

EMS PATIENT CARE WORKSHEET

This form is for use by ambulance service providers to comply with Chapter DHS 110, Wis. Admin. Code as it applies to documentation of ambulance runs by completing and providing patient care information to the receiving facility when the patient is delivered to the facility. This form is not intended to become part of the patient's medical record.

INSTRUCTIONS: Print legibly. Complete all sections of this worksheet. A copy of this worksheet or the ambulance run report must be completed and left with every patient delivered to a receiving facility.

Service Name: _____ Run Number: _____

Incident Date: _____ Incident Location: _____

En-route Time: _____ On-Scene Time: _____ Leave Scene Time: _____

Patient Name: _____

DOB: _____ Age: _____ Sex: Male Female Weight: _____

Patient Address: _____

Provider Impression: _____ Time of Onset: _____

NOI / MOI: _____ Physician: _____

GCS: Eyes (4-1) = _____ Verbal (5-1) = _____ Motor (6-1) = _____ Total (15-3) = _____

LOC: Alert Verbal Pain Unresponsive

Time	BP	Pulse Rate / Quality	Respiratory Rate	Oximetry	Glucometer	EKG Transmitted

Skin: (Check all that apply) Warm Dry Moist Cold Flush Pale

Eyes: (Check all that apply) PERRL Constricted Dilated Non-reactive

O2 Given: Yes No **Rate of Flow:** _____ (Check one) Mask Cannula BVM Other

Breath Sounds: Clear Wet Absent **Stroke Scale:** (Check if present) Facial Arm Speech
Droop Drift Impaired

Allergies: _____ **Last Oral Intake:** _____ **Last Known Well:** _____

Medications: _____

Past Medical Hx:

(Check all that apply) Cardiac CHF Hypertension Seizure Diabetes COPD Asthma

Other: _____

Treatments: _____

Response: _____

CPR: Yes No **Time Started:** _____ **Defib/Shock:** Yes No **Airway:** Yes No

Return of Pulse? Yes No **Rate:** _____ **Respirations?** Yes No **Rate:** _____

Squad Members: _____