

Emergency Medical Services (EMS) Module: NFIRS-6

Objectives

After completing the EMS Module the student will be able to:

1. Identify the different modules that are used to record casualties.
 2. Understand the need for the various modules and which module to use in various circumstances.
 3. Demonstrate how to complete the EMS Module, given hypothetical narrative reports.
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Pretest #6 - Emergency Medical Services (EMS) Module

1. A Basic Module must be completed if the EMS Module is completed.
 - (a) True.
 - (b) False.

2. EMS-type activities are a significant portion of a fire department's operational workload.
 - (a) True.
 - (b) False.

3. The EMS Module is a required NFIRS Module.
 - (a) True.
 - (b) False.

4. The purpose of the EMS Module is to gather basic data as they relate to the provision of emergency medical care by local fire service units.
 - (a) True.
 - (b) False.

5. The EMS Module can be used instead of the Fire Service Casualty Module to document a fire-fighter injury.
 - (a) True.
 - (b) False.

Using the EMS Module

In its infancy, fire department activity reporting was limited to fires only - at least on a national level. Little recognition was given to the “other” activities that fire departments were performing on a daily basis. As fire department management became more responsive to the budgetary concerns and restrictions of fiscal policy, the need to justify all activities and expenditures grew. Many local fire departments began to collect data on their own, using the NFIRS program to attempt to gather management information concerning all of those other activities and stretching the program in directions that were never anticipated. Recognizing that EMS-type activities are a significant portion (well over 50 percent) of a fire department’s operational workload, the EMS Module was created in 1996.

The EMS Module is an optional module. It should be used when that option has been chosen by your State or local authorities. The EMS Module is not intended to replace or otherwise interfere with State or local EMS patient care reporting requirements, nor is it intended to be a comprehensive EMS patient care report. Instead, the data elements in this module should be viewed as “core elements” around which a complete patient care report can be built.

The purpose of the EMS Module is to gather basic data as they relate to the provision of emergency medical care by local fire service units. It is intended to encompass both responding fire suppression units and fire department EMS units.

Use the optional EMS Module to report each medical incident that a department responds to. This module is completed only if the fire department provides emergency medical service. If an independent provider performs EMS, do not use this module.

NOTE: Data on fire services injuries or deaths are recorded on the Fire Service Casualty Module. The EMS Module does not replace the Civilian Fire Casualty Module in cases where a civilian injury or death results from a fire incident.

Whenever specific 300 series Incident Types (e.g., 311, 322, 371, etc.) are entered on the Basic Module, Section C, you also may complete the EMS Module. It also may be completed for injuries treated in certain other incident types (consult the CRG for specifics).

One EMS Module should be completed for each patient, and the number of modules submitted for an incident should match the Number of Patients entered in Block B of the paper form.

Section A: FDID, State, Incident Number, Incident

A	FDID	State	Incident Date	Station	Incident Number	Exposure	<input type="checkbox"/> Delete <input type="checkbox"/> Change	NFIRS-6 EMS
	MM	DD	YYYY					

The information in Section A of the EMS Module is drawn from [Section A](#) of the Basic Module. Use the data in the Basic Module to help you supply the requested information. If you are using an automated system the data need to be entered only once, then they will be transferred automatically into other modules that use the data.

Section B: Number of Patients and Patient Number

B	Number of Patients	Patient Number ☆
	<input type="text"/>	<input type="text"/>
Use a separate form for each patient		

Record the total number of patients in the incident on the first line of Section B. Remember that you need to fill out a separate form for each patient. Enter a number that identifies each individual patient on line two. Assign patient numbers starting with 001.

Section C: Date/Time

C	Date/Time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Time of Patient Transfer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Use the first line to record Time Arrived at Patient. This is the date and time when emergency personnel get to the same location as the patient. This data element is important in situations where there may be a significant amount of time between the time an emergency unit arrives on the scene and the time that direct contact is made with the patient.

Examples:

EMS personnel were prevented from approaching a patient because of a fire, criminal activity, or other adverse conditions.

Responders need to reach an upper floor of a highrise building in order to gain access to a patient.

Enter the Time of Patient Transfer on the second line. This documents the date and time that patient care was transferred from fire department personnel to another care provider, or the time transportation began to an emergency care facility.

Subtracting the Arrival at Patient time from the Transfer time provides an accurate reading of the actual time spent with the patient.

Section D: Provider Impression/Assessment

D Provider Impression/Assessment ☆ Check one box only			<input type="checkbox"/> None/no patient or refused treatment		
10 <input type="checkbox"/> Abdominal pain	18 <input type="checkbox"/> Chest pain	26 <input type="checkbox"/> Hypovolemia	34 <input type="checkbox"/> Sexual assault	35 <input type="checkbox"/> Sting/bite	36 <input type="checkbox"/> Stroke/CVA
11 <input type="checkbox"/> Airway obstruction	19 <input type="checkbox"/> Diabetic symptom	27 <input type="checkbox"/> Inhalation injury	37 <input type="checkbox"/> Syncope	38 <input type="checkbox"/> Trauma	00 <input type="checkbox"/> Other
12 <input type="checkbox"/> Allergic reaction	20 <input type="checkbox"/> Do not resuscitate	28 <input type="checkbox"/> Obvious death	30 <input type="checkbox"/> Pregnancy/OB	31 <input type="checkbox"/> Respiratory arrest	32 <input type="checkbox"/> Respiratory distress
13 <input type="checkbox"/> Altered LOC	21 <input type="checkbox"/> Electrocutation	29 <input type="checkbox"/> OD/poisoning	33 <input type="checkbox"/> Seizure		
14 <input type="checkbox"/> Behavioral/psych	22 <input type="checkbox"/> General illness				
15 <input type="checkbox"/> Burns	23 <input type="checkbox"/> Hemorrhaging/bleeding				
16 <input type="checkbox"/> Cardiac arrest	24 <input type="checkbox"/> Hyperthermia				
17 <input type="checkbox"/> Cardiac dysrhythmia	25 <input type="checkbox"/> Hypothermia				

Record the single clinical assessment that most influenced the responder's actions by marking one of the coded boxes provided. If more than one choice applies to the patient, indicate the single most important clinical assessment that influenced the plan of therapy and management. The box marked should identify the actual assessment. This could be different from the original complaint that the unit responded to.

The assessment recorded on the form should provide the information needed to determine whether the treatments or medications provided matched the protocols related to the clinical impression at the time of treatment.

Section E: Age or Date of Birth, Gender

E₁ Age or Date of Birth		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age		Months (for infants)
OR		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Month	Day	Year

Either enter the patient's age or date of birth in **Block E₁**. You can record an infant's age by marking the Months box.

E₂ Gender	
1 <input type="checkbox"/>	2 <input type="checkbox"/>
Male	Female

Record the patient's gender by marking the appropriate box.

Section F: Race, Ethnicity

F₁ Race	
1 <input type="checkbox"/>	White
2 <input type="checkbox"/>	Black, African American
3 <input type="checkbox"/>	Am. Indian, Alaska Native
4 <input type="checkbox"/>	Asian
5 <input type="checkbox"/>	Native Hawaiian, Other Pacific Islander
0 <input type="checkbox"/>	Other, multiracial
U <input type="checkbox"/>	Undetermined

Mark the box that in **Block F₁** to record the patient's race, if known.

F₂ Ethnicity	
1 <input type="checkbox"/>	Hispanic or Latino
2 <input type="checkbox"/>	Non Hispanic or Latino

F₂ identifies the ethnicity of the patient. Ethnicity is an ethnic classification or affiliation. Currently Hispanic is the only U.S. Census Bureau classification. Hispanic is not considered a race because a person can be black and Hispanic, white and Hispanic, etc.

These data are useful for epidemiological studies, and also can be important in accessing certain types of Federal or State funds directed to specific racial or ethnic groups.

