Commonwealth of Virginia — Emergency Medical Services Medical Record

Response Information

Agency | Agency # | Unit # | INC. #

Location | ZIP | Other Agency On Scene:

Urgency: ☐ Immediate ☐ Non-Immediate ☐ N/A | Response Delay | Date

To Scene	Response Mode	To Dest.
☐	Lights & Sirens	☐
☐	No Lights/No Sirens	☐
☐	Initial Lights & Sirens, Downgraded to No Lights or Sirens	☐
☐	Initial No Lights & Sirens, Upgraded to Lights or Sirens	☐

Primary Role of Unit
☐ Transport
☐ Non-transport
☐ Supervisor
☐ Rescue

To:	Response	Scene	Transport
None	☐	☐	☐
Traffic	☐	☐	☐
Directions	☐	☐	☐
Distance	☐	☐	☐
Weather	☐	☐	☐
Safety	☐	☐	☐
Crowd	☐	☐	☐
Staff Delay	☐	☐	☐
Diversion	☐	☐	☐
Vehicle Crash	☐	☐	☐
Vehicle Failure	☐	☐	☐
HazMat	☐	☐	☐
Extricate >20 mins.		☐	
Language Barrier		☐	
Patient Access Delay		☐	

Times (24hr Format)

PSAP Time				
Unit Disp.				
Enroute				
Arrive Scene				
Arrive Patient				
Leave Scene				
Arrive Dest.				
In Service				
Cancelled				
In Quarters				

Type of Service		Location Type	
☐ 911 Resp.	☐ Flagdown-Emergeny	☐ Home/Residence	☐ Industrial Place/Premises
☐ Intercept	☐ Flagdown-Non-Emergency	☐ Street or Highway	☐ Place of Recreation/Sport
☐ Mutual Aid	☐ Interfacility Trans. (sched)	☐ Public Building	☐ Lake, River, Ocean
☐ Standby	☐ Interfacility Trans. (Un-sched)	☐ Trade/Service (Bus.)	☐ Mine or Quarry
☐ Other	☐ Medical Transport	☐ Residential Facility	☐ Farm
		☐ Health Care Facility	☐ Other Location

Patient Information

Name: | Age

Address: | Apt/Rm

City: | State: | ZIP

Telephone: | Next of Kin Name: | Tel.# | Rel.

SSN/DL # | DL State | DOB M M D D Y Y Y Y

Mileage: End . Start . Total .

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Asian ☐ Other Race ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not Applicable

Medications:

Allergies:

Patient Complaint

Chief Complaint	Secondary Complaint	Chief Complaint Anatomic Location	Chief Complaint Organ System (choose 1)
Duration: ☐ Y ☐ Mos. ☐ D ☐ H ☐ Min ☐ S	Duration: ☐ Y ☐ Mos. ☐ D ☐ H ☐ Min ☐ S	(Choose 1) ☐ N/A ☐ Head ☐ Neck ☐ Chest ☐ ABD ☐ Genitalia ☐ Back ☐ Extremity-Upper ☐ Extremity-Lower ☐ Gen'l/Global ☐ Not Known	☐ Cardio/Vasc. ☐ GI ☐ OB/Gyn ☐ Renal ☐ CNS/Neuro ☐ Global ☐ Psych ☐ Skin ☐ Endocrine/Met. ☐ Musculoskeletal ☐ Pulmonary ☐ N/A

Symptoms

Instructions: Place a P,S, or O in the box next to the Sx P=Primary Symptom S=Secondary Symptom (choose 1) O=Other Symptom(s) (No Limit)

	No Signs/Symptoms		Bright Blood In Stool		Death		Headache		Mental/Psych		Palpitations		Visual Impairment
	Abdominal Pain		CardioResp. Arrest		Device/Equip Prob.		Headache W/Photo.		Nausea/Vomiting		Rash/Itching		Weakness
	Altered Mental Status		Change Stool Color		Diarrhea		Hives		OB-Contractions		Seizure		Wheezing
	Anxiety		Chest Pain		Dizziness		Indegestion		Orthostatic B/P		Swelling		Wound
	Aphasia		Choking		Drainage/Discharge		Lethargic		Pain		Syncope		Other
	Back pain		Constipation		Ear Pain		Loss of Appetite		Pain-Extremity		Transport Onl		
	Bleeding		Cough		Eye Pain		Malaise		Pain-Flank		Unconcious		
	Breathing Problem		Dark Tarry Stool		Fever		Mass/Lesion		Pain-Neck		Vaginal Bleed		

