Southern Illinois Regional EMS System
Patient Care Report

Agency:	Unit Number:	Run Number:	Date:
Incident Location: County		Hospital Destination:	

Patient Info

Pt. Name:				Pt. Address: Street Address	
D.O.B.	mm	dd	yyyy	Age:	City State Zip Code
Telephone Number: ( )					County

Primary Care Physician:	Legal Guardian:

Allergies:

Medications:

Past Medical History:

Glasgow Coma Scale		
Eyes	Verbal	Motor
4 Spontan	5 Oriented	6 Obeys
3 To Speech	4 Confused	5 Localizes
2 Pain	3 Inapp.	4 Withdraws
1 None	2 Garbled	3 Flexion
	1 None	2 Extension
Total:		1 None

Time Information:
Call Received:
Dispatched:
En Route:
Arrived at Scene:
Patient Contact:
Departed Scene:
Arrived Destination:

Medical Control Contact: (Circle) Yes No	Time Contacted:	Weight:
Resource Hospital:	Prior Aid Performed:	Performed By:

Chief Complaint:

Narrative:

Time	Pulse	Resp	B/P	BS	O2 Sat	Rhythm	Treatment	Attempts	Dose	Route

Skin Color & Condition:	Pupils:

Protection Used by Patient: (Circle) Lap/Shoulder Belt Lap Belt Air Bag Deployed Helmet

Patient Location in Vehicle:	Body Substance Isolation Used:
Injury Site and Type:	Cause of Injury:

Cardiac Arrest: Y N	Witnessed Arrest: Y N	Return of Spontaneous Circulation: Y N	AED: Y N
CPR Start Time:	Time of First Defib.:	Advanced AirwayTime:	Attempts:

Signature of Person Receiving Patient	EMS Crew Signatures and License Numbers:
	Circle
	D R 1)
X	D R 2)
Police Department Crash Number:	D R 3)
	D R 4)

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Narrative: