McLean County Area EMS System
Non Transporting Agency

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

PATIENT

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

CHIEF COMPLANT		PAIN SCALE (1 – 10)	
Last Oral Intake			

PERTINENT PAST MEDICAL HISTORY	FAST STROKE SCREEN	CURRENT MEDICATIONS	ALLERGIES
None	+ -	None / Sent With Patient	NKA
	Was Screen Done: Yes / NO		

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)	CREW SIGNATURES	LEVEL	LICENSE NUMBER
C.R.			

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