COMMONWEALTH OF VIRGINIA

PRE-HOSPITAL PATIENT CARE REPORT

HEALTH DEPARTMENT FORM # Q 0189209

Incident # ☐☐☐☐☐☐☐☐ Incident in CITY ☐ COUNTY ☐ of: _____ FIPS 5 1 ☐☐☐ M M D D Y Y Y Y DATE

Agency _____ Agency # ☐☐☐☐☐ Unit # ☐☐☐☐☐ Agency Use # ☐☐☐☐☐☐☐☐

Incident Location _____

LOCATION TYPE				TYPE OF SERVICE		INCIDENT DISPOSITION			
1	Home/Residence	7	Public Building	1	Scene	1	Treated, Transported EMS	6	Patient Refused Care
2	Farm	8	Residential Institution	2	Unsched Interfacility Transfer	2	Treated, Transferred Care	7	Dead at Scene
3	Mine/Quarry	9	Educational Institution	3	Sched Interfacility Transfer	3	Treated, Transported Private Vehicle	8	Cancelled
4	Industrial Place/ Premises	10	Other Specified Location	4	Standby			9	No Patient Found
		11	Unspecified Location	5	Rendezvous	4	Treated and Released	NA	Not Applicable
5	Recreation Place	NA	Not Applicable	NA	Not Applicable	5	No Treatment Required	U	Unknown
6	Street/Highway	U	Unknown	U	Unknown				

TIMES (24 Hour Format)

H	H	M	M	TIME OF CALL
H	H	M	M	DISPATCHED
H	H	M	M	RESPONDING
H	H	M	M	ARRIVE SCENE
H	H	M	M	ARRIVE PATIENT
H	H	M	M	LEAVE SCENE
H	H	M	M	ARRIVE DESTINATION
H	H	M	M	LEAVE DESTINATION
H	H	M	M	RETURN SERVICE

AIC Print _____ ID # _____ FR EMT ST EN CT I P RN MD OTH NA Signature _____

Att 1 Print _____ ID # _____ FR EMT ST EN CT I P RN MD OTH NA Signature _____

Att 2 Print _____ ID # _____ FR EMT ST EN CT I P RN MD OTH NA Signature _____

Operator Print _____ ID # _____ FR EMT ST EN CT I P RN MD OTH NA Signature _____

Operator Print _____ ID # _____ FR EMT ST EN CT I P RN MD OTH NA Signature _____

Other Agency Units Responding

Unit # ☐☐☐☐☐☐☐☐

Unit # ☐☐☐☐☐☐☐☐

Unit # ☐☐☐☐☐☐☐☐

Unit # ☐☐☐☐☐☐☐☐

Patient's Name _____ SSN ☐☐☐☐☐☐☐☐☐

Address _____

City _____ State ____ Zip ☐☐☐☐☐ - ☐☐☐☐

Spouse _____ Parent/Guardian _____

Patient's Phone Number _____

Allergies _____

Med _____

Patient's FIPS 5 1 ☐☐☐

AGE ☐☐☐ ☐Year ☐Mon ☐Day ☐Unk

DOB M M D D Y Y Y Y

WT ☐☐☐ ☐LB ☐KG

Race Code ☐

Gender Code ☐

Patient's Physician _____

Other Personnel _____

Fire _____

Law Officer _____

REASON FOR DISPATCH

PATIENT'S CHIEF COMPLAINT

TYPE OF CALL				PRE-EXISTING CONDITION					
1	Accident/Industrial/Construction	7	Mutual Aid	1	Asthma	7	Chronic Renal Failure	0	Other:
2	Accident/MVC	8	Public Service	2	Diabetes	8	Cancer		
3	Assault	9	Standby	3	Tuberculosis	9	Hypertension		
4	Fire	10	Transport/Routine	4	Emphysema	10	Psychiatric Problems		
5	Injury Not Listed	0	Other:	5	Chronic Resp Failure	11	Seizure Disorder	NA	Not Applicable
6	Medical Emergency			6	Heart Disease	12	Tracheostomy	U	Unknown

