

EMS MEDICAL RUN FORM (NON-TRANSPORT)

Service Type <input type="checkbox"/> Scene <input type="checkbox"/> Standby <input type="checkbox"/> Other	Dispatch nature Location		Destination hospital		Destination Chosen by		Agency		Unit #						
	City/Twp		County		State: MICHIGAN		<input type="checkbox"/> Patient <input type="checkbox"/> Relative <input type="checkbox"/> Protocol <input type="checkbox"/> MC/Hospital <input type="checkbox"/> Physician <input type="checkbox"/> Unknown		ALS <input type="checkbox"/> LALS <input type="checkbox"/> BLS <input type="checkbox"/> MFR <input type="checkbox"/> E-Unit <input type="checkbox"/>						
	Patient Name		Age		DOB		Gender M F		Race		Weight lbs				
Safety Equip. <input type="checkbox"/> N/A <input type="checkbox"/> Lap Belt <input type="checkbox"/> 3 Point <input type="checkbox"/> Child Seat <input type="checkbox"/> Helmet <input type="checkbox"/> P.F.D. <input type="checkbox"/> Eye Prot <input type="checkbox"/> None <input type="checkbox"/> Other	Pt Address		city		state		zip		Date:		Dispatch				
	Pt phone		Primary Physician		<input type="checkbox"/> ALS <input type="checkbox"/> Flight Crew <input type="checkbox"/> Police <input type="checkbox"/> Other		Medcom #		NFIRS #		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3				
	Suspected Substance		Time		Prt		Blood Pressure		Pulse		Resp		Pupils		
Airbag Dep. <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Driver's <input type="checkbox"/> Passenger <input type="checkbox"/> Side	Loss of Consciousness		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unkn		PMH:		Allergies		GCS		P Ox		Dispatch		
	<input type="checkbox"/> None <input type="checkbox"/> ETOH <input type="checkbox"/> Drugs <input type="checkbox"/> Unkn		Rate		Qual		Rate		Qual		Eye		Verbal		
	Use		Rate		Qual		Rate		Qual		Motor		En Route		
Location in Vehicle (Front) 1 2 3 4 5 6 7 8 9	Alert and Oriented to:		<input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time <input type="checkbox"/> Event		Medications		Complaint/Problem		History of Event		On Scene		Location		
	Assessment: Position found		Skin		PMH:		Allergies		CPR		Est. Arrest Time		Type		
	Treatment		Assessment: Position found		Skin		Complaint/Problem		History of Event		Time CPR Started		<input type="checkbox"/> Home <input type="checkbox"/> Acute Care <input type="checkbox"/> Asst. Lvg <input type="checkbox"/> AFC <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 <input type="checkbox"/> Skilled NF <input type="checkbox"/> Other		
Injury Factors <input type="checkbox"/> Ejected from Vehicle <input type="checkbox"/> MVC w/ Fataals at scene <input type="checkbox"/> Extrication > 20 minutes <input type="checkbox"/> Major Vehicle Damage <input type="checkbox"/> MCA/Bicycle No Helmet <input type="checkbox"/> High rate of impact <input type="checkbox"/> Unrestrained <input type="checkbox"/> Rollover <input type="checkbox"/> Fall > 10 ft <input type="checkbox"/> Other		Clinical Impression:		Personnel		No./Level		Form Completed By		Other Agency Units		Level		Present PTA	
Other:		Personnel		No./Level		Form Completed By		Other Agency Units		Level		Present PTA		Dr. Signature only if indicated	
Other:		Personnel		No./Level		Form Completed By		Other Agency Units		Level		Present PTA		Printed	