EMS Aggregate Prehospital Report and Provider Profile Information Form *1

Provider ID Number:___________ **Quarterly Reporting Period:____________** **Report Year:___________**

(Quarterly Reporting Period means the quarter in which the incident occurred.) (Report Year refers to the year in which the incident occurred.)

Part 1 - RUN INFORMATION FOR ALL RESPONSES WHERE THE EMS VEHICLE PHYSICALLY MOVED, THE PATIENT WALKED IN, OR WAS BROUGHT IN DIRECTLY TO THE EMS Items 1 - 2 (TOTAL COUNTS) *2 *3 *4

For Items 1-2, please record the total number of medical responses in the space provided below for this reporting period where the EMS vehicle phyiscally moved, the patient walked in or, was brought in directly to the EMS provider (see Appendix A for specific item definitions).

1. Service Type Requested Choose 1 response per incident.		2. Incident/Patient Disposition Choose 1 response per incident.			
Scene		Treated, Transported/General Hospital		Treated, Refused Transport	
Unscheduled Interfacility Transfer		Treated, Transported/Nursing Home		No Treatment Required	
Scheduled Interfacility Transfer		Treated, Transported/Medical Office/Clinic		Patient Refused Care	
Standby		Treated, Transported/Home		Dead at Scene	
Rendezvous		Treated, Transported/Trauma Center (Trauma Alert Only)		Cancelled	
Not Applicable		Treated, Transported/Other		Not Applicable	
Unknown		Treated, Transferred Care		Unknown	
		Treated, Transported by Private Vehicle		No Patient Found	
		Treated, Released		DNRO (Do Not Resuscitate Order)	

Part 2 - INCIDENT/PATIENT INFORMATION FOR TREATED AND TRANSPORTED PATIENTS ONLY, Items 3-10. (TOTAL COUNTS) *2*3

Excludes Interfacility Transfers unless a critical intervention as specified under Item 8 was involved.

For Items 3-10, please record the total number of patients in the space provided below for this reporting period that were treated and transported (see Appendix A for specific item definitions).

3. Provider Impression (Initial Assessment) When more than one Provider Impression is present, choose the one impression that precipitated and drove patient care decisions.					
Abdominal Pain/Problems		Electrocution		Respiratory Distress	
Airway Obstruction		Flu like Symptoms (Chills/Fever/Dizziness/Weakness/Dehydration/etc.)		Respiratory Not Otherwise Specified (NOS) *6	
Allergic Reaction		General Illness Not Otherwise Specified (NOS) *6		Seizure	
Altered Level of Consciousness *5		Hemorrhage/Bleeding		Sexual Assault/Rape	
Behavioral/Psychiatric Disorder		Hypertension		Smoke Inhalation	
Burns		Hyperthermia		Stings/Venomous Bites	
Cardiac Arrest		Hypothermia		Stroke/CVA/TIA	
Cardiac Rhythm Disturbance		Hypovolemia/Shock		Syncope/Fainting	
Cardiovascular Not Otherwise Specified (NOS) *6		Inhalation Injury (Toxic Gas)		Traumatic Injury Not Otherwise Specified (NOS)	
Chest Pain/Discomfort		Medication Reaction		Vaginal Hemorrhage	
Congestive Heart Failure/Pulmonary Edema		Pain Not Otherwise Specified (NOS) *6*7		Other Not Otherwise Specified (NOS) *6	
Diabetic Symptoms (Hypoglycemia)		Poisoning/Drug Ingestion		Unknown	
Digestive Symptoms (Nausea/Vomiting/Diarrhea)		Pregnancy/OB Delivery			
Digestive Symptoms Not Otherwise Specified (NOS) *6		Respiratory Arrest			