Suspected Diagnosis

Provider Impression

P=Primary S=Secondary Impression (Place only 1 P and 1 S as applicable in the Box)

	Not Applicable		Cancer		Electrocution		Hypovolemia/Shock		Other-OB/gyn		Stroke / CVA
	Abd. Aortic Aneurysm		Cardiac Arrest		Epistaxis		Inhalation Injury		Patient Assist Only		Substance Abuse
	Abd. Pain/Problems		Cardiac Rhythm Dist.		ETOH		Migraine		Poisoning-Drug		Syncope/Fainting
	Airway Obstruction		Chest Pain		Gen Malaise		Obvious Death		Obstetrics/delivery		TIA
	Allergic Reaction		CHF		GI Bleed		Other-Abd/GI		Respiratory Arrest		Toxic Exposure
	Altered Mental Status		COPD		Headache		Other-Cardiovasc.		Respiratory Distress		Traumatic Injury
	Asthma		Dehydration		Heat Related		Other-CNS Prob.		Seizure		Unconcious
	Back Pain(non-injury)		Diabetic Elevated		Hyperthermia		Other-Endocrine/Met.		Sepsis		Vaginal Bleed
	Behavioral/Psych.		Diabetic - Low		Hypotension		Other-GU Problem		Sexual Assault/Rape		Weakness
	Bowel Obstruction		Diarrhea		Hypothermia		Other-Illness/Injury		Smoke Inhalation		Other:
									Stings/Venomous Bites		

Past Medical Surgical History

☐ None	☐ Hypertension		
☐ Asthma	☐ Hypotension		
☐ Cancer:_____	☐ Neuro		
☐ Cardiac:_____	☐ Psych Disorder		
☐ COPD	☐ Renal Failure		
☐ Develop Delayed	☐ Seizures		
☐ Diabetes	☐ Stroke/CVA		
☐ Endocrine	☐ Substance Abuse		
☐ GU/GI	☐ TIA		
☐ High Cholesterol	☐ Tuberculosis		
☐ HIV/AIDS	☐ Other:_____		

Injury/Trauma

Cause of Injury

☐ Not-Applicable	☐ Elder Abuse/Neglect	☐ Lightning	☐ Poisoning-Drug
☐ Aircraft Accident	☐ Electrocution	☐ Machinery Accidents	☐ Poison-Radiation
☐ Assault	☐ Entrapped (Non-MVC)	☐ Mechanical Suffocation	☐ Sexual Assault
☐ Bicycle Accident	☐ Excessive Cold	☐ MVC	☐ Smoke Inhalation
☐ Bites	☐ Excessive Heat	☐ MVC - ATV	☐ Stab/Cut Accidental
☐ Blunt Injury	☐ Explosion	☐ MVC Motorcyle	☐ Stab/Cut Assault
☐ Burn Hot Subst.	☐ Fall	☐ MVC Non-Traffic	☐ Venomous Stings
☐ Burns-Chemical	Fall # of Ft. _____	☐ MVC-Lg. Animal	☐ Water Trans. Accident
☐ Burns-Fire/Flames	☐ Firearm Assault	☐ MVC-Pedestrian	☐ Unknown
☐ Burns-Thermal	☐ Firearm Inj.(accidental)	☐ Non-Motorized Vehicle	☐ Other:
☐ Child Abuse/Nglct	☐ Firearm Self Inflicted	☐ Overexertion	
☐ Drowning	☐ Foreign Body	☐ Poison-Chemical	

Safety Equipment Used

☐ Not Applicable	☐ Airbag Deployed Other
☐ None Used	☐ Helmet Worn
☐ Shoulder Belt	☐ Eye Protection
☐ Lap Belt	☐ Personal Floatation Device
☐ Child Restraint	☐ Protective Clothing
☐ Airbag Deploy Front	☐ Protective Gear Non-Clothing
☐ Airbag Deploy Side	