Section G: Human Factors Contributing to Injury and Other Factors

G₁ Human Factors Contributing to Injury None

Check all applicable boxes

1 Asleep

2 Unconscious

3 Possibly impaired by alcohol

4 Possibly impaired by drug

5 Possibly mentally disabled

6 Physically disabled

7 Physically restrained

8 Unattended person

Use **Block G₁** to clarify patient circumstances that may have contributed to the injury/illness. Mark as many boxes as are applicable. This information can be important to injury researchers who plan injury-reduction programs based on human factors.

G₂ Other Factors None

If an illness, not an injury, skip G₂ and go to H₃

1 Accidental

2 Self-inflicted

3 Inflicted, not self

Use **Block G₂** to address other factors such as accidental, self-inflicted, or inflicted, not self that affect how the injury/illness occurred. Data can be used to show number comparisons between accidental and self-inflicted incidents.

Section H: Body Site of Injury, Injury Type, and Cause of Injury/Illness

H₁ Body Site of Injury <small>List up to five body sites</small>	➔	H₂ Injury Type <small>List one injury type for each body site listed under H₁</small>
<input style="width: 20px; height: 20px;" type="checkbox"/> _____ <input style="width: 20px; height: 20px;" type="checkbox"/> _____ <input style="width: 20px; height: 20px;" type="checkbox"/> _____ <input style="width: 20px; height: 20px;" type="checkbox"/> _____ <input style="width: 20px; height: 20px;" type="checkbox"/> _____		<input style="width: 20px; height: 20px;" type="checkbox"/> _____ <input style="width: 20px; height: 20px;" type="checkbox"/> _____ <input style="width: 20px; height: 20px;" type="checkbox"/> _____ <input style="width: 20px; height: 20px;" type="checkbox"/> _____ <input style="width: 20px; height: 20px;" type="checkbox"/> _____

You can record up to five body sites in Block **H₁**. Describe the body site injured and its corresponding injury type, listing the body site with the most serious injury first. **H₂** links the type of each injury noted to each body site.

Site and type of injury are crucial data elements that will enable EMS planners to identify the types of injuries experienced by patients using the EMS system. These data also are used to analyze the correlation between injury assessment in the field and actual injuries as evaluated in medical receiving facilities.

Enter a code in **Block H₃** to capture the specific cause of the illness/injury. Data analysis provides an understanding of the conditions causing the injury. It also assists with planning treatments in the field and developing illness/injury programs.

Cause of Illness/Injury Codes					
10	Chemical Exposure	20	Heat	31	Non-traffic vehicle (off-road) accident
11	Drug Poisoning	21	Explosives	32	Physical assault/abuse
12	Fall	22	Fire and flames	33	Scalds/other thermal
13	Aircraft related	23	Firearm	34	Smoke inhalation
14	Bite, includes animal bites	25	Fireworks	35	Stabbing assault
15	Bicycle accident	26	Lightning	36	Venomous sting
16	Building collapse/construction accident	27	Machinery	37	Water transport
17	Drowning	28	Mechanical suffocation	00	Other cause
18	Electrical shock	29	Motor vehicle accident	UU	Unknown
19	Cold	30	Motor vehicle accident, pedestrian		

Example:

Patient with two stab wounds in different body sites and a blunt trauma injury to another body site.

Block H₁	Block H₂	Block H₃
(2) neck and shoulder	(18) puncture/stab	(35) stabbing
(7) lower extremities	(18) puncture/stab	(35) stabbing
(1) head	(11) blunt injury	(13) assault

The system captures each separate injury related to a particular body site for as many as five injuries.

Section I: Procedures Used

I Procedures Used		Check all applicable boxes	<input type="checkbox"/> No treatment
01	<input type="checkbox"/> Airway insertion	14	<input type="checkbox"/> Intubation (EGTA)
02	<input type="checkbox"/> Anti-shock trousers	15	<input type="checkbox"/> Intubation (ET)
03	<input type="checkbox"/> Assist ventilation	16	<input type="checkbox"/> IO/IV therapy
04	<input type="checkbox"/> Bleeding control	17	<input type="checkbox"/> Medications therapy
05	<input type="checkbox"/> Burn care	18	<input type="checkbox"/> Oxygen therapy
06	<input type="checkbox"/> Cardiac pacing	19	<input type="checkbox"/> OB care/delivery
07	<input type="checkbox"/> Cardioversion (defib) manual	20	<input type="checkbox"/> Prearrival instructions
08	<input type="checkbox"/> Chest/abdominal thrust	21	<input type="checkbox"/> Restrain patient
09	<input type="checkbox"/> CPR	22	<input type="checkbox"/> Spinal immobilization
10	<input type="checkbox"/> Cricothyroidotomy	23	<input type="checkbox"/> Splinted extremities
11	<input type="checkbox"/> Defibrillation by AED	24	<input type="checkbox"/> Suction/aspirate
12	<input type="checkbox"/> EKG monitoring	00	<input type="checkbox"/> Other
13	<input type="checkbox"/> Extrication		

Many possible procedures are listed in Section I. Procedures are defined as anything done to assess or treat the patient. Mark all applicable boxes to document the procedures either attempted or actually performed during the course of patient care.

Section J: Safety Equipment

J Safety Equipment		<input type="checkbox"/> None
Used or deployed by patient. Check all applicable boxes.		
1	<input type="checkbox"/> Safety/seat belts	
2	<input type="checkbox"/> Child safety seat	
3	<input type="checkbox"/> Airbag	
4	<input type="checkbox"/> Helmet	
5	<input type="checkbox"/> Protective clothing	
6	<input type="checkbox"/> Flotation device	
0	<input type="checkbox"/> Other	
U	<input type="checkbox"/> Undetermined	

If the patient was using any safety equipment at the time of the injury record a description of the type used in Section J.

Nine options are provided. These data provide important information about whether or not appropriate safety devices are being used. This is especially important in industrial and motor vehicle incidents, which are regulated by Federal agencies and local and State laws.

Researchers, consumer groups, and manufacturers use these data to study the effectiveness of safety devices in preventing injuries and reducing deaths. This information also is important to use when improvements are being made to existing safety devices, or when new safety devices are being developed.

Section K: Cardiac Arrest

K	Cardiac Arrest
	Check all applicable boxes
1	<input type="checkbox"/> Pre-arrival arrest?
	If pre-arrival arrest, was it:
1	<input type="checkbox"/> Witnessed?
2	<input type="checkbox"/> Bystander CPR?
2	<input type="checkbox"/> Post-arrival arrest?
	Initial Arrest Rhythm
1	<input type="checkbox"/> V-Fib/V-Tach
0	<input type="checkbox"/> Other
U	<input type="checkbox"/> Undetermined

This section is used to indicate if patient cardiac arrest was pre- or postarrival on the scene of an incident. If it occurred pre-arrival, you should indicate whether or not it was witnessed and/or if bystanders performed CPR.

You also should record the initial arrest rhythm by checking the box next to either V-Fib/V-Tach, Other, or Undetermined.

Data from this section are used to evaluate prehospital CPR and the effect of cardiac care on reducing morbidity.

Section L: Initial Level of Provider and Highest Level of Care Provided on Scene

L₁	Initial Level of Provider	★
1	<input type="checkbox"/> First Responder	
2	<input type="checkbox"/> EMT-B (Basic)	
3	<input type="checkbox"/> EMT-I (Intermediate)	
4	<input type="checkbox"/> EMT-P (Paramedic)	
0	<input type="checkbox"/> Other provider	
N	<input type="checkbox"/> No Training	

Block L₁ is used to collect data about the training level of the fire department responders who provided the initial care. Researchers can use these data to determine the effectiveness of care and measure any trends in the quality of prehospital care being provided by fire departments.

L₂	Highest Level of Care Provided On Scene	<input type="checkbox"/> None
1	<input type="checkbox"/> First Responder	
2	<input type="checkbox"/> EMT-B (Basic)	
3	<input type="checkbox"/> EMT-I (Intermediate)	
4	<input type="checkbox"/> EMT-P (Paramedic)	
0	<input type="checkbox"/> Other provider	

Block L₂ is used to gather training-level information on the fire department responders who provided the highest level of care at the scene of an incident. This knowledge can help determine what kind of effect there is on patient care in the field when responders have higher levels of training/certification.

