

#MT 000768

Portsmouth Medic Transport LLC

Phone Number: 855-854-4100

P1

		Unit # <u>1741</u>		Date <u>1-17-2020</u>					
		Crew Members (Legal Name as printed on EMT Card)		Certification					
		<u>Timothy Sparks</u>		<u>AEMT</u>					
		<u>Kathleen Park</u>		<u>EMT-P</u>					
		Run Type: <input checked="" type="checkbox"/> Emergency <input type="checkbox"/> Transport							
		TIME	B/P	P	R	SPO2	ETCO2	GLUC	TEMP
		<u>1221</u>	<u>135/82</u>	<u>93</u>	<u>18</u>	<u>99</u>			
		TIME	PROCEDURE / RX				DOSE	ROUTE	
Treating Physician / PCP _____		Social Security Number _____							
Medicare _____		Medicaid _____							
Other Insurance _____									
Policy Number _____		Name of Insured _____							
Military Time	TIME	MILEAGE		IV <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
DISPATCHED	<u>1151</u>			Gauge/Cath _____ Location _____					
ENROUTE SCENE	<u>1152</u>	<u>35.2</u>		Started By: _____					
ARRIVE SCENE	<u>1159</u>	<u>42.1</u>		Cardiac Monitor <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Regular <input type="checkbox"/> Irregular					
PATIENT CONTACT				<input type="checkbox"/> 12 Lead					
ENROUTE FACILITY	<u>1220</u>	<u>42.1</u>		<input type="checkbox"/> 4 Lead Interpretation: _____					
ARRIVE FACILITY	<u>1229</u>	<u>45.6</u>		<input type="checkbox"/> Transmitted to _____					
RETURN TO SERVICE				Allergies _____					
				PMHx: <u>Syncope</u>					
				<u>1220 iron</u>					
Chief Complaint/Reason for Stretcher: <u>Seizure Activity</u>									
Narrative: <u>Officer Skeens states "It's a fake seizure. She's fine." Pt AHO, PWD, VADS. Ambulated unassisted. c. Officer up hallway to chair. Answers all questions appropriately. PMS intact. Neg for incontinence, no signs of injury. Officer did not state previous events. Pt states she was thrown, given blanket by EMS. Ambulated.</u>									
Signed: _____		Crew Signature _____							
Printed: <u>Kathleen Park EMT-P</u>		RECEIVING FACILITY SIGNATURES							
Equipment left with Drop off Facility: <input type="checkbox"/> Vent <input type="checkbox"/> BPap <input type="checkbox"/> CPAP <input type="checkbox"/> Other _____		Please sign and print your first and last name and as per Medicare regulations, your signature must contain a legible first and last name.							
		Signed: _____							
		Printed: <u>(Illegible)</u>							
		Copy of PCR left with facility: <input type="checkbox"/> Yes <input type="checkbox"/> No							