MV Impact

☐ N/A	☐ Left Side	☐ Right Rear
☐ Center Front	☐ Right Side	☐ Roll Over
☐ Left Front	☐ Center Rear	☐ Unknown
☐ Right Front	☐ Left Rear	

Vehicle Indicators

☐ N/A	☐ Fire
☐ Ejection	☐ >12" Intrusion
☐ Windshield Star/Spider	☐ Side Post Deformity
☐ Dashboard Deformity	☐ Roll Over/Roof Deformity
☐ Steering Wheel Deformity	☐ DOA Same Vehicle

Exterior Damage Level

☐ None	☐ Moderate
☐ Minor	☐ Major

Cardiac Arrest

Cardiac Arrest:

☐ No	Estimated Time of Arrest PTA:	☐ N/A	☐ 8-10 Minutes
☐ Yes, Prior to EMS Arrival	☐ Unknown	☐ 2-4 Minutes	☐ 10-15 Minutes
☐ Yes, After EMS Arrival	☐ 0-2 Minutes	☐ 4-6 Minutes	☐ 15-20 Minutes
		☐ 6-8 Minutes	☐ >20 Minutes

Pre-Transport Unit AED: ☐ N/A ☐ No Pre-ambulance AED ☐ Other EMS Unit with AED ☐ Non-EMS Responder w/AED ☐ Public Access AED

Resuscitation Attempted: ☐ Not Applicable ☐ Attempted Defibrillation ☐ Attempted Ventilations ☐ Initiated Chest Compressions ☐ Not Attempted - Futile ☐ Not attempted DNR Order ☐ Not Attempted Signs of Circulation

Arrest Etiology: ☐ Presumed Cardiac ☐ Trauma ☐ SIDS (suspected) ☐ Respiratory ☐ Drowning ☐ Electrocution ☐ Other ☐ UNK

Reason CPR Discontinued: ☐ N/A ☐ DNR Provided ☐ Obvious Signs of Death ☐ ROSC ☐ Medical Control Order ☐ Protocol Completed ☐ Unknown

ROSC ☐ No ☐ Yes, Prior to ED & At ED ☐ Yes, Prior to ED Only

DRAFT PAGE 1

Assessment - Physical

Mental Status: ☐ Not Done Oriented to: ☐ Person ☐ Place ☐ Time
☐ Combative ☐ Confused ☐ Incoherent ☐ Hallucinations
☐ Unresponsive ☐ Responsive to Verbal Stim. ☐ Responsive to Painful Stim.

Neuro: ☐ Not Done ☐ Normal ☐ Speech Normal Weakness L R ☐ Tremors
☐ Facial Droop ☐ Speech Slurring ☐ Abnormal Gait ☐ Aphaisic
☐ Seizures ☐ Postictal ☐ Decerebrate Posturing ☐ Decorticate Posturing

Head/Face: ☐ Not Done ☐ Normal ☐ Pain ☐ Swelling ☐ Drainage
☐ Symmetrical Face ☐ Asymmetric Smile/Droop ☐ Mass/Lesion

Pupils: ☐ Not Done ☐ Normal Pupil Size L:____ R:____ Nystagmus L R
Reactive L R Sluggish L R Non-Reactive L R Blind L R
Pupil Deformity L R Cataracts L R Disconjugated L R Glaucoma Pres. L R

Neck: ☐ Note Done ☐ Normal ☐ Trachea Midline ☐ No JVD ☐ SubQ Air
☐ Edema ☐ Stridor ☐ Pain ☐ Tracheal Deviation ☐ JVD ☐ Stiffness

Chest Lungs: ☐ Not Done ☐ Normal ☐ BS Clr & Eql Bilat ☐ Inc. Effort
☐ Rales ☐ Insp. Wheezing ☐ Exp. Wheezing ☐ Rhonchi ☐ Assisted BS
Decreased BS L R Absent BS L R ☐ Chest Pain/Pressure Radiating
☐ Retractions ☐ Acc. Muscle Use ☐ Chest Pain/Pressure Reproducable
Tenderness L R Flailed Seg. L R ☐ Chest Pain/Pressure Non-Reproducable