Section M: Patient Status

M	Patient Status
1	<input type="checkbox"/> Improved
2	<input type="checkbox"/> Remained same
3	<input type="checkbox"/> Worsened
Check if:	
1	<input type="checkbox"/> Pulse on transfer
2	<input type="checkbox"/> No pulse on transfer

Mark the box that indicates whether the patient Improved, Remained same, or Worsened while under fire department care. This determination is made at the time of patient transfer. There is also a box that should be marked whether or not the patient had a pulse on transfer.

Section N: Disposition

N	EMS Disposition	<input type="checkbox"/> Not transported
1	<input type="checkbox"/> FD transport to ECF	
2	<input type="checkbox"/> Non-FD transport	
3	<input type="checkbox"/> Non-FD trans/FD attend	
4	<input type="checkbox"/> Non-emergency transfer	
0	<input type="checkbox"/> Other	
<small>NFIRS-6 Revision 01/01/04</small>		

There are six choices available for documenting the disposition of the patient. These data will allow generation of reports that show the disposition for EMS responses, and can correlate various patient treatments to patient outcomes. This section may help the fire service to look at what its EMS transport needs are.

SUMMARY

Nationally, EMS activities are a significant part of the total service being provided by fire departments. The fire service can use the EMS Module to report all emergency medical incidents to which a fire department unit responds. A separate EMS Module is used for each patient.

EXAMPLE: Injured Person

Directions: Read the call information in the example below. Then look at the completed EMS Module form. Look at each section and follow along with the proper use of the information as applicable to the EMS Module.

Department FDID #TR200, Station #1, is dispatched on a medical call on May 1, 2002. A fire department unit is dispatched to respond to the call at 0223 hours. The unit arrives at 1245 S. First St., Brooklyn, WI 12345 at 0228 and is met by a 22-year-old white female. She has been stabbed in the leg and is bleeding from the wound. Further examination reveals burns on one arm. A first responder stops the bleeding, bandages the wound, and provides care for the burns. The patient's family chooses to provide transportation to the closest hospital for further treatment. She is transferred at 0256 hours. The incident number is 0001234.

A FDID <input type="text" value="TR200"/> State <input type="text" value="WI"/> Incident Date <input type="text" value="05"/> <input type="text" value="01"/> <input type="text" value="2002"/> Station <input type="text" value="001"/> Incident Number <input type="text" value="0001234"/> Exposure <input type="text" value="000"/>		<input type="checkbox"/> Delete <input type="checkbox"/> Change	NFIRS-6 EMS																																
B Number of Patients <input type="text" value="001"/> Patient Number <input type="text" value="001"/>		C Date/Time Check if same date as Alarm date <input checked="" type="checkbox"/> Time Arrived at Patient <input type="text" value="0"/> <input type="text" value="2"/> <input type="text" value="2"/> <input type="text" value="8"/> <input checked="" type="checkbox"/> Time of Patient Transfer <input type="text" value="0"/> <input type="text" value="2"/> <input type="text" value="5"/> <input type="text" value="6"/>																																	
D Provider Impression/Assessment <input type="checkbox"/> Check one box only <input type="checkbox"/> None/no patient or refused treatment																																			
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E1 Age or Date of Birth <input type="text" value="0"/> <input type="text" value="2"/> <input type="text" value="2"/> <input type="checkbox"/> Months (for infants) Age <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> OR Month Day Year		F1 Race <input checked="" type="checkbox"/> 1 White <input type="checkbox"/> 2 Black, African American <input type="checkbox"/> 3 Am. Indian, Alaska Native <input type="checkbox"/> 4 Asian <input type="checkbox"/> 5 Native Hawaiian, Other Pacific Islander <input type="checkbox"/> 0 Other, multiracial <input type="checkbox"/> U Undetermined																																	
E2 Gender <input type="checkbox"/> 1 Male <input checked="" type="checkbox"/> 2 Female		F2 Ethnicity <input type="checkbox"/> 1 Hispanic or Latino <input type="checkbox"/> 2 Non Hispanic or Latino																																	
G1 Human Factors Contributing to Injury <input checked="" type="checkbox"/> None Check all applicable boxes <input type="checkbox"/> 1 Asleep <input type="checkbox"/> 2 Unconscious <input type="checkbox"/> 3 Possibly impaired by alcohol <input type="checkbox"/> 4 Possibly impaired by drug <input type="checkbox"/> 5 Possibly mentally disabled <input type="checkbox"/> 6 Physically disabled <input type="checkbox"/> 7 Physically restrained <input type="checkbox"/> 8 Unattended person		G2 Other Factors <input type="checkbox"/> None If an illness, not an injury, skip G2 and go to H3 <input type="checkbox"/> 1 Accidental <input type="checkbox"/> 2 Self-inflicted <input checked="" type="checkbox"/> 3 Inflicted, not self																																	
H1 Body Site of Injury List up to five body sites <input type="text" value="7"/> Lower Extremity <input type="text" value="6"/> Upper Extremity		H2 Injury Type List one injury type for each body site listed under H1 <input type="text" value="18"/> Puncture/Stab <input type="text" value="12"/> Burn																																	
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I Procedures Used <input type="checkbox"/> No treatment Check all applicable boxes <input type="checkbox"/> 01 Airway insertion <input type="checkbox"/> 02 Anti-shock trousers <input type="checkbox"/> 03 Assist ventilation <input checked="" type="checkbox"/> 04 Bleeding control <input checked="" type="checkbox"/> 05 Burn care <input type="checkbox"/> 06 Cardiac pacing <input type="checkbox"/> 07 Cardioversion (defib) manual <input type="checkbox"/> 08 Chest/abdominal thrust <input type="checkbox"/> 09 CPR <input type="checkbox"/> 10 Cricothyroidotomy <input type="checkbox"/> 11 Defibrillation by AED <input type="checkbox"/> 12 EKG monitoring <input type="checkbox"/> 13 Extrication <input type="checkbox"/> 14 Intubation (EGTA) <input type="checkbox"/> 15 Intubation (ET) <input type="checkbox"/> 16 IO/IV therapy <input type="checkbox"/> 17 Medications therapy <input type="checkbox"/> 18 Oxygen therapy <input type="checkbox"/> 19 OB care/delivery <input type="checkbox"/> 20 Prearrival instructions <input type="checkbox"/> 21 Restrain patient <input type="checkbox"/> 22 Spinal immobilization <input type="checkbox"/> 23 Splinted extremities <input type="checkbox"/> 24 Suction/aspirate <input type="checkbox"/> 00 Other		J Safety Equipment <input checked="" type="checkbox"/> None Used or deployed by patient. Check all applicable boxes. <input type="checkbox"/> 1 Safety/seat belts <input type="checkbox"/> 2 Child safety seat <input type="checkbox"/> 3 Airbag <input type="checkbox"/> 4 Helmet <input type="checkbox"/> 5 Protective clothing <input type="checkbox"/> 6 Flotation device <input type="checkbox"/> 0 Other <input type="checkbox"/> U Undetermined																																	
K Cardiac Arrest <input type="checkbox"/> No treatment Check all applicable boxes <input type="checkbox"/> 1 Pre-arrival arrest? If pre-arrival arrest, was it: <input type="checkbox"/> 1 Witnessed? <input type="checkbox"/> 2 Bystander CPR? <input type="checkbox"/> 2 Post-arrival arrest? Initial Arrest Rhythm <input type="checkbox"/> 1 V-Fib/V-Tach <input type="checkbox"/> 0 Other <input type="checkbox"/> U Undetermined																																			
L1 Initial Level of Provider <input checked="" type="checkbox"/> 1 First Responder <input type="checkbox"/> 2 EMT-B (Basic) <input type="checkbox"/> 3 EMT-I (Intermediate) <input type="checkbox"/> 4 EMT-P (Paramedic) <input type="checkbox"/> 0 Other provider <input type="checkbox"/> N No Training		L2 Highest Level of Care Provided On Scene <input type="checkbox"/> None <input checked="" type="checkbox"/> 1 First Responder <input type="checkbox"/> 2 EMT-B (Basic) <input type="checkbox"/> 3 EMT-I (Intermediate) <input type="checkbox"/> 4 EMT-P (Paramedic) <input type="checkbox"/> 0 Other provider																																	
M Patient Status <input type="checkbox"/> 1 Improved <input checked="" type="checkbox"/> 2 Remained same <input type="checkbox"/> 3 Worsened Check if: <input type="checkbox"/> 1 Pulse on transfer <input type="checkbox"/> 2 No pulse on transfer		N EMS Disposition <input type="checkbox"/> Not transported <input type="checkbox"/> 1 FD transport to ECF <input type="checkbox"/> 2 Non-FD transport <input type="checkbox"/> 3 Non-FD trans/FD attend <input type="checkbox"/> 4 Non-emergency transfer <input checked="" type="checkbox"/> 0 Other																																	

