

GENERIC RUN REPORT

Prehospital Patient Care Chart

INCIDENT NUMBER		UNIT ID		INCIDENT DATE	
INCIDENT ADDRESS			INCIDENT CITY		INCIDENT STATE
INCIDENT COUNTY			INCIDENT LOCATION TYPE See Ref. Sheet		
COMPLAINT REPORTED BY DISPATCH See Ref. Sheet		PRIMARY PAYMENT See Ref. Sheet	EMERGENCY MEDICAL DISPATCH PERFORMED <input type="checkbox"/> No <input type="checkbox"/> Yes w/pre-arrival instructions <input type="checkbox"/> Yes w/out pre-arrival instructions		LEVEL OF SERVICE <input type="checkbox"/> BLS, Emergency <input type="checkbox"/> ALS, Level 1 Emergency <input type="checkbox"/> ALS, Level 2 <input type="checkbox"/> Specialty Care Transport <input type="checkbox"/> Helicopter <input type="checkbox"/> Not Applicable
INCIDENT/PATIENT DISPOSITION					
<input type="checkbox"/> Treated, Transport EMS <input type="checkbox"/> No Patient Found <input type="checkbox"/> Cancelled <input type="checkbox"/> No Treatment Required <input type="checkbox"/> Treated & Released <input type="checkbox"/> Dead at Scene		<input type="checkbox"/> Treated, Transferred care <input type="checkbox"/> Treated, Transported Law Enforcement <input type="checkbox"/> Pt Refused Care			
NUMBER OF PATIENTS ON SCENE <input type="checkbox"/> Single <input type="checkbox"/> None <input type="checkbox"/> Multiple		MASS CASUALTY <input type="checkbox"/> Yes <input type="checkbox"/> No	TYPE OF SERVICE REQUESTED <input type="checkbox"/> 911 Response <input type="checkbox"/> ED to ED Transfer <input type="checkbox"/> Medical Transport <input type="checkbox"/> Mutual Aid		PRIMARY ROLE OF THE UNIT <input type="checkbox"/> Transport <input type="checkbox"/> Non-transport <input type="checkbox"/> Supervisor <input type="checkbox"/> Rescue
TYPE OF DELAY (S)					
DISPATCHER <input type="checkbox"/> None-N/A <input type="checkbox"/> Not known <input type="checkbox"/> Caller Uncooperative <input type="checkbox"/> High Call Volume <input type="checkbox"/> Language Barrier <input type="checkbox"/> Location (Inability to obtain) <input type="checkbox"/> No Unit Available <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Technical Failure <input type="checkbox"/> Other		RESPONSE <input type="checkbox"/> None-N/A <input type="checkbox"/> Crowd <input type="checkbox"/> Directions <input type="checkbox"/> Distance <input type="checkbox"/> Diversion <input type="checkbox"/> Hazmat <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Staff Delay <input type="checkbox"/> Traffic <input type="checkbox"/> Vehicle Crash <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> Weather <input type="checkbox"/> Other		SCENE <input type="checkbox"/> None-N/A <input type="checkbox"/> Crowd <input type="checkbox"/> Directions <input type="checkbox"/> Distance <input type="checkbox"/> Diversion <input type="checkbox"/> Extrication>20 Min <input type="checkbox"/> Hazmat <input type="checkbox"/> Language Barrier <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Staff Delay <input type="checkbox"/> Traffic <input type="checkbox"/> Vehicle Crash <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> Weather <input type="checkbox"/> Other	
		TRANSPORT <input type="checkbox"/> None-N/A <input type="checkbox"/> Crowd <input type="checkbox"/> Directions <input type="checkbox"/> Distance <input type="checkbox"/> Diversion <input type="checkbox"/> Hazmat <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Staff Delay <input type="checkbox"/> Traffic <input type="checkbox"/> Vehicle Crash <input type="checkbox"/> Vehicle Failure <input type="checkbox"/> Weather <input type="checkbox"/> Other		RETURN <input type="checkbox"/> None-N/A <input type="checkbox"/> Clean up <input type="checkbox"/> Decontamination <input type="checkbox"/> Documentation <input type="checkbox"/> ED Overcrowding <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Equipment Replenishment <input type="checkbox"/> Other <input type="checkbox"/> Staff Delay <input type="checkbox"/> Vehicle Failure	
