

## PATIENT CARE REPORT

## BERKELEY MEDICAL RESERVE CORPS

NAME <b>EUA EUAMPSIA</b>		SEX <b>F</b> AGE <b>19</b>	DATE AND TIME OF CALL <b>4/17/19 2000</b>
PHONE <b>212-479-7990</b>		DOB <b>4/7/2000</b>	LOCATION <b>HAAS Pav. SEC 8</b>
STREET <b>42 WALLABY WAY</b>		APT / STE #	CALLER
CITY <b>SYDNEY</b>		ZIP <b>98102</b>	INTAKE BY
CHIEF COMPLAINT <b>"I FEEL VERY NAUSEOUS"</b>			
FOUND / ARRIVED: <input type="checkbox"/> ALONE <input checked="" type="checkbox"/> COMPANION(S) <input type="checkbox"/> STAFF <input type="checkbox"/> SECURITY <input type="checkbox"/> BMRC			
MODE: <input type="checkbox"/> AMBULATORY <input type="checkbox"/> ASSISTED <input type="checkbox"/> WHEELCHAIR <input checked="" type="checkbox"/> GURNEY <input type="checkbox"/> C-SPINE			
CONDITION: <input type="checkbox"/> ALERT <input type="checkbox"/> AGITATED <input type="checkbox"/> COMBATIVE <input type="checkbox"/> LETHARGIC <input checked="" type="checkbox"/> AMS <input type="checkbox"/> UNCONSCIOUS			
WNL ABN NA	DETAILS / FINDINGS		WNL ABN NA
1. NEUROLOGICAL	A/O x 2 <input checked="" type="checkbox"/> P <input type="checkbox"/> U <b>(DID NOT KNOW DAY OF WK/MONTH &amp; CITY)</b> GCS: <b>"BLUZZY VISION". POPPUS PERL</b>		4. GI / GU
<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
2. CARDIOVASCULAR	<b>HYPERTENSIVE. NO CP. EDEMA IN HANDS</b> CP <input type="checkbox"/> <b>&amp; FEET. CAP REFILL &lt;2S. PULSAL P/ERUAL</b>		5. EXTREMITIES
<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
3. RESPIRATORY	<input checked="" type="checkbox"/> EVEN, UNLABORED <input type="checkbox"/> LABORED <input type="checkbox"/> ASSISTING <input type="checkbox"/> SHALLOW <input type="checkbox"/> RAPID <input type="checkbox"/> RETRACTING		6. SKIN
<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	BREATH SOUNDS: <b>N/A</b> SOB <input type="checkbox"/>		<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
ALLERGIES: <b>NKA</b>		PAST MEDICAL HISTORY	
MEDICATIONS: <b>"PRENATAL VITAMINS"</b>		<input type="checkbox"/> ASTHMA / COPD <input type="checkbox"/> CVA (STROKE) <input type="checkbox"/> GI / GU <input type="checkbox"/> SEIZURE <input type="checkbox"/> CARDIAC (MI <input type="checkbox"/> ) <input type="checkbox"/> DIABETES <input type="checkbox"/> HYPERTENSION <input type="checkbox"/> PSYCHIATRIC OTHER: <b>NONE REPORTED</b>	
TIME	HR	BP	RR
2005	92	156/94	14
NARRATIVE: IMPRESSIONS / ASSESSMENTS / TREATMENTS / RESPONSES - CONT ON BACK <b>SpO2 96% MRC 1 DISPATCHED TO AN "ALTERED PREGNANT FEMALE" @ SEC. 8 OF HAAS PAVILION. AOS TO FIND 19 YOF SEATED, VERBALLY RESPONSIVE, w/ CC: "I FEEL VERY NAUSEOUS", AND C/O BLUZZY VISION. PT FOUND TO BE A+O x 2 DUE TO INABILITY TO IDENTIFY CURRENT WK DAY OF WK/MONTH AND CITY/LOCATION). PER Bystanding MOTHER, PT 30 WKS PREGNANT, UNDER PRENATAL CARE, NO PREV PREGNANCIES, NO EXPECTED COMPLICATIONS, NO PAST MEDICAL HX. PT ALSO REPORTED INFREQ UZINATION BEGINNING 1 WK PRIOR AND VOMITING 1 HR PRIOR AFTER LUNCH (DENIES CONSUMING ANY SUSPICIOUS FOODS / ALLERGENS. PT DENIES ANY ABD PAIN, BLEEDING, REGULAR CONTRACTIONS, OR DRUG/ETOH USE PRESENTLY OR DURING PREGNANCY. ALS REQUESTED VIA UCPD DIRECT DIAL @ 2005. PT SEIZURELY LOADED ONTO STAIR CHAIR AND MOVED TO LOBBY w/o INCIDENT... CALL FOR ALS / TRANSPORT</b>			
DISCHARGE DETAILS		DESTINATION: <b>ABMC (ALTA BATES MEDICAL CENTER)</b> <input type="checkbox"/> ALONE <input type="checkbox"/> COMPANION(S) <input type="checkbox"/> POLICE (BADGE: ) <input type="checkbox"/> STAFF	
TIME: <b>2010</b>		CONDITION: <input type="checkbox"/> STABLE <input checked="" type="checkbox"/> UNSTABLE <input checked="" type="checkbox"/> EMS AGENCY: <b>BER ENGINE 3 &amp; R1 MEDIC 5</b>	
I authorize treatment by Berkeley Medical Reserve Corps staff to perform any medical intervention/treatment which is necessary in their professional judgement. <input type="checkbox"/> YES		I acknowledge that any medical information taken by the Berkeley Medical Reserve Corps will be held confidential and may be shared with third parties for the purpose of providing medical care. <input type="checkbox"/> YES	
SIGNATURE:		DATE:	
<b>PT UNABLE TO SIGN DUE TO AMS</b>			
REFUSAL OF TREATMENT			
I have been advised that medical care on my behalf is necessary, and that refusal of care and assistance could be hazardous to my health, and under certain circumstances, include disability or death. OR I acknowledge that I may have a medical problem which may require additional medical attention, and that an ambulance could be arranged to take me to the hospital. Instead, I elect to seek alternative medical care and/or refuse evaluation/treatment and/or transport.			
By signing this form, I am releasing the Berkeley Medical Reserve Corps of any liability or medical claims resulting from my decision to refuse care against medical advice.			
SIGNATURE		PRINTED NAME	
		DATE	

BMRC STAFF NAMES &amp; SIGNATURES, AND NAMES &amp; LICENSE #s / PHONE #s OF ANY ADDITIONAL SUPPORTING HEALTHCARE PROVIDERS:

TREY McTRAINING EMT 2 4/17/19

NARRATIVE CONT ON BACK ↴

## NAZZATIVE CONT

... PT ADVISED OF ALL FINDINGS AND TO ACCEPT ALS TRANSPORT FOR FURTHER ASSESSMENT.  
CONT TO MONITOR & PROVIDE FOR PT NEEDS UNTIL ALS ARRIVAL. TRANSFERRED CARE TO  
BER ENGINE 3 W/ FULL HANDOFF.