

1. INCIDENT DATE		2. OKLAHOMA REPORT NUMBER			3. EMS AGCY #		4. VEHICLE NUMBER			5. EMS UNIT CALL SIGN			6. STATION #																						
7. INCIDENT/PATIENT DISPOSITION																																			
<input type="checkbox"/> Treated, Transport EMS			<input type="checkbox"/> No Patient Found			<input type="checkbox"/> Treated, Transferred Care			<input type="checkbox"/> Treated, Transported Law Enforcement			<input type="checkbox"/> Canceled																							
<input type="checkbox"/> No Treatment Required			<input type="checkbox"/> Pt Refused Care			<input type="checkbox"/> Treated & Released			<input type="checkbox"/> Treated, Transported Private Vehicle			<input type="checkbox"/> Dead at Scene																							
8. INCIDENT ADDRESS				9. INCIDENT CITY				10. INCIDENT ST		11. INCIDENT ZIP			12. INCIDENT COUNTY																						
13. RESPONSE MODE TO SCENE				14. FROM SCENE				Run Times				19. Unit Arrived at Scene:																							
<input type="checkbox"/> Lights/Sirens				<input type="checkbox"/> No Lights/No Sirens				Use Military Time				20. Arrived at Patient:																							
<input type="checkbox"/> Initial Lights/Sirens Downgraded to no Lights/Sirens				<input type="checkbox"/> Initial No Lights/Sirens Upgraded to Lights/Sirens				15. Estimated Time of Onset:		16. PSAP / Initial Call for Help:		21. Unit Left Scene:		22. Patient Arrived at Destination:																					
								17. Unit Notified by Dispatch:		18. Unit Enroute:		23. Unit Back in Service:		24. Unit Back at Home Location:																					
25. TYPE OF SERVICE REQUESTED				26. INCIDENT LOCATION TYPE				27. CONDITION CODE(S) <i>See Reference Sheet</i>																											
<input type="checkbox"/> 911 Response <input type="checkbox"/> Interfacility Transfer <input type="checkbox"/> Mutual Aid <input type="checkbox"/> Medical Transport <input type="checkbox"/> Intercept <input type="checkbox"/> Standby				<input type="checkbox"/> Home/residence <input type="checkbox"/> Sport/recreation place <input type="checkbox"/> Health care facility <input type="checkbox"/> Farm <input type="checkbox"/> Street/highway <input type="checkbox"/> Residential institution <input type="checkbox"/> Mine/quarry <input type="checkbox"/> Public building <input type="checkbox"/> Lake/river <input type="checkbox"/> Industrial place <input type="checkbox"/> Trade/service <input type="checkbox"/> Other <input type="checkbox"/> N/A																															
28. COMPLAINT REPORTED BY DISPATCH (select one) <i>See Reference Sheet</i>				29. EMERGENCY MEDICAL DISPATCH PERFORMED				30. CMS LEVEL OF SERVICE																											
				<input type="checkbox"/> No <input type="checkbox"/> Yes, without pre-arrival instructions <input type="checkbox"/> Yes, with pre-arrival instructions <input type="checkbox"/> Unknown <input type="checkbox"/> N/A				<input type="checkbox"/> BLS, Emergency <input type="checkbox"/> ALS, Level 1 Emergency <input type="checkbox"/> ALS, Level 2 <input type="checkbox"/> Paramedic Intercept <input type="checkbox"/> Specialty Care <input type="checkbox"/> BLS <input type="checkbox"/> ALS Lev 1 <input type="checkbox"/> Helicopter <input type="checkbox"/> Airplane <input type="checkbox"/> Not Applicable																											
31. NUMBER OF PATIENTS AT SCENE			32. MASS CASUALTY			33. PRIMARY ROLE OF THE UNIT			34. Begin			35. Arrive			36. Destination			37. End			38. DEST ZIP			39. ORIG FAC ID			40. REC FAC ID			41. LATITUDE			42. LONGITUDE		
<input type="checkbox"/> Single <input type="checkbox"/> None <input type="checkbox"/> Multiple <input type="checkbox"/> N/A			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			<input type="checkbox"/> Transport <input type="checkbox"/> Supervisor <input type="checkbox"/> Non-transport <input type="checkbox"/> Rescue																													
42. PATIENT LAST NAME				43. PATIENT FIRST NAME				44. MI																											