Abdomen: ☐ Not Done ☐ Normal ☐ Distended ☐ Rigid
Guarding RU LU LL RL Pain/Tenderness RU LU LL RL ☐ Mass

Spine: (Circle)
☐ Not Done Pain to ROM C-Spine T-Spine L-Spine
☐ Normal Tender Para-Spinous C-Spine T-Spine L-Spine
Tender Spinous Process C-Spine T-Spine L-Spine

Extremeties ☐ Not Done ☐ Normal Edema UR UL LR LL
+CMS UR UL LR LL Abnormal CMS UR UL LR LL Weakness UR UL LR LL
Pain UR UL LR LL Abnormal Sensation UR UL LR LL Absent Pulse UR UL LR LL
Abnormal Pulse UR UL LR LL Cold Extremety UR UL LR LL

Skin: ☐ Normal ☐ Warm ☐ Cold ☐ Hot ☐ Dry ☐ Clammy ☐ Diaphoretic
☐ Cap Ret <2 Secs. ☐ Cap Ret 2-4 Secs. ☐ Cap Ret >4 Secs. ☐ Pale ☐ Cyanotic
☐ Poor Turgor ☐ Hives ☐ Rash ☐ Jaundice ☐ Mottled ☐ Lividity ☐ Flushed

Glasgow Coma	Eye	Verbal	Motor	Total	GCS Qualifier	☐ No Qualifiers (N) ☐ Intubated (I)	☐ Sedated (S) ☐ Paralyzed (P)

NIH Stroke Scale (see back of sheet) LOC ___ Questions ___ Commands ___ Gaze ___

Injury Assessment
☐ Not Applicable

A	Skin	1	Abrasions	12	Crush
B	Head	2	Amputation	13	Deformity
C	Face	3	Avulsion	14	Dislo/Fx
D	Neck	4	Bleeding Controlled	15	Ecchymosis
E	Thorax	5	Bleeding Uncontrolled	16	Foreign Body
F	Abdomen	6	Burn	17	Gunshot
G	Spine	7	Burn Blistering	18	Laceration
H	Arm/Hand	8	Burn Charring	19	Pain No Soft Tissue Inj.
I	Pelvis	9	Burn Redness	20	Pain
J	Leg/Foot	10	Burn White/Waxy	21	Puncture/Stab
K	Unspecified	11	Crepitus	22	Soft Tissue Injury

GU: ☐ Not Done ☐ Normal ☐ Burning ☐ Discharge ☐ Foreign Body
Blood From: ☐ Rectum ☐ Vagina ☐ Penis ☐ Pain ☐ Painful Urination
Incontinent: ☐ Bladder ☐ Bowel ☐ Priaprism ☐ Genital Injury ☐ Unstable

Assessment - Vital Signs

Time	LOC	B/P	Pulse	Resp.	SpO2	Pain	ECG
	☐ A ☐ V	/			☐ RA		
Gluc.	☐ P ☐ U ☐ n/a	☐ Palp ☐ Unable ☐ N/O	☐ Regular ☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ Regular ☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ 1-6 L ☐ 7-9 L ☐ 10-25 L	CO2	Defib Joules
	☐ A ☐ V	/			☐ RA		
Gluc.	☐ P ☐ U ☐ n/a	☐ Palp ☐ Unable ☐ N/O	☐ Regular ☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ Regular ☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ 1-6 L ☐ 7-9 L ☐ 10-25 L	CO2	Defib Joules
	☐ A ☐ V	/			☐ RA		
Gluc.	☐ P ☐ U ☐ n/a	☐ Palp ☐ Unable ☐ N/O	☐ Regular ☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ Regular ☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ 1-6 L ☐ 7-9 L ☐ 10-25 L	CO2	Defib Joules

