

Pinellas County Emergency Medical Services
Patient Care Report

Copy

Paramedic: PC EMS ID# [080093] Response Time: Received 1228
 Load: 080093 Dispatched 1229
 Crew: 080672 Responding 1230
 On Scene 1234
 At Patient 1234
 Trauma Alert
 Aero Upgrade
 Xport On Scene
 Xport Depart
 Arrival
 Available 1258

Date: 04/23/10 Incident #: 0000058 7-9 Roll#: 0101 Agency: CL

Final ALS: Yes No Unit ID #: P200 P250 Other Unit ID #: Disposition: Unfounded Deceased Refused Treatment/Transport

Location Type: Incident Location Building/Section/Apt/Lot/Room #: ZIP: 28467 US Hwy 190.

Patient Last Name: [UNKNOWN] First Name: CATHERINE MI

Patient Home Address: [None] Building/Section/Apt/Lot/Room #: 633 Hollywood Bk City: Los Angeles State: CA Country: ZIP:

Age: 56 Sex: Female Race: White Date of Birth: 12/27/1953 Severity: Red Weight (lb): 65

ALS: Normal Obstructed Airway Stridor Unequal Expansion Apnoea

Assessment: Normal Confused Postictal Dysphasic Unresponsive Combative Obunded Seizing Hallucinating Other (Document in Narrative)

Presenting Problem(s): Soft Tissue Injury Pain or Distress Level: 2 Scale = 0 to 10

History of Present Illness: Pt. pts. was grabbed forcibly by Husband by @ Forearm Onset of Current Symptoms: 15 Mins Hours Days History Source: Patient

History: None Asthma Cardiac CVA Seizures HIV Unknown COPD HTN Diabetic Cancer Hepatitis

Other: Pt. Denies

Allergies: None Unknown Codeine Penicillin Sulfis Latex Unknown Caline Drugs Morphine Vallium ASA

Medical Necessity for Service (Transport Unit Only): Patient Found: In Bed On Ground or Floor In Vehicle Geri-chair Other (Document in Narrative)

Position Found: Supine Prone Lateral Recumbent Other (Document in Narrative)

To Stretcher Via: Assisted Backboard Draw Sheet Other (Document in Narrative)

Bed Containment: Patient is unable to get up from bed without assistance AND unable to ambulate AND unable to sit up in wheelchair for duration of transfer. (Document Reasons in Narrative)

Reason for Non-emergency transfer:

Physical Exam & Narrative: 56yo F - Blind Ambulatory on stick, A613 NAD Clo Soft Tissue Injury @ RA 2nd Unarmed Assault - Pt's husband forcibly grabbed her by the arm. PE: P200 - 4mm pink conjunctiva, 25/20 L/O clear + equal Bilat E-Cord, 1/3 @ C/P, @ D/B, @ Cyanosis, @ Accessible muscle use, @ Ux Abdomen soft Nontender, @ Bilateral Motor Surgery Intact @ Ux @ D/B, minor skin tear @ forearm @ B/B @ D/B. T/B: vs. PE, RA, 12/20, Dsg. Applied. Pt. pts refuse transport. Pt advised of combination @ B/B. Pt still refuse. Pt signed Refusal, witnessed by P250 + Crew. Supplemental Attached: Cardiac Arrest Report Attached

Final Field Impression: Condition Codes: Lead Clinician Signature: [Signature] ID Number: 082093

Cause of Injury		Vehicle Deformity		Protection		Trauma Center		Transport Local Criteria	
<input checked="" type="checkbox"/> Assault <input type="checkbox"/> MVC <input type="checkbox"/> GSW <input type="checkbox"/> Stabbing <input type="checkbox"/> Burn <input type="checkbox"/> Fall	<input type="checkbox"/> Marine Vehicle <input type="checkbox"/> Bicycle <input type="checkbox"/> Environment <input type="checkbox"/> HAZMAT <input type="checkbox"/> Heavy Equipment <input type="checkbox"/> Other (Document in Narrative)	<input type="checkbox"/> None <input type="checkbox"/> Dashboard <input type="checkbox"/> Side Window <input type="checkbox"/> Windshield <input type="checkbox"/> Patient's Door <input type="checkbox"/> Steering Wheel	<input type="checkbox"/> None <input type="checkbox"/> Lapbelt <input type="checkbox"/> Shoulder Belt <input type="checkbox"/> Normal Child Seat <input type="checkbox"/> Air Bag <input type="checkbox"/> Para. Float Device	<input type="checkbox"/> Extended Intubation Time <input type="checkbox"/> Death of another Passenger from Trauma <input type="checkbox"/> Rapid Deceleration with Heavy Damage <input type="checkbox"/> Passenger Space Inversion > 1 Foot <input type="checkbox"/> Ejection from Motor Vehicle	<input type="checkbox"/> Moderate - Heavy Damage w/o Passenger Restraints <input type="checkbox"/> Child < 10 HR by Motor Vehicle <input type="checkbox"/> Major Blunt Trauma to Head, Neck, Trunk, or Pelvis <input type="checkbox"/> Falls > 15 Feet (Pediatric: > twice their height)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No TTP Exception (Contact Medical Control - Document in Narrative)		Fall Distance (Feet)	

TRAUMA ALERT CRITERIA				Pediatric Criteria (Age < 16 years)		Trauma Alert	
Adult Criteria (Age >= 16 years) CHECK ALL THAT APPLY				Pediatric Criteria (Age < 16 years)			
<input type="checkbox"/> Active Airway Assist or Intubated	<input type="checkbox"/> Loss of Sensation	<input type="checkbox"/> 2° and/or 3° Burns => 15% BSA	<input type="checkbox"/> Amputation (Proximal Wrist/Ankle)			<input type="checkbox"/> ONE RED	
<input type="checkbox"/> Lack of Radial Pulse with HR > 120	<input type="checkbox"/> 2° and/or 3° Burns => 15% BSA	<input type="checkbox"/> Amputation (Proximal Wrist/Ankle)	<input type="checkbox"/> Penetration to Head, Neck, or Torso			<input type="checkbox"/> TWO BLUE	
<input type="checkbox"/> BP < 80	<input type="checkbox"/> Penetration to Head, Neck, or Torso	<input type="checkbox"/> Two or more Long Bone FX Sites	<input type="checkbox"/> Suspected Spinal Cord Injury			<input type="checkbox"/> PARAMEDIC INTUITION (Document in Narrative)	
<input type="checkbox"/> Glasgow Coma Score <= 12	<input type="checkbox"/> Loss of Sensation	<input type="checkbox"/> Weight <= 11 KG or Length < 33" (Red or Purple Pediatric Tape)	<input type="checkbox"/> Carotid or Femoral Pulse Palpable with No Radial or Pedal Pulse				
<input type="checkbox"/> Best Motor Response <= 4	<input type="checkbox"/> Single Long Bone FX Site due to Fall => 10'	<input type="checkbox"/> Carotid or Femoral Pulse Palpable with No Radial or Pedal Pulse	<input type="checkbox"/> Loss of Consciousness or Amnesia				
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Ejection from Motor Vehicle	<input type="checkbox"/> Loss of Consciousness or Amnesia	<input type="checkbox"/> Single Closed Long Bone FX Site (Do not include Wrist or Ankle Fracture)				
<input type="checkbox"/> Degloving or Avulsion > 5"	<input type="checkbox"/> Steering Wheel Deformed by Patient						

TREATMENT FLOW CHART

Podiatric Tape Color:	Vitals	BP	Pulse	Resp.	SpO2	GCS	Revised 01/01/2007
On-Line Medical Control:	Meds	Dose	Route	Result	Severity		
ETT Confirmed on Transfer by:	ECG	Rhythm	Rate	Ectopy	Lead		
	ETT	Confirmation Method	Route	Size	Depth	ETCO2	
Time	Action/Finding	Parameters					Performed by
1234	Paramedic or Caregiver advised by Prior to Arrival						08009B
1236	V/S	108/72	120	16			080672
1238	20 Srvvy						080672
1240	Drsg Applied @ FA						080677
1257	At signle & hand, witness by Pass - At advised of condition of stability						080677
Patient Condition at Time of Transfer of Care							