45. PATIENT ADDRESS				46. <input type="checkbox"/> SAME AS INCIDENT ADDRESS				47. PATIENT CITY																											
48. STATE		49. PATIENT ZIP CODE			50. COUNTY		51. PT TELEPHONE NUMBER			52. RACE (single-choice)			53. ETHNICITY																						
							Area Code Telephone Number			<input type="checkbox"/> American Indian/Alaska Nat <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pac Islander <input type="checkbox"/> White <input type="checkbox"/> Other			<input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic																						
55. AGE		56. AGE UNITS		57. DATE OF BIRTH		58. SOCIAL SECURITY NUMBER			59. PRIMARY PAYMENT METHOD			Medicare #:			Insurance1 #:																				
		<input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years							<input type="checkbox"/> Not Billed <input type="checkbox"/> Unknown <input type="checkbox"/> Workers Comp <input type="checkbox"/> Medicare <input type="checkbox"/> Other Government <input type="checkbox"/> Self Pay <input type="checkbox"/> Not Available <input type="checkbox"/> Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Not Applicable																										
60. CHIEF COMPLAINT																																			
61. PATIENT MEDICAL HISTORY					62. PATIENT MEDICATION HISTORY					63. PATIENT MEDICATION ALLERGIES																									
64. NARRATIVE:																																			
Receiving Facility: _____ I received a verbal & written report on the care of this patient: _____																																			
INITIAL & FINAL VITAL SIGNS <input type="checkbox"/> Not Applicable										GLASGOW COMA SCALE <input type="checkbox"/> Not Applicable																									
65. Time	66. Pulse	67. Resp	68. SBP	69. DBP	70. Method BP	71. LOC	72. O2 Sat	73. EKG	74. Skin	75. Pupils	76. Eyes	77. Verbal	78. Motor	79. GCS Score																					
					<input type="checkbox"/> Arterial Line <input type="checkbox"/> Auto Cuff <input type="checkbox"/> Manual Cuff <input type="checkbox"/> Palpate Cuff <input type="checkbox"/> Venous Line	<input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U		See Reference sheet	<input type="checkbox"/> Warm <input type="checkbox"/> Pale <input type="checkbox"/> Cool <input type="checkbox"/> Pink <input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Cyanotic <input type="checkbox"/> Diaphoretic	Left      Right <input type="checkbox"/> Normal <input type="checkbox"/> <input type="checkbox"/> Constricted <input type="checkbox"/> <input type="checkbox"/> Dilated <input type="checkbox"/> <input type="checkbox"/> Non-Reactive <input type="checkbox"/>	<input type="checkbox"/> 4 Spon <input type="checkbox"/> 3 Speech <input type="checkbox"/> 2 Pain <input type="checkbox"/> 1 None	<input type="checkbox"/> 5 Oriented <input type="checkbox"/> 4 Confused <input type="checkbox"/> 3 Inapprop <input type="checkbox"/> 2 Garbled <input type="checkbox"/> 1 None	<input type="checkbox"/> 6 Obeys <input type="checkbox"/> 5 Localizes <input type="checkbox"/> 4 W/draws <input type="checkbox"/> 3 Flexion <input type="checkbox"/> 2 Extent <input type="checkbox"/> 1 None																						
MEDICATIONS <input type="checkbox"/> None <input type="checkbox"/> Not applicable																																			
80. Time	81. Medication Given <i>See Reference Sheet</i>				82. Meds Administered By:			83. Med Complications <i>See Reference Sheet</i>			84. Medication Authorization																								
:					<input type="checkbox"/> CM 1 <input type="checkbox"/> CM 2 <input type="checkbox"/> CM 3						<input type="checkbox"/> Protocol (Standing Order) <input type="checkbox"/> On-Line <input type="checkbox"/> Written Orders (Patient Specific) <input type="checkbox"/> On-Scene <input type="checkbox"/> Not Applicable <input type="checkbox"/> Protocol (Standing Order) <input type="checkbox"/> On-Line <input type="checkbox"/> Written Orders (Patient Specific) <input type="checkbox"/> On-Scene <input type="checkbox"/> Not Applicable <input type="checkbox"/> Protocol (Standing Order) <input type="checkbox"/> On-Line <input type="checkbox"/> Written Orders (Patient Specific) <input type="checkbox"/> On-Scene <input type="checkbox"/> Not Applicable																								