PATIENT LAST NAME			PATIENT FIRST NAME		MI
PATIENT ADDRESS <input type="checkbox"/> SAME AS INCIDENT			PATIENT CITY		PATIENT STATE
PATIENT ZIP CODE					
AGE		DATE OF BIRTH	GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male		RACE
ETHNICITY					
CURRENT MEDICATIONS		ALLERGIES		PERTINENT HISTORY	
INJURY PRESENT <input type="checkbox"/> Yes <input type="checkbox"/> No	CAUSE OF INJURY See Ref. Sheet		TYPE OF INJURY <input type="checkbox"/> Blunt <input type="checkbox"/> Penetrating <input type="checkbox"/> Burn <input type="checkbox"/> Not Known		ALCOHOL/DRUG USE INDICATORS <input type="checkbox"/> None <input type="checkbox"/> Pt admits to drug use <input type="checkbox"/> Smell of alcohol on breath <input type="checkbox"/> Pt admits to alcohol use <input type="checkbox"/> Alcohol and/or drug paraphernalia at scene
CHIEF COMPLAINT					CONDITION CODE See Ref. Sheet
CHIEF COMPLAINT ANATOMIC LOCATION <input type="checkbox"/> Abdomen <input type="checkbox"/> Extremity Lower <input type="checkbox"/> General/Global <input type="checkbox"/> Chest <input type="checkbox"/> Back <input type="checkbox"/> Extremity Upper <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Genitalia			CHIEF COMPLAINT ORGAN SYSTEM <input type="checkbox"/> CNS/Neuro <input type="checkbox"/> OB/GYN <input type="checkbox"/> Pulmonary <input type="checkbox"/> Global <input type="checkbox"/> Renal <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Psych <input type="checkbox"/> Skin <input type="checkbox"/> Musculoskeletal		
CARDIAC ARREST <input type="checkbox"/> Yes, Prior to Arrival <input type="checkbox"/> Yes, After Arrival <input type="checkbox"/> No	RESUSCITATION <input type="checkbox"/> Defibrillation <input type="checkbox"/> None-DOA <input type="checkbox"/> Ventilation <input type="checkbox"/> None-DNR <input type="checkbox"/> Chest Compressions <input type="checkbox"/> None-Signs of life		CAUSE OF CARDIAC ARREST <input type="checkbox"/> Presumed Cardiac <input type="checkbox"/> Respiratory <input type="checkbox"/> Unknown <input type="checkbox"/> Trauma <input type="checkbox"/> Electrocution <input type="checkbox"/> Drowning <input type="checkbox"/> Other		
USE OF SAFETY EQUIPMENT <input type="checkbox"/> N/A <input type="checkbox"/> Lap Belt <input type="checkbox"/> Shoulder Belt <input type="checkbox"/> Protective Clothing <input type="checkbox"/> Not Known <input type="checkbox"/> Helmet Worn <input type="checkbox"/> Protective Non-Clothing Gear <input type="checkbox"/> Other <input type="checkbox"/> Child Restraint <input type="checkbox"/> Eye Protection <input type="checkbox"/> Personal Floatation Device				AIRBAG DEPLOYMENT <input type="checkbox"/> None Present <input type="checkbox"/> Deployed Front <input type="checkbox"/> Not Deployed <input type="checkbox"/> Deployed Side <input type="checkbox"/> Deployed Other	
BARRIERS TO EFFECTIVE CARE <input type="checkbox"/> Development Impaired <input type="checkbox"/> Physically Impaired <input type="checkbox"/> Unattended/Unsupervised <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> None <input type="checkbox"/> Physical Restraint <input type="checkbox"/> Unconscious <input type="checkbox"/> Language <input type="checkbox"/> Speech Impaired					
RESPONSE MODE		TRANSPORT MODE			
<input type="checkbox"/> ← Lights/Sirens →		<input type="checkbox"/> →		Initial Call for Help : Unit Left Scene :	
<input type="checkbox"/> ← No Lights/No Sirens →		<input type="checkbox"/> →		Unit Notified : Patient arrived at Destination :	
<input type="checkbox"/> ← Initial Lights/Sirens Downgraded to no Lights/Sirens →		<input type="checkbox"/> →		Unit En Route : Incident Completed :	
<input type="checkbox"/> ← Initial No Lights/Sirens Upgraded to Lights/Sirens →		<input type="checkbox"/> →		Arrive on Scene : Available for Next Incident :	
				Arrived at PT. : :	
PRIOR AID See Ref. Sheet		PERFORMED BY		MEDICATIONS/ PROCEDURES	
				OUTCOME	