Destination Code	Destination Address	City / State	Ground Transport Unit ID#	Type of Transport
				<input type="checkbox"/> Ground Ambulance <input type="checkbox"/> Red Lights & Siren <input type="checkbox"/> Tx/Transfer to Helicopter

Initial Dispatch Priority	Involuntary Transport	Transport Position	Destination Selection	Initial Facility Not Available
	<input type="checkbox"/> Implied Consent <input type="checkbox"/> Baker Act <input type="checkbox"/> Meritman Act <input type="checkbox"/> Chapter 401.448	<input type="checkbox"/> Supine <input type="checkbox"/> Semi-Fowlers <input type="checkbox"/> Fowlers	<input type="checkbox"/> Closest/Most Appropriate <input type="checkbox"/> Patient's Choice <input type="checkbox"/> Trauma Center <input type="checkbox"/> Special Needs/Equipment	<input type="checkbox"/> Selective Divert - Specialty <input type="checkbox"/> Bypass <input type="checkbox"/> Closed
Social Security Number	Patient Photo #	Care Rendered	Mileage	Total Miles / Miles / Closest
		<input type="checkbox"/> O2 <input type="checkbox"/> Meds Given <input type="checkbox"/> Immobilization	<input type="checkbox"/> Start <input type="checkbox"/> Stop	
Medicare #	Medicaid #	Insurance Name	ID #	Group #

Sunrise Member	Direct Adult	Hospital	Team Color	Worker's Comp	Assisted with Transport & Patient Care	Billing Department ONLY		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Additional Meds <input type="checkbox"/> RN (Document Reason for Assistance in Narrative) <input type="checkbox"/> MD	ICD-9	ICD-9	ICD-9
Guarantor Name	Relationship to Patient	Guarantor Photo #				Modifiers	Bill Codes	Medicaid Code
Guarantor Mailing Address	Building/Apt/Lot/Room #	City	State	Country	ZIP	Charge Codes		
Employer Name	Employer Phone #				Invoice #			
Employer Address	City	State	Country	ZIP	Coded by			
Patient Belongings:	Medications	Wallet	Jewelry	Dentures	Cane/Walker	Turned Over To: <input type="checkbox"/> Family <input type="checkbox"/> Facility Staff		
<input type="checkbox"/> None <input type="checkbox"/> Hospital/Facility Bag	<input type="checkbox"/> Eye Glasses	<input type="checkbox"/> Purse	<input type="checkbox"/> Keys	<input type="checkbox"/> Other (Document in Narrative)	<input type="checkbox"/> Other (Document in Narrative)			

<p>Individual Refusal</p> <p>Patient is refusing:</p> <input type="checkbox"/> To be evaluated <input type="checkbox"/> Recommended treatment <input type="checkbox"/> Recommended hospital <input checked="" type="checkbox"/> Ambulance transportation (Document in Narrative)	<p>High Risk</p> <input type="checkbox"/> Minor (Age < 18) with Authorized Representative not available <input type="checkbox"/> Life threatening illness or injury <input type="checkbox"/> Advanced treatment initiated and stopped by the patient or Authorized Representative <input type="checkbox"/> Refusal represents a risk to patient's health, safety, or welfare and/or the Public or EMS System <input type="checkbox"/> High Risk Mechanism of Injury without complaints or with minimal complaints <input type="checkbox"/> Any Alteration in Mental Status (Conduct EMS Cognitive Evaluation)
<p>Low Risk</p> <input checked="" type="checkbox"/> Adult or Authorized Rep. <input checked="" type="checkbox"/> Alert, oriented and no alteration in mental status <input checked="" type="checkbox"/> No apparent life threatening illness or injury	<p>Document in the Narrative and advise OLMC of any observed impairment or deficit, including: vision, hearing, speech, drugs or alcohol use, injuries, or illnesses. Report the Cognitive Eval Score to Medical Control, (the lower the score the higher the degree of impairment). Indicate if the patient's age is < 12 or > 80, or if the patient has less than a 8th grade education, blind, etc.</p>
<p>On-Line Medical Control Consult Required</p>	
<p>Medical Control Determination:</p> <input type="checkbox"/> Refusal Accepted <input type="checkbox"/> Patient Accepted Recommendation <input type="checkbox"/> Involuntary Transport <input type="checkbox"/> Refusal - Against Medical Advice	
<p>Accept Refusal If All Criteria Are Met</p>	

