

DEPARTMENT OF HEALTH & FAMILY SERVICES

AMBULANCE REPORT

STATE OF WISCONSIN

Division of Public Health
DPH 7119 (Rev. 02/01)

Completion of this form meets the requirements of administrative rule HFS 110.04(3)(b).
Some client information in this document is confidential under Wis. Stat. 146.82(1).

Adm. Code HFS 110.04(3)(b)

Form section containing: Date Incident Reported, Service Name and ID No., Responding Unit, Station, Patient Care Record / Alarm No., Incident Address / Location, Incident Municipality, Incident County, Destination Address / Facility Name, Destination Municipality, Destination County.

Form section containing: Mileage (Loaded) End, Begin, Total, Lights And Siren To Scene, Initial Emergent, Downgrade To No Lights and Siren, Initial Non-emergent, Upgrade To Lights and Siren, Crash Report No., Pt. Det., Call Rec., En Route, At Scene, At Pt., Lv. Scene, At Dest., In Service, Crew Member Name / License No., Location Type, Response Type.

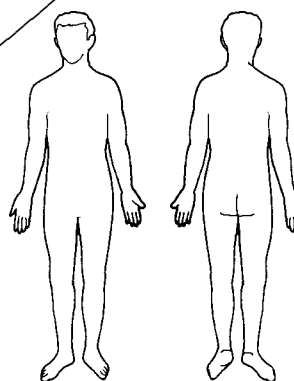
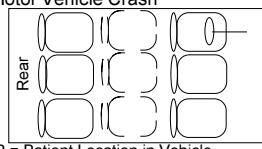
Form section containing: Patient Last Name / First / M.I., Mailing Address, City, State, Zip Code, Phone, Emergency Contact Name, Address, City, State, Zip Code, Phone, Personal Physician, Date of Birth, Age, Weight, Gender, Social Security No. (Optional), Race, Work Related Injury, Employer, Address, City, State, Zip Code, Phone, Insurance 1, Group No., Insured No., Insurance 2, Address, Phone, Group No., Insured No., Medicare, HMO, Medicaid.

Form section containing: Signs / Symptoms, Allergies, Patient's Current Medications, Dose, Last Oral Intake.

Form section containing: Pre-Existing Medical Condition -- Medical, Cardiac, Other.

Form section containing: Vitals, Mental Status/Behavior, Eyes, Breath Sounds, Skin, Moisture, Color, Pain, Capillary Refill.

Form section containing: CPR Provider, Defib Provider, CPR Start Time, Discontinue, Witnessed Arrest, Time.

