

Date:

Location:

|   |                    |                      |         |
|---|--------------------|----------------------|---------|
| Patient Name:   | DOB:               | Male:                | Female: |
|   | Age:               | Weight:              |         |
| Address:  | Emergency Contact: | Primary Rescuer      |         |
|   |                    | Name:                |         |
|   |                    | Address:             |         |
|   |                    | Phone number:        |         |
| Describe the Scene:   |                    | Weather Conditions:  |         |
| Patient Location:   |                    | Ambient Temperature: |         |
| AVPU on Arrival (mental state and/or response to stimuli):                              |                    |                      |         |
| A: Alert and Oriented --> 3 (person/place/time) 2 (person/place) 1 (person) 0 (nothing) |                    |                      |         |
| V: Verbal P: Pain U: Unresponsive   |                    |                      |         |

|              |                                |                       |                     |
|--------------|--------------------------------|-----------------------|---------------------|
| Airway:      | Unobstructed?                  | Partially Obstructed? | Totally Obstructed? |
| Breathing:   | Regular/Irregular?             | Fast/Slow?            | Labored/Shallow?    |
| Circulation: | Pale/Flushed/Jaundice/Grey?    |                       |                     |
| Temperature: | Hot/Cold?                      |                       |                     |
| Condition:   | Dry/Clammy/Excessive Sweating? |                       |                     |

|                                   |
|-----------------------------------|
| HPI (history of present illness): |
| MOI (mechanism(s) of injury):     |

|   |       |
|---|-------|
| Patient Head to Toe Exam  | Time: |
| Onset (when did it begin/how):  |       |
| Prod and Provoke (what makes it worse? Better?):                              |       |
| Quality of pain (what does it feel like, sharp, burning, stabbing, achy):     |       |
| Radiate (where does the pain begin and end, spread, move?):                   |       |
| Severity (on a scale, how intense/dull is the pain?):                         |       |
| Time (has it gotten worse/better since x., has it changed since incident x?): |       |

Date:

Location:

|   |      |          |       |                |      |                   |      |
|---|------|----------|-------|----------------|------|-------------------|------|
| Problem List:                                     |      | Tx Plan: |       |                |      | Time Tx Complete: |      |
|   |      |          |       |                |      |                   |      |
|   |      |          |       |                |      |                   |      |
| Allergies/Epi Pen (Y/N)/<br>Reaction/ Treatment:  | Time | AVPU     | Pulse | RR             | SCTM | BP                | Pain |
|   |      |          |       |                |      |                   |      |
|   |      |          |       |                |      |                   |      |
| Medications with a Dose:                          |      |          |       |                |      |                   |      |
|   |      |          |       |                |      |                   |      |
| Past Medical Hx:                                  |      |          |       |                |      |                   |      |
|   |      |          |       |                |      |                   |      |
| Last In/Out:                                      |      |          |       |                |      |                   |      |
|   |      |          |       |                |      |                   |      |
|   |      |          |       |                |      |                   |      |
| Evacuation Plan (including patient reassessment): |      |          |       | Rescuer Notes: |      |                   |      |
|   |      |          |       |                |      |                   |      |