Assessment 2

DISPATCH

Patient Record No.		Crew Information
Arrival Mode		
☐ Ambulatory ☐ Stretcher ☐ Gator ☐ Wheelchair ☐ Ambulance		
Location of Patient at Time of Injury/Illness		

PATIENT MEDICAL SURVEY

Patient Name			DOB	
Patient Address			Age (Years)	M ☐ F ☐
		Phone Number		

Past Medical History ☐ None

☐ Asthma ☐ CABG ☐ Cancer ☐ COPD ☐ Diabetes ☐ GI Bleed ☐ Hypertension ☐ Psychiatric
☐ Atrial Fib ☐ CAD ☐ CHF ☐ CVA/TIA ☐ ESRD ☐ High Cholesterol ☐ Myocardial Infarction ☐ Seizures/Convulsions

Allergies		Current Medications				
		Common	Name	Dose	Name	Dose
☐ NKDA		☐ None				
☐ PCN		☐ Albuterol				
☐ Sulfa		☐ ASA				
☐ Latex		☐ NTG				
☐ IVP Dye						

History of Present Illness	
Medical Category	☐ Trauma ☐ Cardiac ☐ Medical ☐ Abdominal ☐ Headache ☐ Burns ☐ Fall Victim ☐ Stroke ☐ Respiratory ☐ Pediatric ☐ OB/GYN ☐ Minor Injury ☐ Sick Person ☐ Other

Chief Complaint	Initial GCS	Neuro	Pupils L	Pupils R
		A ☐ V ☐ P ☐ U ☐		Size
		Y N		
		☐ Loss of Consciousness ☐		React
		☐ Chemical Paralysis ☐		
		☐ Immobilized ☐		

Respiratory Effort	Breath Sounds L	Breath Sounds R	Skin Temp		Skin Temp Taken Via	Cap Refill
			☐ Cool ☐ Hot	°C ☐		☐ Delayed
			☐ Warm	°F ☐		☐ Brisk

Skin Moisture	Skin Color	JVD	Edema	Cap Refill
☐ Dry ☐ Diaphoretic	☐ Normal ☐ Pale-Ashen ☐ Jaundice			☐ < 2 seconds
☐ Moist ☐ Clammy	☐ Cyanotic ☐ Flushed ☐ Mottled			☐ > 2 seconds

PROCEDURES + VITALS

Time	Proc	Action/Meds	Dose/Size	HR	BP	SaO2	EtCO2	Resp	Res Eft	Rhythm	Pain	GCS
					/							
					/							
					/							

DISPOSITION

Disposition	Destination (Hospital)	Report Given To (Name & Title)	Transporting EMS	Depart Time
☐ Walked After Rx				
☐ Refused				
☐ Transferred to ER	Report Called ☐ Yes ☐ No			

REFUSAL

This is to certify that I, _____, am refusing treatment and/or transportation to the hospital. I acknowledge that I have been informed of the risk(s) involved in such a refusal and hereby release Demo Service from any and all liability resulting from my decision.

Patient Signature		Witness Signature	

Attendant Signature		Date		Time	