

Patient Care Report

Section 1: Pre-care information

Incident date:

Incident number:

Incident address:

Incident city:

Incident state:

Area/zip code:

Incidence location type:

Section 2: Emergency services

Emergency medical dispatch performed:

- ☐ No
- ☐ Yes, pre-arrival by bystanders
- ☐ Yes, on-arrival by emergency services

If yes, elaborate on medical dispatch details performed:

Chief complaint (reported by dispatch):

Dispatch or vehicle number:

Emergency service officer name:

Signature:

Date:

Section 3: Patient information

Name (last name, first name, MI):

Date of birth:

Age:

Gender:

SSN:

Race:

Ethnicity:

Patient address:

- ☐ Same as incident (skip Section 3a)
- ☐ Other (complete Section 3a)

| | |
|---|--------------------------------------|
| Section 3a: Patient address | |
| Street address: | City: |
| State: | Area/zip code: |
| Section 4: Patient health status | |
| Previous medical history: | Previous medications: |
| | |
| Current medications: | Allergies (if known): |
| | |
| Patient chief complaint: | Additional notes/information: |
| | |
| Section 5: Vital signs | |
| Level of consciousness (LOC) | Speech |
| Alert: | Coherent: |
| | |
| Voice: | Incoherent: |
| | |
| Pain: | Slurred: |
| | |
| Unresponsive: | Silent: |
| | |

| | |
|---|--------------------------------------|
| Skin | Color |
| Normal: | Normal: |
| | |
| Damp: | Cyanotic: |
| | |
| Hot: | Flushed: |
| | |
| Cold: | Pale: |
| | |
| Respiration | Pulse (bpm) |
| Normal | Normal |
| Rales | Rapid |
| Distressed | Slow |
| Absent | Absent |
| Blood pressure | Additional notes/checks: |
| Normal | |
| High | |
| Low | |
| Section 6: Physical examination | |
| Injury present: <ul style="list-style-type: none">Yes (go to section 6a.)No (skip to section 6b.) | |
| Section 6a: Injury | |
| Cause of injury: | Injury Type: |
| | <input type="checkbox"/> Burn |
| | <input type="checkbox"/> Blunt |
| | <input type="checkbox"/> Penetration |
| | <input type="checkbox"/> Other: |
| | <input type="checkbox"/> Unknown |

Section 6b: Substance use

Indicators:

- ☐ None
- ☐ Smell of alcohol on breath
- ☐ Slurring or intoxicated behaviors
- ☐ Alcohol or drugs found on scene or on patient
- ☐ Patient admits to alcohol use
- ☐ Patient admits to drug use

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 - ☐ Patient admits to drug use

Additional notes (i.e., substance details):

Section 7: Preliminary diagnosis

Preliminary diagnosis:

Additional notes and procedures:

Practitioner name:

Date:

Practitioner signature:

Section 8: Patient diagnosis

Diagnostic procedures:

Resources and tools used:

| | |
|--|---|
| Results: | Diagnosis: |
| | |
| Medical condition(s): | |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Head trauma |
| <input type="checkbox"/> A.M.S | <input type="checkbox"/> Hyperthermia |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Hypothermia |
| <input type="checkbox"/> Altered L.O.C | <input type="checkbox"/> MVC |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Burns | <input type="checkbox"/> Full arrest |
| <input type="checkbox"/> Cardiac arrest | <input type="checkbox"/> Poisoning/overdose |
| <input type="checkbox"/> Cardiac chest pain | <input type="checkbox"/> Respiratory complaints |
| <input type="checkbox"/> Childbirth | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Shock |
| <input type="checkbox"/> Coma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> CVA | <input type="checkbox"/> Other(s): |
| Additional notes: | |
| | |
| Practitioner name: | Date: |
| Practitioner signature: | |
| Section 9: Patient consultation | |
| <ul style="list-style-type: none">• Patient grants treatment (go to section 9a)• Patient refuses treatment (go to section 9b) | |

Section 9a:

This is to verify the patient accepts treatment and is aware of the risks of doing so.

Patient name:

Date:

Patient signature:

Witness name:

Date:

Witness signature:

Section 9b:

This is to verify the patient refuses treatment and is aware of the risks of doing so.

Patient name:

Date:

Patient signature:

Witness name:

Date:

Witness signature:

Section 10: Treatment and interventions

Treatment type(s):

Treatment detail(s):

Medication(s):

Treatment administrator:

Signature:

Date:

Patient response(s) to treatment:

| | |
|--------------------------------|--------------|
| Additional notes: | |
| | |
| Practitioner name: | Date: |
| Practitioner signature: | |
| Section 11: Summary | |
| Patient care summary: | |
| | |
| Medications: | |
| | |
| Recommendations: | |
| | |
| Follow-up: | |
| Additional notes: | |
| | |
| Practitioner name: | Date: |
| Practitioner signature: | |