

Midland Park Ambulance Corps Patient Care Report

| | | | | | | | |
|---|---|--|--------------------------------|--|---|--|--|
| Date: __/__/__ | | Unit: _____ | Patient # __ of __ | End Mileage: _____ | <input type="checkbox"/> Mutual Aid To: _____ | | |
| Patient Information | Age: _____ | DOB: __/__/____ | | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | | Times (Military): Dispatched: _____ In Service: _____ On Scene: _____ In Route: _____ Arrived: _____ Available: _____ Out Svc: _____ | |
| | Name: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Last First M.I. </div> | | | | | | |
| | Address: _____ | | | Town: _____ | | | |
| Call Information | Call Type: _____ | | Location of PT At Scene: _____ | | | | |
| | Location of Call: _____ <input type="checkbox"/> PT's Home <input type="checkbox"/> Other: _____ | | PT's Physician: _____ | | | | |
| Clinical Information | | | | | | | |
| Patient History: | | Chief Complaint: _____ | | Time of Symptom Onset: _____ | | | |
| | | Aid Given: _____ Given By: <input type="checkbox"/> PD <input type="checkbox"/> Family <input type="checkbox"/> Bystander <input type="checkbox"/> Other: _____ | | | | | |
| | | Allergies: _____ | | | | | |
| | | Medications: _____ | | | | | |
| | | Remarks: _____ _____ _____ _____ | | | | | |
| Vitals | | | | | | | |
| Time | BP | Pulse | Respirations | Lung Sounds | Consciousness | Pupils | |
| | | | | | A V P U = | L+ L- L(u) R+ R- R(u) | |
| | | | | | A V P U = | L+ L- L(u) R+ R- R(u) | |
| | | | | | A V P U = | L+ L- L(u) R+ R- R(u) | |
| | | | | | A V P U = | L+ L- L(u) R+ R- R(u) | |
| | | | | | A V P U = | L+ L- L(u) R+ R- R(u) | |
| Treatment/Interventions Given | | Injured Area: | | | | Loss of Consciousness | |
| | | <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Face <input type="checkbox"/> Chest <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen </div> <div> Arm <input type="checkbox"/> Hip Hand <input type="checkbox"/> Leg Foot <input type="checkbox"/> </div> </div> | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Call Outcome | | CREW | | | | ALS | |
| <input type="checkbox"/> BLS Transport <input type="checkbox"/> BLS/ALS Transport <input type="checkbox"/> Air Transport <input type="checkbox"/> Refusal (Attach RMA Form) <input type="checkbox"/> D.O.A. <input type="checkbox"/> Cancelled <input type="checkbox"/> Other / Non-Emergency <input type="checkbox"/> Refusal (Attach RMA Form) | | <input type="checkbox"/> Duty <input type="checkbox"/> 2nd Rig <input type="checkbox"/> General | | | | Unit # _____ <input type="checkbox"/> Not Called <input type="checkbox"/> Unavailable <input type="checkbox"/> Cancelled by PD <input type="checkbox"/> Cancelled by BLS <input type="checkbox"/> Cancelled by MD <input type="checkbox"/> Responded & Released <input type="checkbox"/> Responded ALS Transport <input type="checkbox"/> Responded No Transport | |
| | | Driver ID# to scene _____ to hospital _____ to garage _____ Crew: _____ On Scene: _____ | | | | | |
| | | Patient Transferred To: | | | | | |
| | | <input type="checkbox"/> Valley <input type="checkbox"/> Other _____ Passengers: _____ Equipment Left: _____ | | | | | |
| | | Preparer's Signature: _____ ID#: _____ | | | | | |
| | | | | | | <input type="checkbox"/> RMA Attached | |