☐ Additional Info on page 3

Medication Administration

Time	Medication	Dose	Route	Resp.	Crew #	Time	Medication	Dose	Route	Resp	Crew #

Airway/Intravenous Procedures

Time	Size	Type	Loc.	Fluid/Lock	ATT.	Succ.	Crew #

Procedure	Time:	Crew #:	Procedure	Time:	Crew #:	Procedure	Procedure
☐ None			☐ Glucose Check			☐ Supraglottic Airway	☐ External Pacing
☐ Asst Vent. RPM _____			☐ Splint Extremety			☐ CPAP	R _____ M _____
☐ O2 Cannula LPM _____			☐ Splint Traction			☐ Intubated (ETT)	☐ Defib/Cardioversion
☐ O2 Mask LPM _____			☐ Spinal Immob.			☐ Ventilator	☐ CPR
☐ O2 Neb/BB LPM _____			☐ Bleeding Contr			☐ Crichothyrotomy	☐ IV Access
☐ Nasal Airway Sz. _____			☐ Burn Care			☐ NG Tube	☐ IO Access
☐ Oral Airway Sz. _____			☐ OB Care			☐ Chest Decomp	☐ IV Fluids
☐ Suction			☐ Other			☐ ECG Monitoring	☐ Medications

Receiving Facility:

Facility Diverted From:

Physician Signature:

DEA#

Facility Notified By ☐ N/A ☐ Unable ☐ Radio ☐ Direct ☐ Cell

12 Lead Communicated In Advance ☐ N/A ☐ Yes ☐ No

Specialty Team Notified ☐ N/A ☐ Stroke Alert ☐ Trauma Alert ☐ STEMI Alert

Procedure Authorization ☐ N/A ☐ Protocal ☐ On-line ☐ On-scene (MD Name) _____ ☐ Written Order

Drug Box

Old #	New #

Narcs Accounted For

Reason for Choice	Type of Destination	Incident Dispostion
☐ Closest Facility	☐ Hospital	☐ Tx'd & Transported
☐ Patient Choice	☐ Other EMS Unit	☐ Patient Refusal
☐ Protocol	☐ Air medical unit	☐ Tx'd/Went by POV
☐ Specialty Res Ctr	☐ Dr. Office/Clinic	☐ Tx'd/Transf. Care
☐ On-line Control	☐ Police/Jail	☐ Tx'd & Release
☐ Law Enf. Choice	☐ Other	☐ EMS Not Needed
☐ Insurance Status	☐ Nursing Home	☐ Ref to Police
☐ Pt's MD Choice	☐ Home	☐ Dead at Scene
☐ Family Choice	☐ Morgue	☐ Cancelled
☐ Diversion		☐ No Pt. Found

Turn Around Delay: ☐ N/A - No Delay ☐ Restocking ☐ Drug Box Exchange ☐ Clean Up
☐ Decontamination ☐ Documentation ☐ Staff Delay ☐ Veh. Failure ☐ Other

Func.	Printed Name	Signature	VA. Certification No.
AIC 1			FR EMT Enh. Int. P
DRIV 2			FR EMT Enh. Int. P
ATT 3			FR EMT Enh. Int. P RN MD Oth
ATT 4			FR EMT Enh. Int. P RN MD Oth

DRAFT PAGE 1B

EMS Informed Consent to Refuse

I, the undersigned, refuse all further treatment and/or transport for _____ from the named EMS Agency and assume full responsibility for his/her/my treatment against the advice of the emergency medical provider. By signing this form I am confirming the following items:

- I am of legal age (or the legal parent/guardian of above patient) to decline these services; and,
- I make this decision being of sound mind and not under the impairment of any alcohol or substances (legal or illegal) and,
- Been informed of the potential need for further medical evaluation;

  Recommended evaluation/treatment/services being refused;

  ☐ further medical diagnostic tests (i.e. x-ray, laboratory tests, etc.);

  ☐ further injury/illness care or management;

  ☐ ID further medical evaluation by a health care professional;

  ☐ other: _____;

  AND,
- Been informed of the potential risks associated with the refusal of services;

  Potential risks associated may include, but not limited to:

  ☐ undiagnosed injury or illness;

  ☐ improper healing of injury;

  ☐ worsening of injury or illness with or without changing signs or symptoms;

  ☐ subsequent changes in condition including unconsciousness (coma), shock or death;

  ☐ other: _____;

  AND,
- Understand this refusal in no way reduces my ability to recall EMS services in the future.

