EMSRB
Minnesota Emergency Medical Services Regulatory Board

EMS Quick Report

Transport EMS Agency:

Incident Date: _____/_____/20____ Incident #: ________ Response #: ________

Unit#: # Pt's @ Scene: ________

Transport EMS Crew/Role: #1 ________ Driver / Care Provider #2 ________ Driver / Care Provider

Additional Crew:

Response Mode to Scene:

List all other First Responder Agencies who were present on scene and had contact with the patient:

EMS

PATIENT

Patient Last Name: ________ Age: ________ Sex: ________

Patient First Name: ________ DOB: ____/____/____

Patient Address:

HX

Allergies: ________

Medical Hx: ________

Medications: ________

EVENT

Pt's Chief Complaint:

Call Type: ☐ Scene ☐ Transfer ☐ Intercept

Primary Impression:

Secondary Impression:

Symptoms:

Incident Type:
- ☐ TRAUMA (Alert given? **Yes / No**)
- ☐ CARDIAC (if STEMI or OHCA, Alert given? **Yes / No**)
- ☐ STROKE (Alert given? **Yes / No**)
- ☐ OTHER : ________________

TIMES

Dispatch/PSAP: ______:______

Dispatched: ______:______

En-Route: ______:______

On Scene: ______:______

Left Scene: ______:______

@Destination: ______:______

Record Times as Applicable:

Date/Time of Injury or Last Known Well: _____/_____/20____ @ _____:_____

Time At Patient: ______:______ (First Medical Contact)

Time of ALERT: ______:______ (TRAUMA/STROKE/STEMI/OHCA Alert)

(Alert = Pre-notification to hospital) - circle type of alert

Cardiac Arrest

Time of Initial Arrest ______:______ Time of ROSC: ______:______

Witnessed by: Initial CPR by:

Time CPR Started ______:______ Initial ECG Rhythm: ________________

Injury/Trauma

Cause of Injury:

Mechanism of Injury:

VITALS

Time	AVPU	GCS	HR	RR	BP	SpO_2	$ETCO_2$	Blood Glucose	Pain Scale	ECG Findings
:										
:										
:										
:										
:										
:										
:										
:										

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Time	PRIOR CARE		MEDICATION/PROCEDURE PROVIDED	# ATTEMPTS	Patient Reponse
:	Y	N			
:	Y	N			
:	Y	N			
:	Y	N			
:	Y	N			
:	Y	N			
:	Y	N			
:	Y	N			
:	Y	N			
:	Y	N			

TREATMENT

Initial Pt. Acuity: R Y G

NOTES & PHYSICAL EXAM

Destination

Facility Name:

Type of Destination:

Transport Mode From Scene:

Reason for Choosing:

Final Pt. Acuity: R Y G

TRANSFER OF CARE

Pt Received By:

(Print Name)

Transfer of Care Time:

____:____

Signature of Person Receiving Pt:

This form is intended to be used by EMS personnel to provide Pt care information to the receiving facility upon delivery of the Pt, and should **BE LEFT AT THE RECEIVING FACILITY PRIOR TO DEPARTURE OF THE CREW. THIS FORM DOES NOT REPLACE THE NEED TO SUBMIT AN ePCR and does not collect all Minnesota required elements**. Agencies must submit ePCRs to MNSTAR Elite within 24 hours of call completion, and hospitals may access those patient care reports on Hospital Hub. To gain access to Hospital Hub, please contact the EMSRB (email: emsrb@state.mn.us or Phone: 651.201.2800)