PROCEDURES <input type="checkbox"/> None <input type="checkbox"/> Not applicable																																			
85. Time	86. Procedure <i>See Reference Sheet</i>		87. # Attempts		88. Successful			89. Done By:			90. Procedure Complications <i>See Reference Sheet</i>																								
:					<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA			<input type="checkbox"/> CM 1 <input type="checkbox"/> CM 2 <input type="checkbox"/> CM 3																											
<input type="checkbox"/> I have been given notice of HIPAA Privacy Practices.  <input type="checkbox"/> This is to certify that I am refusing treatment/transport. I have been informed of the risk(s) involved, and thereby release the ambulance service, its attendants, and its affiliates from responsibility that may result from this action.  <input type="checkbox"/> Patient Authorization & Release: I, the undersigned, hereby authorize _____ ("Provider") to provide me with emergency or non-emergency transportation and/or any medical treatment or services it deems necessary. I acknowledge that I am responsible for paying for all charges based on Providers current billing rates, regardless of whether or not I personally requested emergency medical services (EMS) originally. I hereby assign to Provider all my insurance and third party agency benefits for EMS and authorize such benefits to be paid to Provider. I authorize the release of any medical, hospital, or other records or information about me, or my dependents to my insurance carriers in order to determine insurance or other third party benefits for EMS to which my dependents or I may be entitled.																																			
Witness			Date / Time			Patient / Guardian			Date / Time																										

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<b>SYMPTOMS</b> 91. P=PRIMARY (pick one) <input type="checkbox"/> Not applicable 92. A =ASSOCIATED (multi) <input type="checkbox"/> Not applicable  <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;">           P A  <input type="checkbox"/> Transport Only  <input type="checkbox"/> None  <input type="checkbox"/> Bleeding  <input type="checkbox"/> Breathing  <input type="checkbox"/> Changes in Responsiveness  <input type="checkbox"/> Choking  <input type="checkbox"/> Death  <input type="checkbox"/> Device/Equip Problem  <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Drainage/Discharge         </td> <td style="width:50%; border: none;">           P A  <input type="checkbox"/> Fever  <input type="checkbox"/> Malaise  <input type="checkbox"/> Mass/Lesion  <input type="checkbox"/> Mental/Psych  <input type="checkbox"/> Nausea/Vomiting  <input type="checkbox"/> Pain  <input type="checkbox"/> Palpitations  <input type="checkbox"/> Rash/Itching  <input type="checkbox"/> Swelling  <input type="checkbox"/> Weakness  <input type="checkbox"/> Wound         </td> </tr> </table>		P A <input type="checkbox"/> Transport Only <input type="checkbox"/> None <input type="checkbox"/> Bleeding <input type="checkbox"/> Breathing <input type="checkbox"/> Changes in Responsiveness <input type="checkbox"/> Choking <input type="checkbox"/> Death <input type="checkbox"/> Device/Equip Problem <input type="checkbox"/> Diarrhea <input type="checkbox"/> Drainage/Discharge	P A <input type="checkbox"/> Fever <input type="checkbox"/> Malaise <input type="checkbox"/> Mass/Lesion <input type="checkbox"/> Mental/Psych <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Rash/Itching <input type="checkbox"/> Swelling <input type="checkbox"/> Weakness <input type="checkbox"/> Wound	<b>PROVIDER IMPRESSION</b> 93. P= PRIMARY (pick one) <input type="checkbox"/> Not applicable  <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;">           P S  <input type="checkbox"/> Abdominal pain  <input type="checkbox"/> Airway obstruct  <input type="checkbox"/> Allergic reaction  <input type="checkbox"/> Altered LOC  <input type="checkbox"/> Behavior/psych  <input type="checkbox"/> Cardiac arrest  <input type="checkbox"/> Cardiac arrhythmia  <input type="checkbox"/> Chest pain  <input type="checkbox"/> CHF  <input type="checkbox"/> COPD         </td> <td style="width:50%; border: none;">           P S  <input type="checkbox"/> Diabetic  <input type="checkbox"/> Electrocutation  <input type="checkbox"/> Hyperthermia  <input type="checkbox"/> Hypothermia  <input type="checkbox"/> Hypovolemia/shock  <input type="checkbox"/> Inhalation injury/toxic gas  <input type="checkbox"/> Inhalation/smoke  <input type="checkbox"/> Obvious Death  <input type="checkbox"/> Poisoning/drug OD  <input type="checkbox"/> Pregnancy/OB delivery         </td> </tr> </table>		P S <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Airway obstruct <input type="checkbox"/> Allergic reaction <input type="checkbox"/> Altered LOC <input type="checkbox"/> Behavior/psych <input type="checkbox"/> Cardiac arrest <input type="checkbox"/> Cardiac arrhythmia <input type="checkbox"/> Chest pain <input type="checkbox"/> CHF <input type="checkbox"/> COPD	P S <input type="checkbox"/> Diabetic <input type="checkbox"/> Electrocutation <input type="checkbox"/> Hyperthermia <input type="checkbox"/> Hypothermia <input type="checkbox"/> Hypovolemia/shock <input type="checkbox"/> Inhalation injury/toxic gas <input type="checkbox"/> Inhalation/smoke <input type="checkbox"/> Obvious Death <input type="checkbox"/> Poisoning/drug OD <input type="checkbox"/> Pregnancy/OB delivery	94. S=SECONDARY (pick one) <input type="checkbox"/> Not applicable  <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;">           P S  <input type="checkbox"/> Respiratory arrest  <input type="checkbox"/> Respiratory distress  <input type="checkbox"/> Seizure  <input type="checkbox"/> Sexual assault/rape  <input type="checkbox"/> Stings/venomous bites  <input type="checkbox"/> Stroke/CVA  <input type="checkbox"/> Syncope/fainting  <input type="checkbox"/> Traumatic injury  <input type="checkbox"/> Vaginal hemorrhage         </td> <td style="width:50%; border: none;"> <b>95. ALCOHOL/DRUG USE INDICATORS</b> (multi-choice)  <input type="checkbox"/> Not applicable  <input type="checkbox"/> None  <input type="checkbox"/> Smell of alcohol <b>present</b>  <input type="checkbox"/> Pt admits to alcohol use  <input type="checkbox"/> Pt admits to drug use  <input type="checkbox"/> Alcohol and/or drug paraphernalia at scene         </td> </tr> </table>		P S <input type="checkbox"/> Respiratory arrest <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Seizure <input type="checkbox"/> Sexual assault/rape <input type="checkbox"/> Stings/venomous bites <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Syncope/fainting <input type="checkbox"/> Traumatic injury <input type="checkbox"/> Vaginal hemorrhage	<b>95. ALCOHOL/DRUG USE INDICATORS</b> (multi-choice) <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Smell of alcohol <b>present</b> <input type="checkbox"/> Pt admits to alcohol use <input type="checkbox"/> Pt admits to drug use <input type="checkbox"/> Alcohol and/or drug paraphernalia at scene																														
P A <input type="checkbox"/> Transport Only <input type="checkbox"/> None <input type="checkbox"/> Bleeding <input type="checkbox"/> Breathing <input type="checkbox"/> Changes in Responsiveness <input type="checkbox"/> Choking <input type="checkbox"/> Death <input type="checkbox"/> Device/Equip Problem <input type="checkbox"/> Diarrhea <input type="checkbox"/> Drainage/Discharge	P A <input type="checkbox"/> Fever <input type="checkbox"/> Malaise <input type="checkbox"/> Mass/Lesion <input type="checkbox"/> Mental/Psych <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Rash/Itching <input type="checkbox"/> Swelling <input type="checkbox"/> Weakness <input type="checkbox"/> Wound																																								