	INCIDENT NUMBER	UNIT ID	INCIDENT DATE
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TRAUMA TRIAGE CRITERIA <input type="checkbox"/> 2 nd /3 rd burn >10% BSA or face/feet/hand/genital/airway <input type="checkbox"/> Amp prox to wrist/ankle <input type="checkbox"/> Decreasing LOC <input type="checkbox"/> GCS Motor >4 <input type="checkbox"/> GCS Total ≥13 <input type="checkbox"/> Head/neck/torso crush <input type="checkbox"/> Extremity inj w/neurovasc comp <input type="checkbox"/> Extremity crush <input type="checkbox"/> Torso inj w/pelvic fx		<input type="checkbox"/> Flail chest <input type="checkbox"/> Torso inj w/abd tender/ distended/seatbelt sign <input type="checkbox"/> LOC ≥5 min <input type="checkbox"/> Mech of inj <input type="checkbox"/> Did not meet any triage criteria <input type="checkbox"/> Pen inj head/neck/torso <input type="checkbox"/> Pen inj prox to knee/elbow w/neurovasc comp <input type="checkbox"/> Spinal cord inj <input type="checkbox"/> Special Considerations <input type="checkbox"/> 2+ prox humerus/femur fxs	ADULTS ONLY <input type="checkbox"/> Pulse >120 w/hemor shock <input type="checkbox"/> Tension pneumothorax <input type="checkbox"/> Resp <10 or >29 <input type="checkbox"/> Required intubation <input type="checkbox"/> SysBP <90, or no radial pulse w/carotid pulse	PEDS ONLY <input type="checkbox"/> Poor perfusion <input type="checkbox"/> Resp distress/failure
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SYMPTOMS PRIMARY=P ASSOCIATED=A P A P A <input type="checkbox"/> <input type="checkbox"/> None <input type="checkbox"/> <input type="checkbox"/> Mass/Lesion <input type="checkbox"/> <input type="checkbox"/> Bleeding <input type="checkbox"/> <input type="checkbox"/> Mental/Psych <input type="checkbox"/> <input type="checkbox"/> Breathing <input type="checkbox"/> <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> <input type="checkbox"/> Changes in Responsiveness <input type="checkbox"/> <input type="checkbox"/> Pain <input type="checkbox"/> <input type="checkbox"/> Choking <input type="checkbox"/> <input type="checkbox"/> Palpitations <input type="checkbox"/> <input type="checkbox"/> Death <input type="checkbox"/> <input type="checkbox"/> Rash/Itching <input type="checkbox"/> <input type="checkbox"/> Device/Equip Prob <input type="checkbox"/> <input type="checkbox"/> Swelling <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> Transport Only <input type="checkbox"/> <input type="checkbox"/> Drainage/Discharge <input type="checkbox"/> <input type="checkbox"/> Weakness <input type="checkbox"/> <input type="checkbox"/> Fever <input type="checkbox"/> <input type="checkbox"/> Wound <input type="checkbox"/> <input type="checkbox"/> Malaise		PROVIDER IMPRESSION P S <input type="checkbox"/> <input type="checkbox"/> Abd pain <input type="checkbox"/> <input type="checkbox"/> Airway obstruct <input type="checkbox"/> <input type="checkbox"/> Allergic rxn <input type="checkbox"/> <input type="checkbox"/> Altered LOC <input type="checkbox"/> <input type="checkbox"/> Behavior/psych <input type="checkbox"/> <input type="checkbox"/> Cardiac arrest <input type="checkbox"/> <input type="checkbox"/> Cardiac arrhythmia <input type="checkbox"/> <input type="checkbox"/> Chest pain <input type="checkbox"/> <input type="checkbox"/> Diabetic		PRIMARY=P SECONDARY=S P S P S <input type="checkbox"/> <input type="checkbox"/> Electrocution <input type="checkbox"/> <input type="checkbox"/> Resp arrest <input type="checkbox"/> <input type="checkbox"/> Hyperthermia <input type="checkbox"/> <input type="checkbox"/> Resp distress <input type="checkbox"/> <input type="checkbox"/> Hypothermia <input type="checkbox"/> <input type="checkbox"/> Seizure <input type="checkbox"/> <input type="checkbox"/> Hypovolemia/shock <input type="checkbox"/> <input type="checkbox"/> Sexual assault/rape <input type="checkbox"/> <input type="checkbox"/> Inhalation/toxic gas <input type="checkbox"/> <input type="checkbox"/> Stings/bites <input type="checkbox"/> <input type="checkbox"/> Inhalation/smoke <input type="checkbox"/> <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> <input type="checkbox"/> Death <input type="checkbox"/> <input type="checkbox"/> Syncope <input type="checkbox"/> <input type="checkbox"/> Poisoning/drug OD <input type="checkbox"/> <input type="checkbox"/> Injury <input type="checkbox"/> <input type="checkbox"/> OB/delivery <input type="checkbox"/> <input type="checkbox"/> Vag bleed	
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MEDICATIONS				
TIME	MEDICATION	DOSE	ROUTE	REACTIONS See Ref. Sheet
:				
:				
:				
:				
:				