☐ Check here if refusal information was translated to a language other than English for patient understanding.
Interpreted by: _____

Additional Notes: _____

Printed Name: _____ Relationship: _____

Signature Date

DRAFT PAGE 1A BACK

Release of information and financial responsibility statement: I authorize the above named Ambulance Service to release any information pertinent to my case to any insurance company, adjuster, attorney, governmental agency, or third party involved in the case. Also I authorize any holder of medical information or documentation needed to determine benefits or benefits payable for related services or any service provided to me now or in the future to be released to the above named Ambulance Service. I authorize that payment be made directly to the above named Ambulance Service for any services that are reimbursable by my insurance(s). I understand that I am responsible for and will pay all fees for services as rendered. I further understand that such payment will not be delayed while awaiting any settlement, judgment, or insurance payment. If collection procedures are required, I agree to pay the cost of collections, including attorney fees and court costs.

_____ _____
Patient Signature Date

NOTICE TO MEDICARE BENEFICIARIES: Current Medicare Rules & Regulations require us to notify you when services provided, or to be provided, may not be covered by Medicare. Medicare pays for services it determines to be reasonable and necessary **under Section 1882** (a) (1) of the Social Security Act. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under the Medicare program standards, Medicare will deny payment for that service.

At the present time, and with the information we have been able to obtain thus far, we believe that for the services you have requested, or are about to be provided to you, or that were provided to you on _____ by the above named EMS agency., Medicare is likely to deny payment. Therefore, we are required to give you notice advising you that in the event Medicare denies payment, you will be responsible for the account balance.

Please read the statement below and sign:

I have been notified by the above named EMS agency that they believe that in this case, Medicare is likely to deny payment for the items/services identified above, for the reason stated. If Medicare denies payment, I understand that I will be personally responsible for the account balance.

_____ _____
Patient Signature Date

Supplemental Information INC. #

Supplemental Vitals

Time	LOC	B/P	Pulse	Resp.	SpO2	Pain	ECG	Time	LOC	B/P	Pulse	Resp.	SpO2	Pain	ECG
	☐ A ☐ V	/			☐ RA				☐ A ☐ V	/			☐ RA		
Gluc.	☐ P	☐ Palp	☐ Regular	☐ Regular	☐ 1-6 L	CO2	Defib Joules	Gluc.	☐ P	☐ Palp	☐ Regular	☐ Regular	☐ 1-6 L	CO2	Defib Joules
	☐ U ☐ n/a	☐ Unable ☐ N/O	☐ Reg-Irreg ☐ Irreg-Irreg	☐ Reg-Irreg ☐ Irreg.-Irreg.	☐ 7-9 L ☐ 10-25 L				☐ U ☐ n/a	☐ Unable ☐ N/O	☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ 7-9 L ☐ 10-25 L		

Time	LOC	B/P	Pulse	Resp.	SpO2	Pain	ECG	Time	LOC	B/P	Pulse	Resp.	SpO2	Pain	ECG
	☐ A ☐ V	/			☐ RA				☐ A ☐ V	/			☐ RA		
Gluc.	☐ P	☐ Palp	☐ Regular	☐ Regular	☐ 1-6 L	CO2	Defib Joules	Gluc.	☐ P	☐ Palp	☐ Regular	☐ Regular	☐ 1-6 L	CO2	Defib Joules
	☐ U ☐ n/a	☐ Unable ☐ N/O	☐ Reg-Irreg ☐ Irreg-Irreg	☐ Reg-Irreg ☐ Irreg.-Irreg.	☐ 7-9 L ☐ 10-25 L				☐ U ☐ n/a	☐ Unable ☐ N/O	☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ 7-9 L ☐ 10-25 L		

Time	LOC	B/P	Pulse	Resp.	SpO2	Pain	ECG	Time	LOC	B/P	Pulse	Resp.	SpO2	Pain	ECG
	☐ A ☐ V	/			☐ RA				☐ A ☐ V	/			☐ RA		
Gluc.	☐ P	☐ Palp	☐ Regular	☐ Regular	☐ 1-6 L	CO2	Defib Joules	Gluc.	☐ P	☐ Palp	☐ Regular	☐ Regular	☐ 1-6 L	CO2	Defib Joules
	☐ U ☐ n/a	☐ Unable ☐ N/O	☐ Reg-Irreg ☐ Irreg-Irreg	☐ Reg-Irreg ☐ Irreg.-Irreg.	☐ 7-9 L ☐ 10-25 L				☐ U ☐ n/a	☐ Unable ☐ N/O	☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ 7-9 L ☐ 10-25 L		