P S <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Airway obstruct <input type="checkbox"/> Allergic reaction <input type="checkbox"/> Altered LOC <input type="checkbox"/> Behavior/psych <input type="checkbox"/> Cardiac arrest <input type="checkbox"/> Cardiac arrhythmia <input type="checkbox"/> Chest pain <input type="checkbox"/> CHF <input type="checkbox"/> COPD	P S <input type="checkbox"/> Diabetic <input type="checkbox"/> Electrocutation <input type="checkbox"/> Hyperthermia <input type="checkbox"/> Hypothermia <input type="checkbox"/> Hypovolemia/shock <input type="checkbox"/> Inhalation injury/toxic gas <input type="checkbox"/> Inhalation/smoke <input type="checkbox"/> Obvious Death <input type="checkbox"/> Poisoning/drug OD <input type="checkbox"/> Pregnancy/OB delivery																																								
P S <input type="checkbox"/> Respiratory arrest <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Seizure <input type="checkbox"/> Sexual assault/rape <input type="checkbox"/> Stings/venomous bites <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Syncope/fainting <input type="checkbox"/> Traumatic injury <input type="checkbox"/> Vaginal hemorrhage	<b>95. ALCOHOL/DRUG USE INDICATORS</b> (multi-choice) <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Smell of alcohol <b>present</b> <input type="checkbox"/> Pt admits to alcohol use <input type="checkbox"/> Pt admits to drug use <input type="checkbox"/> Alcohol and/or drug paraphernalia at scene																																								
<b>96. CHIEF COMPLAINT ANATOMIC LOCATION</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> Abdomen <input type="checkbox"/> Extremity Lower <input type="checkbox"/> Genitalia <input type="checkbox"/> Back <input type="checkbox"/> Extremity Upper <input type="checkbox"/> Head <input type="checkbox"/> Chest <input type="checkbox"/> General/Global <input type="checkbox"/> Neck		<b>97. CHIEF COMPLAINT ORGAN SYSTEM</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> Endocrine/Metabolic <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Pulmonary <input type="checkbox"/> Cardiovascular <input type="checkbox"/> GI <input type="checkbox"/> OB/GYN <input type="checkbox"/> Renal <input type="checkbox"/> CNS/Neuro <input type="checkbox"/> Global <input type="checkbox"/> Psych <input type="checkbox"/> Skin		<b>98. Incident Work-Related</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable																																					
<b>99. CARDIAC ARREST</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes, Prior to Arrival <input type="checkbox"/> Yes, After Arrival <input type="checkbox"/> No		<b>100. RESUSCITATION</b> (multi) <input type="checkbox"/> Not applicable <input type="checkbox"/> Defibrillation <input type="checkbox"/> None-DOA <input type="checkbox"/> Ventilation <input type="checkbox"/> None-DNR/ <b>DNAR</b> <input type="checkbox"/> Chest Comp <input type="checkbox"/> None-Signs of life		<b>101. TIME OF ARREST</b> (mins) <input type="checkbox"/> Not applicable <input type="checkbox"/> 0-2 <input type="checkbox"/> 2-4 <input type="checkbox"/> 4-6 <input type="checkbox"/> 6-8 <input type="checkbox"/> 8-10 <input type="checkbox"/> 10-15 <input type="checkbox"/> 15-20 <input type="checkbox"/> >20		<b>102. ARREST WITNESSED BY:</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> Lay Person <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Not Witnessed		<b>103. CAUSE OF ARREST</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> Drowning <input type="checkbox"/> Unknown <input type="checkbox"/> Respiratory <input type="checkbox"/> Presumed Cardiac <input type="checkbox"/> Electrocutation <input type="checkbox"/> Trauma <input type="checkbox"/> Other																																	
