Administration of Antibiotics by EMS for Open Fracture

Statewide Pilot Program

Patient Data Form

This form must be completed for every patient that receives antibiotics for suspected open fracture.

Summary data must be submitted to your regional EMS Council monthly (within 30 days of the last day of the month of the incident). Summary data must be submitted by the agency using the pilot program summary document.

All data forms created under this pilot must be retained by the EMS agency for possible audit/review for a period of at least 3 years after the date when the pilot program is terminated.

Patient Name:

Patient Date of Birth: **Patient Age:**

EMS Agency Name:

Incident Number: **Incident County:**

Incident Municipality:

Date of Incident: **Time of Initial 9-1-1 Call:**

Mechanism of Injury (Check): ☐ Fall ☐ Motorized Vehicle ☐ Machinery
☐ Sports-related ☐ Other:

Bone(s) involved (Check all that apply): ☐ Face/Skull ☐ Humerus ☐ Forearm
☐ Wrist ☐ Hand ☐ Pelvis ☐ Femur ☐ Tibia/Fibula ☐ Ankle ☐ Foot

Date Antibiotic Started: **Time Antibiotic Started:**

If under 50 kg., estimated patient weight:

Complications / Issues (Check all that apply):

☐ **Anaphylaxis / Serious Allergy (Check all that apply):**
☐ Face/Lip Swelling ☐ Wheezing/SOB ☐Hypotension
☐Altered Mental Status/Syncope ☐Widespread Hives ☐ EPINEPHrine given

☐ **Mild Allergy (Check all that apply):**
☐ Rash

☐ **Incomplete Dose of Medication (Check all that apply):**
☐ IV Infiltrated ☐ IV Dislodged

ALS Provider Name: **Certification Number:**

EMS Agency Medical Director QI

Known Drug Allergies Documented (Including when NKDA) check one: ☐ Yes ☐ No

Complications / Issues (Check one) ☐ None ☐ Complication / Issue identified
If Complication identified you must provide a descriptive response

If access to hospital diagnosis, was there an open facture? (Check one)
☐ Yes ☐ No ☐ Hospital Outcome Not Available

Other Comments:

Date QI Completed:

Physician Review (Printed Name)

Physician Signature: