

# EMS MEDICAL RUN FORM (ALS PAGE 1)

<b>Response</b>	Priority to Scene <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other	Name: _____ DOB / / Age SSN _____ Est. Weight Kg. Gender M F Ethnicity _____ Pt. Zip Code _____ Primary Physician _____ PH# _____ Medications: _____ Chief Complaint: _____ IPI: _____	Location Dispatch Nature _____ City/Township _____ County _____ Incident State MICHIGAN Allergies _____	Agency _____ Unit # _____ Unit Type <input type="checkbox"/> ALS <input type="checkbox"/> BLS <input type="checkbox"/> LALS <input type="checkbox"/> E-UNIT <input type="checkbox"/> MFR Date _____ Medcom # _____ Incident # _____ TOC _____ Dispatch _____ En Route _____ On Scene _____ Est. Arr. Pt. _____ Depart _____ MC Contact _____ Arr. Hosp. _____ In Service _____	Destination Diverted From: _____ Chosen By <input type="checkbox"/> Patient <input type="checkbox"/> Relative <input type="checkbox"/> Protocol <input type="checkbox"/> MC <input type="checkbox"/> Hospital <input type="checkbox"/> Physician Other _____ Transport Status <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other <input type="checkbox"/> No Transport <input type="checkbox"/> DOA <input type="checkbox"/> DOS Time of Death _____
		Assessment: Position Found _____ Skin _____ Loss of Consciousness Y N Unk. _____ Suspected Substance Use: <input type="checkbox"/> None <input type="checkbox"/> ETOH <input type="checkbox"/> Drugs <input type="checkbox"/> Unknown Cardiac Rhythm _____ Blood Sugar / / Clinical Impression: _____ Pupils _____ Resp _____ Pulse _____ Blood Pressure _____ Priority _____ Time _____ GCS Verbal _____ Motor _____ P Ox _____ Treatment: _____ Pacing Rate _____ mA _____ Capture: Electrical Y N Mechanical Y N Site _____ Size _____ # Attempts _____ Attempt By _____ Est. By _____ Site _____ Size _____ # Attempts _____ Attempt By _____ Est. By _____ Amount of Bolus: cc Total Infused: cc <input type="checkbox"/> I/O Site _____ I/O Secured? Y I/O Secured with _____ Transport: _____	Airway Management O2 Time _____ Liter Flow _____ <input type="checkbox"/> NC <input type="checkbox"/> NRB <input type="checkbox"/> OPA Size _____ <input type="checkbox"/> NPA Size _____ <input type="checkbox"/> BYM <input type="checkbox"/> ETDLA <input type="checkbox"/> Nasal ET Nare R L <input type="checkbox"/> Oral ET Depth _____ ET Time _____ ET Size _____ # of Attempts _____ Attempts by _____ Est. By # _____ Secured with _____ ET Confirmed by Dr. _____	Pt. Turned Over To <input type="checkbox"/> Nurse <input type="checkbox"/> Doctor <input type="checkbox"/> Flight Crew <input type="checkbox"/> Police Other _____ ET Confirmed by: <input type="checkbox"/> Visualization <input type="checkbox"/> Lung Sounds <input type="checkbox"/> ETCO2 Other _____ <input type="checkbox"/> Post Moves	
		IV Info Site _____ Size _____ # Attempts _____ Attempt By _____ Est. By _____ Site _____ Size _____ # Attempts _____ Attempt By _____ Est. By _____ Amount of Bolus: cc Total Infused: cc <input type="checkbox"/> I/O Site _____ I/O Secured? Y I/O Secured with _____ Transport: _____	Trauma Pt. Neuros at Hospital _____ Ambulance Personnel No. / Level _____ 1 _____ 2 _____ 3 _____ 4 _____ Form Completed By _____	Other Agencies/Units Level Present PTA Y N Y N Y N Dr. Signature _____ Printed _____ DEA # _____	
		Medication Time _____ Dose _____ Route _____ Auth _____ Narcotics Witnessed By: _____ IV/Drug Bag # / Narc. Used _____ Narc. Container # Narc. Wasted _____			
		Location Type <input type="checkbox"/> Home <input type="checkbox"/> Acute Care <input type="checkbox"/> Asst. Living <input type="checkbox"/> A.F.C. <input type="checkbox"/> Public Bldg. <input type="checkbox"/> Industrial <input type="checkbox"/> Farm <input type="checkbox"/> Roadway <input type="checkbox"/> School <input type="checkbox"/> Recreation Other _____			
		Safety Equipment (Trauma Only) Airbag Deployed Y N N/A <input type="checkbox"/> Lap Belt <input type="checkbox"/> Shoulder Belt <input type="checkbox"/> Child Seat <input type="checkbox"/> Helmet <input type="checkbox"/> P.F.D. <input type="checkbox"/> Eye Protection <input type="checkbox"/> None <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown Other _____			
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