EXERCISE SCENARIO 6.1: Unconscious Person

Directions: Read the call information in the exercise below. Use the information provided to complete the EMS Module form. Compare your work to the answers provided on the completed EMS Module form. If your answers are different from the ones provided, read over the EMS Module again.

A fire department first-responder unit, TR 100, Station 001, is dispatched at 1405 hours on April 1, 1997 to a medical call – incident #9704567. The unit is staffed with a driver, an officer, and an EMT. They arrive at 210 W. Main Street, Minlo, WI 12345 at 1407 hours and reach the patient's side at 1410. They find a 22-year-old white male unconscious on the floor. His friends tell them that he just shot up on heroin and has overdosed. The patient shows signs of shallow breathing, pin-point pupils, and has a faint pulse. The EMT inserts an airway, administers oxygen, and assists in ventilation.

A private medic unit arrives and the Paramedic administers a dose of Narcan. The patient responds and begins breathing on his own. At 1440, the Paramedic determines that the patient has stabilized and arranges transport to an emergency room for further evaluation.

A FDID <input type="text"/> State <input type="text"/> Incident Date <input type="text"/> MM <input type="text"/> DD <input type="text"/> YYYY <input type="text"/> Station <input type="text"/> Incident Number <input type="text"/> Exposure <input type="text"/>		<input type="checkbox"/> Delete <input type="checkbox"/> Change	NFIRS-6 EMS
B Number of Patients <input type="text"/> Patient Number <input type="text"/>		C Date/Time <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Use a separate form for each patient		<input type="checkbox"/> Time Arrived at Patient <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> Time of Patient Transfer <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
D Provider Impression/Assessment <input type="checkbox"/> Check one box only <input type="checkbox"/> None/no patient or refused treatment			
10 <input type="checkbox"/> Abdominal pain	18 <input type="checkbox"/> Chest pain	26 <input type="checkbox"/> Hypovolemia	34 <input type="checkbox"/> Sexual assault
11 <input type="checkbox"/> Airway obstruction	19 <input type="checkbox"/> Diabetic symptom	27 <input type="checkbox"/> Inhalation injury	35 <input type="checkbox"/> Sting/bite
12 <input type="checkbox"/> Allergic reaction	20 <input type="checkbox"/> Do not resuscitate	28 <input type="checkbox"/> Obvious death	36 <input type="checkbox"/> Stroke/CVA
13 <input type="checkbox"/> Altered LOC	21 <input type="checkbox"/> Electrocutation	29 <input type="checkbox"/> OD/poisoning	37 <input type="checkbox"/> Syncope
14 <input type="checkbox"/> Behavioral/psych	22 <input type="checkbox"/> General illness	30 <input type="checkbox"/> Pregnancy/OB	38 <input type="checkbox"/> Trauma
15 <input type="checkbox"/> Burns	23 <input type="checkbox"/> Hemorrhaging/bleeding	31 <input type="checkbox"/> Respiratory arrest	00 <input type="checkbox"/> Other
16 <input type="checkbox"/> Cardiac arrest	24 <input type="checkbox"/> Hyperthermia	32 <input type="checkbox"/> Respiratory distress	
17 <input type="checkbox"/> Cardiac dysrhythmia	25 <input type="checkbox"/> Hypothermia	33 <input type="checkbox"/> Seizure	
E1 Age or Date of Birth <input type="text"/> <input type="checkbox"/> Months (for infants) Age <input type="text"/> OR <input type="text"/> Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>	F1 Race 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black, African American 3 <input type="checkbox"/> Am. Indian, Alaska Native 4 <input type="checkbox"/> Asian 5 <input type="checkbox"/> Native Hawaiian, Other Pacific Islander 0 <input type="checkbox"/> Other, multiracial U <input type="checkbox"/> Undetermined	G1 Human Factors Contributing to Injury <input type="checkbox"/> None Check all applicable boxes 1 <input type="checkbox"/> Asleep 2 <input type="checkbox"/> Unconscious 3 <input type="checkbox"/> Possibly impaired by alcohol 4 <input type="checkbox"/> Possibly impaired by drug 5 <input type="checkbox"/> Possibly mentally disabled 6 <input type="checkbox"/> Physically disabled 7 <input type="checkbox"/> Physically restrained 8 <input type="checkbox"/> Unattended person	G2 Other Factors <input type="checkbox"/> None If an illness, not an injury, skip G2 and go to H3 1 <input type="checkbox"/> Accidental 2 <input type="checkbox"/> Self-inflicted 3 <input type="checkbox"/> Inflicted, not self
E2 Gender 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	F2 Ethnicity 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Non Hispanic or Latino		
H1 Body Site of Injury List up to five body sites <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		H2 Injury Type List one injury type for each body site listed under H1 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	H3 Cause of Illness/Injury <input type="text"/> Cause of illness/injury <input type="text"/>
I Procedures Used <input type="checkbox"/> No treatment Check all applicable boxes 01 <input type="checkbox"/> Airway insertion 02 <input type="checkbox"/> Anti-shock trousers 03 <input type="checkbox"/> Assist ventilation 04 <input type="checkbox"/> Bleeding control 05 <input type="checkbox"/> Burn care 06 <input type="checkbox"/> Cardiac pacing 07 <input type="checkbox"/> Cardioversion (defib) manual 08 <input type="checkbox"/> Chest/abdominal thrust 09 <input type="checkbox"/> CPR 10 <input type="checkbox"/> Cricothyroidotomy 11 <input type="checkbox"/> Defibrillation by AED 12 <input type="checkbox"/> EKG monitoring 13 <input type="checkbox"/> Extrication 14 <input type="checkbox"/> Intubation (EGTA) 15 <input type="checkbox"/> Intubation (ET) 16 <input type="checkbox"/> IO/IV therapy 17 <input type="checkbox"/> Medications therapy 18 <input type="checkbox"/> Oxygen therapy 19 <input type="checkbox"/> OB care/delivery 20 <input type="checkbox"/> Prearrival instructions 21 <input type="checkbox"/> Restrain patient 22 <input type="checkbox"/> Spinal immobilization 23 <input type="checkbox"/> Splinted extremities 24 <input type="checkbox"/> Suction/aspirate 00 <input type="checkbox"/> Other		J Safety Equipment <input type="checkbox"/> None Used or deployed by patient. Check all applicable boxes. 1 <input type="checkbox"/> Safety/seat belts 2 <input type="checkbox"/> Child safety seat 3 <input type="checkbox"/> Airbag 4 <input type="checkbox"/> Helmet 5 <input type="checkbox"/> Protective clothing 6 <input type="checkbox"/> Flotation device 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined	K Cardiac Arrest Check all applicable boxes 1 <input type="checkbox"/> Pre-arrival arrest? If pre-arrival arrest, was it: 1 <input type="checkbox"/> Witnessed? 2 <input type="checkbox"/> Bystander CPR? 2 <input type="checkbox"/> Post-arrival arrest? Initial Arrest Rhythm 1 <input type="checkbox"/> V-Fib/V-Tach 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined
L1 Initial Level of Provider <input type="checkbox"/> <input type="checkbox"/> 1 <input type="checkbox"/> First Responder 2 <input type="checkbox"/> EMT-B (Basic) 3 <input type="checkbox"/> EMT-I (Intermediate) 4 <input type="checkbox"/> EMT-P (Paramedic) 0 <input type="checkbox"/> Other provider N <input type="checkbox"/> No Training	L2 Highest Level of Care Provided On Scene <input type="checkbox"/> None 1 <input type="checkbox"/> First Responder 2 <input type="checkbox"/> EMT-B (Basic) 3 <input type="checkbox"/> EMT-I (Intermediate) 4 <input type="checkbox"/> EMT-P (Paramedic) 0 <input type="checkbox"/> Other provider	M Patient Status 1 <input type="checkbox"/> Improved 2 <input type="checkbox"/> Remained same 3 <input type="checkbox"/> Worsened Check if: 1 <input type="checkbox"/> Pulse on transfer 2 <input type="checkbox"/> No pulse on transfer	N EMS Disposition <input type="checkbox"/> Not transported 1 <input type="checkbox"/> FD transport to ECF 2 <input type="checkbox"/> Non-FD transport 3 <input type="checkbox"/> Non-FD trans/FD attend 4 <input type="checkbox"/> Non-emergency transfer 0 <input type="checkbox"/> Other

