

Patient Next of Kin Name / Phone			Patient Name					
EMS Agency Name / Affiliate Number			Address			City	State	Zip
Date	Time	Incident Number	Age	Gender (M / F)	Date of Birth	SSN		
Incident Location:		Chief Complaint / Provider Impression:						

BRIEF HISTORY / PERTINENT SYMPTOMS	For Stroke, Chest Pain, Trauma or Altered Mental Status	
	Time of Persistent Symptoms, Injury, or Last Seen Normal	
	Date	Time
	EMS Contact Time – First EMS	ALS Contact Time

PERTINENT PHYSICAL EXAM FINDINGS	MEDICATIONS
	<input type="checkbox"/> NONE
ALLERGIES	<input type="checkbox"/> NKDA
	Patient Medications or Medication List Delivered with Report <input type="checkbox"/> Yes

VITAL SIGNS									
Time	Pulse	Blood Pressure	Resp	Glucose	SaO2	Mental Status (AVPU)			
		/				<input type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain	<input type="checkbox"/> Unresponsive
		/				<input type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain	<input type="checkbox"/> Unresponsive
		/				<input type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain	<input type="checkbox"/> Unresponsive

ECG		
Rhythm:	12-lead ECG Interpretation:	Copy of Rhythm Strip/ all 12-lead ECGs Delivered with Report <input type="checkbox"/> Yes

EMS TREATMENT			NOTES / COMMENTS
Time	Medication/ Intervention	Dose	

IV <input type="checkbox"/> Yes <input type="checkbox"/> No	IV Fluid Type:	Size/Location:	Total IV Fluid Volume Given: mL	Oxygen: LPM
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PROVIDER TRANSFERRING CARE	CERTIFICATION NUMBER	CARE TRANSFERRED TO	
QRS Provider		Receiving Hospital/Agency Name:	Time of Transfer
QRS Provider Signature:			
EMS Provider		Receiving Healthcare Provider Signature:	
EMS Provider Signature:		Signature: _____ (Print) _____	