

Ambulance Patient Care Report



Agency Name E2.1		Date of Incident	Call Number E2.3		Incident Number E2.2
Response Times			Response Information		Personnel
PSAP Call E5.2	Arrive Scene E5.6	In Service E5.11	PCR Number E1.1	Starting Mileage E2.16	Attendant E4.1
Dispatch Notified E5.3	Arrive Patient E5.7	Unit Cancelled	# of Patients E8.5	At Scene Mileage E2.17	Attendant
Unit Dispatched E5.4	Leave Scene E5.9	In Quarters E5.13	Responding Unit E2.12	Dest. Mileage E2.18	Attendant
Enroute E5.5	Arrive Dest. E5.10		Crew Number	Ending Mileage E2.19	Attendant

E8.6

Incident Information				First Responder Agencies E8.1	
Incident Address E8.11			Room/Apt		
City E8.12		County E8.13	State E8.14	Zip Code E8.15	
Type of Location E8.7					
<input type="checkbox"/> Airport <input type="checkbox"/> Home/Residence <input type="checkbox"/> Mine or Quarry <input type="checkbox"/> Residential Institution <input type="checkbox"/> Other <input type="checkbox"/> Farm <input type="checkbox"/> Industrial Place <input type="checkbox"/> Place of Sport <input type="checkbox"/> Street or Highway <input type="checkbox"/> Healthcare Facility <input type="checkbox"/> Lake, River <input type="checkbox"/> Public Building <input type="checkbox"/> Trade or Service					
Response Request			To		Response Mode
<input type="checkbox"/> Response (Scene) <input type="checkbox"/> Interfacility Transfer <input type="checkbox"/> Medical Transport (Scheduled) <input type="checkbox"/> Standby <input type="checkbox"/> Intercept <input type="checkbox"/> Mutual Aid E2.4			<input type="checkbox"/> E2.20 Lights and Siren <input type="checkbox"/> No Lights or Siren <input type="checkbox"/> Initial No Lights and Siren Upgraded to Lights and Siren <input type="checkbox"/> Initial Lights and Siren Downgraded to No Lights and Siren		From E20.14
Disposition					
<input type="checkbox"/> Treated: E20.10 <input type="checkbox"/> Transported by EMS <input type="checkbox"/> Transferred Care <input type="checkbox"/> Released <input type="checkbox"/> Cancelled <input type="checkbox"/> Patient Refused Care <input type="checkbox"/> Dead at Scene					

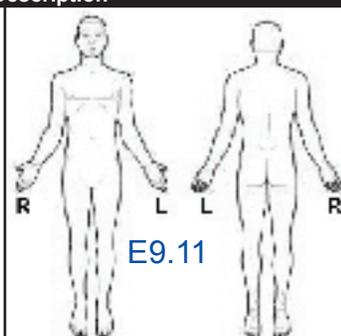
Factors Affecting Care		
<input type="checkbox"/> Amb. Crash <input type="checkbox"/> Amb. Failure <input type="checkbox"/> Crowd <input type="checkbox"/> Directions <input type="checkbox"/> Distance	<input type="checkbox"/> Diversion <input type="checkbox"/> Extrication <input type="checkbox"/> HazMat <input type="checkbox"/> Language Barrier <input type="checkbox"/> Staff Delay	<input type="checkbox"/> Safety <input type="checkbox"/> Traffic <input type="checkbox"/> Weather <input type="checkbox"/> None <input type="checkbox"/> Other
Destination/Hospital Name E20.2		Facility Diverted From E23.9

Destination Determination					
<input type="checkbox"/> Closest Facility <input type="checkbox"/> Protocol Guideline <input type="checkbox"/> Patient/Family Choice					
<input type="checkbox"/> Specialty Resource Ctr. <input type="checkbox"/> Law Enforcement Choice <input type="checkbox"/> Diversion E20.16					
Destination Type					
<input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Medical Office/Clinic <input type="checkbox"/> Nursing Home <input type="checkbox"/> Air Ambulance					
<input type="checkbox"/> Ground Ambulance <input type="checkbox"/> Police/Jail <input type="checkbox"/> Morgue <input type="checkbox"/> Other E20.17					
Primary Role of Unit					
<input type="checkbox"/> ALS Ground <input type="checkbox"/> BLS Ground <input type="checkbox"/> Critical Care Ground <input type="checkbox"/> ERU <input type="checkbox"/> Fixed Wing					
<input type="checkbox"/> Non-Transport <input type="checkbox"/> Other Transport <input type="checkbox"/> Rescue <input type="checkbox"/> Rotor Craft <input type="checkbox"/> Supervisor E2.5					

Patient Information					
Last Name E6.1		First Name E6.2		M.I. E6.3	
Address E6.4				Room/Apt	
City E6.5		County E6.6		State E6.7	
Zip Code E6.8	Phone Number () E6.17		KG	Gender M / F E6.11	
Social Security Number E6.16		DOB E6.16 / /		Age E6.14	
Patient Physician		Guardian Name			
Race E6.12		Ethnicity E6.13			
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino			

Prior Aid (Select All That Apply)					
<input type="checkbox"/> AED - ERU <input type="checkbox"/> AED - First Responder <input type="checkbox"/> AED - Public Access <input type="checkbox"/> CPR <input type="checkbox"/> Extrication <input type="checkbox"/> Spinal Immobilization <input type="checkbox"/> Splinting		Airway: E9.1 <input type="checkbox"/> BVM <input type="checkbox"/> Combitube <input type="checkbox"/> Nebulizer Treatment <input type="checkbox"/> Oxygen <input type="checkbox"/> Suction		Performed By E9.2 <input type="checkbox"/> EMS Provider <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Lay Person <input type="checkbox"/> Other Healthcare Provider <input type="checkbox"/> Patient	
Outcome/Condition E9.3 <input type="checkbox"/> Improved <input type="checkbox"/> Worse <input type="checkbox"/> Unchanged					

Provider Impression - Primary/Secondary (Select One For Each)											
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Patient Chief Complaint										Onset Date / Time		Primary Organ System Affected		
Description E9.5										E5.1		<input type="checkbox"/> Cardiovascular <input type="checkbox"/> CNS/Neuro <input type="checkbox"/> Endocrine/Metabolic <input type="checkbox"/> GI/Abdomen <input type="checkbox"/> Global/Other Illnesses <input type="checkbox"/> Musculoskeletal/Injury <input type="checkbox"/> OB/GYN <input type="checkbox"/> Psych/ Behavioral <input type="checkbox"/> Respiratory <input type="checkbox"/> Renal/GU Problems <input type="checkbox"/> Skin E9.12		
Signs & Symptoms (Select All That Apply)														
P	S	P	S	P	S	P	S	P	S					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Rash/Itching					
<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Choking	<input type="checkbox"/>	Malaise	<input type="checkbox"/>	Rash/Itching	<input type="checkbox"/>	Swelling					
<input type="checkbox"/>	Behavioral/Psych	<input type="checkbox"/>	Death	<input type="checkbox"/>	Mass/Lesion	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	Weakness					
<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	Device/Equipment Problem	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	Wound					
<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	None	<input type="checkbox"/>	Wound	<input type="checkbox"/>						
<input type="checkbox"/>	Change in Resp	<input type="checkbox"/>	Drainage/Discharge	<input type="checkbox"/>	Pain	<input type="checkbox"/>		<input type="checkbox"/>						
										E9.14				
Cause of Injury (Select One)										Injury Description				
Injury Present		<input type="checkbox"/> Aircraft Crash <input type="checkbox"/> Assault E10.1 <input type="checkbox"/> Bicycle Crash <input type="checkbox"/> Bites <input type="checkbox"/> Chemical Poisoning <input type="checkbox"/> Child Battering <input type="checkbox"/> Drug Poisoning <input type="checkbox"/> Drowning <input type="checkbox"/> Electrocution (Non-Lightning) <input type="checkbox"/> Excessive Cold <input type="checkbox"/> Excessive Heat <input type="checkbox"/> Falls <input type="checkbox"/> Fire and Flames <input type="checkbox"/> Firearm Assault <input type="checkbox"/> Firearm Injury (Accidental) <input type="checkbox"/> Firearm (Self Inflicted) <input type="checkbox"/> Lightning			<input type="checkbox"/> Machinery Accidents <input type="checkbox"/> Mechanical Suffocation <input type="checkbox"/> MV, Non-Traffic Crash <input type="checkbox"/> MV, Traffic Crash <input type="checkbox"/> Motorcycle Crash <input type="checkbox"/> Non-Motorized Vehicle Crash <input type="checkbox"/> Pedestrian Traffic Crash <input type="checkbox"/> Radiation Exposure <input type="checkbox"/> Sexual Assault / Rape <input type="checkbox"/> Smoke Inhalation <input type="checkbox"/> Stabbing/Cutting (Assault) <input type="checkbox"/> Stabbing/Cutting (Accidental) <input type="checkbox"/> Strike Blunt/Thrown Obj. <input type="checkbox"/> Unarmed Fight/Brawl <input type="checkbox"/> Venomous Stings <input type="checkbox"/> Water Transport Crash			Identify the area of injury with the following numbers 1 Amputation 2 Bleeding-Controlled 3 Bleeding-Uncontrolled 4 Burn 5 Crush 6 Dislocation/Fracture 7 Gunshot 8 Laceration 9 Pain without swelling/bruising 10 Puncture/Stab 11 Soft Tissue swelling/bruising						
<input type="checkbox"/> Yes E9.4 <input type="checkbox"/> No														
Injury Intent E10.2														
<input type="checkbox"/> Intentional, Other (Assaulted) <input type="checkbox"/> Intentional, Self <input type="checkbox"/> Unintentional														
Mechanism														
<input type="checkbox"/> Blunt <input type="checkbox"/> Burn E10.3 <input type="checkbox"/> Other <input type="checkbox"/> Penetrating														
Initial Assessment														
Level of Responsiveness		Airway		Breathing				Circulation						
<input type="checkbox"/> Alert <input type="checkbox"/> Verbal <input type="checkbox"/> Painful <input type="checkbox"/> Unresponsive E14.22		<input type="checkbox"/> Patent <input type="checkbox"/> Non Patent Action taken:		Rate	Quality	L	Lung Sounds	R	Color	Temp	Condition	Cap Refill		
				<input type="checkbox"/> < 10 <input type="checkbox"/> 10-24 <input type="checkbox"/> > 24 <input type="checkbox"/> Apneic	<input type="checkbox"/> Normal <input type="checkbox"/> Labored <input type="checkbox"/> Fatigued <input type="checkbox"/> Absent <input type="checkbox"/> Not Assessed	<input type="checkbox"/> Clear <input type="checkbox"/> Wet <input type="checkbox"/> Wheezes <input type="checkbox"/> Diminished <input type="checkbox"/> Absent		<input type="checkbox"/> Normal <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/> Flush	<input type="checkbox"/> Normal <input type="checkbox"/> Hot <input type="checkbox"/> Cool <input type="checkbox"/> Cold	<input type="checkbox"/> Normal <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Dry	<input type="checkbox"/> < 2 sec <input type="checkbox"/> 2 - 4 sec <input type="checkbox"/> > 4 sec <input type="checkbox"/> Absent			
Alcohol/Drug Use		Glasgow Coma Score				Pupils		Barriers to Patient Care						
<input type="checkbox"/> Alcohol/Drugs at Scene <input type="checkbox"/> Patient Admits Alcohol Use <input type="checkbox"/> Patient Admits Drug Use <input type="checkbox"/> Smell of Alcohol <input type="checkbox"/> None E12.19		Eye Opening	Verbal	Motor	Time	L	R	<input type="checkbox"/> Developmentally Impaired E12.1 <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Language <input type="checkbox"/> Physically Impaired <input type="checkbox"/> Physically Restrained <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Unattended or Unsupervised (Including Minors) <input type="checkbox"/> Unconscious <input type="checkbox"/> None						
		4 Spontaneous 3 To Speech 2 To Pain 1 Not at All E14.15	5 Oriented 4 Confused 3 Inappropriate Words 2 Inappropriate Sounds 1 None E14.16	6 Obeys Commands 5 Localized Pain 4 Withdraws to Pain 3 Flexion to Pain 2 Extension to Pain 1 None E14.17	E14.19 Score Time Score	<input type="checkbox"/> Reactive <input type="checkbox"/> Sluggish <input type="checkbox"/> Constricted <input type="checkbox"/> Dilated <input type="checkbox"/> Nonreactive								
Allergies <input type="checkbox"/> NKA		Patient's Medications												
Time	BP	Pulse	Resp	Rhythm	SpO2	Procedures	# Attempts	Success	Medication	Dose	Route	Response	Crew #	
E14.1	E14.4	E14.5	E14.7	E14.11	E14.3	E14.9		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				<input type="checkbox"/> Improved <input type="checkbox"/> Worse <input type="checkbox"/> Unchanged		
								<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				<input type="checkbox"/> Improved <input type="checkbox"/> Worse <input type="checkbox"/> Unchanged		
E18.1								<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	E18.3	E18.5	E18.6	E18.4	<input type="checkbox"/> Improved <input type="checkbox"/> Worse <input type="checkbox"/> Unchanged	E18.9
								<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				<input type="checkbox"/> Improved <input type="checkbox"/> Worse <input type="checkbox"/> Unchanged		
E19.1						E19.3	E19.5	<input type="checkbox"/> Yes <input type="checkbox"/> No E19.6 <input type="checkbox"/> N/A				<input type="checkbox"/> Improved <input type="checkbox"/> Worse E19.8 <input type="checkbox"/> Unchanged	E19.9	
								<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				<input type="checkbox"/> Improved <input type="checkbox"/> Worse <input type="checkbox"/> Unchanged		
								<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				<input type="checkbox"/> Improved <input type="checkbox"/> Worse <input type="checkbox"/> Unchanged		
								<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				<input type="checkbox"/> Improved <input type="checkbox"/> Worse <input type="checkbox"/> Unchanged		

Disclaimer: This page is provided for optional use by the ambulance provider; it is not required by the Minnesota EMS Regulatory Board.

Billing Information						
Medicare Number		Medicaid Number			Other	
Primary Insurance						
Company Name		Insurance Number			Group Number	
Insured Last Name <input type="checkbox"/> Same as Patient's		Insured First Name <input type="checkbox"/> Same as Patient's			M.I.	Relationship To Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian
Address <input type="checkbox"/> Same as Patient's		City	County	State	Zip Code	Home Phone
Secondary Insurance						
Secondary Insurance Company Name		Secondary Insurance Number			Group Number	
Insured Last Name <input type="checkbox"/> Same as Patient's		Insured First Name <input type="checkbox"/> Same as Patient's			M.I.	Relationship To Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian
Address <input type="checkbox"/> Same as Patient's		City	County	State	Zip Code	Home Phone
Type of Insurance						
<input type="checkbox"/> Private Insurance <input type="checkbox"/> Workers Comp <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> HMO/PPO <input type="checkbox"/> Contract Services						
Authorization For Billing						

I authorize the release to the Social Security Administration and Centers for Medicare and Medicaid Services, any HMO/PPO, other private or public insurance, or their agents, fiscal intermediaries or carriers or an independent agency performing billing or collection functions on behalf of the ambulance service, any personal, medical or billing information needed for this or a related claim. I understand I will be responsible for any services that are not paid/covered by my insurance. A copy of this authorization shall be valid as the original and shall remain in effect until revoked in writing by the patient/insured. I request payment of medical insurance benefits either to me or to the ambulance service.

Signature	Date
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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided with a copy of the ambulance services "Notice of Privacy Practices."

Signature	Date
Name Printed	Relationship To Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian

Waiver of Liability

I refuse treatment and/or transportation by the providing ambulance service. I assume responsibility for my own, my child's, or any family member's medical treatment. I have been advised to seek the attention of a physician. I release the providing ambulance service, its employees, officers and directors from liability resulting from my own, my child's, or any other family member's refusal of medical treatment or transportation.

Signature	Date
-----------	------

If Signing For A Minor

Signature	Date
Name Printed	Relationship To Patient <input type="checkbox"/> Parent/Guardian

Patient's Belongings

Patient's Belongings	Location of Belongings	Who Belongings Were Left With
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