



University of San Jose – Recoletos
Adelante Life Emergency Rescue Team
PRE-HOSPITAL DATA FORM



CASE NUMBER		DATE		DISPATCH TIME			
LAST NAME		FIRST NAME			MI	AGE	SEX
PATIENT ASSESSMENT							
CHIEF COMPLAINTS							
		LEVEL OF CONSCIOUSNESS		AIRWAY			
		NATURE OF ILLNESS		BREATHING			
		MECHANISM OF INJURY		CIRCULATION			
		CONSIDERATION FOR C SPINE					
VITAL SIGNS			PATIENT PRIORITY	<input type="radio"/> HIGH PRIORITY <input type="radio"/> LOW PRIORITY			
VITAL	TIME H	TIM H	TIME H	HISTORY TAKING			
TEMP (°C)				S A M P L E	SIGNS AND SYMPTOMS		
BP (mmHg)					ALLERGIES		
RR (RPM)					MEDICATION		
PULSE (bpm)					PAST MEDICAL		
SpO2 (%)					LAST INTAKE		
GCS					EVENTS PRIOR		
RTS							
RBS (mg/dl)							
PROVIDER IMPRESSION				MANAGEMENT:			
SECONDARY ASSESSMENT							
<div><div>D</div><div>C</div><div>A</div><div>B</div><div>P</div><div>T</div><div>L</div><div>S</div></div>	DEFORMITIES		PAIN ASSESSMENT			APGAR SCORE	
	CONTUSION		O	ONSET		APPEARANCE	
	ABRASION		P	PROVOCATION		PAIN	
	BURN		Q	QUALITY		GRIMACE	
	PUNCTURE		R	RADIATION		ACTIVITY	
	TENDERNESS		S	SEVERITY		RESPIRATION	
	LACERATION		T	TIMING			
SWELLING				TOTAL			
NOTES:							
TEAM INFORMATION				ENDORSEMENT			
TEAM LEADER				RECEIVING FACILITY			
CREW				RECEIVING PERSONNEL			TIME RECEIVED
VEHICLE/ AMBULANCE		TIME DEPART		TIME ARRIVED			

INFORMED CONSENT

I knowingly and willingly submit myself to any/all range of medical services that the USJR ALERT EMS personnel will provide. The type and extent of treatment I will receive will be determined based on the thorough and holistic assessment of the responder. I know the information shared with USJR ALERT EMS staff is confidential and no information will be disclosed to the receiving without my consent.

Also, I waive USJR ALERT EMS responders and personnel of any liabilities after they divulge me from their professional care.

I have fully read and fully understood the above statement.

Patient name and signature

Date

Time

Guardian name and signature

Date

Time

REFUSAL OF TREATMENT OR TRANSPORT

This form is being provided to me because I have refused assessment and treatment and/or refused transport to the nearest hospital via USJR ALERT EMS ambulance for myself (or on behalf of this patient.)

- I understand that the Medics or the Ambulance Nurses are not physicians and are not qualified to make a diagnosis and that their intervention is not a substitute for that of a physician in the hospital.
- I recognize that there may be a serious injury or illness that could get worse if without medical attention even though I (or the patient) may feel fine at the present time.
- I understand that I may change my mind and dial _____; or other means of communication if assistance or treatment is needed later.
- I acknowledge that this advice has been explained to me by the EMS and that I have read this form and understand its terms.

Signature over Printed Name of Patient/SO

Signature over Printed Name of Witness

REFUSAL FOR ADMISSION

Medical Facility: _____

By signing this document, I acknowledge that the patient’s medical condition has been properly endorsed by the USJR ALERT EMS responder, to the medical facility stated above and to the physician/Nurse on duty. Despite this, the facility refuses or declines to admit the patient due to: _____

Reason for refusal:

Physician / Nurse on Duty

Date

Witness

Date