

INTERIM PATIENT REPORT

Ambulance Co:		Date:	<input type="checkbox"/> M <input type="checkbox"/> F	Age:	Weight:	<input type="checkbox"/> KG <input type="checkbox"/> Lbs.	Time of onset:				
Incident #:		Address:									
Pt. Name:		Address:									
C/C:		Trauma: <input type="checkbox"/> Meets TT Criteria <input type="checkbox"/> Meets "Critical Trauma"									
Event HX:		LOC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		How Long?		Damage: <input type="checkbox"/> Major <input type="checkbox"/> Minor					
		<input type="checkbox"/> MVC <input type="checkbox"/> MCC <input type="checkbox"/> Bicycle		Est. Speed: Extrication Time:		Impact Type:					
				<input type="checkbox"/> Rollover <input type="checkbox"/> Ejected		<input type="checkbox"/> Driver <input type="checkbox"/> Front <input type="checkbox"/> Passenger <input type="checkbox"/> Back					
PMH: <input type="checkbox"/> Cardiac <input type="checkbox"/> Stroke <input type="checkbox"/> HTN <input type="checkbox"/> CA <input type="checkbox"/> Psych <input type="checkbox"/> Diabetes <input type="checkbox"/> COPD <input type="checkbox"/> Other:		Safety Equipment:		<input type="checkbox"/> None <input type="checkbox"/> Seatbelt <input type="checkbox"/> Helmet <input type="checkbox"/> Unknown <input type="checkbox"/> Airbag <input type="checkbox"/> Protect. Gear <input type="checkbox"/> Incorrect Use <input type="checkbox"/> Car Seat <input type="checkbox"/> Other:							
PMD:		Specialist:		Other Trauma:		<input type="checkbox"/> Pedestrian <input type="checkbox"/> Fall ___ Ft. <input type="checkbox"/> GSW <input type="checkbox"/> Caliber: <input type="checkbox"/> Assault <input type="checkbox"/> Stab <input type="checkbox"/> Law at scene <input type="checkbox"/> Self Inflicted					
Meds: <input type="checkbox"/> See List		Medical									
Allergies: <input type="checkbox"/> NKDA		Problem List:									
		Treatment PTA:									
Time	Bp	P	R	T	O₂Sat	Pain	GCS	Pupils	CM - Rhythm	O₂/L	Delivery
						/10			<input type="checkbox"/> w/ectopy		
Time	Bp	P	R	T	O₂Sat	Pain	GCS	Pupils	CM - Rhythm	O₂/L	Delivery
						/10			<input type="checkbox"/> w/ectopy		
Treatment:											
Pt. Response: <input type="checkbox"/> Improved <input type="checkbox"/> Maintained <input type="checkbox"/> Improved <input type="checkbox"/> Deteriorated											
Destination: <input type="checkbox"/> Pt. Request <input type="checkbox"/> BH Order <input type="checkbox"/> Closest <input type="checkbox"/> Diversion <input type="checkbox"/> Law <input type="checkbox"/> Trauma Ctr. <input type="checkbox"/> Specialty Ctr.											

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