Supplemental Meds/Proc

Medication Administration

Time	Medication	Dose	Route	Resp.	Crew #	Time	Medication	Dose	Route	Resp	Crew #

Airway/Intravenous Procedures

Time	Size	Type	Loc.	Fluid/Lock	ATT.	Succ.	Crew #

Supplemental Narrative

DRAFT PAGE 1B BACK

Additional Patient Meds/All.

Additional Patient Medications:

A photocopy of this page will need to be made in order to leave a copy with the patient at the receiving facility

Func.	Printed Name	Signature	VA. Certification No.
AIC 1			FR EMT Enh. Int. P

Glasgow Coma Scale

Eye Opening	
Spontaneous	4
To Verbal Stimulation	3
To Painful Stimulation	2
None	1
Verbal	
Over 5 years	
Oriented/Appropriate	5
Confused	4
Inappropriate Words	3
Non-specific Sounds	2
None	1
2 - 5 years	
Appropriate Words	5
Inappropriate Words	4
Cries and/or Screams	3
Grunts	2
None	1
0 - 23 months	
Smiles/Coos/Cries Appropriately	5
Cries/Inconsolable	4
Inappropriate Cries	3
Persistent Cry/Grunting	2
None	1
Motor	
Over 5 years	
Obeys Commands	6
Localization of Pain	5
Withdrawal (pain)	4
Flexor Posturing (pain)	3
Extensor Posturing (pain)	2
None	1
Up to 5 years	
Spontaneous	6
Localization of Pain	5
Withdrawal of Pain	4
Flexor Posturing (pain)	3
Extensor Posturing (pain)	2
None	1
TOTAL GLASGOW COMA SCALE	3-15

NIH/CINCINNATI STROKE SCALE (FAST)	
F-(face)	FACIAL DROOP: Have patient smile or show teeth. (Look for asymmetry) **Normal:** Both sides of the face move equally or not at all. **Abnormal:** One side of the patient's face droops. Note: Document Left vs. Right
A-(arm)	MOTOR WEAKNESS: Arm drift (close eyes, extend arms, palms up) **Normal:** Remain extended equally, drifts equally, or does not move at all. **Abnormal:** One arm drifts down when compared with the other. Document Left vs. Right
S-(speech)	"You can't teach an old dog new tricks" (repeat phrase) **Normal:** Phrase is repeated clearly and correctly. **Abnormal:** Words are slurred (dysarthria) or abnormal (aphasia) or none.
T-Time	Time of SYMPTOM ONSET:

Acute Stroke Fibrinolytic Checklist	YES	NO	?
Current use of anticoagulants (e.g. warfarin/coumadin)	☐	☐	☐
Has blood pressure consistently over 185/110 mm Hg	☐	☐	☐
Witnessed seizure at symptom onset	☐	☐	☐
Intracranial hemorrhage history	☐	☐	☐
GI or GU bleeding history within 3 weeks	☐	☐	☐
This event within 3 months prior of prior stroke	☐	☐	☐
This event within 3 months of serious head trauma	☐	☐	☐
This event within 21 days of myocardial infarction	☐	☐	☐
This event within 21 days of lumbar puncture (spinal tap)	☐	☐	☐
This event within 14 days of major surgery or trauma	☐	☐	☐

