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**SERVICIO DE AMBULANCIA Y ATENCION PREHOSPITALARIA**

Registration sheet

SHEET No. 8473

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| AMB. 12  SERVICE DETAILS | | | | | | | | | DAY | | | | | MONTH | | | | YEAR | | **DATA IN CASE OF TRAUMA** | | | | | | | | | | | | | | | | | | |
| 03 | | | | | 01 | | | | 17 | | INJURIES | | | | Bruises | | | Wound | | Burn | | | Fracture | | | Sprain | | Dislocation | |
| ZONE: | COLONY | | CENTER | | | | HOTEL ZONE | | | | | | | FEDERAL HIGHWAY | | | | | | SKULL-FACE | | | |  | | |  | |  | | |  | | |  | |  | |
| TIME: FROM 20:44 TO 21:05 | | | | | | | | PRIORITY | | | | | | I | | II | III | | IV | VERTEBRAL COLUMN | | | |  | | |  | |  | | |  | | |  | |  | |
| TRASNFER FROM: Consultorio Medico de Akumal | | | | | | | | | | | | | | | | | | | | NECK | | | |  | | |  | |  | | |  | | |  | |  | |
| TO: Hospiten Riviera | | | | | | | | | | | | | | | | | | | | CLAVICLE | | | |  | | |  | |  | | |  | | |  | |  | |
| WHO REFERS: Dr. Josue J. Quintal | | | | | | | | | | | | | | | | | | | | ARM | | | |  | | |  | |  | | |  | | |  | |  | |
| DOCTOR WHO RECEIVES: Dr. Salgado | | | | | | | | | | | | | | | | | | | | FOREARM | | | |  | | |  | |  | | |  | | |  | |  | |
| OPERATOR: Christian Hernandez | | | | | | | | | | | | | | | | | | | | HANDS OR FINGERS | | | |  | | |  | |  | | |  | | |  | |  | |
| PARAMEDIC: Gabriela Hernandez | | | | | | | | | | | | | | | | | | | | HIP | | | |  | | |  | |  | | |  | | |  | |  | |
| **PATIENT DETAILS** | | | | | | | | | | | | | | | | | | | | THIGH | | | |  | | |  | |  | | |  | | |  | |  | |
| NAME: Tonda S mothers Gregory | | | | | | | | | | | | | | | | | | | | LEG | | | |  | | |  | |  | | |  | | |  | |  | |
| ADDRESS: | | | | | | | | | | | | | | | | | | | | ANKLE | | | |  | | |  | |  | | |  | | |  | |  | |
| COUNTRY OF ORIGIN: USA / Colorado | | | | | | | | | | | | | | | | | | | | FEET OR FINGERS | | | |  | | |  | |  | | |  | | |  | |  | |
| SEX: FEMININE | | | | | | | | | AGE: 69 YEARS | | | | | | | | | | | CHEST | | | | UPP | LOW | | UPP | LOW |  | | |  | | |  | |  | |
| STATE OF CONSCIOUSNESS: CONSCIOUS | | | | | | | | | | | | | GLASGOW 15 | | | | | | | ABDOMEN | | | | UPP | LOW | | UPP | LOW |  | | |  | | |  | |  | |
| VITAL SIGNS | | | | | | | | | | | | | | | | | | | | GENITALS | | | |  | | |  | |  | | |  | | |  | |  | |
| BLOOD PRESSURE S 130 | | | | | | D 70 | | | | OXYGEN SATURATION 99 % | | | | | | | | | | OTHER | | | | SPECIFY SITE AND TYPE: | | | | | | | | | | | | | | |
| HEART RATE 98 | | | | BREATHING RATE 20 | | | | | | | | | | | TEMPERATURE | | | | |  | | | | | | | | | | | | | | | | | | |
| I AUTHORIZE RYUM UNDER MY REQUEST TO TRASNFER I REALEASE RYUM AND PARAMEDICS, DOCTORS FROM ANY REPSONSIBILITY.  I AUTHORIZE RYUM YO GIVE ME MEDICAL TREATMENT AND PERFORM ANY PROCEDURE REQUIRED TO STABILIZE AND TRANSFER ALSO AUTHORIZE TO RELEASE INFORMATION TO ANY AUTHORITY SUCH THE INSURANCE COMPANY OR LEGAL ENTITIES.  IF THE PATIENT IS UNABLE TO SIGN, HIS / HER REPRESENTATIVE WILL SIGN IT ON HIS / HER BEHALF, AND UNDERTAKE TO FULFIL THE AFROMENTIONED OBLIGATIONS.    NAME SIGNATURE | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| PROCEDURES: | | | | | | | | | | | | | | | | | | |
| Healing | | Dislocation reduction | | | | Fracture reduction | | | | Splint | | | | Pulling | | Collar | | Medical |
|  |  | | Intubation | | Cardiopulmonary resuscitation | | | | | | | | Mast. | | | Chest | | None |
| OTHERS: ABC, SAMPLE, Monitoring of vital signs, Intravenous therapy, Oxygen therapy, transfer to Hospital | | | | | | | | | | | | | | | | | | |
| CONSUMPTION OF MATERIALS AND MEDICINES:  CONCEPT QUANTITY | | | | | | | | | | | | | | | | | | |
| Saline Solution | | | | | | | | | | | 1 | | | | | | | |
| Normal drip | | | | | | | | | | | 1 | | | | | | | |
| (illegible)  # 10 | | | | | | | | | | | 1 | | | | | | | |
| Non sterile Gloves | | | | | | | | | | | 1 pair | | | | | | | |
| Disposable sheet | | | | | | | | | | | 1 | | | | | | | |
| Adult nasal tip | | | | | | | | | | | 1 | | | | | | | |
| **DETAILS OF ATTENTION** | | | | | | | | | | | | | | | | | | | | transpor tape | | | | | | | | | | | 1 | | | | | | | |
| REASON FOR ATTENTION | | | | | ILLNESS | | | | | | TRAUMA | | | | | |  | | |  | | | | | | | | | | | | | | | | | | |
| **DIAGNOSIS IN CASE OF ILLNESS** | | | | | | | | | | | | | | | | | | | | Patient conscious, oriented, calm, cooperative, Refers to oppressive precordial pain when doing physical activities, rhythmic cardiac sounds, ventilated lung fields, rest without alterations, no history, no allergies. | | | | | | | | | | | | | | | | | | |
| NEUROLOGICAL | | CARDIOVASCULAR | | | | | | | | | | RESPIRATORY | | | | | | | |
| DIGESTIVE | | METABOLIC | | | | | | | | | | RENAL | | | | | | | |
| UROGENITAL | | GYNECO-OBSTETRICS | | | | | | | | | | MENTAL DISORDER | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| SYSTEMIC | | EMOTIONAL DISTRESS | | | | | | | | | | OTHER | | | | | | | | OBSERVATIONS: | | | | | | | | | | | | | | | | | | |
| SPECIFY: Likely precordial pain | | | | | | | | | | | | | | | | | | | | Patient Signature Doctor signature who receives | | | | | | | | | | | | | | | | | | |