HISTORY OF PRESENT ILLNESS/PHYSICAL EXAM/OTHER INFORMATION: _____

1 min APGAR: _____ 5 min APGAR: _____ BURN %: _____

Time	LOC	Pulse	Respirations	BP	Perfusion	Pupils	EKG	Defib Joules	Pulse Ox	Glucose	GCS Score
	☐ Alert ☐ Voice ☐ Pain ☐ Unresp	Rate: ☐Not Obtained ☐Unable To	Rate: ☐Not Obtained ☐Unable To ☐ Normal ☐ Increased, not labored ☐ Increased/labored OR Decreased/fatigued ☐ Absent	/ ☐ Palpated ☐ Not Obtained ☐ Unable To	☐ Normal ☐ Decreased ☐ Not Obtained	☐ PERL ☐ R > L ☐ L > R ☐ DIL ☐ CON ☐ UNREACT					EYE: VERBAL: MOTOR: TOTAL:
	☐ Alert ☐ Voice ☐ Pain ☐ Unresp	Rate: ☐Not Obtained ☐Unable To	Rate: ☐Not Obtained ☐Unable To ☐ Normal ☐ Increased, not labored ☐ Increased/labored OR Decreased/fatigued ☐ Absent	/ ☐ Palpated ☐ Not Obtained ☐ Unable To	☐ Normal ☐ Decreased ☐ Not Obtained	☐ PERL ☐ R > L ☐ L > R ☐ DIL ☐ CON ☐ UNREACT					EYE: VERBAL: MOTOR: TOTAL:
	☐ Alert ☐ Voice ☐ Pain ☐ Unresp	Rate: ☐Not Obtained ☐Unable To	Rate: ☐Not Obtained ☐Unable To ☐ Normal ☐ Increased, not labored ☐ Increased/labored OR Decreased/fatigued ☐ Absent	/ ☐ Palpated ☐ Not Obtained ☐ Unable To	☐ Normal ☐ Decreased ☐ Not Obtained	☐ PERL ☐ R > L ☐ L > R ☐ DIL ☐ CON ☐ UNREACT					EYE: VERBAL: MOTOR: TOTAL:
	☐ Alert ☐ Voice ☐ Pain ☐ Unresp	Rate: ☐Not Obtained ☐Unable To	Rate: ☐Not Obtained ☐Unable To ☐ Normal ☐ Increased, not labored ☐ Increased/labored OR Decreased/fatigued ☐ Absent	/ ☐ Palpated ☐ Not Obtained ☐ Unable To	☐ Normal ☐ Decreased ☐ Not Obtained	☐ PERL ☐ R > L ☐ L > R ☐ DIL ☐ CON ☐ UNREACT					EYE: VERBAL: MOTOR: TOTAL:

AGENCY USE _____

MECHANISM OF INJURY	
1	Aircraft Related Accident
2	Assault
3	Bicycle Accident
4	Bites
5	Burns/Thermal/Chemical
6	Chemical Poisoning
7	Drowning
8	Drug Poisoning
9	Electrocution (non-lightning)
10	Excessive Cold
11	Excessive Heat
12	Falls
13	Firearm Injury
14	Lightning
15	Machinery Accidents
16	Mechanical Suffocation
17	MVC-Non-Public Road/Off Road
18	MVC-Public Road
19	Pedestrian Traffic Accident
20	Radiation Exposure
21	Smoke Inhalation
22	Sports Injury
23	Stabbing
24	Venomous Stings (plants, animals)
25	Water Transport Accident
O	Other: _____
NA	Not Applicable
U	Unknown

SIGNS AND SYMPTOMS	
1	Abdominal Pain
2	Back Pain
3	Bloody Stools
4	Breathing Difficulty
5	Cardioresp Arrest
6	Chest Pain
7	Choking
8	Diarrhea
9	Dizziness
10	Ear Pain
11	Eye Pain
12	Fever/Hyperthermia
13	Headache
14	Hypertension
15	Hypothermia
16	Nausea
17	Paralysis
18	Palpitations
19	Preg./Childbirth/Miscarriage
20	Seizures/Convulsions
21	Syncope
22	Unresponsive/Unconscious
23	Vaginal Bleeding
24	Vomiting
25	Weakness (malaise)
O	Other:

CLINICAL ASSESSMENT	
1	Abdominal Pain/Problems
2	Airway Obstruction
3	Allergic Reaction
4	Altered Level of Consciousness
5	Behavioral/Psychiatric Disorder
6	Cardiac Arrest
7	Cardiac Rhythm Disturbance
8	Chest Pain/Discomfort
9	Diabetic
10	Electrocution
11	Hyperthermia
12	Hypothermia
13	Hypovolemia/Shock
14	Inhalation Injury (Toxic Gas)
15	Obvious Death
16	Poisoning/Drug Ingestion
17	Pregnancy/OB Delivery
18	Respiratory Arrest
19	Respiratory Distress
20	Seizure
21	Smoke Inhalation
22	Stings/Venomous Bites
23	Stroke/CVA
24	Syncope/Fainting
25	Traumatic Injury
26	Vaginal Hemorrhage
27	General Illness
O	Other: _____
U	Unknown

