



EMS INCIDENT REPORT

COORDINATES X \_\_\_\_\_ Y \_\_\_\_\_

TRAIL NAME: \_\_\_\_\_  
LOCATION NAME: ☐ BIG SKY ☐ BRIGHTON ☐ CRYSTAL

Incident # \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ SSN \_\_\_\_\_  
Local Lodging Address \_\_\_\_\_  
Local Lodging Phone Number \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_  
Age \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_  
Medical Alert Tag? \_\_\_\_\_ If yes, what for \_\_\_\_\_  
Contact Lenses? \_\_\_\_\_ Worn skiing? \_\_\_\_\_

Mechanism of injury \_\_\_\_\_  
Chief complaint \_\_\_\_\_  
Past Medical History \_\_\_\_\_  
Medication History \_\_\_\_\_  
Allergies \_\_\_\_\_  
Referred to which Medical Facility? \_\_\_\_\_

Incident Time \_\_\_\_\_ Dispatch Time \_\_\_\_\_  
At Scene Time \_\_\_\_\_ Trans Time \_\_\_\_\_  
Left Aid Rm \_\_\_\_\_ Left Area \_\_\_\_\_  
ALS Arrived \_\_\_\_\_

Helmet? Y N  
Loss of Consciousness? Y N  
Lung Sounds Present? R L Equal? Y N  
Motor Functions? Arms R L Legs? R L

(Time 24 hr.)	Pulse	Blood Pressure	Respirations	O2 Admin.	SPO2	Temp.	Blood Sugar

Please circle appropriate responses:

Radial Pulse	Cap. Refill	Resp. Effort	Pupils	Skin Cond	Sensory Distal	Pulse Distal	Neck Veins
Regular Irregular	Normal Delayed	Normal Shallow Reactive Air Hunger Absent	R Reactive L R Unreactive L R Dilated L R Midrange L R Pinpoint L	Moist Dry Warm Cool Normal Pale Cyan Red	(Y/N) Before Tx _____ After Tx _____	(Y/N) Before Tx _____ After Tx _____ N/A	Normal Flat Distended

Eyes Open	Verbal Response	Motor Response	Glasgow Score	R Injury Zone L
1st 4 Spontain 3 To Speech 2 To Pain 1 None	2nd 5 Oriented 4 Confused 3 Inapprop. 2 Incomprehen. 1 None	1st 6 Obeys cmds. 5 Localized 4 Withdrawn 3 Flex To Pain 2 Ext. To Pain 1 None	1st Time 2nd Time	Head Neck Back Chest Abdomen Hip Up Leg Low Leg Knee Ankle Foot Shoulder Up Arm Low Arm Elbow Wrist Hand
#	Glasgow Score	Systolic B/P	Respiratory Rate	Trauma Score
4	1st 13-15 2nd	1st >89 2nd	1st 10-29 2nd	1st Time 2nd Time
3	9-12	76-89	>29	
2	6-8	50-75	6-9	
1	4-5	1-49	1-5	
0	3	0	0	

Equipment Used: Backboard ☐ # \_\_\_\_\_ Jiffy ☐ # \_\_\_\_\_ Pede. Jiffy ☐ # \_\_\_\_\_ Blanket ☐  
Snowmobile Assist ☐ \_\_\_\_\_  
Other ☐ Describe \_\_\_\_\_

Body Fluid Exposure?	Drug/IV Solution	GA	RT	Dose	Time	Dose	Time
YES NO							
ERF #							

Narrative: Specific Patient Care Provided & Actions Taken: Shock ☐ Assesment ☐ History ☐ O2 ☐  
At Scene: \_\_\_\_\_  
In Aid Room: \_\_\_\_\_

