

# ARKANSAS • Emergency Medical Services

# Prehospital Care Report

LICENSE NUMBER	VEHICLE DECAL NUMBER	DATE	RECEIVED	DISPATCH	ENROUTE	ARRIVE SCENE	DEPART SCENE	ARRIVE DEST.	RETURN SERVICE	COUNTY	COMMUNITY CODE
		MO DAY YR	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0		0 0 0 0 0 0
		0 0 98	1 1 1 1	1 1 1 1	1 1 1 1	1 1 1 1	1 1 1 1	1 1 1 1	1 1 1 1		1 1 1 1 1 1
		0 0 99	2 2 2 2	2 2 2 2	2 2 2 2	2 2 2 2	2 2 2 2	2 2 2 2	2 2 2 2		2 2 2 2 2 2
		0 0 99	3 3 3 3	3 3 3 3	3 3 3 3	3 3 3 3	3 3 3 3	3 3 3 3	3 3 3 3		3 3 3 3 3 3
		0 0 00	4 4 4 4	4 4 4 4	4 4 4 4	4 4 4 4	4 4 4 4	4 4 4 4	4 4 4 4		4 4 4 4 4 4
		0 0 01	5 5 5 5	5 5 5 5	5 5 5 5	5 5 5 5	5 5 5 5	5 5 5 5	5 5 5 5		5 5 5 5 5 5
		0 0 01	6 6 6 6	6 6 6 6	6 6 6 6	6 6 6 6	6 6 6 6	6 6 6 6	6 6 6 6		6 6 6 6 6 6
		0 0 01	7 7 7 7	7 7 7 7	7 7 7 7	7 7 7 7	7 7 7 7	7 7 7 7	7 7 7 7		7 7 7 7 7 7
		0 0 02	8 8 8 8	8 8 8 8	8 8 8 8	8 8 8 8	8 8 8 8	8 8 8 8	8 8 8 8		8 8 8 8 8 8
		0 0 02	9 9 9 9	9 9 9 9	9 9 9 9	9 9 9 9	9 9 9 9	9 9 9 9	9 9 9 9		9 9 9 9 9 9

CALLER BY	RESP/TRANSP	INCIDENT LOCATION	INCIDENT TYPE	ASSISTANCE	RESCUE/EXTRICATION
<input type="checkbox"/> Pt/Family <input type="checkbox"/> Bystander <input type="checkbox"/> Fire <input type="checkbox"/> Police <input type="checkbox"/> Ext. Care Fac. <input type="checkbox"/> Acute Care Fac. <input type="checkbox"/> 911 Used? <input checked="" type="checkbox"/>	<b>TO SCENE:</b> <input type="checkbox"/> Emergency <input type="checkbox"/> Non-Emerg. <input type="checkbox"/> Delayed <b>FROM SCENE:</b> <input type="checkbox"/> Emergency <input type="checkbox"/> Non-Emerg. <input type="checkbox"/> Delayed	<input type="checkbox"/> Pt Residence <input type="checkbox"/> Residence <input type="checkbox"/> Highway 55+ <input type="checkbox"/> Oth. Traffic Way <input type="checkbox"/> Office/Business <input type="checkbox"/> Bar/Restaurant <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Farm/Ranch <input type="checkbox"/> Indust./Manuf. <input type="checkbox"/> Construction <input type="checkbox"/> Jail <input type="checkbox"/> Religious Facil. <input type="checkbox"/> Education Facil. <input type="checkbox"/> Leisure Facility <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Water <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic/Dr's Ofc. <input type="checkbox"/> Ext. Care Fac. <input type="checkbox"/> Other <input type="checkbox"/> Rural Setting <input type="checkbox"/> Urban Setting <input type="checkbox"/> Work Related? <input checked="" type="checkbox"/>	<input type="checkbox"/> MVC <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian <input type="checkbox"/> Assault <input type="checkbox"/> Sex Assault <input type="checkbox"/> ATV <input type="checkbox"/> Bicycle <input type="checkbox"/> Bite/Sting <input type="checkbox"/> Drown/Near <input type="checkbox"/> Electrical <input type="checkbox"/> Fall <input type="checkbox"/> Fire/Burn <input type="checkbox"/> Shooting <input type="checkbox"/> Stabbing <input type="checkbox"/> Toxic Expos. <input type="checkbox"/> Oth. Trauma <input type="checkbox"/> Medical/Illness <input type="checkbox"/> Inter-Facility <input type="checkbox"/> Standby <input type="checkbox"/> Other <input type="checkbox"/> Scheduled? <input checked="" type="checkbox"/>	<input type="checkbox"/> None <input type="checkbox"/> Extric./Moved <input type="checkbox"/> CPR <input type="checkbox"/> Wound Mgt. <input type="checkbox"/> Airway <input type="checkbox"/> Defib.	<input type="checkbox"/> RS/10Sprd <input type="checkbox"/> Cme-a-Ing <input type="checkbox"/> Hyd. Sprd <input type="checkbox"/> Air Chisel <input type="checkbox"/> Air Bags <input type="checkbox"/> Jaws <input type="checkbox"/> Other