Release of Medical Assistance

Date: MM/DD/YY

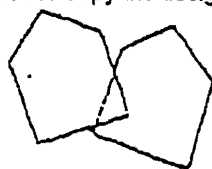
The undersigned patient, parent or authorized representative of the patient, is apparently a competent adult and certifies that the undersigned has been fully informed and understands that:

the patient requires emergency medical care and/or:
 that the patient could go to a hospital for further emergency care and/or;
 the undersigned's refusal of medical care may impair the patient's health or result in death.

Understanding the above, the undersigned patient, parent or authorized representative of the patient refuses emergency medical care and/or transport to a hospital by ambulance, assumes all risk and consequences of such refusal and releases Pinellas County and the Pinellas County Emergency Medical Services Authority, and each and every officer, agent, subcontractor and employee of Pinellas County and the Pinellas County Emergency Medical Services Authority, from any and all liability, including all claims and causes of action that the undersigned or any person acting on behalf of the undersigned may have or claim to have in the future against Pinellas County or Pinellas County Emergency Medical Services Authority, by reason of any illness, injuries, death or other consequences resulting directly or indirectly from the undersigned's refusal of medical care.

Patient's Name:	Witness Signature:	Printed Name or Agency/ID #
	<i>[Signature]</i>	<i>[Signature]</i> P-50
Patient or Authorized Representative Signature:	<input checked="" type="checkbox"/> Patient <input type="checkbox"/> Authorized Rep. <input type="checkbox"/> Refused to Sign	Paramedic Signature:
<i>[Signature]</i>		<i>[Signature]</i> 0802A3
<p>PC EMS ID#</p>		

EMS Cognitive Evaluation (Minimum Passing Score = 23)

Questions/Tasks	Maximum Points	Actual Points
1. What is the Year? () Season? () Month? () Day of Week? () Their Birthday? ()	5	<input type="checkbox"/>
2. Where are we? () Street? () City? () State? () Country? ()	5	<input type="checkbox"/>
3. The evaluator will name any three objects. Repeat the names of these objects three times. Ask the patient to repeat the names of these objects after three seconds.	3	<input checked="" type="checkbox"/>
4. Begin with the number 100 and ask the patient to count backward by fives to at least five numbers (i.e., 100, 95, 90, 85, 80).	5	<input type="checkbox"/>
5. Ask the patient to repeat the names of the three objects of question three.	3	<input type="checkbox"/>
6. Show the patient a pen and a watch. Ask the patient to name them.	2	<input type="checkbox"/>
7. Ask the patient to repeat: "no ifs, ands, or buts."	1	<input type="checkbox"/>
8. Ask the patient to follow 3 three-stage command: "Take this paper in your right hand, fold it and place it on the floor."	2	<input type="checkbox"/>
9. Ask the patient to read and do the following: "RAISE YOUR RIGHT HAND."	1	<input type="checkbox"/>
10. Ask the patient to write any complete sentence:	1	<input type="checkbox"/>
11. Ask the patient to copy the design below:	1	<input type="checkbox"/>
	<p>Maximum 29 Points</p>	<p><input type="checkbox"/></p> <p>Total Score</p>