<b>STEMI</b> <input type="checkbox"/> Not applicable <b>104. 12-Lead EKG used:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>105. Transmitted for interpretation:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>106. Interpreter (indicate all):</b> <input type="checkbox"/> Paramedic <input type="checkbox"/> Physician <input type="checkbox"/> Computer Program <b>107. STEMI probable:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inconclusive				<b>108. Stroke Scale</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> Not available <input type="checkbox"/> Not known <input type="checkbox"/> Cincinnati Stroke Scale Negative <input type="checkbox"/> LA Stroke Scale Negative <input type="checkbox"/> Cincinnati Stroke Scale Non-conclusive <input type="checkbox"/> LA Stroke Scale Non-conclusive <input type="checkbox"/> Cincinnati Stroke Scale Positive <input type="checkbox"/> LA Stroke Scale Positive																																					
<b>PRIOR AID RECEIVED PRIOR TO ARRIVAL OF UNIT</b> See Reference Sheet <b>109. PRIOR AID PERFORMED BY:</b> <input type="checkbox"/> EMS Provider <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Lay Person <input type="checkbox"/> Unknown <input type="checkbox"/> EMS Provider <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Lay Person <input type="checkbox"/> Unknown <input type="checkbox"/> EMS Provider <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Lay Person <input type="checkbox"/> Unknown <input type="checkbox"/> EMS Provider <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Lay Person <input type="checkbox"/> Unknown				<b>110. PRIOR AID (Use PROCEDURES List and/or MEDICATIONS List)</b> <b>111. OUTCOME OF PRIOR AID</b> <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Worse <input type="checkbox"/> Unknown																																					
<b>113. TRAUMA PRESENT</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes <input type="checkbox"/> No				<b>114. CAUSE OF INJURY</b> <input type="checkbox"/> Not applicable See Ref. Sheet		<b>115. MECHANISM OF INJURY</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> Blunt <input type="checkbox"/> Penetrating <input type="checkbox"/> Burn <input type="checkbox"/> Not Known		<b>116. HOSPITAL TEAM NOTIFIED</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> Trauma <input type="checkbox"/> Yes <input type="checkbox"/> Stroke <input type="checkbox"/> No <input type="checkbox"/> STEMI		<b>117. TIME HOSPITAL TEAM NOTIFIED</b> _____		<b>118. Trauma Triage Level</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> Priority 2 <input type="checkbox"/> Priority 1 <input type="checkbox"/> Priority 3																													
<b>119. TRAUMA TRIAGE CRITERIA</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> GCS <=13 <input type="checkbox"/> GCS improving <input type="checkbox"/> Resp compromise resulting from trauma <input type="checkbox"/> Hemodynamic compromise from trauma <input type="checkbox"/> Blunt trauma/no hemodynamic trauma <input type="checkbox"/> Penetrating injury to trunk-neck-head <input type="checkbox"/> Penetrating injuries to extremities <input type="checkbox"/> Amputation proximal to wrist or ankle <input type="checkbox"/> Paralysis resulting from trauma <input type="checkbox"/> Flail chest <input type="checkbox"/> Two or more proximal long bone fractures <input type="checkbox"/> Open or depressed skull fracture <input type="checkbox"/> Unstable pelvis <input type="checkbox"/> PTS <= 8 <input type="checkbox"/> BSA >= 10% <input type="checkbox"/> BSA < 10% <input type="checkbox"/> Other single system injury <input type="checkbox"/> Minor injuries						<b>Intercept:</b> <b>120. TIME REQUESTED:</b> _____ <b>121. TIME ARRIVED:</b> _____ <b>122. TIME OF CARE TRANSFER:</b> _____ <b>123. REC AGENCY:</b> _____			<b>124. TRAUMA REFERRAL CENTER (TReC) NOTIFIED</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <b>125. TReC TRACKING #:</b> _____ <b>126. TIME TReC NOTIFIED:</b> _____																																
