Pre-Hospital Care Form

Alarm No._____

Name: _____ Age: _____ DOB: _____
Last First Middle

Patient Address: _____ Sex: ☐ M ☐ F

Incident Address: _____
Street City State

Injuries or Major Complaint:

Trauma ID No._____

Date of Alarm:		Transported: ☐ Yes ☐ No		☐ Ambulance	☐ Private	☐ LifeFlight	
Time							Considerations:
Pulse							Pupils
Blood Pressure							Ears
Respirations							Skin Color & Feel
SaO_2							Motor Functions
CAO x 1-2-3-4							Bowel Sounds
Lung Sounds							
Blood Sugar							Physician:
Glascow Coma							

IV ATTEMPTS:

Time	By Who	Successful	Location	Type of Medication

History of Present Illness:

Physical Examination:

Treatment:

Changes in Patient:

Past Medical History:

Allergies:

Medications:

EMT	Senior EMT \ Level	EMT \ Level	EMT \ Level
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