

GENERIC RUN REPORT

Prehospital Patient Care Chart

A Microsoft Word version of this form is available from the EMS Office of Research & Analysis

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"/> Treated, Transferred care <input type="checkbox"/> Treated, Transported Law Enforcement <input type="checkbox"/> Cancelled <input type="checkbox"/> No Treatment Required <input type="checkbox"/> Pt Refused Care <input type="checkbox"/> Treated & Released <input type="checkbox"/> Dead at Scene <input type="checkbox"/> Treated, Transported Private Vehicle						
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"/> Scene Response <input type="checkbox"/> ED to ED Transfer <input type="checkbox"/> Mutual Aid <input type="checkbox"/> Intercept		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"/> Ambulance Crash <input type="checkbox"/> Ambulance 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"/> Ambulance Crash <input type="checkbox"/> Ambulance 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"/> Ambulance Crash <input type="checkbox"/> Ambulance 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"/> Ambulance 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"/> Endocrine/Metabolic <input type="checkbox"/> Global <input type="checkbox"/> Renal <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Gastrointestinal <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"/> Trauma <input type="checkbox"/> Electrocutation <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 <input type="checkbox"/> None				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 <input type="checkbox"/> N/A		
BARRIERS TO STANDARD PATIENT CARE <input type="checkbox"/> Development Impaired <input type="checkbox"/> Physically Impaired <input type="checkbox"/> Unattended/Unsupervised <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Morbid Obesity <input type="checkbox"/> Physical Restraint <input type="checkbox"/> Unconscious <input type="checkbox"/> Language <input type="checkbox"/> Speech Impaired <input type="checkbox"/> None						
RESPONSE MODE		TRANSPORT MODE				
<input type="checkbox"/> Lights/Sirens		<input type="checkbox"/>		Initial Call for Help	:	
<input type="checkbox"/> No Lights/No Sirens		<input type="checkbox"/>		Unit Notified	:	
<input type="checkbox"/> Initial Lights/Sirens Downgraded to no Lights/Sirens		<input type="checkbox"/>		Unit En Route	:	
<input type="checkbox"/> Initial No Lights/Sirens Upgraded to Lights/Sirens		<input type="checkbox"/>		Arrive on Scene	:	
				Arrived at PT.	:	
PRIOR AID See Ref. Sheet						
PRIOR AID OUTCOME <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Worse <input type="checkbox"/> Unknown						
PERFORMED BY		MEDICATIONS/ PROCEDURES		PERFORMED BY		