4. Cause of Injury *8 Choose up to 3 responses for this item per patient if an external cause of injury was involved under Item 3.					
Aircraft Related Crash		Fight or Brawl Unarmed		Motor Vehicle/Train	
Animal Bite		Fire and Flames		Motor Vehicle to Other	
Barotrauma (Scuba)		Firearm (Assault/Accidental Injury/Self Inflicted)		Overexertion/Strain	
Bicycle (Rider/Passenger Injured)		Inhalation/Ingestion (Food, Beads, etc.)		Radiation Exposure	
Burn/Scald (Non-fire and Flame Related)		Lightning		Rape	
Chemical Poisoning (Unintentional)		Machinery		Smoke Inhalation	
Child Assaults		Mechanical Suffocation (Plastic Bag, Crib, etc.)		Stabbing Assault	
Diving Related Traumatic Injury (Excl. Scuba & Snorkeling)		Motorcycle (Cyclist/Cyclist Passenger Injured)		Struck by Object (Unintentional) NOS *6	
Drowning		Motor Vehicle Non-traffic (Off public Road or Highway)*9		Venomous Bite/Stings (Plants/Animals)	
Drug Poisoning (Unintentional)		Motor Vehicle to Bicycle-(Cyclist/Cyclist Passenger Injured)		Water Transport	
Electrocution (Non-lightning)		Motor Vehicle to Fixed Object (Occupant Injured)		Other Injury Not Otherwise Specified	
Excessive Cold		Motor Vehicle to Motorcycle (Cyclist/Passenger Injured)		Not Applicable	
Excessive Heat		Motor Vehicle to Motor Vehicle (Occupant Injured)		Unknown	
Fall (Unintentional)		Motor Vehicle to Pedestrian (Pedestrian Injured)			

5. Injury Site/Type (5A-Site/5B-Type) Choose up to 5 responses per patient if Item 3 was a trauma *10.				6. Patient's Age Category (Years)	
A. Site of Injury (multiple response)		*B. Type of Injury (Multiple response)*		Under 1	
External (Including burns)		Amputation		1 through 4	
Head Only (Excluding Neck, Cervical Spine & Ear)		Blunt Injury		5 through 14	
Face (Including Ears)		Burn		15 through 54	
Neck		Crush		55 through 64	
Thorax (Excluding Thoracic Spine)		Dislocation/Fracture		65 through 74	
Abdomen (Excluding Lumbar Spine)		Gunshot		75 through 84	
Spine		Laceration		85 plus	
Upper Extremities		Pain without Swelling/Bruising		Unknown	
Lower Extremities or Bony Pelvis		Puncture/Stab			
Body Region Unspecified		Soft Tissue Swelling/Bruising			

7. County of Incident	

8. Critical Treatment/Intervention(s)? Choose as many responses as necessary for this item per patient.			
A. Treatments/Procedures Administered?			
AED Only Prior to Arrival Licensed EMS Provider		Intraosseous Catheter	
AED & CPR Prior to Arrival Licensed EMS Provider		Intubation	
AED Only by Licensed EMS Provider		Military Anti-Shock Trousers (MAST)/BP	
AED & CPR by Licensed EMS Provider		Military Anti-Shock Trousers (MAST)/Fracture	
Bag Valve Mask (BVM) w/o Intubation		Multi-lead Electrocardiogram (ECG)-3 Lead	
Blood Glucose Testing/Monitoring		Multi-lead Electrocardiogram (ECG)-12 Lead Plus	
Cardiac Pacing		Needle Thoracostomy	
Chest Tube		Nasogastric (NG)/Orogastric (OG) Tube	
CPR Only Prior to Arrival of Licensed EMS Provider		Obstetrical Care/Delivery	
CPR Only by Licensed EMS Provider		Spinal/Cervical Immobilization	
Cricothyrotomy		Volume Resuscitation (Fluid)	
Defibrillation (Excluding AED)			
B. Medication Administered?			
Aspirin for Chest Pain		Paralytic Drugs for Intubation	
Cardiac Drug(s) for Cardiac Care NOS *6 *11		Thrombolytics	
Medication for Pain			
C. Alert Called (Hospital Notified Patient is En Route)?			
Cardiac Alert (Acute Myocardial Infarction)		Trauma Alert	
Stroke Alert			

9. Patient's Highest Level of Care (Based of Treatment Level) By Mode of Transportation	
ALS Treatment Level By Ground	
ALS Treatment Level By Rotor Craft	
ALS Treatment Level By Fixed Wing	
BLS Treatment Level By Ground	
Other	

10. Return of Spontaneous Circulation (ROSC) for Cardiac Arrest Patients		
A. For Cardiac Arrest Patients in a Shockable Rhythm:	Yes	No
AED admin. prior to arrival of EMS & ROSC present at ED transfer?		
AED admin. by EMS and ROSC present at ED transfer?		
No AED administered. and ROSC present at ED transfer?		
B. For Cardiac Arrest Patients Not in Shockable Rhythm:	Yes	No
ROSC present at ED transfer?		

