



# PEI MFR PATIENT CARE REPORT



Dept/Agency Name(Do Not Abbreviate or Use station Number) \_\_\_\_\_

|                   |      |   |   |   |                    |                 |              |
|-------------------|------|---|---|---|--------------------|-----------------|--------------|
| Incident Location | Date | M | D | Y | Time Call Received | Time of Arrival | Time Cleared |
|-------------------|------|---|---|---|--------------------|-----------------|--------------|

**PATIENT INFORMATION** Chief Complaint \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB / M / D / Y Age \_\_\_\_\_

What Happened? (Mechanism of Injury) \_\_\_\_\_  
 Ambulance on scene prior to MFR Arrival? Yes  No   
 (If Yes, patient info is NOT required)  
 Did you assist the Medics? Yes  No

When Did It Happen/Start? \_\_\_\_\_  
 Ambulance on Scene: Time: \_\_\_\_\_ Unit#: \_\_\_\_\_

**MEDICAL CONDITIONS** None  Lung Disease  Seizures  Stroke   
 Heart Problems  Diabetes  High BP  Infectious Disease  Other: \_\_\_\_\_

**ALLERGIES** None Known  Unknown  ASA  Sulfa  Penicillin  Bee Sting  Peanuts  Other \_\_\_\_\_

Have Family Gather Meds and Hospital Card \_\_\_\_\_

| ASSESSMENT                                 |                                  | Skin                          |                                 | Vitals |           |       |       | Level of Pain         |
|--|----------------------------------|-------------------------------|---------------------------------|--------|-----------|-------|-------|-----------------------|
| Level of Consciousness                     | Color                            | Temp                          | Condition                       | Time   | Resp Rate | Pulse | BP    |                       |
| Alert <input type="checkbox"/>             | Pink <input type="checkbox"/>    | Hot <input type="checkbox"/>  | Dry <input type="checkbox"/>    | _____  | _____     | _____ | _____ | 1 2 3 4 5 6 7 8 9 10  |
| Responds to Voice <input type="checkbox"/> | Pale <input type="checkbox"/>    | Cold <input type="checkbox"/> | Moist <input type="checkbox"/>  | _____  | _____     | _____ | _____ | Mild → → → → → Severe |
| Responds to Pain <input type="checkbox"/>  | Blue <input type="checkbox"/>    | Warm <input type="checkbox"/> | Sweaty <input type="checkbox"/> | _____  | _____     | _____ | _____ |                       |
| Unresponsive <input type="checkbox"/>      | Flushed <input type="checkbox"/> |                               |                                 |        |           |       |       |                       |

**CARDIAC ARREST**

Time of collapse or last seen? \_\_\_\_\_ Time CPR started? \_\_\_\_\_

Was the arrest witnessed? Yes  No  If yes, by whom?  Family  Bystander  MFR Dept.  Other \_\_\_\_\_

CPR on Arrival of MFR? Yes  No  If yes, by whom?  Family  Bystander  Police  Other \_\_\_\_\_

Initial Analyze: No Shock Advised  Shock Advised  Time of First Shock? \_\_\_\_\_ Total # of Shocks by MFR? \_\_\_\_\_

| TREATMENT  | Breathing  | Circulation  | Trauma / Burn   | Protective Equipment  |
|--|--|--|---|---|
| Airway<br>OPA <input type="checkbox"/> NPA <input type="checkbox"/><br>Recovery Position <input type="checkbox"/><br>Jaw Thrust <input type="checkbox"/><br>Head Tilt <input type="checkbox"/><br>Suction <input type="checkbox"/><br>Abdominal Thrusts <input type="checkbox"/> | BVM Yes <input type="checkbox"/> No <input type="checkbox"/><br>O2 Admin Yes <input type="checkbox"/> No <input type="checkbox"/><br>LPM _____ | CPR<br>Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Bandage Applied? Yes <input type="checkbox"/> No <input type="checkbox"/><br>Wet <input type="checkbox"/> Dry <input type="checkbox"/><br>Controlled Bleeding? Yes <input type="checkbox"/> No <input type="checkbox"/><br>C-collar <input type="checkbox"/> KED <input type="checkbox"/> Backboard <input type="checkbox"/><br>Splint <input type="checkbox"/> Circulation OK post splinting: Yes <input type="checkbox"/> No <input type="checkbox"/> | Seat Belt Use Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/><br>Helmet Worn Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/><br>Airbag Deployed Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/><br>Car Seat Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/> |

**NOTES**

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\_\_\_\_\_

\_\_\_\_\_

**PROVIDER INFORMATION**

|               |                           |                 |                 |
|---------------|---------------------------|-----------------|-----------------|
| Documented By | Name - Please Print _____ | Signature _____ | MFR Tag # _____ |
| Provider #1   | Name - Please Print _____ | Signature _____ | MFR Tag # _____ |
| Provider #2   | Name - Please Print _____ | Signature _____ | MFR Tag # _____ |