

MOUNTAIN-VALLEY EMS FIRST RESPONDER REPORT

Call Date ____/____/____	Department	Unit Number	Incident Name/Number	Medical Aid Number
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Response <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	Code	Transport <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	Time of Call	Time Enroute	Time Arrived on Scene	Time Left Scene/ Call Canceled	Mechanism of Injury
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Patient Name (last, first, MI)	Patient Address	Incident Location
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Patient Age	Patient DOB ____/____/____	Patient Gender p Male p Female	Est. Patient Weight	No. Pts. at Scene
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Chief Complaint _____	Allergies _____
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Medical History _____	Medications _____
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Initial Physical Examination <small>Unremarkable</small> Head <input type="checkbox"/> _____ Neck <input type="checkbox"/> _____ Chest <input type="checkbox"/> _____ Abdomen <input type="checkbox"/> _____ Back <input type="checkbox"/> _____ Pelvis <input type="checkbox"/> _____ Limbs <input type="checkbox"/> _____ Neuro <input type="checkbox"/> _____ Skin Signs <input type="checkbox"/> _____	GCS <table style="width: 100%;"> <tr> <td style="width: 33%;">Eye 4 spont 3 voice 2 pain 1 none</td> <td style="width: 33%;">Verbal 5 oriented 4 confused 3 inappropriate 2 incomprehensible 1 none</td> <td style="width: 33%;">Motor 6 obeys 5 localizes 3 flexion 2 extension 1 none</td> </tr> </table> TIME E + V + M = TOTAL _____ + _____ + _____ = _____	Eye 4 spont 3 voice 2 pain 1 none	Verbal 5 oriented 4 confused 3 inappropriate 2 incomprehensible 1 none	Motor 6 obeys 5 localizes 3 flexion 2 extension 1 none
Eye 4 spont 3 voice 2 pain 1 none	Verbal 5 oriented 4 confused 3 inappropriate 2 incomprehensible 1 none	Motor 6 obeys 5 localizes 3 flexion 2 extension 1 none		

Care Giver	Time	Procedure DESCRIPTION	Response/Comments	Blood Pressure	Pulse Rate	Resp Rate
				/		
				/		
				/		
				/		
				/		
				/		
				/		

<p style="text-align: center;"><input type="checkbox"/> REFUSAL OF SERVICE</p> <p>I HEREBY RELEASE _____ OF ANY LIABILITY WHICH MAY BE INCURRED DUE TO ANY REFUSAL OF THEIR SERVICES. I HAVE BEEN ADVISED TO SEE A PHYSICIAN OF MY CHOICE.</p> <p>_____ PATIENT'S OR RESPONSIBLE PERSON'S SIGNATURE</p> <p>_____ DATE</p>	(Hospital Use Only)	
Special Scene Conditions <input type="checkbox"/> Fire <input type="checkbox"/> Complicated extrication <input type="checkbox"/> DNR <input type="checkbox"/> Drug use suspected <input type="checkbox"/> ETOH use suspected <input type="checkbox"/> Haz-mat	Safety Eq Used <input type="checkbox"/> Lap restraint <input type="checkbox"/> Lap/shoulder restraint <input type="checkbox"/> Child safety seat <input type="checkbox"/> Airbag <input type="checkbox"/> Helmet <input type="checkbox"/> Protective clothing	MVA Conditions <input type="checkbox"/> Bent steering wheel <input type="checkbox"/> Death in same vehicle <input type="checkbox"/> Ejection <input type="checkbox"/> Passenger compartment intrusion <input type="checkbox"/> Rollover

Care Transferred To Agency _____ Time _____	Name (print) Rpt.p _____
Name _____	