<b>127. VEHICULAR INJURY INDICATORS</b> <input type="checkbox"/> Dash Deformity <input type="checkbox"/> Fire <input type="checkbox"/> Not applicable <input type="checkbox"/> DOA Same Vehicle <input type="checkbox"/> Rollover/Roof Deformity <input type="checkbox"/> Space Intrusion >1 foot <input type="checkbox"/> Ejection <input type="checkbox"/> Side Post Deformity <input type="checkbox"/> Windshield Spider/Star <input type="checkbox"/> Steering Wheel Deformity				<b>128. USE OF SAFETY EQUIPMENT [multi]</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Child Restraint <input type="checkbox"/> Lap Belt <input type="checkbox"/> Protective Gear <input type="checkbox"/> Eye Protection <input type="checkbox"/> Pers Flotation Device <input type="checkbox"/> Shoulder Belt <input type="checkbox"/> Helmet Worn <input type="checkbox"/> Protective Clothing <input type="checkbox"/> Other (Airbag)																																					
<b>129. AIRBAG DEPLOYMENT</b> <input type="checkbox"/> Airbag Deployed Front <input type="checkbox"/> Airbag Deployed Other <input type="checkbox"/> Airbag Deployed Side <input type="checkbox"/> Airbag Not Deployed <input type="checkbox"/> No Airbag Present <input type="checkbox"/> Unknown				<b>130. PATIENT POSITION</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown <input type="checkbox"/> Driver <input type="checkbox"/> Left (non-driver) <input type="checkbox"/> Middle <input type="checkbox"/> Right <input type="checkbox"/> Other																																					
<b>131. TYPE OF DESTINATION</b> <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Medical Office/Clinic <input type="checkbox"/> Morgue <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other EMS (air) <input type="checkbox"/> Other EMS (ground) <input type="checkbox"/> Police/Jail <input type="checkbox"/> Other <input type="checkbox"/> Not applicable		<b>132. REASON FOR CHOOSING DESTINATION</b> <input type="checkbox"/> Closest <input type="checkbox"/> On-line Med Control <input type="checkbox"/> Diversion <input type="checkbox"/> Other <input type="checkbox"/> Family Choice <input type="checkbox"/> Pt Choice <input type="checkbox"/> Insurance <input type="checkbox"/> Pt Physician's Choice <input type="checkbox"/> Law Enforcement Choice <input type="checkbox"/> Protocol <input type="checkbox"/> Specialty Resource Center <input type="checkbox"/> Not applicable		<b>133. ED DISPOSITION</b> <input type="checkbox"/> Admit-floor <input type="checkbox"/> Admit-ICU <input type="checkbox"/> Death <input type="checkbox"/> Not Applicable <input type="checkbox"/> Released <input type="checkbox"/> Transferred <input type="checkbox"/> Unknown		<b>134. HOSPITAL DISPOSITION</b> <input type="checkbox"/> Death <input type="checkbox"/> Not applicable <input type="checkbox"/> Discharge <input type="checkbox"/> Transfer-other hosp <input type="checkbox"/> Transfer-nursing home <input type="checkbox"/> Transfer-other <input type="checkbox"/> Transfer-rehab <input type="checkbox"/> Unknown																																			