PROCEDURES				
TIME	PROCEDURE	# ATTEMPTS	SUCCESSFUL	COMPLICATIONS See Ref. Sheet
:			<input type="checkbox"/> YES <input type="checkbox"/> NO	
:			<input type="checkbox"/> YES <input type="checkbox"/> NO	
:			<input type="checkbox"/> YES <input type="checkbox"/> NO	
:			<input type="checkbox"/> YES <input type="checkbox"/> NO	
:			<input type="checkbox"/> YES <input type="checkbox"/> NO	

VITAL SIGNS								
TIME	PULSE	SYS BP	DIA BP	RESP	O2 SAT	GCS EYE	GCS VERBAL	GCS MOTOR
:								
:								
:								
:								
:								

ADV DIRECTIVE <input type="checkbox"/> State DNR Form <input type="checkbox"/> Family Request DNR (no form) <input type="checkbox"/> Living Will <input type="checkbox"/> Other Healthcare DNR <input type="checkbox"/> None <input type="checkbox"/> Other	DESTINATION
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TYPE OF DESTINATION <input type="checkbox"/> Hosp ED/OR/L&D <input type="checkbox"/> Other EMS (air) <input type="checkbox"/> Other EMS (ground) <input type="checkbox"/> Other	REASON FOR CHOOSING DESTINATION <input type="checkbox"/> Closest <input type="checkbox"/> On-line Med Control <input type="checkbox"/> Diversion <input type="checkbox"/> Other <input type="checkbox"/> Family Choice <input type="checkbox"/> Pt. Choice <input type="checkbox"/> Insurance <input type="checkbox"/> Pt. Physician's Choice <input type="checkbox"/> Law Enforcement Choice <input type="checkbox"/> Protocol <input type="checkbox"/> <input type="checkbox"/> Specialty Resource Center	ED DISPOSITION <input type="checkbox"/> Admit-floor <input type="checkbox"/> Admit-ICU <input type="checkbox"/> Death <input type="checkbox"/> Discharge <input type="checkbox"/> Transfer-other hosp	HOSPITAL DISPOSITION <input type="checkbox"/> Death <input type="checkbox"/> Discharge <input type="checkbox"/> Transfer-other hosp <input type="checkbox"/> Transfer-nursing home <input type="checkbox"/> Transfer-other <input type="checkbox"/> Transfer-rehab
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NARRATIVE		

CREW MEMBER	CREW MEMBER	CREW MEMBER
CREW MEMBER	CREW MEMBER	CREW MEMBER