Arkansas Department of Health EMS Field Patient Care Report – Short Form

All Pertinent Sections Should Be Completed for all Patients at Time of Care Transfer to ED Staff

Agency _____ **Phone** _____ **Receiving Hospital** _____ **Run#** ____-_____

Patient Name _____ **DOB** _____ **Age** _____ **Gender**_____

Date____/____/_____ **Time**_____:_____ **LOC** ☐ Alert ☐ Verbal ☐ Pain ☐ Unresponsive

Trauma

Trauma Band #: _____ ATCC Contacted: ☐ Yes ☐ No Trauma Alert by EMS: ☐ Yes ☐ No

GCS	
Initial:	
Post:	

Eye Opening	Spontaneous To Speech To Pain None	4 3 2 1	**Best Verbal Response**	Oriented Disoriented Monosyllabic Incomprehensible None	5 4 3 2 1	**Best Motor Response**	Obeys Commands Localizes Pain Withdraws from Pain Abnormal Flexion Extension to Pain None	6 5 4 3 2 1

M MOI / Chief Complaint: _____.
I Injuries: _____.
S Signs/Symptoms: _____.
T Treatments: _____.

STROKE

Prehospital Stroke Screen Performed: ☐ Yes ☐ No		Stroke Alert called to hospital by EMS: ☐ Yes ☐ No	
Glucose 60-400 ☐ Yes ☐ No		Last Known Well Time: _____:_____ Date: _____	
Balance - **sudden loss of balance?** ☐ Yes ☐ No		Name providing well time:	
Eyes - **sudden change in vision or trouble seeing?** ☐ Yes ☐ No		Phone number: _____-_____-_____	
Face - **Facial Drooping?** ☐ Yes ☐ No		Times (approximation - in whole minutes)	
Arms - **Does one arm drift downward??** ☐ Yes ☐ No		Dispatch to patient contact (goal<8):	Minutes
Speech - **Is their speech slurred or strange?** ☐ Yes ☐ No		Arrival to first vital set (goal<5):	Minutes
Time - **Did you document last known well time?** ☐ Yes ☐ No		Arrival to glucose check (goal<5):	Minutes
Potential Stroke Patient? ☐ Yes ☐ No		Total time on scene (goal <15):	Minutes
Stroke Band # - starts with "S"	S	Total transport time:	Minutes

STEMI

12, 15, or 18 Lead Obtained: ☐ Yes ☐ No		STEMI Alert called to hospital by EMS: ☐ Yes ☐ No	
STEMI Indicated: ☐ Yes ☐ No		Elevation in leads:	
Initial Rhythm:		Depression in leads:	
Was ECG transmitted to the recieveing facility: ☐ Yes ☐ No			

Treatments

Vitals

Time	Blood Pressure	Pulse	BPM	O_2 Sat	EKG
	/				
	/				

Airway

Oxygen	NC NRB BVM
OPA/NPA	☐ Yes ☐ No
Tube	ETT King Other
Size	
Depth	
PAI	☐ Yes ☐ No

Meds

Time	Medication/Fluid	Dose	Rate	Total Administered

PMHx: Meds: Allergies:

Notes:

EMS Field HCP: Name & Title: _____ Time of care transfer: _____

Receiving HCP: Name & Title: _____

PCR Short Form This form is to be used by EMS services to provide patient care information to the receiving facility upon delivery of the patient when a complete patient care report cannot be completed. Please print legibly. Complete this form and leave with the RN receiving the patient.

THIS FORM DOES NOT REPLACE THE OFFICIAL AMBULANCE RUN REPORT OR PATIENT CARE REPORT