Region 1- Patient Care Report-Short/Non-Transport Form

Company _____Unit # _____ Date_____

Receiving Facility_____ Time _____

Patient Name _____

Address: _____

Age _____ DOB_____

Vital Signs: HR_____RR_____B/P_____ O2 Sat_____

Chief complaint /Mechanism of Injury _____

Crew Telephone Contact #_____

Crew Member #1_____

Crew Member #2 _____

LOC
Alert ☐
Verbal ☐
Pain ☐
Unresponsive ☐

Glascow Coma Scale:_____

Lung Sounds
Clear ☐
Bilateral ☐
Wheezes ☐
Rales/Crackles ☐
Ronchi ☐
Diminished ☐

Gluco Check: _____

Treatments
IV/IO Rate _____TKO ☐
Monitor On: Yes ☐ No ☐
Time: _____

12 Lead: Yes ☐ No ☐ Time:_____
STEMI: Yes ☐ No ☐
Transmitted: Yes ☐ Time:_____ No ☐
Interpretation:
NSR ☐ Brady ☐ Tach ☐ Other_____

Stroke Assessment
G - + -
F - + -
A- + -
S- + -
T- _____
Last seen normal

Skin
Normal ☐
Pale ☐
Flushed ☐
Moist ☐
Diaphoretic ☐

Pain
Yes ☐
No ☐
Severity (1-10)
On Arrival_____
At Hospital_____

Oxygen
liters/Minute____
Nasal Cannula ☐
NRB ☐
ETT ☐
King Airway ☐
CPAP ☐

Immobilization
Yes ☐ No ☐

Long Board ☐
Cervical Collar ☐
HIM ☐

Time	BP	Pulse	Resp	02 Sat	Temp

Time	Rhythm	Time	Rhythm

Medications

Med	Time/Dose	Time/Dose	Time/Dose

Defibrillation X _____

Medical History:

Patient's Meds: None ☐

Allergies: None ☐
List:

Other Information:

Final Report Completed-Date _____Time:_____

Final Report Faxed To Rec Hosp. Date _____Time_____