First Responder

Patient Care Report

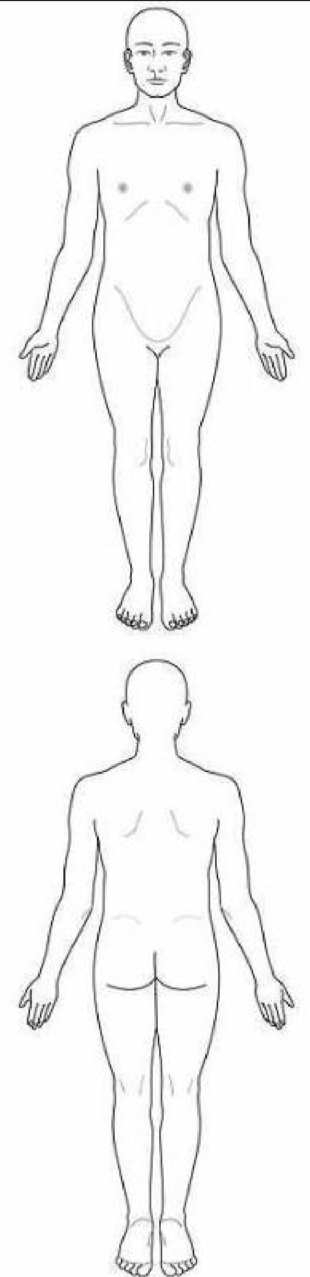
INCIDENT#:	SERVICE NAME:		DATE:	
AMBULANCE/ VEHICLE #:	LOCATION OF EVENT:	ASSISTANT NAMES: ☐ LAW ENFORCEMENT ☐ FIRE ☐ MEDEVAC ☐ CHA/CHAP ☐ OTHER__________	TIME DISPATCHED	
			TIME ENROUTE	
☐ TRANSPORT ☐ TREATMENT GIVEN, NO TRANSPORT ☐ REFUSAL (ATTACH FORM) ☐ MEDEVAC ASSIST	NATURE OF CALL:		TIME ARRIVE SCENE	
			TIME LEFT SCENE	
	PATIENT CHIEF COMPLAINT:		TIME ARRIVE DESTINATION	
			TIME LEFT DESTINATION	
			TIME BACK IN SERVICE	

PATIENT NAME (FIRST, MI, LAST, SUFFIX)			PARENT/GUARDIAN NAME:	
❑ MALE ❑ FEMALE	DATE OF BIRTH:	AGE:	PHONE:	ALTERNATE PH:

PATIENT ADDRESS (PHYSICAL & MAILING)	CITY:	STATE:	ZIP:

SUBJECTIVE REPORT

SYMPTOMS - “WHAT YOU ARE TOLD”:



ALLERGIES: ❑ NO KNOWN	MEDICATIONS/OVER THE COUNTER/HERBAL REMEDY/VITAMINS/DRUGS/ALCOHOL: ❑ NO KNOWN

PAST/PERTINENT MEDICAL HISTORY:

LAST ORAL INTAKE/OUTPUT & WHEN:

EVENTS LEADING UP TO:

OTHER NOTES

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VITAL SIGNS										
TIME	BLOOD PRESSURE	PULSE REG/IRREG	RESP RATE (NORMAL/ SHALLOW/ DEEP)	LOC: AWAKE– VOICE– PAIN- UNRESPONSIVE	OXYGEN SATURATION	SKIN COLOR- TEMP- CONDITION	GLASCOW COMA SCALE			
							EYE +	VERBAL +	MOTOR =	TOTAL
	/	R / IR	N / S / D	A V P U			1 2 3 4	1 2 3 4 5	1 2 3 4 5 6	
	/	R / IR	N / S / D	A V P U			1 2 3 4	1 2 3 4 5	1 2 3 4 5 6	
	/	R / IR	N / S / D	A V P U			1 2 3 4	1 2 3 4 5	1 2 3 4 5 6	
	/	R / IR	N / S / D	A V P U			1 2 3 4	1 2 3 4 5	1 2 3 4 5 6	
	/	R / IR	N / S / D	A V P U			1 2 3 4	1 2 3 4 5	1 2 3 4 5 6	

MEDICATION ADMINISTERED:	DOSE:	ROUTE:	TIME:
❑ OXYGEN			

EYE:	VERBAL:	MOTOR:
4 SPONTANEOUS 3 VERBAL 2 PAIN 1NONE	5 ORIENTED 4 DISORIENTED 3 INAPPROPRIATE 2 INCOMPREHENSIBLE 1 NONE	6 OBEYS COMMAND 5 LOCALIZES PAIN 4 WITHDRAWS PAIN 3 FLEXES TO PAIN 2 EXTENDS TO PAIN 1 NONE

OBSERVATIONS & EXAMINATION:

PLAN & TREATMENT:

CPR PERFORMED: ❑ YES ❑ NO	AED USED			PULSE RETURNED	
WITNESSED ARREST: ❑ YES ❑ NO	❑ YES ❑ NO	TIME:	# OF SHOCKS:	❑ YES ❑ NO	TIME:

PROVIDERS

PERSON WHO COMPLETED THE FORM (PRINTED NAME, SIGNATURE, LEVEL):	DRIVER (PRINTED NAME, SIGNATURE, LEVEL):
PROVIDER (PRINTED NAME, SIGNATURE, LEVEL):	PROVIDER (PRINTED NAME, SIGNATURE, LEVEL):
PROVIDER (PRINTED NAME, SIGNATURE, LEVEL):	PROVIDER (PRINTED NAME, SIGNATURE, LEVEL):
DELIVERED TO:	**RECEIVING PHYSICIAN/PROVIDER** (PRINTED NAME, SIGNATURE, LEVEL):