

Reviewed by Physician  
 YES  NO

# ALASKA PRE-HOSPITAL PATIENT REPORT

NAME OF SERVICE				PATIENT'S NAME (Last, First, M.I.)			
AMBULANCE NO.	RUN NO.	MO.	DAY	YEAR	ADDRESS		
ADDRESS OF INCIDENT				CITY	STATE	ZIP	PHONE
PROBLEM REPORTED AS:				SOCIAL SECURITY NO.		DOB: MO DAY YEAR	
DESTINATION				INSURER	AGE	SEX	<input type="checkbox"/> WHITE <input type="checkbox"/> HISP. <input type="checkbox"/> ASIAN/PAC. ISLD. <input type="checkbox"/> BLACK <input type="checkbox"/> NAT. AM. <input type="checkbox"/> UNKNOWN
MED. CONTROL				NEXT OF KIN			PHONE

VITAL SIGNS						DRUGS/FLUIDS					
Time	Pulse	B.P.	Resp.	Airway	Pupils	GCS	Skin	IVs.	Time	Med	Amount
		/		<input type="checkbox"/> Normal <input type="checkbox"/> Partly Obstruct. <input type="checkbox"/> Obstruct. <input type="checkbox"/> SaO <sub>2</sub>	L. _____ R. _____	Eye _____ Verbal _____ Motor _____ Total _____ Unknown <input type="checkbox"/>	<input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Sweaty <input type="checkbox"/> Cyanotic <input type="checkbox"/> _____	Soln _____ Loc _____ Size _____ Attempts _____			
		/		<input type="checkbox"/> Normal <input type="checkbox"/> Partly Obstruct. <input type="checkbox"/> Obstruct. <input type="checkbox"/> SaO <sub>2</sub>	L. _____ R. _____	Eye _____ Verbal _____ Motor _____ Total _____ Unknown <input type="checkbox"/>	<input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Sweaty <input type="checkbox"/> Cyanotic <input type="checkbox"/> _____	Soln _____ Loc _____ Size _____ Attempts _____			
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### HISTORY

Chief Complaint/Mechanism of Injury: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Assessment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

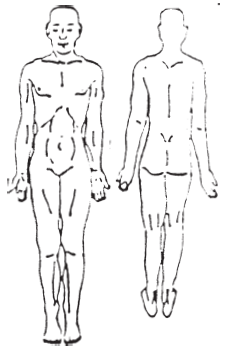
\_\_\_\_\_

Treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**CHIEF COMPLAINT/MOI**

Trauma  Cardiac  
 Burns  Diabetes  
 OB  Drowning  
 Alcohol  Respiratory  
 Frostbite  Hypothermia  
 Poisoning  Drug OD  
 Seizure  Behavioral  
 Other Medical  Stroke

**LOCATION**

Home/Res.  Public Building  
 School  Industry/Business  
 Mountains  Wild/Off-Road  
 Highway  Boat/Water  
 Recreation  Medical Facility  
 Unknown  Other

**SAFETY EQUIPMENT USED**

Lap Belt  Shoulder Belt  
 Helmet  Airbag Deployed  
 PFD  Child Safety Seat  
 None  Prot. Clothing  
 NA  Unknown

NATURE OF CALL	TRANSPORTED BY	EVENT	TIME	MILEAGE	ODOMETER	PATIENT DISPOSITION
<input type="checkbox"/> Emergent <input type="checkbox"/> Non-Emergent  <input type="checkbox"/> Scene <input type="checkbox"/> Transfer <input type="checkbox"/> Standby <input type="checkbox"/> Rendezvous <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	<input type="checkbox"/> Ground Ambulance <input type="checkbox"/> Air Ambulance <input type="checkbox"/> Helicopter (Military) <input type="checkbox"/> Helicopter (Commercial) <input type="checkbox"/> Air Taxi <input type="checkbox"/> Scheduled Flight <input type="checkbox"/> Boat <input type="checkbox"/> Snowmobile <input type="checkbox"/> Other (specify)	Incident Occurred		Start		<input type="checkbox"/> Treated/Transported by EMS <input type="checkbox"/> Treated/Transferred Care <input type="checkbox"/> Treated/Transported by Private Veh. <input type="checkbox"/> Treated/Released <input type="checkbox"/> No Treatment Required <input type="checkbox"/> Patient Refused Care <input type="checkbox"/> Dead at Scene <input type="checkbox"/> Cancelled <input type="checkbox"/> No Patient Found  <input type="checkbox"/> WORK RELATED <input type="checkbox"/> SUSPECTED ALCOHOL USE <input type="checkbox"/> SUSPECTED DRUG USE
		Call Received		Scene		
		Enroute		Destination		
		Arrived at Scene		Base		
		Enroute w/Patient		Total		
		Arrived at Destination		Personal Belongings with Patient:		
		Back in Service		Equipment Left with Patient:		
RESPONDER'S NAME	CERT.	RESPONDER'S NAME	CERT.	RECORDER'S SIGNATURE		

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

Reviewed by Physician

YES  NO

# ALASKA PRE-HOSPITAL PATIENT REPORT

NAME OF SERVICE										
AMBULANCE NO.	RUN NO.	MO.	DAY	YEAR						
ADDRESS OF INCIDENT										
PROBLEM REPORTED AS:										
DESTINATION					INSURER	AGE	SEX	<input type="checkbox"/> WHITE	<input type="checkbox"/> HISP.	<input type="checkbox"/> ASIAN/PAC. ISLD.
MED. CONTROL								<input type="checkbox"/> BLACK	<input type="checkbox"/> NAT. AM.	<input type="checkbox"/> UNKNOWN

## HISTORY

Chief Complaint/Mechanism of Injury: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- CHIEF COMPLAINT/MOI**
- Trauma
  - Burns
  - OB
  - Alcohol
  - Frostbite
  - Poisoning
  - Seizure
  - Other Medical
  - Cardiac
  - Diabetes
  - Drowning
  - Respiratory
  - Hypothermia
  - Drug OD
  - Behavioral
  - Stroke
- LOCATION**
- Home/Res.
  - School
  - Mountains
  - Highway
  - Recreation
  - Unknown
  - Public Building
  - Industry/Business
  - Wild/Off-Road
  - Boat/Water
  - Medical Facility
  - Other
- SAFETY EQUIPMENT USED**
- Lap Belt
  - Helmet
  - PFD
  - None
  - NA
  - Shoulder Belt
  - Airbag Deployed
  - Child Safety Seat
  - Prot. Clothing
  - Unknown

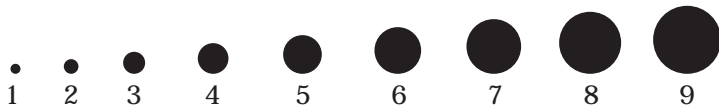
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		Call Received		Scene	
		Enroute		Destination	
		Arrived at Scene		Base	
		Enroute w/Patient		Total	
		Arrived at Destination		Personal Belongings with Patient:	
		Back in Service		Equipment Left with Patient:	

- PATIENT DISPOSITION**
- Treated/Transported by EMS
  - Treated/Transferred Care
  - Treated/Transported by Private Veh.
  - Treated/Released
  - No Treatment Required
  - Patient Refused Care
  - Dead at Scene
  - Cancelled
  - No Patient Found
  - WORK RELATED
  - SUSPECTED ALCOHOL USE
  - SUSPECTED DRUG USE

RESPONDER'S NAME	CERT.	RESPONDER'S NAME	CERT.	RECORDER'S SIGNATURE
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## PUPIL SIZE CHART



## GLASCOW COMA SCALE

### BEST EYE RESPONSE

ADULT & CHILD	INFANT (12 MONTHS)	POINTS
Spontaneous	Spontaneous	4
To Command	To Voice	3
To Pain	To Pain	2
None	None	1
TOTAL		

### BEST VERBAL RESPONSE

ADULT & CHILD	INFANT (12 MONTHS)	POINTS
Oriented	Coos and Babbles	5
Confused	Irritable Cry	4
Inappropriate	Cries to Pain	3
Incomprehensible	Moans to Pain	2
None	None	1
TOTAL		

### BEST MOTOR RESPONSE

ADULT & CHILD	INFANT (12 MONTHS)	POINTS
Obeys Command	Spontaneous Movement	6
Localizes Pain	Withdraws (Touch)	5
Withdraws	Withdraws (Pain)	4
Flexion to Pain	Flexion to Pain	3
Extension to Pain	Extension to Pain	2
None	None	1
TOTAL		

### BEST EYE RESPONSE

Total: Best Eye Response	
Total: Best Verbal Response	
Total: Best Motor Response	
GLASCOW COMA SCORE	

## EKG STRIPS

