

GREENUP EMERGENCY AMBULANCE SERVICE LLC PATIENT CARE REPORT

Phone Number: 855-854-4100

P1

<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		Medics - 14		11-22-19	
Na _____		Unit # _____		Date _____	
Address _____		Crew Members _____		Certification _____	
City <u>Flatwoods</u> State <u>KY</u> Zip <u>41139</u>		(Legal Name as printed on EMT Card) <u>Troy Gillette EMT-P</u>		<u>1030817 EMT-P</u>	
DOB <u>08/02/1936</u> Age <u>83</u> Phone <u>606 473-4140</u>		<u>Sierra Wheeler EMT-B</u>		<u>1052134 EMT-B</u>	
Run Type <input checked="" type="checkbox"/> Emergency <input type="checkbox"/> Transport					
TIME B/P P R SPO2 ETCO2 GLUC TEMP					
04:46 <u>172/88</u> 81 16 96					
04:54 <u>164/80</u> 82 16 96					
Drop Off Location _____ Address _____					
City <u>ASHLAND</u> State <u>KY</u> Zip <u>41101</u>					
Transport Mode: <input type="checkbox"/> Emergency <input checked="" type="checkbox"/> Non-Emergency					
Treating Physician /PCP _____ Social Security Number _____					
Medicare _____ Medicaid _____					
Other Insurance _____					
Policy Number _____ Name of Insured _____					
Military Time		TIME		MILEAGE	
DISPATCHED		04:29		76.0	
ENROUTE SCENE		04:34		77.1	
ARRIVE SCENE		04:37		78.9	
PATIENT CONTACT		04:38		05:26	
ENROUTE FACILITY		04:52		05:26	
ARRIVE FACILITY		04:57		05:26	
RETURN TO SERVICE		05:26		05:26	
Chief Complaint/Reason for Stretcher: <u>Fall</u>					
Narrative: <u>83 year female patient who called 911 for a life assist when we arrived found patient sitting in the floor in her living room patient initially denied any injury and wanted help to the restroom. When we helped her to the restroom we noticed her mouth had been bleeding she advised she had struck her mouth on a fall earlier. When she got out of bed we advised patient she should go to the hospital and she agreed to be transported to OHSU ER.</u>					
<input checked="" type="checkbox"/> Continued					
Signed: <u>Troy Gillette EMT-P</u>		RECEIVING FACILITY SIGNATURES			
Printed: <u>Troy Gillette EMT-P</u>		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: <u>Sierra Wheeler EMT-B</u>		Signed: <u>Morgan Harris RN</u>			
Printed: <u>Sierra Wheeler EMT-B</u>		Printed: <u>Morgan Harris RN</u>			
Equipment left with Drop off facility: <input type="checkbox"/> Vent <input type="checkbox"/> BiPap <input type="checkbox"/> CPAP <input type="checkbox"/> Other _____		Copy of PCR left with facility: <input type="checkbox"/> Yes <input type="checkbox"/> No			