North Dakota EMS Patient Care Report

Disp Type | Level

Service Name: (Please Print)

Service #:	Unit #:	Incident #:	PCR #:	Date of Onset: / /	Time: :	Date Incident Reported: / /	PCR Report Date: / /

Incident | Location

PSAP Time of Call :	Arrive Patient :	Starting Mileage	Patient name
Dispatched :	Depart Scene :	At Scene Mileage	Street Address
Enroute :	Arrive at Destination :	Destination Mileage	City / State / Zip
Arrived at Scene :	Available :	Ending Mileage	Phone / Date of Birth / Age

Veh Type | Disposition

Unit Role | To Scene

Factor 1 | From Scene

Scene Address	Scene GPS Longitude: / Scene GPS Latitude:	Social Security Number	Sex

Scene City	State	Scene Zip	Scene County	Scene Township/FIPS	Receiving Agency

Chief Complaint	Pre-Existing Conditions	Allergies

Factor 2 | Inj Ind. 1

Factor 3 | Inj Ind. 2

Medications

Time	Pulse	BP	Resps	GCS	SaO_2	EKG Interpretation

Factor 4 | Inj Ind. 3

Signs and Symptoms

Factor 5 | Safety 1

Narrative

Impression | Safety 2

Time	Medication	Route	Initial	Effect

Dest Type | Safety 3

Dest Det | Safety 4

Suspected | Safety 5

Cause 1 | Prior Aid

Cause 2 | Impact 1

Cause 3 | Impact 2

Cause 4 | Impact 3

Cause 5 | Position

Care Turned Over To:

PROCEDURES S = Successful U = Unsuccessful

TIME		# of ATTEMPTS	CREW #	S/U	TIME		# of ATTEMPTS	CREW #	S/U	TIME		# of ATTEMPTS	CREW #	S/U
	Abdominal Thrusts					Delivery (OB)					Needle Thorac.			
	Auto Defib.					Demand Valve					NG Tube			
	Back Blows					EKG					Oropharyngeal Airway			
	Bag Valve Mask					Extrication					Oxygen Administered			
	Bandage					Full Spinal Immobilization					Pacing			
	Bleeding Controlled					Intubation - multi-lumen airway					Pocket Mask			
	Blood Draw					Intubation Nasotrachial					Splint - Extremity			
	Blood Gluc. Level Check					Intubation Oro Tracheal					Splint - Traction			
	Blood Product Admin.					Irrigation					Suctioning			
	Burn Care					IV Centra Vein					Surgical Airway			
	Cardiovert					IV Intraosseous					Tourniquet			
	Cervical Collar					IV Peripheral					Urinary Cath.			
	Cold Pack					MASTApplied					Ventilator			
	CPR					MASTInflated					Other			
	Defib - Manual					Nasopharyngeal Airway					Not Applicable *			

1st CPR | 1st Defib | Shocks | Race

Signature of Provider

Patient Name (PLEASE PRINT)

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BILLING INFORMATION				MILEAGE	INSURANCE TYPE
Insurance - Primary	Number:	Insurance - Secondary	Number:	Beg:	❑ No Insurance ❑ Private Pay
Responsible Party:				End:	❑ Private Insurance ❑ Medicare
(Last Name)	(First Name)	(MI)		Total:	❑ Medicaid ❑ Medicare/Medicaid
(Address)					❑ VA Insurance ❑ Unknown
(City)	(State)	(Zip)	(Phone)		❑ Not Applicable

RECEIPT OF SERVICE	REFUSAL OF SERVICE
I acknowledge receipt of the EMS services listed in this document and accept full responsibility for all charges. I authorize payment of medical benefits from my insurance company to provide of such services and authorize the provider to release medical and other necessary information to my insurance company for that purpose.	This is to certify that I am refusing treatment / transport. I have been informed of the risk(s) involved, and hereby release the ambulance service, its attendants, and its affiliates, from all responsibility which may result from this action.
Patient Signature Date/Time	Patient Signature Date/Time

CREW	CREW MEMBER NAMES	STAFF ID	DRIVER		LEVEL
1			Y	N	
2			Y	N	
3			Y	N	
4			Y	N	

EKG STRIPS