MED. HISTORY	SUSPECTED MEDICAL ILLNESS	INJURY SITE/TYPE	INJURY CRITERIA	PT PROTECTION	POSSIBLE CONTRIBUTING FACTORS
<input type="checkbox"/> Pt States None <input type="checkbox"/> Unknown <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Behavioral <input type="checkbox"/> Cancer <input type="checkbox"/> Cardiac <input type="checkbox"/> COPD <input type="checkbox"/> CVA <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug/ETOH <input type="checkbox"/> Hypertension <input type="checkbox"/> Seizure <input type="checkbox"/> Other	<b>P = Primary S = Secondary</b> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Airway Obstruct. <input type="checkbox"/> Allergic React. <input type="checkbox"/> Behavioral <input type="checkbox"/> Breathing Diff. <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Cardiac Sym. <input type="checkbox"/> Chest Pain <input type="checkbox"/> CVA <input type="checkbox"/> Dehydration <input type="checkbox"/> Dizziness <input type="checkbox"/> Gynecological <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypo/Hyperglyc. <input type="checkbox"/> Hypo/Hypertherm. <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Obstetrical <input type="checkbox"/> Overdose <input type="checkbox"/> Paralysis <input type="checkbox"/> Poison <input type="checkbox"/> Resp. Arrest <input type="checkbox"/> Seizure <input type="checkbox"/> Shock <input type="checkbox"/> Unconscious <input type="checkbox"/> Weakness <input type="checkbox"/> Other	<input type="checkbox"/> None <input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Eye <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Back <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelv/Genit. <input type="checkbox"/> Upper Ext. <input type="checkbox"/> Lower Ext.	<input type="checkbox"/> Flail Chest <input type="checkbox"/> Burns >20%/Face <input type="checkbox"/> Fall >20' <input type="checkbox"/> Paralysis <input type="checkbox"/> Speed 40+ MPH <input type="checkbox"/> Deformity 20+ <input type="checkbox"/> Intrusion 12+ <input type="checkbox"/> Rollover <input type="checkbox"/> Ejection <input type="checkbox"/> Death Same MV <input type="checkbox"/> Motorcycl 20+ MPH <input type="checkbox"/> Ped. v MV >5 MPH	<input type="checkbox"/> Shoulder/Lap Belt <input type="checkbox"/> Shoulder Belt <input type="checkbox"/> Lap Belt <input type="checkbox"/> Airbag (Deployed) <input type="checkbox"/> Safety Seat <input type="checkbox"/> Helmet <input type="checkbox"/> Per. Flotation Device <input type="checkbox"/> None Used <input type="checkbox"/> Not Available <input type="checkbox"/> Unknown <b>PT LOCATION</b> <input type="checkbox"/> Driver <input type="checkbox"/> Truck Bed <input type="checkbox"/> Front <input type="checkbox"/> Rear <input type="checkbox"/> Other	<input type="checkbox"/> Alcohol <input type="checkbox"/> Substance(s) <input type="checkbox"/> Delay in Detection <input type="checkbox"/> Delay in EMS Access <input type="checkbox"/> Extrication >15 min. <input type="checkbox"/> Equipment <input type="checkbox"/> HAZMAT <input type="checkbox"/> Patient Abused <input type="checkbox"/> Self-Infliction <input type="checkbox"/> Sports <input type="checkbox"/> Terrain <input type="checkbox"/> Weather

GENDER	ETHNIC ORIGIN	INITIAL VITAL SIGNS	BLS TREATMENT	ALS TREATMENT	MEDICATIONS
<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hisp. <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<b>SYSTOLIC</b> 0 0 0 <b>DIASTOLIC</b> 0 0 0 <b>PULSE</b> 0 0 0 <b>RESP.</b> 0 0 0	Assessment Airway Clear Abdom. Thrust Back Blows Bleed. Control CPR Defib.-Auto Extrication MAST OB Delivery Oxygen Pulse Oximeter Restraints Splint Extremit. Suction Ventilation Other BLS	Blood Draw Cardiac Mon. Cardiac Pacing Cardioversion Defibril.-Manual Cricothyrotomy EOA/EGTA Glucometer Intubation-Nasal Intubation-Oral IV-Ext. Jugular IV-Intraosseous IV-Peripheral Medicat. Admin. Needle Thorac. Other ALS	Adenosine Albuterol Atropine Bicarb Bretylium Calcium Dextrose 50% Diazepam Diphenhydr. Dobutamine Dopamine Epi (1:1000) Epi (1:10000) Heparin Isoproterenol Lidocaine Mag. Sulfate Meperidine Metaproterenol Morphine Nitroglycerin Nitrous Oxide Oxytocin Procainamide Terbutaline Verapamil Other

RESPONSE OUTCOME	TRANSPORT TO	PATIENT DESTINATION	RESEARCH CODE	ATTEMPTS	IV TYPE/RATE
<input type="checkbox"/> Care Transfer <input type="checkbox"/> Treat, No Trans. <input type="checkbox"/> Cancelled <input type="checkbox"/> Refused <input type="checkbox"/> False Call <input type="checkbox"/> P.O.V. <input type="checkbox"/> No Pt Found <input type="checkbox"/> Standby <input type="checkbox"/> D.O.A.	<input type="checkbox"/> Emergency Dept. <input type="checkbox"/> Trauma Center <input type="checkbox"/> Dir. Admit Hosp. <input type="checkbox"/> Ext. Care Fac. <input type="checkbox"/> Dr's Office/Clinic <input type="checkbox"/> Home <input type="checkbox"/> Other	0 0 0 0 1 1 1 1 2 2 2 2 3 3 3 3 4 4 4 4 5 5 5 5 6 6 6 6 7 7 7 7 8 8 8 8 9 9 9 9	0 0 0 0 1 1 1 1 2 2 2 2 3 3 3 3 4 4 4 4 5 5 5 5 6 6 6 6 7 7 7 7 8 8 8 8 9 9 9 9	B B P P PN PN MP MP RP RP	Defib. 1 2 3+ U Intub. 1 2 3+ U Intraoss. 1 2 3+ U IV 1 2 3+ U D5W <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> NS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LR <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Oth. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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PLEASE DO NOT MARK IN THIS AREA







