

# COPY PORTSMOUTH AMBULANCE SERVICE PATIENT CARE REPORT

Pg. 1

855-854-4100

Unit #

Crew Members

(Legal Name as printed on EMT Card)

Date

Certification

Celia O'Connor

Anthony Price

EMT-P

EMT-B

Run Type: ☐ Emergency ☒ Transport

TIME	B/P	P	R	SPO2	ETCO2	GLUC	TEMP
1927	123/80	98	14	93%			

TIME	PROCEDURE/ RX	DOSE	ROUTE

Medicare

Medicaid

Other Insurance

Policy Number

Name of Insured

\*Military Time\*

TIME

MILEAGE

DISPATCHED

ENROUTE SCENE

ARRIVE SCENE

PATIENT CONTACT

ENROUTE FACILITY

ARRIVE FACILITY

RETURN TO SERVICE

1844

128.0

1904

143.7

1919

143.7

1943

158.6

IV ☒ Yes ☐ No

Gauge/Gth

Location

Started By: Celia O'Connor, P.O.C.

Cardiac Monitor

☐ Yes

☒ No

☐ Regular

☐ 12 Lead

☒ 4 Lead Interpretati

on:

☐ Transmitted to

Allergies

PMHx: Pneumonia

Chief Complaint/Reason for Stretcher: Chest Pain 16% ejection fraction

Narrative: A: PT found lying in bed. PT A: OX4 + complains of generally "feeling ill"

R: PT walked to cot + secured straps x 3 mits x 2. P, T loaded + secured in M1425 vitals taken PT in POC. PT walked to bed @ GMC + secured rails x 2

T: PT transported w/o incident or delay. Care 4m Nurse

☐ Continued

Signed:

Printed:

Celia O'Connor EMT-P

Equipment left with Drop off Facility:

☐ Vent ☐ BiPAP ☐ CPAP ☐ Other

RECEIVING FACILITY SIGNATURES

Please sign and print your first and last name and as per Medicare guidelines, your signature must contain a legible first and last name.

Signed:

Jackie Toru-Dum

Printed:

Jackie Toru-Dum

Copy of PCR left with facility: ☐ Yes ☐ No

QA000029