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)

When Did It Happen/Start?

Ambulance on scene prior to MFR Arrival? Yes ☐ No ☐
(If Yes, patient info is NOT required)

Did you assist the Medics? Yes ☐ No ☐

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

Level of Consciousness	Skin: Color	Skin: Temp	Skin: Condition	Vitals: Time	Vitals: Resp Rate	Vitals: Pulse	Vitals: BP	Level of Pain
Alert ☐ Responds to Voice ☐ Responds to Pain ☐ Unresponsive ☐	Pink ☐ Pale ☐ Blue ☐ Flushed ☐	Hot ☐ Cold ☐ Warm ☐	Dry ☐ Moist ☐ Sweaty ☐	____ ____ ____	____ ____ ____	____ ____ ____	____ ____ ____	1 2 3 4 5 6 7 8 9 10 Mild→→→→→→→Severe

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

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

NOTES

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 #