<b>135. TYPE OF DELAY(S) (select all)</b> <b>DISPATCHER</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Caller Uncooperative <input type="checkbox"/> High Call Volume <input type="checkbox"/> Language Barrier <input type="checkbox"/> Location (Inability to obtain) <input type="checkbox"/> No Unit Available <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Technical Failure <input type="checkbox"/> Other		<b>136. TYPE OF DELAY(S) (select all)</b> <b>RESPONSE</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Crowd <input type="checkbox"/> Directions <input type="checkbox"/> Distance <input type="checkbox"/> Diversion <input type="checkbox"/> HazMat <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Staff Delay <input type="checkbox"/> Traffic <input type="checkbox"/> Vehicle Crash <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> Weather <input type="checkbox"/> Other		<b>137. TYPE OF DELAY(S) (select all)</b> <b>SCENE</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Crowd <input type="checkbox"/> Directions <input type="checkbox"/> Distance <input type="checkbox"/> Diversion <input type="checkbox"/> Extrication>20 Min <input type="checkbox"/> HazMat <input type="checkbox"/> Language Barrier <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Staff Delay <input type="checkbox"/> Traffic <input type="checkbox"/> Vehicle Crash <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> Weather <input type="checkbox"/> Other		<b>138. TYPE OF DELAY(S) (select all)</b> <b>TRANSPORT</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Crowd <input type="checkbox"/> Directions <input type="checkbox"/> Distance <input type="checkbox"/> Diversion <input type="checkbox"/> HazMat <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Staff Delay <input type="checkbox"/> Traffic <input type="checkbox"/> Vehicle Crash <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> Weather <input type="checkbox"/> Other		<b>139. TYPE OF DELAY(S) (select all)</b> <b>RETURN</b> <input type="checkbox"/> Not applicable <input type="checkbox"/> None <input type="checkbox"/> Clean up <input type="checkbox"/> Decontamination <input type="checkbox"/> Documentation <input type="checkbox"/> ED Overcrowding <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Equipment Replenishment <input type="checkbox"/> Staff Delay <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> Other																																	
<b>Enter CREW MEMBER Information for: 140. CREW MEMBER ID NUMBER 141. LEVEL OF SERVICE 142. CREW MEMBER ROLE</b>																																									
<b>CREW MEMBER 1 ID NUMBER</b> <table border="1" style="width:100%; height: 20px;"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>														<b>CREW MEMBER 2 ID NUMBER</b> <table border="1" style="width:100%; height: 20px;"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>														<b>CREW MEMBER 3 ID NUMBER</b> <table border="1" style="width:100%; height: 20px;"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>													
Crew Member1 Signature <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> P <input type="checkbox"/> EMR <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Student <input type="checkbox"/> Other				Crew Member2 Signature <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> P <input type="checkbox"/> EMR <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Student <input type="checkbox"/> Other				Crew Member3 Signature <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> P <input type="checkbox"/> EMR <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Student <input type="checkbox"/> Other																																	
<b>CREW MEMBER 1 ROLE</b> <input type="checkbox"/> Primary Patient Caregiver <input type="checkbox"/> Driver <input type="checkbox"/> Secondary Patient Caregiver <input type="checkbox"/> Other <input type="checkbox"/> Third Patient Caregiver				<b>CREW MEMBER 2 ROLE</b> <input type="checkbox"/> Primary Patient Caregiver <input type="checkbox"/> Driver <input type="checkbox"/> Secondary Patient Caregiver <input type="checkbox"/> Other <input type="checkbox"/> Third Patient Caregiver				<b>CREW MEMBER 3 ROLE</b> <input type="checkbox"/> Primary Patient Caregiver <input type="checkbox"/> Driver <input type="checkbox"/> Secondary Patient Caregiver <input type="checkbox"/> Other <input type="checkbox"/> Third Patient Caregiver																																	

