117255 TO REORDER CALL PIP PRINTING 508-797-5551

Central Massachusetts E.M.S. Run Report

The information submitted on this form is supplied by the attendant within the limitation of the time available and based on his or her perception of the patient's condition at the pick-up location and in transit, as well as other information made available to the attendant. The information submitted does not necessarily reflect the full extent of the patient's injuries that can be discovered as a result of a more extensive examination by a physician or through the use of equipment which is not available to the attendant.

	Control Number	Date	Dispatch Priority	Patient Name

Age:	Sex: M F	Patient's Physician:	Mechanism of Injury and Chief Complaint:

Degree of Distress: Mild Moderate Severe	History of Present Illness:

Past Medical History:

Medications:

Allergies:
☐ NKDA

Vital Signs: ☐ Unable to obtain ☐ Not attempted

Time Taken:	Blood Pressure: (E)		Pulse:	Resps: (F)	
	/	4 = >89 3 = 76-89			4 = 10-29 3 = >29
	/	2 = 50-75 1 = 1-49			2 = 6-9 1 = 1-5
	/	0 = no pulse			0 = none

Other Physical Findings:

Skin:
☐ Hot ☐ Warm ☐ Cool
☐ Diaphoretic ☐ Dry
Color:
☐ Normal ☐ Cyanotic
☐ Flushed ☐ Pale

☐ Regular
☐ Irregular
☐ Normal
☐ Bounding
☐ Weak

☐ Normal
☐ Obstructed
☐ Shallow
☐ Labored
☐ Absent

Breath Sounds:

Right		Left
☐	Clear	☐
☐	Decreased	☐
☐	Crackles	☐
☐	Wheezes	☐

Pupils:

Right		Left
☐	Reactive	☐
☐	Unreactive	☐
☐	Dilated	☐
☐	Mid-point	☐
☐	Constricted	☐

Size (mm)

Eye Opening: (A)
④ Spontaneous ② To Pain
③ To Voice ① None

Verbal Response: (B)
⑤ Oriented
④ Confused
③ Inappropriate
② Incomprehensible
① None

Coma Score (D)

Motor Response: (C)
⑥ Obeys ⑤ Localizes
④ Withdrawls
③ Flexes ② Extends
① None ☐ Unknown

Coma Scale
13-15 = 4 4-5 = 1
9-12 = 3 0-3 = 0
6-8 = 2 (A+B+C=D)

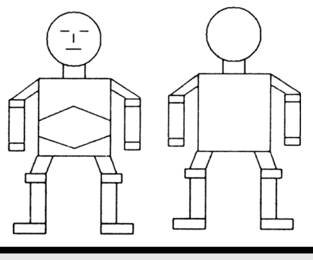
Pedi Trauma Score: (draw line through parameter and add score)

Score	Size	Airway	Systolic BP	CNS	Skeletal	Cutaneous
+2	>20Kg	Normal	>90 mmHg	awake	none	none
+1	10-20 Kg	Maintainable	50-90 mmHg	Obtunded	single fx	laceration
-1	<10 Kg	unmaintainable	<50 mmHg	coma	open/mult fx	Major

Type of Injury: ☐ None ☐ Possible Internal

[number suspected Injury site]

Front **Back**



1. Abrasion
2. Amputation
3. Avulsion
4. Blunt Trauma
5. Bruise / Contusion
6. Burns (show % + deg)
7. Concussion
8. Dislocation
9. Fracture - closed
10. Fracture - open
11. Laceration
12. Puncture
13. Sprain / Strain

vehicle

Trauma Score: (D+E+F)

Emergency Care Administered: ☐ None
☐ Oxygen ________ LPM
☐ Suction
☐ Ventilation
☐ Airway Insert
☐ Cardiac Compression
☐ Spinal Immobilization
☐ Splinting
☐ Bandaging
☐ Hemorrhage Control
☐ Saline Irrigation
☐ Ice Packs
☐ Burn Packs
☐ Obstet. Delivery
☐ Psych. First Aid
☐ Extrication
☐ Vomiting Induced

