

Table with columns for AGENCY/UNIT NUMBER, INCIDENT COUNTY, INCIDENT STATE, DATE (Y, M, D, D), RECEIVED (H, M, S), DISPATCH (H, M, S), EN-ROUTE (H, M, S), ARRIVE LOC. (H, M, S), PT. CONTACT (H, M, S), DEPART LOC. (H, M, S), ARRIVE DEST. (H, M, S).

Table with columns for LOCATION TYPE, DNR?, RESIDENCE COUNTY, RESIDENCE ZIP CODE, PATIENT DATE OF BIRTH (Y, Y, M, M, D, D), PT. AGE OR EST., PT. GENDER, ALLERGIES, PRE-EXISTING CONDITIONS.

Table with columns for COMPLAINT/ILLNESS/SIGNS/SYMPTOMS, SYSTOLIC BP, DIASTOLIC BP, PULSE RATE, RESP. RATE, WEIGHT, LOC, CARDIAC RHYTHM, LUNG SOUNDS, SKIN COLOR, SKIN TEMP, SKIN MOISTURE.

Table with columns for PROCEDURES/TREATMENTS, CREW MEMBER NUMBER, EMS RESOURCE HOSPITAL, GLASGOW COMA SCALE (EYES, VERBAL, MOTOR), TOTAL GLASGOW, TOTAL RTS.

Table with columns for MEDICATIONS, ROUTE MEDS ADMIN., IV RATE/TYPE, LOCK.

6286773

PLEASE DO NOT MARK IN THIS AREA

Medical Audit Information – Privileged and Confidential Under EMS Act and Medical Studies Act