<b>Patient's Equipment</b> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Skis    <input type="checkbox"/> Snowboard    <input type="checkbox"/> Other _____</div><div><input type="checkbox"/> Owned    <input type="checkbox"/> Borrowed    <input type="checkbox"/> Demo    <input type="checkbox"/> Rental</div></div> Name on rental form _____ Shop Name _____ Boot Size _____ Pair # _____ Ski Length _____ Rental # _____ Binding Settings: Toe (R) _____ (L) _____ Heel (R) _____ (L) _____				<b>Skis removed by:</b> R    L Fall <input type="checkbox"/> <input type="checkbox"/> Self <input type="checkbox"/> <input type="checkbox"/> Ski Patrol <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/>		<b>Stated Ability:</b> Beginner/Novice <input type="checkbox"/> Intermediate <input type="checkbox"/> Advanced/Expert <input type="checkbox"/>	
Falls Today <input type="checkbox"/> First <input type="checkbox"/> 2-9 <input type="checkbox"/> 10+	Lessons Taken <input type="checkbox"/> Never <input type="checkbox"/> This Yr. <input type="checkbox"/> Last Yr. <input type="checkbox"/> ____ Yrs. ago	Incident occurred while: <input type="checkbox"/> Alpine Skiing <input type="checkbox"/> Nordic Skiing <input type="checkbox"/> Snowboarding <input type="checkbox"/> Lift Related <input type="checkbox"/> Ski School <input type="checkbox"/> Premise Related <input type="checkbox"/> Other	Trail Rating <input type="checkbox"/> Easiest <input type="checkbox"/> More Diff. <input type="checkbox"/> Most diff. <input type="checkbox"/> N/A	Surface at scene <input type="checkbox"/> Powder <input type="checkbox"/> Moguls <input type="checkbox"/> Ice <input type="checkbox"/> Packed <input type="checkbox"/> Variable <input type="checkbox"/> Wet Snow	Visibility <input type="checkbox"/> Clear <input type="checkbox"/> Overcast <input type="checkbox"/> Fog <input type="checkbox"/> Snowing <input type="checkbox"/> Raining <input type="checkbox"/> Night	Wind <input type="checkbox"/> Calm <input type="checkbox"/> Mod. <input type="checkbox"/> High	Temp. <input type="checkbox"/> <0 F <input type="checkbox"/> 0-32F <input type="checkbox"/> >32F
Days Skied this season <input type="checkbox"/> First <input type="checkbox"/> 2-9 <input type="checkbox"/> 10+	Investigation suggested <input type="checkbox"/> Yes <input type="checkbox"/> No	Forms to be attached: <input type="checkbox"/> Ski School    Instructor(s) _____ <input type="checkbox"/> Lift related    Lift _____ <input type="checkbox"/> Top <input type="checkbox"/> Base    Operator _____ <input type="checkbox"/> Injured Party <input type="checkbox"/> Witness Statement <input type="checkbox"/> Collision <input type="checkbox"/> Incident Supplement <input type="checkbox"/> VECC Sheet <input type="checkbox"/> Other _____					
Comments:							
Probable Injury: _____							
Arrived Aid Room: <input type="checkbox"/> Ski Patrol <input type="checkbox"/> Walk-in <input type="checkbox"/> Other _____							
Left Area By: <input type="checkbox"/> Ambulance <input type="checkbox"/> Private Car <input type="checkbox"/> Bus <input type="checkbox"/> Air Ambulance <input type="checkbox"/> Other _____							
EMS Response: <input type="checkbox"/> Ski Patrol <input type="checkbox"/> Brighton Clinic <input type="checkbox"/> Doctor <input type="checkbox"/> Paramedic <input type="checkbox"/> Ambulance <input type="checkbox"/> Air Ambulance <input type="checkbox"/> Other _____							
Patient Incident Description (In patient's own words)							
Patient's Signature X							
Witness Name _____ Phone Number _____ Permanent Address _____ Statement: _____							
Witness Signature x							
Patrollers at Scene _____ Toboggan Driver _____ Additional Patrollers _____ Signature of Individual completing form _____ Print Name _____ NSPS# _____ Signature of Individual checking form _____ Print Name _____ NSPS# _____							
<b>*** RELEASE OF MEDICAL RESPONSIBILITY ***</b>							
Having been offered assessment and evaluation, emergency treatment, transportation off the hill, and/or ambulance transportation, I refuse: <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Assessment and Evaluation</div><div><input type="checkbox"/> Toboggan Transportation</div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Emergency Treatment</div><div><input type="checkbox"/> Ambulance Transportation</div></div> <p>that has been offered to me, my child or ward. I, the undersigned, do hereby release Boyne USA, Inc., et al. and their personnel from any and all further responsibility to the below mentioned patient and agree to consult a physician of my own choice. The possible consequences of my refusal have been clearly explained to me.</p> <div style="display: flex; justify-content: space-between;"><div>Name of Patient (please print) _____</div><div>Signature of Patient _____</div></div> <div style="display: flex; justify-content: space-between;"><div>Patroller (please print) _____ NSPS# _____</div><div>Parent or Legal Guardian _____</div></div> <div style="display: flex; justify-content: space-between;"><div>Date _____</div><div>Signature of Witness (if patient refuses) _____</div></div> <div style="text-align: center; margin-top: 10px;"><input type="checkbox"/> Patient, Parent, or Legal Guardian refused to sign release after refusing services as checked above.</div>							