Defibrillation Time (paced)	Joules (ma)	Performed by:
___ : ___	______	________
___ : ___	______	________
___ : ___	______	________
___ : ___	______	________
___ : ___	______	________
___ : ___	______	________

☐ Blood Drawn by: ________

☐ EOA / EGTA Placed by: ________

☐ Endotracheal tube placed by: ________

Size: ________

Time ___ : ___

IV Administration (Drug Mix) by: **1.** ________ **2.** ________ **3.** ________

Solution / Rate ___ / ___ ___ / ___ ___ / ___

Gauge / Route ___ / ___ ___ / ___ ___ / ___

Time Started ___ : ___ ___ : ___ ___ : ___

Medication	Dose	Time	Ad. by	Dose	Time	Ad. by

Other Treatment:

Service Name:	Vehicle Number	
EMT Name & No.:	Time Received	
EMT Name & No.:	Dispatched	
EMT Name & No.:	Arrived Scene	**AID REFUSAL:** I acknowledge that medical care is offered me by this ambulance service and I refuse care. Signature:
EMT Name & No.:	Departed scene	Witness:
Dispatch Location:	Arrived Hosp.	Med. Ctrl. Physician:
Pick-up Location:	Back in Service	Med. Ctrl. Hospital:
Destination:	Est. Incident time	Attendant's Signature:

WHITE COPY TO AMBULANCE YELLOW COPY TO HOSPITAL

UNIT NUMBER _____ RETURNED _____

DATE _____ OPERATOR _____ TECHNICIAN _____ UNIT # _____

PATIENT _____ M F DOB _____ AGE _____

ADDRESS _____ SSI# _ _ _–_ _–_ _ _ _

CITY _____ STATE _____ ZIP _____ PHONE _____

M.V. Reg. # _____

MEDICARE

__ __ __ – __ __ – __ __ __ __ – __

MEDEX

MASS HEALTH

CARD # __ __ __ __ __ __ __ __ __ __
NAME _____
ID # __ __ __ __ __ __ __ __ __ __
RECIPIENT # 01 02 03 04

OTHER INSURANCE

INSURANCE CO. _____
ADDRESS _____
GROUP # _____ ID# _____
SUBSCRIBER NAME _____
CARD HOLDER NAME _____
EMPLOYER _____

RESPONSIBLE PARTY

NAME _____
ADDRESS _____
CITY _____ ST _____ ZIP _____
RELATIONSHIP _____
PHONE _____
SSI# _____

AUTO ACCIDENT

OWNERS NAME _____
ADDRESS _____
PHONE _____
REG _____ YR _____ MAKE _____
INSURANCE AGENT _____
AGENTS ADDRESS _____
INSURANCE CO _____
INS CO ADDRESS _____

TRANSPORT INFORMATION

DIAGNOSIS _____
_____ MD _____
TRANSFER EMERGENCY AUTO ACCIDENT
OXYGEN MONITOR COLLAR
MILES END _____ START _____ TOTAL _____
CALL SOURCE _____
LEFT AT _____ ARRIVED AT _____
FROM _____
TO _____

INDUSTRIAL ACCIDENT

EMPLOYER _____
ADDRESS _____
PHONE _____

PHYSICIAN _____

PHYSICIANS "UPIN" # _____

SIGNATURE OF PERSON VERIFYING SERVICE _____

MEDICARE PATIENTS ONLY: I authorize any holder of medical or other information about me to release to the S.S.A. and H.C.F.A. or its intermediaries or carriers and _____ Ambulance Service, Inc. any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to _____ Ambulance Services, Inc.

_____
Signature of Patient or Authorized Representative

I also acknowledge that I have received a copy of the _____ Notice of Privacy Practices.
Service Name

Signature of Patient or Authorized Representative: _____

Relation to Patient _____

Patient Unable to sign due to: _____

Patient given _____ Notice of Privacy Practices
Service Name

Yes_____ No_____ Family Member _____

OTHER: I understand it is my responsibility to notify _____ Ambulance of any or all insurance information. I also authorize payment to be made directly to_____ Ambulance Service, Inc.

_____
Patient Signature