CAUSE OF INJURY										INJURY DESCRIPTION										SAFETY EQUIPMENT										SUSPECTED ALCOHOL/DRUG USE																													
<input type="checkbox"/> MVC <input type="checkbox"/> Pedestrian vs. MV <input type="checkbox"/> MV-non-traffic <input type="checkbox"/> Bike Related <input type="checkbox"/> Boat Related <input type="checkbox"/> Aircraft Related <input type="checkbox"/> Acc. Drug Poison <input type="checkbox"/> Acc. Chem. Poison <input type="checkbox"/> Fire <input type="checkbox"/> Venomous Sting <input type="checkbox"/> Bites <input type="checkbox"/> Lightning										<input type="checkbox"/> Mech. Suffocation <input type="checkbox"/> Machinery Acc. <input type="checkbox"/> Electrocutation <input type="checkbox"/> Radiation Exposure <input type="checkbox"/> Firearm Acc. <input type="checkbox"/> Firearm Assault <input type="checkbox"/> Firearm Self Infl. <input type="checkbox"/> Rape <input type="checkbox"/> Stabbing Assault <input type="checkbox"/> Child Battering <input type="checkbox"/> Not Appl. <input type="checkbox"/> Unknown										<input type="checkbox"/> None <input type="checkbox"/> Pain, No Swell <input type="checkbox"/> Soft Tis. Swell <input type="checkbox"/> Blunt Injury <input type="checkbox"/> Laceration <input type="checkbox"/> Disloc/Fract <input type="checkbox"/> Puncture/Stab <input type="checkbox"/> Gunshot <input type="checkbox"/> Amputation <input type="checkbox"/> Crush <input type="checkbox"/> Burn										<input type="checkbox"/> None Used <input type="checkbox"/> Shoulder Belt Only <input type="checkbox"/> Lap Belt Only <input type="checkbox"/> Shoulder & Lap Belt <input type="checkbox"/> Child Safety Seat <input type="checkbox"/> Airbag Deployed, No Belt <input type="checkbox"/> Airbag Deployed, Lap Belt <input type="checkbox"/> Airbag Deployed, Lap/Shoulder Belt <input type="checkbox"/> Airbag-Deployed, Child Safety Seat										<input type="checkbox"/> Helmet <input type="checkbox"/> Eye Protection <input type="checkbox"/> Protective Clothing <input type="checkbox"/> Flotation Device <input type="checkbox"/> Protective Gear <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown										<input type="checkbox"/> Alcohol, Yes <input type="checkbox"/> Drugs, Yes <input type="checkbox"/> Both, Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown									
TIME CPR START		TIME CPR STOP		PROVIDER 1ST CPR		TIME OF 1ST DEF. SHOCK		RETURN SPON. CIRC.		MINIMUM TRAUMA FIELD TRIAGE																																																	
H M S		H M S		<input type="checkbox"/> Bystander <input type="checkbox"/> EMS <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown		H M S		<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/> Not Applicable		CATEGORY 1 <input type="checkbox"/> Hypotension-Adult <input type="checkbox"/> Hypotension-Peds <input type="checkbox"/> Glasgow = or < 10 <input type="checkbox"/> Penetrate Head, Neck, Torso, Groin <input type="checkbox"/> Trauma & Burn = or > 20% TBSA <input type="checkbox"/> Amputation Above Wrist or Ankle <input type="checkbox"/> Limb Paralysis/Sensory Def. Above Wrist/Ankle <input type="checkbox"/> Two or More Proximal Long Bone Fractures					CATEGORY 2 <input type="checkbox"/> Ejection from MV <input type="checkbox"/> Death in Same Passenger Compartment <input type="checkbox"/> Falls > 20ft.-Adult <input type="checkbox"/> Fall-Peds (3x Body Length) <input type="checkbox"/> Pregnancy > = 24 Weeks																																												
MILITARY TIME		MILITARY TIME		WITNESS ARREST		MILITARY TIME		CARE FACTORS																																																			
0 1 2 3 4 5 6 7 8 9		0 1 2 3 4 5 6 7 8 9		<input type="checkbox"/> Bystander <input type="checkbox"/> EMS <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown		0 1 2 3 4 5 6 7 8 9		<input type="checkbox"/> Adverse Road Conditions <input type="checkbox"/> Adverse Weather <input type="checkbox"/> Crowd Control <input type="checkbox"/> Hazardous Materials <input type="checkbox"/> Language Barrier <input type="checkbox"/> Prolonged Extrinsic <input type="checkbox"/> Unsafe Scene <input type="checkbox"/> Vehicle Problems <input type="checkbox"/> Other <input type="checkbox"/> Not Applicable																																																			
DESTINATION/ TRANSFERRED TO		HOSPITAL CODE		DESTINATION DETERMINATION		TREATMENT AUTHORIZATION		LIGHTS/SIRENS FROM SCENE		911 USAGE		INCIDENT DISPOSITION																																															
<input type="checkbox"/> Home <input type="checkbox"/> Hospital (Complete Code Section) <input type="checkbox"/> Long Term Care <input type="checkbox"/> Medical Office/Clinic <input type="checkbox"/> Morgue <input type="checkbox"/> Other Air EMS Responder <input type="checkbox"/> Other Ground EMS Responder <input type="checkbox"/> Police/Jail/Lockup <input type="checkbox"/> Not Applicable		0 1 2 3 4 5 6 7 8 9		<input type="checkbox"/> Closest Facility <input type="checkbox"/> Patient/Family Request <input type="checkbox"/> Patient/Physician Request <input type="checkbox"/> Managed Care <input type="checkbox"/> Law Enforcement Request <input type="checkbox"/> Medical Control <input type="checkbox"/> Diversion/Bypass		<input type="checkbox"/> Protocol <input type="checkbox"/> On-Line <input type="checkbox"/> On-Scene <input type="checkbox"/> Written Orders <input type="checkbox"/> Not Applicable		<input type="checkbox"/> Non-Emergent-No L/S <input type="checkbox"/> Downgraded-No L/S <input type="checkbox"/> Upgraded-L/S <input type="checkbox"/> Emergent-L/S		<input type="checkbox"/> None <input type="checkbox"/> 911 <input type="checkbox"/> E911 <input type="checkbox"/> E911 w/EMD Assist <input type="checkbox"/> Other Phone <input type="checkbox"/> 311, Then 911 <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown		<input type="checkbox"/> Treat/Transport <input type="checkbox"/> Treat/Transfer Care <input type="checkbox"/> Treat/Transport by Car <input type="checkbox"/> Treat/Release <input type="checkbox"/> No Treat Request <input type="checkbox"/> Patient Refused Care <input type="checkbox"/> Dead At Scene <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown <input type="checkbox"/> No Patient Found																																															
CONTACT W/BODY FLUIDS?		CREW MEMBERS					CREW MEMBER #1					CREW MEMBER #2					CREW MEMBER #3																																										
<input checked="" type="radio"/> Yes <input type="radio"/> No		#1	#2	#3	#4	#5																																																					
STANDARD PRECAUTIONS?		P	P	P	P	P	0 1 2 3 4 5 6 7 8 9					0 1 2 3 4 5 6 7 8 9					0 1 2 3 4 5 6 7 8 9																																										
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NOTE:
Crew Member Number fields are to be completed only if the EMS System requires it.