A FDID <input type="text" value="TR100"/> State <input type="text" value="WI"/> Incident Date <input type="text" value="04"/> <input type="text" value="01"/> <input type="text" value="1997"/> Station <input type="text" value="001"/> Incident Number <input type="text" value="9704567"/> Exposure <input type="text" value="000"/>		<input type="checkbox"/> Delete <input type="checkbox"/> Change	NFIRS-6 EMS																																
B Number of Patients <input type="text" value="001"/> Patient Number <input type="text" value="001"/>		C Date/Time Check if same date as Alarm date <input checked="" type="checkbox"/> Time Arrived at Patient <input type="text" value="14"/> <input type="text" value="10"/> <input checked="" type="checkbox"/> Time of Patient Transfer <input type="text" value="14"/> <input type="text" value="40"/>																																	
D Provider Impression/Assessment <input checked="" type="checkbox"/> Check one box only <input type="checkbox"/> None/no patient or refused treatment																																			
<table style="width:100%; border: none;"> <tr> <td style="width: 25%; border: none;">10 <input type="checkbox"/> Abdominal pain</td> <td style="width: 25%; border: none;">18 <input type="checkbox"/> Chest pain</td> <td style="width: 25%; border: none;">26 <input type="checkbox"/> Hypovolemia</td> <td style="width: 25%; border: none;">34 <input type="checkbox"/> Sexual assault</td> </tr> <tr> <td style="border: none;">11 <input type="checkbox"/> Airway obstruction</td> <td style="border: none;">19 <input type="checkbox"/> Diabetic symptom</td> <td style="border: none;">27 <input type="checkbox"/> Inhalation injury</td> <td style="border: none;">35 <input type="checkbox"/> Sting/bite</td> </tr> <tr> <td style="border: none;">12 <input type="checkbox"/> Allergic reaction</td> <td style="border: none;">20 <input type="checkbox"/> Do not resuscitate</td> <td style="border: none;">28 <input type="checkbox"/> Obvious death</td> <td style="border: none;">36 <input type="checkbox"/> Stroke/CVA</td> </tr> <tr> <td style="border: none;">13 <input type="checkbox"/> Altered LOC</td> <td style="border: none;">21 <input type="checkbox"/> Electrocutation</td> <td style="border: none;">29 <input checked="" type="checkbox"/> OD/poisoning</td> <td style="border: none;">37 <input type="checkbox"/> Syncope</td> </tr> <tr> <td style="border: none;">14 <input type="checkbox"/> Behavioral/psych</td> <td style="border: none;">22 <input type="checkbox"/> General illness</td> <td style="border: none;">30 <input type="checkbox"/> Pregnancy/OB</td> <td style="border: none;">38 <input type="checkbox"/> Trauma</td> </tr> <tr> <td style="border: none;">15 <input type="checkbox"/> Burns</td> <td style="border: none;">23 <input type="checkbox"/> Hemorrhaging/bleeding</td> <td style="border: none;">31 <input type="checkbox"/> Respiratory arrest</td> <td style="border: none;">00 <input type="checkbox"/> Other</td> </tr> <tr> <td style="border: none;">16 <input type="checkbox"/> Cardiac arrest</td> <td style="border: none;">24 <input type="checkbox"/> Hyperthermia</td> <td style="border: none;">32 <input type="checkbox"/> Respiratory distress</td> <td></td> </tr> <tr> <td style="border: none;">17 <input type="checkbox"/> Cardiac dysrhythmia</td> <td style="border: none;">25 <input type="checkbox"/> Hypothermia</td> <td style="border: none;">33 <input type="checkbox"/> Seizure</td> <td></td> </tr> </table>				10 <input type="checkbox"/> Abdominal pain	18 <input type="checkbox"/> Chest pain	26 <input type="checkbox"/> Hypovolemia	34 <input type="checkbox"/> Sexual assault	11 <input type="checkbox"/> Airway obstruction	19 <input type="checkbox"/> Diabetic symptom	27 <input type="checkbox"/> Inhalation injury	35 <input type="checkbox"/> Sting/bite	12 <input type="checkbox"/> Allergic reaction	20 <input type="checkbox"/> Do not resuscitate	28 <input type="checkbox"/> Obvious death	36 <input type="checkbox"/> Stroke/CVA	13 <input type="checkbox"/> Altered LOC	21 <input type="checkbox"/> Electrocutation	29 <input checked="" type="checkbox"/> OD/poisoning	37 <input type="checkbox"/> Syncope	14 <input type="checkbox"/> Behavioral/psych	22 <input type="checkbox"/> General illness	30 <input type="checkbox"/> Pregnancy/OB	38 <input type="checkbox"/> Trauma	15 <input type="checkbox"/> Burns	23 <input type="checkbox"/> Hemorrhaging/bleeding	31 <input type="checkbox"/> Respiratory arrest	00 <input type="checkbox"/> Other	16 <input type="checkbox"/> Cardiac arrest	24 <input type="checkbox"/> Hyperthermia	32 <input type="checkbox"/> Respiratory distress		17 <input type="checkbox"/> Cardiac dysrhythmia	25 <input type="checkbox"/> Hypothermia	33 <input type="checkbox"/> Seizure	
10 <input type="checkbox"/> Abdominal pain	18 <input type="checkbox"/> Chest pain	26 <input type="checkbox"/> Hypovolemia	34 <input type="checkbox"/> Sexual assault																																
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12 <input type="checkbox"/> Allergic reaction	20 <input type="checkbox"/> Do not resuscitate	28 <input type="checkbox"/> Obvious death	36 <input type="checkbox"/> Stroke/CVA																																
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14 <input type="checkbox"/> Behavioral/psych	22 <input type="checkbox"/> General illness	30 <input type="checkbox"/> Pregnancy/OB	38 <input type="checkbox"/> Trauma																																
15 <input type="checkbox"/> Burns	23 <input type="checkbox"/> Hemorrhaging/bleeding	31 <input type="checkbox"/> Respiratory arrest	00 <input type="checkbox"/> Other																																
16 <input type="checkbox"/> Cardiac arrest	24 <input type="checkbox"/> Hyperthermia	32 <input type="checkbox"/> Respiratory distress																																	
17 <input type="checkbox"/> Cardiac dysrhythmia	25 <input type="checkbox"/> Hypothermia	33 <input type="checkbox"/> Seizure																																	
E1 Age or Date of Birth <input type="text" value="0"/> <input type="text" value="2"/> <input type="text" value="2"/> <input type="checkbox"/> Months (for infants) Age <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> OR Month Day Year		F1 Race 1 <input checked="" type="checkbox"/> White 2 <input type="checkbox"/> Black, African American 3 <input type="checkbox"/> Am. Indian, Alaska Native 4 <input type="checkbox"/> Asian 5 <input type="checkbox"/> Native Hawaiian, Other Pacific Islander 0 <input type="checkbox"/> Other, multiracial U <input type="checkbox"/> Undetermined																																	
E2 Gender 1 <input checked="" type="checkbox"/> Male 2 <input type="checkbox"/> Female		F2 Ethnicity 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Non Hispanic or Latino																																	
G1 Human Factors Contributing to Injury <input type="checkbox"/> None Check all applicable boxes 1 <input type="checkbox"/> Asleep 2 <input type="checkbox"/> Unconscious 3 <input type="checkbox"/> Possibly impaired by alcohol 4 <input checked="" type="checkbox"/> Possibly impaired by drug 5 <input type="checkbox"/> Possibly mentally disabled 6 <input type="checkbox"/> Physically disabled 7 <input type="checkbox"/> Physically restrained 8 <input type="checkbox"/> Unattended person		G2 Other Factors <input type="checkbox"/> None If an illness, not an injury, skip G2 and go to H3 1 <input type="checkbox"/> Accidental 2 <input checked="" type="checkbox"/> Self-inflicted 3 <input type="checkbox"/> Inflicted, not self																																	
H1 Body Site of Injury List up to five body sites <input type="text" value="8"/> <input type="text" value="Internal"/>		H2 Injury Type List one injury type for each body site listed under H1 <input type="text" value="00"/> <input type="text" value="Other"/>																																	
H3 Cause of Illness/Injury <input type="text" value="11"/> <input type="text" value="11"/> Cause of illness/injury Drug Overdose																																			
I Procedures Used <input type="checkbox"/> No treatment Check all applicable boxes 01 <input checked="" type="checkbox"/> Airway insertion 02 <input type="checkbox"/> Anti-shock trousers 03 <input checked="" type="checkbox"/> Assist ventilation 04 <input type="checkbox"/> Bleeding control 05 <input type="checkbox"/> Burn care 06 <input type="checkbox"/> Cardiac pacing 07 <input type="checkbox"/> Cardioversion (defib) manual 08 <input type="checkbox"/> Chest/abdominal thrust 09 <input type="checkbox"/> CPR 10 <input type="checkbox"/> Cricothyroidotomy 11 <input type="checkbox"/> Defibrillation by AED 12 <input type="checkbox"/> EKG monitoring 13 <input type="checkbox"/> Extrication 14 <input type="checkbox"/> Intubation (EGTA) 15 <input type="checkbox"/> Intubation (ET) 16 <input type="checkbox"/> IO/IV therapy 17 <input type="checkbox"/> Medications therapy 18 <input checked="" type="checkbox"/> Oxygen therapy 19 <input type="checkbox"/> OB care/delivery 20 <input type="checkbox"/> Prearrival instructions 21 <input type="checkbox"/> Restrain patient 22 <input type="checkbox"/> Spinal immobilization 23 <input type="checkbox"/> Splinted extremities 24 <input type="checkbox"/> Suction/aspirate 00 <input type="checkbox"/> Other		J Safety Equipment <input checked="" type="checkbox"/> None Used or deployed by patient. Check all applicable boxes. 1 <input type="checkbox"/> Safety/seat belts 2 <input type="checkbox"/> Child safety seat 3 <input type="checkbox"/> Airbag 4 <input type="checkbox"/> Helmet 5 <input type="checkbox"/> Protective clothing 6 <input type="checkbox"/> Flotation device 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined																																	
K Cardiac Arrest Check all applicable boxes 1 <input type="checkbox"/> Pre-arrival arrest? If pre-arrival arrest, was it: 1 <input type="checkbox"/> Witnessed? 2 <input type="checkbox"/> Bystander CPR? 2 <input type="checkbox"/> Post-arrival arrest? Initial Arrest Rhythm 1 <input type="checkbox"/> V-Fib/V-Tach 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined																																			
L1 Initial Level of Provider <input checked="" type="checkbox"/> 1 <input type="checkbox"/> First Responder 2 <input checked="" type="checkbox"/> EMT-B (Basic) 3 <input type="checkbox"/> EMT-I (Intermediate) 4 <input type="checkbox"/> EMT-P (Paramedic) 0 <input type="checkbox"/> Other provider N <input type="checkbox"/> No Training		L2 Highest Level of Care Provided On Scene <input type="checkbox"/> None 1 <input type="checkbox"/> First Responder 2 <input checked="" type="checkbox"/> EMT-B (Basic) 3 <input type="checkbox"/> EMT-I (Intermediate) 4 <input type="checkbox"/> EMT-P (Paramedic) 0 <input type="checkbox"/> Other provider																																	
M Patient Status 1 <input checked="" type="checkbox"/> Improved 2 <input type="checkbox"/> Remained same 3 <input type="checkbox"/> Worsened Check if: 1 <input checked="" type="checkbox"/> Pulse on transfer 2 <input type="checkbox"/> No pulse on transfer		N EMS Disposition <input type="checkbox"/> Not transported 1 <input type="checkbox"/> FD transport to ECF 2 <input checked="" type="checkbox"/> Non-FD transport 3 <input type="checkbox"/> Non-FD trans/FD attend 4 <input type="checkbox"/> Non-emergency transfer 0 <input type="checkbox"/> Other																																	

