

## Assessment Std WNS

<b>DISPATCH</b>	<b>Run #</b>	<b>Date</b>	<b>Dsp. Time</b>	<b>Crew Information</b>									
	<b>Response</b>	<b>Patient Category</b>	<b>Dispatched As</b>	D <input type="checkbox"/> P <input type="checkbox"/> D <input type="checkbox"/> P <input type="checkbox"/>									
	<b>Dispatch Location</b>							<input type="checkbox"/> Residence	<input type="checkbox"/> Street<50	<input type="checkbox"/> Business	<input type="checkbox"/> Asst Living		
<b>PATIENT MEDICAL SURVEY</b>	<b>Patient Name</b>	<b>Date of Birth</b>	<b>Age (Years)</b>	<b>M</b> <input type="checkbox"/>	<b>F</b> <input type="checkbox"/>								
	<b>Patient Address</b>	<b>Phone Number</b>	<b>Social Security</b>										
<b>PATIENT MEDICAL SURVEY</b>	<b>Primary Insurance</b>	<b>Policy #</b>	<b>Group #</b>										
	<b>Past Medical History</b>												
<b>PATIENT MEDICAL SURVEY</b>	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> Asthma <input type="checkbox"/> CHF <input type="checkbox"/> ESRD <input type="checkbox"/> None <input type="checkbox"/> Atrial Fib <input type="checkbox"/> COPD <input type="checkbox"/> GI Bleed <input type="checkbox"/> Psychiatric <input type="checkbox"/> CABG <input type="checkbox"/> CVA/TIA <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Seizures/Convulsions <input type="checkbox"/> CAD <input type="checkbox"/> Dementia <input type="checkbox"/> Hypertension <input type="checkbox"/> Substance Abuse												
	<b>Allergies</b>	<b>Current Medications</b>											
<b>PATIENT MEDICAL SURVEY</b>	<input type="checkbox"/> NKDA <input type="checkbox"/> PCN <input type="checkbox"/> Sulfa <input type="checkbox"/> Latex <input type="checkbox"/> IVP Dye	<b>Common</b>	<b>Name</b>	<b>Dose</b>	<b>Name</b>	<b>Dose</b>							
		<input type="checkbox"/> None <input type="checkbox"/> Albuterol <input type="checkbox"/> ASA <input type="checkbox"/> NTG											
<b>PATIENT MEDICAL SURVEY</b>	<b>Chief Complaint</b>	<b>Initial GCS</b>	<b>Neuro</b>		<b>L</b>	<b>Pupils</b>	<b>R</b>						
			A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> <input type="checkbox"/> Chemical Paralysis <input type="checkbox"/> <input type="checkbox"/> Immobilized <input type="checkbox"/>				<b>Size</b>		<b>React</b>				
<b>PATIENT MEDICAL SURVEY</b>	<b>Respiratory Effort</b>	<b>L</b>	<b>Breath Sounds</b>	<b>R</b>	<b>Skin Temp</b>		<b>Skin Temp Taken Via</b>	<b>Cap Refill</b>					
					<input type="checkbox"/> Cool <input type="checkbox"/> Hot <input type="checkbox"/> Warm	°C <input type="checkbox"/> °F <input type="checkbox"/>		<input type="checkbox"/> Delayed <input type="checkbox"/> Brisk <input type="checkbox"/> < 2 seconds <input type="checkbox"/> > 2 seconds					
<b>PATIENT MEDICAL SURVEY</b>	<b>Skin Moisture</b>	<b>Skin Color</b>		<b>JVD</b>	<b>Edema</b>								
	<input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Moist <input type="checkbox"/> Clammy	<input type="checkbox"/> Normal <input type="checkbox"/> Pale-Ashen <input type="checkbox"/> Jaundice <input type="checkbox"/> Cyanotic <input type="checkbox"/> Flushed <input type="checkbox"/> Mottled											
<b>PROCEDURES + VITAL SIGNS</b>	<b>Time</b>	<b>PROC</b>	<b>Action/Meds</b>	<b>Dose/Size</b>	<b>HR</b>	<b>BP</b>	<b>SaO2</b>	<b>EtCO2</b>	<b>Resp</b>	<b>RE</b>	<b>Rhythm</b>	<b>Pain</b>	<b>GCS</b>
						/							
							/						
							/						
							/						
<b>NARRATIVE</b>													
<b>DISPOSITION</b>	<b>Outcome</b>	<b>Destination</b>	<b>Condition Upon Arrival</b>				<b>Mode</b>						
							<input type="checkbox"/> Lights + Sirens <input type="checkbox"/> No Lights + Sirens						
<b>DISPOSITION</b>	<b>Patient Position in Vehicle</b>	<b>Destination Basis</b>	<b>Crew Signature</b>		<b>Crew #1</b> <input type="checkbox"/>								
					<b>Crew #2</b> <input type="checkbox"/>								
<b>Rec'd By</b>					<b>Receiving Signature</b>								