

Request call review

FR

- FIRST RESPONDER:
- EMS
 - FIRE
 - POLICE
 - OTHER

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES
PATIENT CARE REPORT



NAME OF SERVICE:	UNIT #:	SERVICE PROVIDER CERT #:	INCIDENT / CASE #:
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DISPATCH DATE:	DISPATCH TIME:	ENROUTE TO SCENE:	ARRIVAL ON SCENE:	DEPARTED SCENE:	RETURNED TO SERVICE:
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NATURE OF CALL:	CHIEF COMPLAINT:
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INCIDENT LOCATION:	STREET & TOWN:	CITY:	STATE:	ZIP CODE:
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PATIENT NAME:	DOB:	AGE:	SEX:	SOCIAL SECURITY #:
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ADDRESS:	APT / ROOM #:
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CITY / TOWN:	STATE:	ZIP CODE:
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VEHICULAR TRAUMA: <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> NON-VEHICULAR TRAUMA <input type="checkbox"/> OTHER	IMPACTING: <input type="checkbox"/> AUTO <input type="checkbox"/> TRUCK <input type="checkbox"/> TREE / POLE <input type="checkbox"/> OTHER	OCCUPANT OF: <input type="checkbox"/> AUTO <input type="checkbox"/> TRUCK <input type="checkbox"/> BUS <input type="checkbox"/> MOTORCYCLE <input type="checkbox"/> BICYCLE <input type="checkbox"/> OTHER	EXTRICATION FROM: <input type="checkbox"/> NO EXTRICATION REQUIRED <input type="checkbox"/> VEHICLE <input type="checkbox"/> BUILDING <input type="checkbox"/> REMOTE PLACE <input type="checkbox"/> OTHER	PATIENT PROTECTIVE DEVICES: <input type="checkbox"/> NONE <input type="checkbox"/> SEAT BELT <input type="checkbox"/> AIRBAG – FRONT <input type="checkbox"/> AIRBAG – SIDES <input type="checkbox"/> CHILD SEAT <input type="checkbox"/> OTHER
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NON-VEHICULAR TRAUMA TYPE:	SET #:	1	2	PUPILLARY RESPONSE:	COMMUNICATION BARRIER:	MEDICATIONS (LIST):
<input type="checkbox"/> FALL >6 FT <input type="checkbox"/> FALL <6 FT <input type="checkbox"/> GUNSHOT <input type="checkbox"/> KNIFE <input type="checkbox"/> ATHLETICS <input type="checkbox"/> DOMESTIC VIOLENCE <input type="checkbox"/> ELECTRICITY <input type="checkbox"/> INDUSTRIAL / MACHINERY <input type="checkbox"/> OTHER	TIME:			L R <input type="checkbox"/> EQUAL <input type="checkbox"/> UNEQUAL <input type="checkbox"/> REACTIVE TO LIGHT <input type="checkbox"/> NON – REACTIVE	<input type="checkbox"/> LANGUAGE <input type="checkbox"/> DEAF <input type="checkbox"/> MUTE <input type="checkbox"/> DEAF & MUTE <input type="checkbox"/> BLIND <input type="checkbox"/> DEVELOP. DISABILITY <input type="checkbox"/> OTHER	ALLERGIES (LIST):
	LOC:					
	RESP:					
	BP:					
	PULSE:					
PPE: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> VITAL SIGNS NOT ALLOWED BY PATIENT (EXPLAIN IN NARRATIVE)		NAME OF GUARDIAN (IF PATIENT IS A MINOR):			

PATIENT REASSURANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO	SPLINTING: <input type="checkbox"/> YES <input type="checkbox"/> NO	OXYGEN ADMINISTERED? <input type="checkbox"/> YES _____ L / M <input type="checkbox"/> NO	EPI-PEN ADMINISTERED? <input type="checkbox"/> YES <input type="checkbox"/> NO	CPR PERFORMED: <input type="checkbox"/> YES <input type="checkbox"/> NO	AED USED? <input type="checkbox"/> YES <input type="checkbox"/> NO
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NAME FIRST RESPONDER (PRINT):	TIME OF DEFIB:
FIRST RESPONDER SIGNATURE:	
FIRST RESPONDER CERTIFICATION #:	
NAME SECOND RESPONDER (PRINT):	NUMBER OF SHOCKS:
SECOND RESPONDER CERTIFICATION #:	
PULSE RETURNED: <input type="checkbox"/> YES <input type="checkbox"/> NO TIME:	

NARRATIVE: