

EMS Quick Report

Transport EMS Agency: _____

Incident Date: ____/____/20____

Incident #: _____

Response #: _____

Unit#: _____

Pt's @ Scene: _____

Transport EMS Crew/Role:

#1

Driver

Driver

Care Provider

#2

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:

Patient Last Name: _____

Age: _____

Sex: _____

Patient First Name: _____

DOB: _____ / _____ / _____

Patient Address: _____

Allergies: _____

Medical Hx: _____

Medications: _____

Pt's Chief Complaint: _____

Call Type: Scene Transfer Intercept

Primary Impression: _____

Secondary Impression: _____

Symptoms: _____

Incident Type: TRAUMA (Alert given? **Yes / No**)

STROKE (Alert given? **Yes / No**)

CARDIAC (if STEMI or OHCA, Alert given? **Yes / No**)

OTHER : _____

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: _____

Time	AVPU	GCS	HR	RR	BP	SpO ₂	ETCO ₂	Blood Glucose	Pain Scale	ECG Findings
:										
:										
:										
:										
:										
:										
:										
:										
:										

PATIENT

TIMES

EMS

HX

EVENT

VITALS