DRAFT BACK TOP Goldenrod

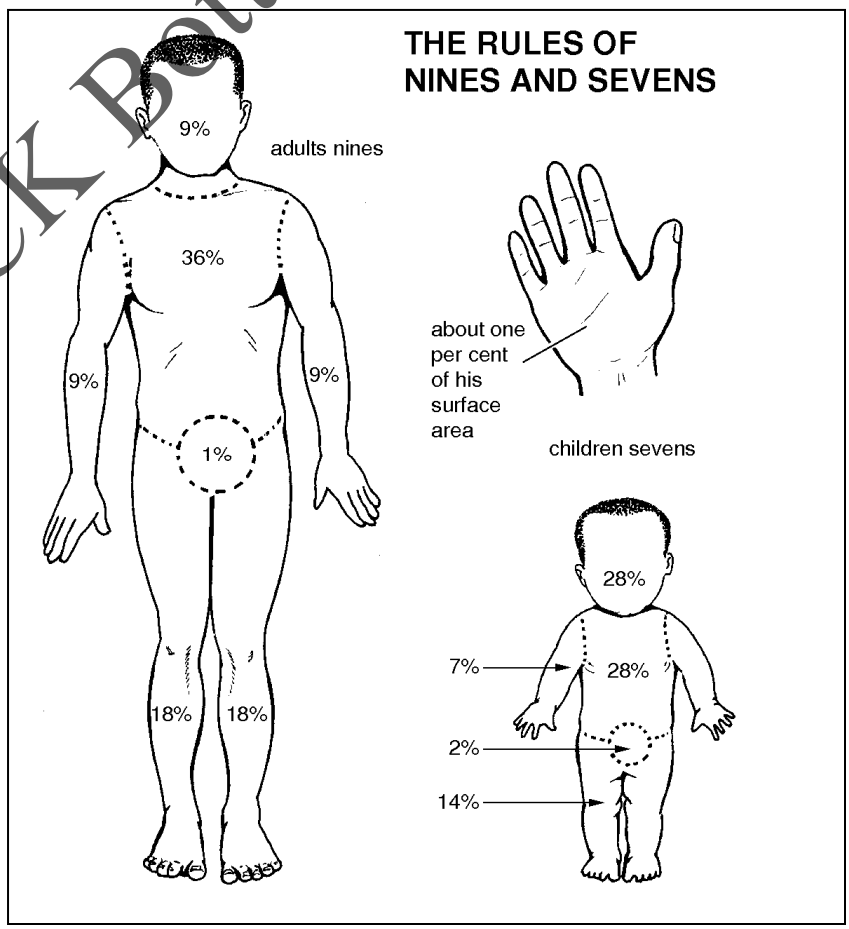
Patients with the following burn injuries should be considered for referral to a burn center	
►	Inhalation injuries.
►	Partial thickness and full-thickness burns involving the face, eyes, ears, hands, feet, genitalia or perineum of those that involve skin overlying major joints.
►	Partial thickness and full thickness burns greater than 10% of the total body surface area (BSA) in patients under 10 or over 50 years of age.
►	Partial thickness burns and full thickness burns greater than 20% BSA in other age groups.
►	Full-thickness burns greater than 5% BSA in any age group.
►	Electrical burns, including lightning injuries; (significant volumes of tissue beneath the surface may be injured and result in acute renal failure and other complications).
►	Significant chemical burns.
►	Burn injury in patients with pre-existing illness that could complicate management, prolongs recovery, or affects mortality.
►	Any burn patient in whom concomitant trauma poses an increased risk of morbidity or mortality may be treated initially in a trauma center until stable before transfer to a burn center.
►	Children with burns seen in hospitals without qualified personnel or equipment for their care should be transferred to a burn center with these capabilities.
►	Burn injury in patients who will require special social and emotional or long term rehabilitative support, including cases involving child abuse and neglect.

Burn Sizing "Rule of 9's" (palm of patient's hand 1% BSA)			
Adult Patients		**Infant Patients**	
Head	9%	Head	18%
Torso Front	18%	Torso Front	18%
Torso Rear	18%	Torso Rear	18%
Right Arm	9%	Right Arm	9%
Left Arm	9%	Left Arm	9%
Right Leg	18%	Right Leg	14%
Left Leg	18%	Left Leg	14%
Groin	1%	Groin	1%
Total Body Surface Area:			

Further information about Virginia's Pre-Hospital Information Bridge (VPHIB) can be found on-line at:

State Bridge:
https:/VPHIB.VDH.Virginia.gov

OEMS Informatics Web-page:
http://www.vdh.virginia.gov/OEMS/Trauma/Informatics.htm



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