Traumatic Injury <input type="checkbox"/> Unconscious/Fainting <input type="checkbox"/> Unknown Problem Man Down <input type="checkbox"/> Transferring/Interfacility/Palliative Care <input type="checkbox"/> MCI (Mass Casualty Incident)
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INJURY		TRAUMA - Complete Trauma Injury Matrix and Triage Criteria if Mechanism is Blunt, Burn or Penetrating																																																																																																																									
CAUSE OF INJURY (select from list): INTENT OF INJURY: <input type="checkbox"/> Intentional, other <input type="checkbox"/> Unintentional <input type="checkbox"/> Intentional, self <input type="checkbox"/> N/A / Unknown MECHANISM OF INJURY <input type="checkbox"/> Blunt <input type="checkbox"/> Other <input type="checkbox"/> Not Applicable <input type="checkbox"/> Burn <input type="checkbox"/> Penetrating <input type="checkbox"/> Not Known 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	TRAUMA INJURY MATRIX Mark Corresponding Injury Box with an "X" <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr> <th></th> <th>Head</th> <th>Face</th> <th>Neck</th> <th>Thorax</th> <th>Abdomen</th> <th>Spine</th> <th>Pelvis</th> <th>U-extrem</th> <th>L-extrem</th> </tr> <tr> <td>Amputation</td> <td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td> </tr> <tr> <td>Bleeding Cntrl</td> <td>11</td><td>21</td><td>31</td><td>41</td><td>51</td><td>61</td><td>71</td><td>81</td><td>91</td> </tr> <tr> <td>Bleeding Un-Cntrl</td> <td>11U</td><td>21U</td><td>31U</td><td>41U</td><td>51U</td><td>61U</td><td>71U</td><td>81U</td><td>91U</td> </tr> <tr> <td>Burn</td> <td>12</td><td>22</td><td>32</td><td>42</td><td>52</td><td>62</td><td>72</td><td>82</td><td>92</td> </tr> <tr> <td>Crush</td> <td>13</td><td>23</td><td>33</td><td>43</td><td>53</td><td>63</td><td>73</td><td>83</td><td>93</td> </tr> <tr> <td>Dislocation- Fx</td> <td>14</td><td>24</td><td>34</td><td>44</td><td>54</td><td>64</td><td>74</td><td>84</td><td>94</td> </tr> <tr> <td>Gunshot</td> <td>15</td><td>25</td><td>35</td><td>45</td><td>55</td><td>65</td><td>75</td><td>85</td><td>95</td> </tr> <tr> <td>Laceration</td> <td>16</td><td>26</td><td>36</td><td>46</td><td>56</td><td>66</td><td>76</td><td>86</td><td>96</td> </tr> <tr> <td>Pain W/O Swelling-Brusing</td> <td>17</td><td>27</td><td>37</td><td>47</td><td>57</td><td>67</td><td>77</td><td>87</td><td>97</td> </tr> <tr> <td>Puncture-Stab</td> <td>18</td><td>28</td><td>38</td><td>48</td><td>58</td><td>68</td><td>78</td><td>88</td><td>98</td> </tr> <tr> <td>Soft Tissue Swelling/Brusing</td> <td>19</td><td>29</td><td>39</td><td>49</td><td>59</td><td>69</td><td>79</td><td>89</td><td>99</td> </tr> </table>		Head	Face	Neck	Thorax	Abdomen	Spine	Pelvis	U-extrem	L-extrem	Amputation	10	20	30	40	50	60	70	80	90	Bleeding Cntrl	11	21	31	41	51	61	71	81	91	Bleeding Un-Cntrl	11U	21U	31U	41U	51U	61U	71U	81U	91U	Burn	12	22	32	42	52	62	72	82	92	Crush	13	23	33	43	53	63	73	83	93	Dislocation- Fx	14	24	34	44	54	64	74	84	94	Gunshot	15	25	35	45	55	65	75	85	95	Laceration	16	26	36	46	56	66	76	86	96	Pain W/O Swelling-Brusing	17	27	37	47	57	67	77	87	97	Puncture-Stab	18	28	38	48	58	68	78	88	98	Soft Tissue Swelling/Brusing	19	29	39	49	59	69	79	89	99	<input type="checkbox"/> TRAUMA TEAM NOT ACTIVATED FULL ACTIVATION <input type="checkbox"/> GCS < 12 or <input type="checkbox"/> Systolic BP < 90 or <input type="checkbox"/> Resp Rate < 10 or > 30 <input type="checkbox"/> Penetrating Trauma Head/Neck/Torso/Groin PARTIAL ACTIVATION <input type="checkbox"/> Amputation(s) <input type="checkbox"/> Crush, Mangled Extrem <input type="checkbox"/> Flail Chest <input type="checkbox"/> Traumatic Paralysis <input type="checkbox"/> 2 or More Proximal Long Bone Fractures <input type="checkbox"/> Pelvic Fracture <input type="checkbox"/> Skull Fracture Open or Depressed	MECHANISMS TO CONSIDER High Risk MVC <input type="checkbox"/> > 12 Inches Intrusion Occupant <input type="checkbox"/> > 18 Inches into Vehicle (any site) <input type="checkbox"/> Ejection (Partial or Complete) <input type="checkbox"/> Death In Compartment <input type="checkbox"/> Falls: 2 X Patient's Height <input type="checkbox"/> Auto vs. Ped/Bike, Thrown, Run Over or with significant Impact > 20 mph <input type="checkbox"/> Motorcycle/Bike > 20mph <input type="checkbox"/> Recreational Vehicle: ATV, etc. <input type="checkbox"/> Burns > 10% OTHER CONSIDERATIONS <input type="checkbox"/> Age: Geriatric - Pediatric <input type="checkbox"/> Pregnancy > 20 weeks <input type="checkbox"/> EMS Provider Judgment
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PROCEDURES (Check Off Procedures Performed)			
BLS PROCEDURES: <input type="checkbox"/> None <input type="checkbox"/> Airway Cleared <input type="checkbox"/> Airway Oral <input type="checkbox"/> Airway Bagged <input type="checkbox"/> Airway Nasal <input type="checkbox"/> Airway Suctioning <input type="checkbox"/> Blood Glucose Analysis <input type="checkbox"/> Childbirth <input type="checkbox"/> CPR <input type="checkbox"/> Other (not O2/Vitals)	<input type="checkbox"/> Defibrillation AED <input type="checkbox"/> Defibrillation - AED Placement of Pads NO Shock <input type="checkbox"/> Extrication <input type="checkbox"/> Rescue <input type="checkbox"/> Restraints Physical <input type="checkbox"/> Spinal Immobilization <input type="checkbox"/> Splinting <input type="checkbox"/> Splinting Pelvic <input type="checkbox"/> Splinting Traction <input type="checkbox"/> Wound Care	EMT I & P PROCEDURES: <input type="checkbox"/> None <input type="checkbox"/> ALS Assessment <input type="checkbox"/> 12 Lead ECG <input type="checkbox"/> 12 Lead Cellular Transmittal <input type="checkbox"/> Airway Combutube <input type="checkbox"/> Airway Intub Confirm Co2 <input type="checkbox"/> Ary Intub Confirm Esophageal Bulb <input type="checkbox"/> Airway Nebulizer Treatment <input type="checkbox"/> Airway Orotracheal Intub <input type="checkbox"/> Capnography <input type="checkbox"/> Cardiac Monitor	<input type="checkbox"/> Cardioversion (Synchronized) <input type="checkbox"/> Chest Decompression <input type="checkbox"/> Defibrillation Manual <input type="checkbox"/> External Cardiac Pacing <input type="checkbox"/> Qualitative Rhythm Interpretation Venous Access: <input type="checkbox"/> Blood Draw <input type="checkbox"/> External Jugular <input type="checkbox"/> Extremity <input type="checkbox"/> Intraosseous Adult <input type="checkbox"/> Intraosseous Ped
			PUBLIC ACCESS DEFIBRILLATION <input type="checkbox"/> None <input type="checkbox"/> PAD No Shock Advised <input type="checkbox"/> PAD Shocked EMT P PROCEDURES ONLY: <input type="checkbox"/> Airway Nasotracheal Intub <input type="checkbox"/> Airway Needle Cricothyrotomy <input type="checkbox"/> Cardioversion <input type="checkbox"/> Nasogastric Tube Insertion <input type="checkbox"/> Urinary Catheterization