EXERCISE SCENARIO 6-2: MVA on I-95

Directions: Read the call information in the exercise below. Use the information provided to complete the entire EMS Module form and other required forms. Compare your work to the answers provided in Appendix A. If your answers are different from the ones provided, read over the EMS Module again.

The Alberta Fire Department (FDID #92188) received a call for an MVA on I-95 near mile marker 73 and Exit 2B in Brunswick, Virginia, 23351 on May 3, 2005. The dispatcher assigned the incident (#5455) to Engine Co. 2 and Truck 1 from Shift C. The units received the alarm at 11:58 p.m. and arrived at the scene in six minutes with 4 firefighters on each unit. The owner of the vehicle, Mr. Robert L. Anderson, was driving to Emporia, Virginia, to return his son, Joseph, to his mother. Mr. Anderson lives at 1630 Second Avenue, Jarrett, North Carolina, 24501. His telephone number is 555-432-0987. He said that he was driving for 2 hours and became drowsy from a prescription drug that he took; he lost control of the car and it crashed into the guardrail. He called 9-1-1 from his cellular telephone. The vehicle was a 1999 Ford Explorer, Virginia License Plate Number ACZ586, and VIN 1FBEU54X3ABC45634. Mr. Anderson, a 49-year-old black male, was bleeding from the head. He cut his head when his car hit the guardrail. He was not wearing a safety belt and the airbag in the vehicle did not inflate. Firefighter Steve Cooke, EMT-Basic, approached Officer Morrison at 12:06 a.m. Firefighter Cooke stopped the bleeding. No other treatment was needed. Mr. Anderson's overall status improved. The towing service provider gave Mr. Anderson a ride from the incident. The last unit cleared the scene at 12:35 a.m. FF1 Steve B. LaCivita, Badge No. 230, completed the report after returning to Station No. 1. Captain Ernest Greene, Badge No. 100, was the officer in charge. The incident was in Census Tract 501.2, District A05. The Virginia Department of Transportation, 23 Washington Street NE, Richmond, VA 23219, manages Virginia highways.