Service Name and ID No.		Patient Last Name / First / M.I.				Patient Care Record / Alarm No.											
PHYSICAL EXAMINATION	Physical Examination						Glasgow Coma Scale										
	<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <p style="text-align: center;">Pain (No Trauma)</p> <table border="1" style="width: 100%; text-align: center;"> <tr><td>Blunt</td><td>Dis / FX</td><td>Gunshot</td><td>Laceration / Abrasion</td><td>Puncture / Stab</td><td>Soft Tissue Swelling</td><td>Burn</td></tr> </table> </div> <div style="width: 50%; text-align: center;"> <input type="checkbox"/> N/A  </div> </div>						Blunt	Dis / FX	Gunshot	Laceration / Abrasion	Puncture / Stab	Soft Tissue Swelling	Burn	A. Eye Opening		Scene Enroute	
							Blunt	Dis / FX	Gunshot	Laceration / Abrasion	Puncture / Stab	Soft Tissue Swelling	Burn				
							Spontaneous		4	4							
							To voice		3	3							
							To pain		2	2							
							None		1	1	Time						
							B. Verbal Response										
							Oriented		5	5							
							Confused		4	4							
Inappropriate words							3	3									
Incomprehensible Words		2	2														
None		1	1														
C. Motor Response																	
Obeys commands		6	6														
Purposeful movement		5	5														
Withdraws to pain		4	4														
Flexion to pain		3	3														
Extension to pain		2	2														
None		1	1														
A. + B. + C. =						<input type="checkbox"/> N/A											
TRAUMATIC INJURY	Motor Vehicle Crash <input type="checkbox"/> N/A		Type <input type="checkbox"/> N/A	Exterior Damage <input type="checkbox"/> N/A	Interior Damage <input type="checkbox"/> N/A	Restraints <input type="checkbox"/> N/A	Safety Equipment <input type="checkbox"/> N/A										
	 <p>P = Patient Location in Vehicle X = Location of Damage to Vehicle</p>		<input type="checkbox"/> Car <input type="checkbox"/> Motorcycle	<input type="checkbox"/> None	<input type="checkbox"/> None	Airbag <input type="checkbox"/> Obs <input type="checkbox"/> Rprt	<input type="checkbox"/> None <input type="checkbox"/> Float. Dev.										
			<input type="checkbox"/> Truck <input type="checkbox"/> ATV	<input type="checkbox"/> Minor	<input type="checkbox"/> Spidered Window	<input type="checkbox"/> Lap Belt <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Helmet <input type="checkbox"/> Unknown										
			<input type="checkbox"/> Van <input type="checkbox"/> Snowmobile	<input type="checkbox"/> Moderate	<input type="checkbox"/> St. Wh. Bent	<input type="checkbox"/> Shoulder Belt <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Eye Prot. <input type="checkbox"/>										
			<input type="checkbox"/> Semi <input type="checkbox"/> Watercraft	<input type="checkbox"/> Major	<input type="checkbox"/> Compart. Intrusion	<input type="checkbox"/> Child Seat <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Prot. Clothing <input type="checkbox"/>										
			<input type="checkbox"/> Bus <input type="checkbox"/> Aircraft	<input type="checkbox"/> Rollover	<input type="checkbox"/> Patient Ejected												
			Cause of Injury <input type="checkbox"/> N/A		<input type="checkbox"/> Chemical Exposure	<input type="checkbox"/> Excessive Heat	<input type="checkbox"/> Lightning	<input type="checkbox"/> Physical Assault	<input type="checkbox"/> Stings (Plant / Animal)								
			<input type="checkbox"/> Aircraft Related	<input type="checkbox"/> Child Battering Suspected	<input type="checkbox"/> Fire / Flames	<input type="checkbox"/> Machinery Injury	<input type="checkbox"/> Poison, Not Drugs	<input type="checkbox"/> Radiation Exposure	<input type="checkbox"/> Water Transport Incident								
			<input type="checkbox"/> Athletic Event	<input type="checkbox"/> Drowning	<input type="checkbox"/> Firearm Self-Inflicted	<input type="checkbox"/> Mechanical Suffocation	<input type="checkbox"/> Sexual Assault	<input type="checkbox"/> Smoke Inhalation	<input type="checkbox"/> Unknown								
			<input type="checkbox"/> Bicycle Crash	<input type="checkbox"/> Drug Ingestion	<input type="checkbox"/> Firearm Accidental	<input type="checkbox"/> Motor Vehicle (Non-Traff.)	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Stings / Bites	<input type="checkbox"/> Other _____								
<input type="checkbox"/> Bite			<input type="checkbox"/> Electrocutation (Non-Light.)	<input type="checkbox"/> Firearm Assault	<input type="checkbox"/> Motor Vehicle (Traffic)	<input type="checkbox"/> Strokes / CVA / TIA											
<input type="checkbox"/> Excessive Cold	<input type="checkbox"/> Firearm Assault																
Provider Impression		If more than one impression is checked, Circle Primary One															
<input type="checkbox"/> Abd. Pn. / Problems	<input type="checkbox"/> Cardiac Arrest	<input type="checkbox"/> Electrocutation	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Respiratory Arrest	<input type="checkbox"/> Syncope / Fainting												
<input type="checkbox"/> Airway Obstruction	<input type="checkbox"/> Cardiac Rhythm. Disturb.	<input type="checkbox"/> GI Bleed	<input type="checkbox"/> Hypovolemia / Shock	<input type="checkbox"/> Respiratory Distress	<input type="checkbox"/> Traumatic Injury												
<input type="checkbox"/> Allergic Reaction	<input type="checkbox"/> Chest Pn. Discomfort	<input type="checkbox"/> Headache	<input type="checkbox"/> Intoxication Suspected / Alcohol Ingestion	<input type="checkbox"/> Seizure	<input type="checkbox"/> Vaginal Hemorrhage												
<input type="checkbox"/> Altered L.O.C.	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Obvious Death	<input type="checkbox"/> Sexual Assault / Rape	<input type="checkbox"/> Unknown												
<input type="checkbox"/> Behavioral / Psych	<input type="checkbox"/> Diabetic Symptoms	<input type="checkbox"/> Hyperthermia / Fever	<input type="checkbox"/> Poison / Drug Ingestion	<input type="checkbox"/> Toxic Inhalation	<input type="checkbox"/> Other _____												
Chief Complaint / Mechanism of Injury:		Time of Onset:		Procedure or Treatment		EMT	EMT										
Comments:				<input type="checkbox"/> Assisted Ventilation	_____	_____	_____										
				<input type="checkbox"/> Backboard	_____	_____	_____										
				<input type="checkbox"/> Bleeding Control	_____	_____	_____										
				<input type="checkbox"/> Burn Care	_____	_____	_____										
				<input type="checkbox"/> CPR	_____	_____	_____										
				<input type="checkbox"/> Cervical Immobilization	_____	_____	_____										
				<input type="checkbox"/> DNR Protocol	_____	_____	_____										
				<input type="checkbox"/> Glucose Administration	_____	_____	_____										
				<input type="checkbox"/> Nasopharyngeal Airway	_____	_____	_____										
				<input type="checkbox"/> Obstetric Care / Delivery	_____	_____	_____										
		<input type="checkbox"/> Oropharyngeal Airway	_____	_____	_____												
		<input type="checkbox"/> O2 By Mask _____ liters	_____	_____	_____												
		<input type="checkbox"/> O2 By Cannula _____ liters	_____	_____	_____												
		<input type="checkbox"/> Physical Exam	_____	_____	_____												
		<input type="checkbox"/> Radio / Phone Report	_____	_____	_____												
		<input type="checkbox"/> Splint of Extremity	_____	_____	_____												
		<input type="checkbox"/> Traction Splint	_____	_____	_____												
		<input type="checkbox"/> Vital Signs	_____	_____	_____												
		<input type="checkbox"/> OTHER: _____	_____	_____	_____												
		<input type="checkbox"/> None	_____	_____	_____												
If an advanced skill is performed, complete form DPH 7300																	
MISCELLANEOUS	Incident Disposition				Lights And Siren During Transport: <input type="checkbox"/> N/A												
	<input type="checkbox"/> Treated / Transported by EMS				<input type="checkbox"/> Non-Emergent, No Lights or Siren												
	Destination Type - AND - Destination Determination		<input type="checkbox"/> Treated / Transferred Care		<input type="checkbox"/> No Treat. Needed		<input type="checkbox"/> Emergent, Lights and Siren										
	<input type="checkbox"/> Home / Residence	<input type="checkbox"/> Closest Facility	<input type="checkbox"/> To Aero-Medical Unit	<input type="checkbox"/> No Treat. Needed	<input type="checkbox"/> Initial Emergent, Downgrade To No Lights and Siren		<input type="checkbox"/> Initial Non-emergent, Upgrade To Lights and Siren										
	<input type="checkbox"/> Police / Jail	<input type="checkbox"/> Diversion	<input type="checkbox"/> To ALS Unit	<input type="checkbox"/> Dead at Scene	<input type="checkbox"/> Cancelled												
	<input type="checkbox"/> Medical Office / Clinic	<input type="checkbox"/> EMT Choice	<input type="checkbox"/> To BLS Unit	<input type="checkbox"/> Cancelled	<input type="checkbox"/> Unknown												
	<input type="checkbox"/> Skilled Nursing Facil.	<input type="checkbox"/> Law Enforce. Choice	<input type="checkbox"/> To Law Enforcement	<input type="checkbox"/> Unknown	<input type="checkbox"/> No Patient Found												
	<input type="checkbox"/> Hospital Direct Admit	<input type="checkbox"/> Managed Care															
	<input type="checkbox"/> Hospital ED	<input type="checkbox"/> On Line Med. Direction	<input type="checkbox"/> Treated / No Transport														
	<input type="checkbox"/> Morgue	<input type="checkbox"/> Patient / Family Choice	<input type="checkbox"/> Treat. / Trans. by Priv. Veh.														
<input type="checkbox"/> Other	<input type="checkbox"/> Patient / Phys. Choice	<input type="checkbox"/> Treat. / Trans. by Other Means															
		<input type="checkbox"/> Protocol															
		<input type="checkbox"/> Specialty Center															
		<input type="checkbox"/> Other															
Arrival Status <input type="checkbox"/> N/A		PPE Used <input type="checkbox"/> N/A		Facility Notified By <input type="checkbox"/> N/A		Difficulties Encountered											
<input type="checkbox"/> Unchanged	<input type="checkbox"/> Gloves	<input type="checkbox"/> Radio	<input type="checkbox"/> Dispatch	<input type="checkbox"/> Other _____		<input type="checkbox"/> Extrication											
<input type="checkbox"/> Better	<input type="checkbox"/> Gown	<input type="checkbox"/> Phone	<input type="checkbox"/> Hazardous Material			<input type="checkbox"/> Language Barrier											
<input type="checkbox"/> Worse	<input type="checkbox"/> Goggles	<input type="checkbox"/> Unable*	<input type="checkbox"/> Road			<input type="checkbox"/> Unsafe Scene											
<input type="checkbox"/> DOA	<input type="checkbox"/> Mask	<input type="checkbox"/> No Need*	<input type="checkbox"/> Vehicle Problems			<input type="checkbox"/> Weather <input type="checkbox"/> N/A											
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____	<input type="checkbox"/> Direct															
		<input type="checkbox"/> EKG Telemetry															
		<input type="checkbox"/> * Explain _____															
				Time Report Received: By: _____													
				Report Given To: _____													
				EMT Signature _____													