INJURY DESCRIPTION	Stab/Bruise	Burn Injury	Laceration	Deformity	Punc/Stab	Gunshot	Amputation	Crush	Burn
Face									
Head									
Neck									
Spine									
Thorax									
Hand, Arm									
Abdomen									
Foot, Leg									
Body region unspecified									
N/A ☐									

TIME CARDIAC ARREST WITNESSED	TIME 1ST CPR	PROVIDER OF 1ST CPR	TIME 1ST DEFIB
H H M M	H H M M	1 Bystander 2 Responder NA N/Appl U Unknown	H H M M

PROVIDER OF 1ST DEFIB	DEFIB DEVICE	TIME CPR DISC	TIME CIRCULATION RETURNED
1 Bystander 2 Responder NA N/Appl U Unknown	1 AED 2 Manual NA N/Appl U Unk	H H M M	H H M M

	PROCEDURES	ID Number
1	Assisted Ventilation (BVM)	
2	Positive Pressure Ventilation LPM:	
7	Nasal Airway LPM:	
9	Oral Airway LPM:	
10	Nasal Cannula LPM:	
11	Oxygen Mask LPM:	
12	Backboard	
13	Bleeding Controlled	
14	Burn Care	
15	CPR	
16	ECG Monitoring	
17	Defibrillation/Cardioversion (AED)	
18	Immobilization - Extremity	
19	Immobilization - Spine	
20	Immobilization - Traction Splint	
21	Intravenous Catheter	
22	Intraosseous Catheter	
23	Intravenous Fluids	
24	MAST/PSAG	
25	Medication Administration	
26	OB Care/Delivery	
27	Pacing	
O	Other	
NA	Not Applicable	

	PROCEDURES - AIRWAY	Size	Loc.	Attempts	#Suc	Time	ID Number
3	Chest Decompression						
4	Cricothyrotomy						
5	EGTA/EOA/PLT/CBT						
6	ET						
8	NG Tube						

IV ACCESS

	Location	Gauge	Attpts	Suc	Time	Fluid/Type	Vol./Rate	ID Number
1								
2								
3								
4								
5								

	MEDICATION	Dose/Route	Time	ID Number	Dose/Route	Time	ID Number
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

TREATMENT AUTHORIZATION	
1	Standing Orders
2	On-line
3	On-scene
4	Transfer Orders
5	DNR
NA	Not Applicable
U	Unknown

PHYSICIAN'S NOTES/ORDERS/SIGNATURE:

PHYSICIAN DEA#:

NARCOTICS ACCOUNTED FOR: SIGNATURE

IV BOX: OLD# NEW#
OLD# NEW#
DRUG BOX: OLD# NEW#

END Mileage
START Mileage
TOTAL Mileage

MV IMPACT	
1	Head-on
2	Lateral
3	Ejection
4	Rear
5	Rollover
6	Rotation
NA	Not Appl
U	Unknown

SAFETY EQUIPMENT			
1	None Used	7	Helmet
2	Shoulder Only	8	Eye Protection
3	Lap Only	9	Protective Clothing
4	Shoulder/Lap	10	Pers. Float. Device
5	Safety Seat	NA	Not Applicable
6	Air Bag	U	Unknown

LEVEL OF CARE PROVIDED	
1	BLS
2	ALS
N/A	Not Applicable

DESTINATION TRANSFERRED	
1	Home
2	Police/Jail
3	Medical Office/Clinic
4	Other EMS Responder (Ground)
5	Other EMS Responder (Air)
6	Hospital
7	Morgue
N/A	Not Applicable

DESTINATION DETERMINATION	
1	Closest Facility
2	Patient/Family Choice
3	Patient/Physician Choice
4	Managed Care
5	Law Enforcement Choice
6	Protocol
7	Specialty Resource Center
8	On-line Medical Direction
9	Diversion
O	Other: _____
NA	Not Applicable

Receiving Facility:
#

EMS Informed Consent to Refuse

I, the undersigned, refuse all further treatment and/or transport for _____ from the named EMS Agency and assumes full responsibility for his/her/my treatment against the advice of the emergency medical provider. By signing this form I am confirming the following items:

- I am of legal age (or the legal parent/guardian of above patient) to decline these services; and,
- I make this decision being of sound mind and not under the impairment of any alcohol or substances (legal or illegal); and,
- Been informed of the potential need for further medical evaluation;

  Recommended evaluation/treatment/services being refused:

  ☐ further medical diagnostic tests (i.e. x-ray, laboratory tests, etc.);

  ☐ further injury/illness care or management;

  ☐ further medical evaluation by a health care professional;

  ☐ other: _____;

  and,
- Been informed of the potential risks associated with the refusal of services;

  Potential risks associated may include, but not limited to:

  ☐ undiagnosed injury or illness;

  ☐ improper healing of injury;

  ☐ worsening of injury or illness with or without changing signs or symptoms;

  ☐ subsequent changes in condition including unconsciousness (coma), shock or death;

  ☐ other: _____;

  and,
- Understand this refusal in no way reduces my ability to recall EMS services in the future.

☐ Check here if refusal information was translated to a language other than English for patient understanding.

Interpreted by: _____

Additional Notes: _____

Printed Name: _____ Relationship: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Release of information and financial responsibility statement: I authorize the above named Ambulance Service to release any information pertinent to my case to any insurance company, adjuster, attorney, governmental agency, or third party involved in the case. Also I authorize any holder of medical information or documentation needed to determine benefits or benefits payable for related services or any service provided to me now or in the future to be released to the above named Ambulance Service. I authorize that payment be made directly to the above named Ambulance Service for any services that are reimbursable by my insurance(s). I understand that I am responsible for and will pay all fees for services as rendered. I further understand that such payment will not be delayed while awaiting any settlement, judgement, or insurance payment. If collection procedures are required, I agree to pay the cost of collections, including attorney fees and court costs.

Patient Signature _____ Date _____ Witness _____ Date _____

NOTICE TO MEDICARE BENEFICIARIES: Current Medicare Rules & Regulations require us to notify you when services provided, or to be provided, may not be covered by Medicare. Medicare pays for services it determines to be Reasonable and Necessary under Section 1882 (a) (1) of the Social Security Act. If Medicare determines that a particular service, although it would otherwise be covered, is not Reasonable and Necessary under the Medicare program standards, Medicare will deny payment for that service.

At the present time, and with the information we have been able to obtain thus far, we believe that for the services you have requested, or are about to be provided to you, or that were provided to you on _____ by the above named Ambulance Service, Inc., Medicare is likely to deny payment. Therefore, we are required to give notice advising you that in the event Medicare denies payment you will be responsible for payment in full.

Please read the statement below and sign:

I have been notified by the above named Ambulance service that they believe that in this case, Medicare is likely to deny payment for the items/services identified above, for the reason stated. If Medicare denies payment, I understand that I will be personally responsible for the account balance.

Patient Signature _____ Date _____

Inventory of patient belongings transported with patient:

Signature of person receiving patient belongings

• Attach EKG Strips •

CINCINNATI STROKE SCALE (FAST)	
F-(face)	FACIAL DROOP: Have patient smile or show teeth. (Look for asymmetry.) Normal: Both sides of the face move equally or not at all. Abnormal: One side of the patient's face droops.
A-(arm)	MOTOR WEAKNESS: Arm drift (close eyes, extend arms, palms up). Normal: Remain extended equally, or drifts equally or does not move at all. Abnormal: One arm drifts down when compared with the other.
S-(speech)	"You can't teach an old dog new tricks" (repeat phrase.) Normal: Phrase is repeated clearly and correctly. Abnormal: Words are slurred (dysarthria) or abnormal (asphasia) or none.
T-	**Time of SYMPTOM ONSET:** _____

Virginia Board of Pharmacy Regulations:

18VAC110-20-500 *. Licensed emergency medical services agencies program.

The pharmacy may prepare a drug kit for a licensed emergency medical services agency provided:

1. The pharmacist-in-charge of the hospital pharmacy shall be responsible for all controlled drugs contained in this drug kit.

2. The drug kit is sealed in such a manner that it will preclude any possibility of loss of drugs.

3. Drugs may be administered by a technician upon an oral order or written standing order of an authorized medical practitioner in accordance with §54.1-3408 of the Code of Virginia. Oral orders shall be reduced to writing by the technician and shall be signed by a medical practitioner. Written standing orders shall be signed by the operational medical director for the emergency medical services agency. The technician shall make a record of all drugs administered to a patient. This administration record shall be signed by the medical practitioner who assumes responsibility for the patient at the hospital. If the patient is not transported to the hospital or if the attending medical practitioner at the hospital refuses to sign the record, a copy of this record shall be signed and placed in delivery to the hospital pharmacy who was responsible for that kit exchange by the agency's operational medical director within seven days of the administration.

4. When the drug kit has been opened, the kit shall be returned to the pharmacy and exchanged for an unopened kit. The record of the drugs administered shall accompany the opened kit when exchanged. An accurate record shall be maintained by the pharmacy on the exchange of the drug kit for a period of one year.

5. The record of the drugs administered shall be maintained as a part of the pharmacy records pursuant to state and federal regulations for a period of not less than two years.

Virginia Administrative Code