PREHOSPITAL CARE REPORT

PCR# _____

Call Date	Provider Number	Unit Number	Incident Number	Interfacility Transfer Number	Call Disposition
___/___/___					

Response	Transport	Time of Call	Time Enroute	Time First ALS on Scene	Time Arrived on Scene	Time Left Scn / Call Canceled	Time Arrived at Destination	Contact Made with:	Time of Contact
☐ 1 Code	☐ 1	:	:	:	:	:	:	☐ Base Hospital ☐ Receiving Facility ☐ Control Facility ☐ None	:
☐ 2	☐ 2								
☐ 3	☐ 3								

Patient Name (Last, First, Mi)	Patient Address	Incident Location
	_____	_____

Patient Age	Patient DOB	Patient Gender	Est. Patient Weight	County	Map Zone	No. Pts. At Scene
Mos Yrs	___/___/___	☐ Male ☐ Female	kg			

Chief Complaint _____ Pain Level: ___

Allergies _____

Medical History _____

Medications _____

Initial Physical Examination

	Unremarkable	
Head	☐	_____
Neck	☐	_____
Chest	☐	_____
Abdomen	☐	_____
Back	☐	_____
Pelvis	☐	_____
Limbs	☐	_____
Neuro	☐	_____
Skin Signs	☐	_____

GCS

Eye	Verbal	Motor
4 spont	5 oriented	6 obeys
3 voice	4 confused	5 localizes
2 pain	3 inapprop	4 withdrwl
1 none	2 incompr	3 flexion
	1 none	2 extensn
		1 none

Time	E	V	M	Total
:	___	+ ___	+ ___ =	_____
:	___	+ ___	+ ___ =	_____
:	___	+ ___	+ ___ =	_____

Mechanism of Injury

Types of Illness/Injury

Field Clinical Impression:

Care Giver FD/PD/BS/PH	Time	Procedure / Medication (with dose, route) CODE	DESCRIPTION	Response / Comments / ECG (MD Signature: Base Order)	Resp Rate	Blood Pressure	Pulse Rate	Pain Level
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☐ Medication Wasted: Time: Signature: Witness Signature:

Special Scene Conditions:
- ☐ ALS w/o base contact
- ☐ Complicated extrication
- ☐ DNR
- ☐ Drug use suspected
- ☐ ETOH use suspected
- ☐ Hazardous materials
- ☐ MCI
- ☐ Multiple EMS providers
- ☐ Possible provider exposure
- ☐ Unsafe scene
- ☐ Other:

Safety Eq Used:
- ☐ Lap Restraint
- ☐ Lap/Shoulder restraint
- ☐ Child Safety seat
- ☐ Airbag
- ☐ Helmet
- ☐ Protective Clothing

MVA Conditions:
- ☐ Bent steering wheel
- ☐ Death in same vehicle
- ☐ Ejection
- ☐ Passenger comptmnt intrusn
- ☐ Rollover

Destination Decision Reason
- ☐ Nearest Rec. Facility
- ☐ MCI/DCF
- ☐ Physician request
- ☐ Pt/Family request
- ☐ Triage to trauma center
- ☐ Triage to other specialty center
- ☐ Other _____

Receiving Hosp

Base Hospital

Tier I Trauma Triage:
- ☐ GCS Motor Score < 5
- ☐ Systolic BP < 85
- ☐ Penetrating Trauma: Head, Neck, Chest, Torso
- ☐ Paramedic Judgement

Tier II Trauma Triage
- ☐ Flail Chest
- ☐ Combo Burn/Trauma
- ☐ 2 or more long bone fx.
- ☐ Pelvic fracture
- ☐ pedestrian thrown/run over
- ☐ Judgement of the paramedic or flight nurse
- ☐ Open/depress, skull fx
- ☐ Paralysis
- ☐ Amput. Prox. wrist/ankle
- ☐ Fall > 20 ft.
- ☐ Pregnancy

Pediatric Trauma Triage
- ☐ Glasgow Coma Score Motor Component < 5 AND
- ☐ BP < 80 if patient over age 6; < 70 if under 6
- ☐ Advanced airway or continuous support of airway
- ☐ Penetrating trauma: head, neck, chest, torso or proximal to elbow/knee with vascular compromise
- ☐ Flail Chest
- ☐ Amput. Prox. wrist/ankle
- ☐ Pelvis Fracture
- ☐ Traumatic paralysis

Base MD _____

MICN _____

Care Transferred To		Cert. Number	Name (print)	Signature
Agency	Time :	A)		
		B)		
Name		C)		

☐ Continuation form used