A <input type="checkbox"/> Delete <input type="checkbox"/> Change <input type="checkbox"/> No Activity NFIRS-1 Basic	
FDID <input type="text"/> State <input type="text"/> Incident Date <input type="text"/> MM <input type="text"/> DD <input type="text"/> YYYY <input type="text"/> Station <input type="text"/> Incident Number <input type="text"/> Exposure <input type="text"/>	
B Location Type <input type="checkbox"/> Check this box to indicate that the address for this incident is provided on the Wildland Fire Module in Section B, "Alternative Location Specification." Use only for wildland fires.	
<input type="checkbox"/> Street address <input type="checkbox"/> Intersection <input type="checkbox"/> In front of <input type="checkbox"/> Rear of <input type="checkbox"/> Adjacent to <input type="checkbox"/> Directions <input type="checkbox"/> US National Grid	
Number/Milepost <input type="text"/> Prefix <input type="text"/> Street or Highway <input type="text"/> Street Type <input type="text"/> Suffix <input type="text"/> Apt./Suite/Room <input type="text"/> City <input type="text"/> State <input type="text"/> ZIP Code <input type="text"/>	
Cross Street, Directions or National Grid, as applicable	
C Incident Type <input type="checkbox"/> <input type="text"/> Incident Type	E1 Dates and Times Midnight is 0000 Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> Hour <input type="text"/> Min <input type="text"/> Check boxes if dates are the same as Alarm Date. <input type="checkbox"/> Alarm <input type="checkbox"/> Arrival <input type="checkbox"/> Controlled <input type="checkbox"/> Last Unit Cleared
D Aid Given or Received <input type="checkbox"/> None	ARRIVAL required, unless canceled or did not arrive CONTROLLED optional, except for wildland fires LAST UNIT CLEARED, required except for wildland fires
1 <input type="checkbox"/> Mutual aid received 2 <input type="checkbox"/> Auto. aid received 3 <input type="checkbox"/> Mutual aid given 4 <input type="checkbox"/> Auto. aid given 5 <input type="checkbox"/> Other aid given	Their FDID <input type="text"/> Their State <input type="text"/> Their Incident Number <input type="text"/>
E2 Shifts and Alarms Local Option Shift or Platoon <input type="text"/> Alarms <input type="text"/> District <input type="text"/>	
E3 Special Studies Local Option Special Study ID# <input type="text"/> Special Study Value <input type="text"/>	
F Actions Taken <input type="checkbox"/>	G1 Resources <input type="checkbox"/> Check this box and skip this block if an Apparatus or Personnel Module is used.
Primary Action Taken (1) <input type="text"/> Additional Action Taken (2) <input type="text"/> Additional Action Taken (3) <input type="text"/>	Apparatus <input type="text"/> Personnel <input type="text"/> Suppression <input type="text"/> EMS <input type="text"/> Other <input type="text"/>
G2 Estimated Dollar Losses and Values	
LOSSES: Required for all fires if known. Optional for non-fires. None	
Property \$ <input type="text"/> ; <input type="text"/> ; <input type="text"/> <input type="checkbox"/> Contents \$ <input type="text"/> ; <input type="text"/> ; <input type="text"/> <input type="checkbox"/> PRE-INCIDENT VALUE: Optional Property \$ <input type="text"/> ; <input type="text"/> ; <input type="text"/> <input type="checkbox"/> Contents \$ <input type="text"/> ; <input type="text"/> ; <input type="text"/> <input type="checkbox"/>	
Completed Modules	H1 Casualties <input type="checkbox"/> None
<input type="checkbox"/> Fire-2 <input type="checkbox"/> Structure Fire-3 <input type="checkbox"/> Civilian Fire Cas.-4 <input type="checkbox"/> Fire Service Cas.-5 <input type="checkbox"/> EMS-6 <input type="checkbox"/> HazMat-7 <input type="checkbox"/> Wildland Fire-8 <input type="checkbox"/> Apparatus-9 <input type="checkbox"/> Personnel-10 <input type="checkbox"/> Arson-11	Deaths <input type="text"/> Injuries <input type="text"/> Fire Service <input type="text"/> <input type="text"/> Civilian <input type="text"/> <input type="text"/>
H2 Detector Required for confined fires. 1 <input type="checkbox"/> Detector alerted occupants 2 <input type="checkbox"/> Detector did not alert them U <input type="checkbox"/> Unknown	
H3 Hazardous Materials Release <input type="checkbox"/> None	
1 <input type="checkbox"/> Natural gas: slow leak, no evacuation or HazMat actions 2 <input type="checkbox"/> Propane gas: <21-lb tank (as in home BBQ grill) 3 <input type="checkbox"/> Gasoline: vehicle fuel tank or portable container 4 <input type="checkbox"/> Kerosene: fuel burning equipment or portable storage 5 <input type="checkbox"/> Diesel fuel/fuel oil: vehicle fuel tank or portable storage 6 <input type="checkbox"/> Household solvents: home/office spill, cleanup only 7 <input type="checkbox"/> Motor oil: from engine or portable container 8 <input type="checkbox"/> Paint: from paint cans totaling <55 gallons 0 <input type="checkbox"/> Other: special HazMat actions required or spill > 55 gal (Please complete the HazMat form.)	
I Mixed Use Property <input type="checkbox"/> Not mixed	
10 <input type="checkbox"/> Assembly use 20 <input type="checkbox"/> Education use 33 <input type="checkbox"/> Medical use 40 <input type="checkbox"/> Residential use 51 <input type="checkbox"/> Row of stores 53 <input type="checkbox"/> Enclosed mall 58 <input type="checkbox"/> Business & residential 59 <input type="checkbox"/> Office use 60 <input type="checkbox"/> Industrial use 63 <input type="checkbox"/> Military use 65 <input type="checkbox"/> Farm use 00 <input type="checkbox"/> Other mixed use	
J Property Use <input type="checkbox"/> None	
Structures 131 <input type="checkbox"/> Church, place of worship 161 <input type="checkbox"/> Restaurant or cafeteria 162 <input type="checkbox"/> Bar/tavern or nightclub 213 <input type="checkbox"/> Elementary school, kindergarten 215 <input type="checkbox"/> High school, junior high 241 <input type="checkbox"/> College, adult education 311 <input type="checkbox"/> Nursing home 331 <input type="checkbox"/> Hospital	341 <input type="checkbox"/> Clinic, clinic-type infirmary 342 <input type="checkbox"/> Doctor/dentist office 361 <input type="checkbox"/> Prison or jail, not juvenile 419 <input type="checkbox"/> 1- or 2-family dwelling 429 <input type="checkbox"/> Multifamily dwelling 439 <input type="checkbox"/> Rooming/boarding house 449 <input type="checkbox"/> Commercial hotel or motel 459 <input type="checkbox"/> Residential, board and care 464 <input type="checkbox"/> Dormitory/barracks 519 <input type="checkbox"/> Food and beverage sales
Outside 124 <input type="checkbox"/> Playground or park 655 <input type="checkbox"/> Crops or orchard 669 <input type="checkbox"/> Forest (timberland) 807 <input type="checkbox"/> Outdoor storage area 919 <input type="checkbox"/> Dump or sanitary landfill 931 <input type="checkbox"/> Open land or field	936 <input type="checkbox"/> Vacant lot 938 <input type="checkbox"/> Graded/cared for plot of land 946 <input type="checkbox"/> Lake, river, stream 951 <input type="checkbox"/> Railroad right-of-way 960 <input type="checkbox"/> Other street 961 <input type="checkbox"/> Highway/divided highway 962 <input type="checkbox"/> Residential street/driveway
539 <input type="checkbox"/> Household goods, sales, repairs 571 <input type="checkbox"/> Gas or service station 579 <input type="checkbox"/> Motor vehicle/boat sales/repairs 599 <input type="checkbox"/> Business office 615 <input type="checkbox"/> Electric-generating plant 629 <input type="checkbox"/> Laboratory/science laboratory 700 <input type="checkbox"/> Manufacturing plant 819 <input type="checkbox"/> Livestock/poultry storage (barn) 882 <input type="checkbox"/> Non-residential parking garage 891 <input type="checkbox"/> Warehouse	
981 <input type="checkbox"/> Construction site 984 <input type="checkbox"/> Industrial plant yard	
Look up and enter a Property Use code and description only if you have NOT checked a Property Use box.	
Property Use <input type="text"/> Code <input type="text"/>	

K1 Person/Entity Involved

Local Option Business Name (if applicable) _____ Area Code _____ Phone Number _____

Check this box if same address as incident Location (Section B). Then skip the three duplicate address lines.

