Patient Care Report
Clemson University EMT Program

Patient #:		Date:	
		Age:	Weight:
Dispatched As:			☐ Male ☐ Female
*Evac Priority:	Red / Priority 1	Yellow / Priority 2	Green / Priority 3

☐ Medical ☐ Trauma
☐ Cardiac ☐ First Aid

Chief Complaint:

*NOI / MOI:

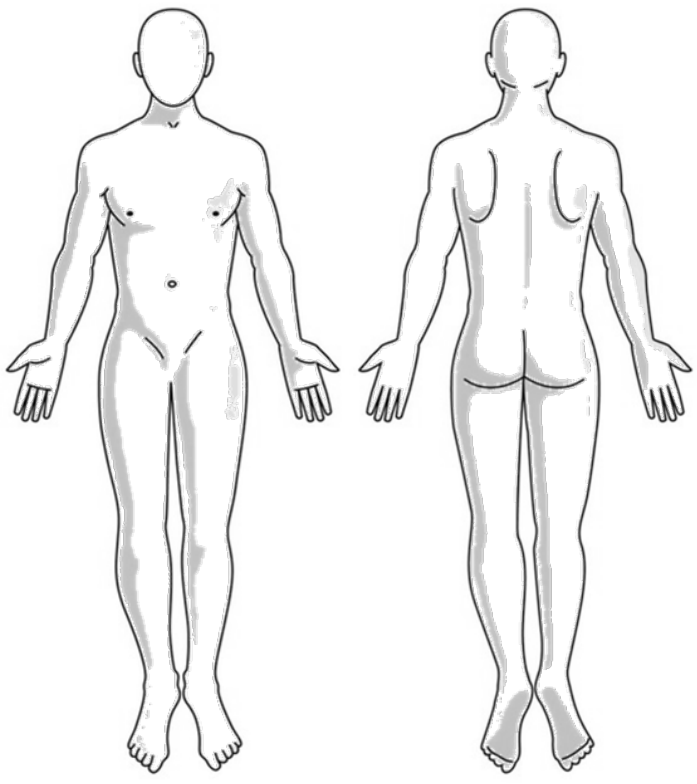
S / S:

A	Patent	NPA	OPA	Advanced Airway	**Glasgow Coma Scale:**	Eye: 4 3 2 1	Verbal: 5 4 3 2 1	Motor: 6 5 4 3 2 1	Total (E+V+M):
B	O2	Canula	NRB	BVM					
C	Radial	Carotid	None						

Patient Signs						
Speech	Skin Moisture	Color	Respiratory		Pulse	Pupils
Coherent	Normal	Normal	Clear	L / R	Normal	Reactive L / R
Incoherent	Dry	Pale	Wet	L / R	Rapid	Dilated L / R
Slurred	Moist / Clammy	Bluish	Decreased	L / R	Weak/Slow	Equal
Silent	Profuse Sweating	Flushed / Red	Absent		Absent	Unequal

Vitals

Time	LOC / AVPU	Pulse	BP	RR / Quality	O2 Saturation	BGL	Pain
			/				
			/				
			/				
			/				
			/				
			/				



Loss of Consciousness: ☐ No ☐ Yes Minutes:

Medications

Time	Medication	Route	Response

Waiver of Treatment / Patient Refusal

I acknowledge that I have been informed that my medical condition requires immediate treatment and/or transport to a physician and that with refusing further emergency medical treatment there is a risk of serious injury, illness, or death. Understanding these risks, I hereby release the attending medical personnel, their home agency, and their advising physician from all responsibility regarding any ill effects which may result from this decision.

Patient Signature: Date: N/A	Witness Signature: Date: N/A

Transfer of Care

☐ Hospital ED ☐ ALS - Air ☐ ALS - Ground
☐ BLS ☐ Other (Specify):

Receiving Signature:
Date:

EMS Provider Signature:
Date:

Patient Care Report - Additional Information

Sample History
Signs / Symptoms:
Allergies:
Medications:
Past History
Last Intake:
Events:

Narrative

* Treatments, Interventions, and Response		
Time	Treatment / Intervention	Patient Response

* Transportation Plan and/or ETA to Evacuation Location

* Additional Resource / Equipment Needs