Footnotes:

*1. A response/patient may only be counted once per category except under Part II for Items 4, 5, 8 which allow for multiple responses.

*2. Leave space blank when a particular item is not tracked by your agency and record a 0 if an item is tracked but did not occur during this reporting period.

*3. If necessary an agency may group sub-category codes into a higher level sub-category for reporting purposes. For example different types of motor vehicle crashes may be collapsed into the sub-category General Motor Vehicle Crash. This modification must be noted and defined on the form.

*4. If multiple patients were evaluated at the scene they should be included in the total count for this part (e.g. 50 children evaluated from a school bus accident would be counted as 50 responses.

*5. Refers to patients with any altered level of consciousness not related to any other listed impression.

*6. NOS (Not Otherwise Specified) includes impressions not otherwise specified on provided list.

*7. Refers to incidents where pain NOS (e.g., head, neck, back, hip, extremity, generalized pain, etc.) was the single clinical impression that drove patient care. Excludes pain due to an external cause of injury or pain related to a specified illness or condition.

*8. Required when the "Provider Impression" under Item 3 was due to an external cause of injury.

*9. Motor Vehicle Non Traffic Accident is any motor vehicle accident which occurs entirely in any place other than a public road. Note: A public road as defined in the 1989 ICD9/CM, refers to any road open to the use of the public for purposes of vehicular traffic as a matter of right or custom.

*10. A trauma means a blunt, penetrating or burn injury caused by external force or violence.

*11. Cardiac Drugs for Cardiac Care includes all cardiac drugs administered for Cardiac Care with the exclusion of Aspirin for Chest Pain, Paralytics and Medications for Pain Management.

*12. Record the total number of active staff hours worked in the reporting period.

Part 3 - EMS Provider Profile Information ☐ New (First time completing) ☐ Update (Change in provider information)

This part only needs to be completed when Part I and or Part II of this form are completed for the first time or when there are changes in provider profile information. Please check the new or update box above to indicate whether the information recorded below is being completed for the first time or if the information being recorded is an update. This part must completed by all State of Florida licensed providers.

1. Provider ID:
2. Provider Type:

Contact:

3. Name

4. Mailing Address:

5. Phone Number: ( ) -
6. Fax Number: ( ) -
7. Email Address

8. Counties and Cites of Operation (Include Areas with Mutual Aid Agreements):

/ / / /
/ / / /
/ / / /

9. Zip Codes Covered (Include Areas with Mutual Aid Agreements):

/ / / / /
/ / / / /
/ / / / /

10. Total Number of Active Staff Hours Worked *12

Paramedics: ____________________

EMTs: ____________________

Other: ____________________

11. Total Number of Permitted Vehicles:

Advanced Life Support (ALS) ____________________

Basic Life Support (BLS) ____________________

Air Rotor ____________________

Air Fixed Wings ____________________

Reports are due to the Bureau of EMS quarterly as follows:

Quarter (based on date of incident)	Due:
Qtr 1- January 1 through March 31	04/30
Qtr 2- April 1 through June 30	07/30
Qtr 3- July 1 through September 30	10/30
Qtr 4- October 1 through December 31	01/30 (of the following calendar year)

Send reports to*: Bureau of Emergency Medical Services
Attention: Prehospital Aggregate Data Staff
4052 Bald Cypress Way, Bin C-18
Tallahassee, Florida 32399-1738
*** SEE FORM SUBMISSION REPORTING REQUIREMENTS BELOW**

For assistance, comments or questions call:
EMS Aggregate Prehospital Data staff at
(850)-245-4440
E-mail: EMSData@doh.state.fl.us

Form submission reporting requirements:

All forms must be readable and submitted to the Bureau of EMS on or in the same format shown in this document. Forms will be made available upon request at the address listed above and on the Bureau's web page. Aggregate data shall be submitted to the bureau using any medium, software, or by mail or hand delivery. Electronic submissions shall be made by using approved software, media or file format as specified by the Bureau of EMS. Electronic specifications will be made available upon request.