

MEDICAL REPORT FORM

Date: _____ / _____ / _____

AGENCY NAME	RUN NUMBER	LOCATION
Nature of call:		PATIENTS DOCTOR:

TIMES						
TIME OF CALL	TIME OF PAGE	TIME INROUTE	TIME AT SCENE	TIME CARE TRANSFERED	CLEARED SCENE	IN QUARTERS

P A T I E N T	PATIENT LAST NAME	FIRST	M.I.	HOME PHONE #: ()	AGE / SEX	DATE OF BIRTH / /
	STREET ADDRESS:					
	CITY	STATE	ZIP CODE	LEGAL GUARDIAN:		

CHIEF COMPLAINT	PAIN SCALE (1 - 10)
Last Oral Intake	

PERTINENT PAST MEDICAL HISTORY None <input type="checkbox"/>	FAST STROKE SCREEN + <input type="checkbox"/> - <input type="checkbox"/> Was Screen Done Yes <input type="checkbox"/> NO <input type="checkbox"/>	CURRENT MEDICATIONS None <input type="checkbox"/> Sent With Patient <input type="checkbox"/>	ALLERGIES NKA <input type="checkbox"/>

NARRATIVE:	

GLASGOW COMA SCALE					
EYES		VERBAL		MOTOR	
Spont.	4	Orientated	5	Obeys	6
To Speech	3	Confused	4	Localizes	5
To Pain	2	Inapp.	3	Withdraw	4
None	1	Garbled	2	Flexion	3
		None	1	Extension	2
				None	1

SKIN			
COLOR	Temp	MOISTURE	
Normal	Normal	Normal	
Pale	Cool	Dry	
Flushed	Warm	Moist	
Cyanotic	Hot	Diaphoretic	
Blood Sugar		Time	

LUNG SOUNDS		
	R	L
CLEAR		
DIMINISHED		
ABSENT		
WHEEZES		
CRACKLES		
COARSE		

PUPILS		
	R	L
PEARL		
Dilated		
Constricted		
Nonreactive		

OXYGEN	
Time:	
4L NC	
15L NRB	
BVM	

VITALS				
TIME	B/P	PULSE	RESP.	PULSE/OX
	/			%
	/			%
	/			%
	/			%
	/			%

FIELD MANAGEMENT			
C-Collar	CPR	Nasal Airway	
Head Immobilized	Defibrillation	Oral Glucose	
Spine Board	Suction	Splinting	
Straps	Combi-Tube	Hemorrhage Control	
AED	Oral Airway	Bandage	
Other:			

CREW NAME (PRINT)
C.R.

CREW SIGNATURES

LEVEL

LICENSE NUMBER