Mr., Ms., Mrs. First Name _____ MI _____ Last Name _____ Suffix _____

Number _____ Prefix _____ Street or Highway _____ Street Type _____ Suffix _____

Post Office Box _____ Apt./Suite/Room _____ City _____

State _____ ZIP Code _____

More people involved? Check this box and attach Supplemental Forms (NFIRS-1S) as necessary.

K2 Owner

Local Option Same as person involved? Then check this box and skip the rest of this block.

Business Name (if applicable) _____ Area Code _____ Phone Number _____

Check this box if same address as incident Location (Section B). Then skip the three duplicate address lines.

Mr., Ms., Mrs. First Name _____ MI _____ Last Name _____ Suffix _____

Number _____ Prefix _____ Street or Highway _____ Street Type _____ Suffix _____

Post Office Box _____ Apt./Suite/Room _____ City _____

State _____ ZIP Code _____


L Remarks:

Local Option

Fire Module Required?

Check the box that applies and then complete the Fire Module based on Incident Type, as follows:

<input type="checkbox"/> Buildings 111	Complete Fire & Structure Modules
<input type="checkbox"/> Special structure 112	Complete Fire Module & Section I, Structure Module
<input type="checkbox"/> Confined 113-118	Basic Module Only
<input type="checkbox"/> Mobile property 120-123	Complete Fire Module
<input type="checkbox"/> Vehicle 130-138	Complete Fire Module
<input type="checkbox"/> Vegetation 140-143	Complete Fire or Wildland Module
<input type="checkbox"/> Outside rubbish fire 150-155	Basic Module Only
<input type="checkbox"/> Special outside fire 160	Complete Fire or Wildland Module
<input type="checkbox"/> Special outside fire 161-163	Complete Fire Module
<input type="checkbox"/> Crop fire 170-173	Complete Fire or Wildland Module

 **ITEMS WITH A ★ MUST ALWAYS BE COMPLETED!**

More remarks? Check this box and attach Supplemental Forms (NFIRS-1S) as necessary.

M Authorization

Check box if same as Officer in charge.

Officer in charge ID _____ Signature _____ Position or rank _____ Assignment _____ Month _____ Day _____ Year _____

Member making report ID _____ Signature _____ Position or rank _____ Assignment _____ Month _____ Day _____ Year _____

A <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="text-align: center;"> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> </div> <div style="text-align: center;"> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> </div> </div> <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 5px;"> <div style="text-align: center;"> <p>FDID <input type="checkbox"/> <input type="checkbox"/></p> <p>State <input type="checkbox"/> <input type="checkbox"/></p> <p>Incident Date <input type="checkbox"/> <input type="checkbox"/></p> <p>Station <input type="checkbox"/> <input type="checkbox"/></p> <p>Incident Number <input type="checkbox"/> <input type="checkbox"/></p> <p>Exposure <input type="checkbox"/> <input type="checkbox"/></p> </div> <div style="text-align: right;"> <input type="checkbox"/> Delete <input type="checkbox"/> Change </div> <div style="border: 1px solid black; padding: 2px; text-align: center;"> NFIRS-2 Fire </div> </div>		
B Property Details <p>B1 <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input type="checkbox"/> Not Residential Estimated number of residential living units in building of origin <i>whether or not all units became involved</i></p> <p>B2 <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input type="checkbox"/> Buildings not involved Number of buildings involved</p> <p>B3 <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input type="checkbox"/> None <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input type="checkbox"/> Less than one acre Acres burned (outside fires)</p>	C On-Site Materials or Products <input type="checkbox"/> None <p>Complete if there were any significant amounts of commercial, industrial, energy, or agricultural products or materials on the property, <i>whether or not they became involved</i></p> <p>Enter up to three codes. Check one box for each code entered.</p> <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> On-site material (1)</p> <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> On-site material (2)</p> <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> On-site material (3)</p> <p>On-Site Materials Storage Use</p> <p>1 <input type="checkbox"/> Bulk storage or warehousing 2 <input type="checkbox"/> Processing or manufacturing 3 <input type="checkbox"/> Packaged goods for sale 4 <input type="checkbox"/> Repair or service U <input type="checkbox"/> Undetermined</p> <p>1 <input type="checkbox"/> Bulk storage or warehousing 2 <input type="checkbox"/> Processing or manufacturing 3 <input type="checkbox"/> Packaged goods for sale 4 <input type="checkbox"/> Repair or service U <input type="checkbox"/> Undetermined</p> <p>1 <input type="checkbox"/> Bulk storage or warehousing 2 <input type="checkbox"/> Processing or manufacturing 3 <input type="checkbox"/> Packaged goods for sale 4 <input type="checkbox"/> Repair or service U <input type="checkbox"/> Undetermined</p>	
D Ignition <p>D1 <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input type="checkbox"/> Area of fire origin</p> <p>D2 <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input type="checkbox"/> Heat source</p> <p>D3 <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input type="checkbox"/> Item first ignited <input type="checkbox"/> Check box if fire spread was confined to object of origin.</p> <p>D4 <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> <input type="checkbox"/> Type of material first ignited Required only if item first ignited code is 00 or <70</p>	E1 Cause of Ignition <input type="checkbox"/> None <p><input type="checkbox"/> Check box if this is an exposure report. ➔ Skip to Section G</p> <p>1 <input type="checkbox"/> Intentional 2 <input type="checkbox"/> Unintentional 3 <input type="checkbox"/> Failure of equipment or heat source 4 <input type="checkbox"/> Act of nature 5 <input type="checkbox"/> Cause under investigation U <input type="checkbox"/> Cause undetermined after investigation</p> <p>E2 Factors Contributing to Ignition <input type="checkbox"/> None</p> <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> Factor contributing to ignition (1)</p> <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> Factor contributing to ignition (2)</p>	E3 Human Factors Contributing to Ignition <input type="checkbox"/> None <p>Check all applicable boxes</p> <p>1 <input type="checkbox"/> Asleep 2 <input type="checkbox"/> Possibly impaired by alcohol or drugs 3 <input type="checkbox"/> Unattended person 4 <input type="checkbox"/> Possibly mentally disabled 5 <input type="checkbox"/> Physically disabled 6 <input type="checkbox"/> Multiple persons involved</p> <p>7 <input type="checkbox"/> Age was a factor</p> <p>Estimated age of person involved <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/></p> <p>1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female</p>
F1 Equipment Involved in Ignition <input type="checkbox"/> None ➔ If equipment was not involved, skip to Section G <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> Equipment Involved</p> <p>Brand <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/></p> <p>Model <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/></p> <p>Serial # <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/></p> <p>Year <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/></p>	F2 Equipment Power Source <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> Equipment Power Source</p> <p>F3 Equipment Portability</p> <p>1 <input type="checkbox"/> Portable 2 <input type="checkbox"/> Stationary</p> <p>Portable equipment normally can be moved by one or two persons, is designed to be used in multiple locations, and requires no tools to install.</p>	G Fire Suppression Factors <input type="checkbox"/> None <p>Enter up to three codes.</p> <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> Fire suppression factor (1)</p> <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> Fire suppression factor (2)</p> <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> Fire suppression factor (3)</p>
H1 Mobile Property Involved <input type="checkbox"/> None <p>1 <input type="checkbox"/> Not involved in ignition, but burned 2 <input type="checkbox"/> Involved in ignition, but did not burn 3 <input type="checkbox"/> Involved in ignition and burned</p> <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> Mobile property model</p> <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> Year</p> <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> License Plate Number <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> State <input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> VIN</p> <p style="border: 1px solid black; padding: 2px; text-align: center;">Structure fire? Please be sure to complete the Structure Fire form (NFIRS-3).</p>	H2 Mobile Property Type and Make <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> Mobile property type</p> <p><input style="width: 50px; border-bottom: 1px solid black; margin-bottom: 5px;" type="text"/> Mobile property make</p>	Local Use <p><input type="checkbox"/> Pre-Fire Plan Available Some of the information presented in this report may be based upon reports from other agencies:</p> <p><input type="checkbox"/> Arson report attached <input type="checkbox"/> Police report attached <input type="checkbox"/> Coroner report attached <input type="checkbox"/> Other reports attached</p>

