Wood River Rescue Patient Care Report

Confidentia

Complete Record @ www.nebems.com

eNARSIS #_____

1. Chief Complaint

Age: **D.O.B.** **Gender: M / F**

Complaint:

2. General Impression

3. Primary Assessment

Response X____ (Person, Place, Time, Event)

☐ Alert ☐ Verbal ☐ Pain ☐ Unresponsive

Airway

☐ Clear ☐ Noisy ☐ Obstructed

Breathing

☐ Normal ☐ Shallow ☐ Labored ☐ Absent

Circulation

☐ Normal ☐ Pale ☐ Flushed ☐ Cyanotic

4. Vitals Signs

EMT				
Time				
Position				
B / P				
Pulse				
Resp.				
O_2 Sat				
	@ room air	@____lpm	@____lpm	@___lpm

5. Medical History

☐ Asthma ☐ Cancer ☐ Cardiac ☐ Diabetes

☐ Hypertension ☐ Hypotension ☐ Musco./Skel.

☐ Renal ☐ Respiratory ☐ Seizures ☐ Stroke/CVA

☐ Other: _____

6. Sample History

Signs/Symptoms	
Allergies	
Medications	
Past History	
Last Oral Intake	
Events Leading	

7. Patient Doctor

8. General Assessment

R Lung Sounds L		Skin		R Pupils L	
☐	Normal ☐	☐	Normal	☐	Normal ☐
☐	Abnormal ☐	☐	Pale	☐	Dilated ☐
☐	Decreased ☐	☐	Flushed	☐	Constricted ☐
☐	Absent ☐	☐	Cyanotic	☐	Sligish ☐
☐	Rales ☐	☐	Jaundiced	☐	No Reaction ☐
☐	Ronchi ☐	☐	Cool	☐	N/A ☐
☐	Stridors ☐	☐	Warm		
☐	Wheezes ☐	☐	Hot		
		☐	Wet		
		☐	Dry		
		☐	_____		

Abdomen	UR	LR	UL	LL
Normal	☐	☐	☐	☐
Tender	☐	☐	☐	☐
Rigid	☐	☐	☐	☐
Distended	☐	☐	☐	☐

Temperture / Blood Sugar	
Temperature	
Blood Sugar	

Glasgow Coma Score	RTS / Trauma Score

9. OPQRST

Onset	
Provocation	
Quality	
Radiation	
Severity	
Time	

10. Assessments/Procedures

Head	
Neck	
Chest	
Back	
Abdominal	
Upp. Extr.	
Low. Extr.	

11. Splints & Immobilization

☐ Short Board ☐ Long Board ☐ K.E.D

☐ Stretcher ☐ Scoop Stretcher ☐ Stair Chair

☐ Cervical Collar ☐ PASG ☐ Blanket Roll

☐ Air Splint ☐ SAM Splint ☐ Hare Traction

☐ Arm Splint ☐ Rigid ☐ Pillow

☐ Other:_____

12: Incident Details

Date	
Address	
City	State
Zip	

13. Run Times & Odometer

	Times	Mileage
Received	:	
Dispatched	:	
Enroute	:	.
At Scene	:	.
Left Scene	:	
At Destination	:	.
In Service	:	
At Station	:	.
Unit Cancelled	:	.

14. Patient Information

Name	
Address	
City	State
Zip	

15. Race & Ethnicity

☐ American Indian ☐ White

☐ Native Hawiian ☐ Black

☐ Other ☐ Asian

Ethnicity

☐ Not Hispanic / Latino

☐ Hispanic / Latino

16. Defibrillation

Approximate time of Arrest	
Bystander CPR in Progress	
EMS CPR in Progress	
Time of First Shock	
Number of Shocks delivered	
Time Last Shock	

17. Drug Used

Drug	Dose	Time	Provider

18. Additional Notes

19. Pre-Hospital Providers

Primary		Other	
Secondary			
Third			
Fourth		Driver	

20. Transfer of Care

Receiving Hospital:_____ Date:_____

EMS MEDICAL NECESSITY FORM

REVISED 2/2013

Transport Date_____

Patient Name _____

LOADED ODOMETER end_____
LOADED ODOMETER start_____
Loaded Miles_____

Chief Complaint _____

Assessment performed by _____EMT
____ALS Certified ____BLS Certified
Name of ALS intercepting service (if applicable)

_____

Point of Pickup: _____ Zip Code_____
____ Patient's Home ____ Skilled Nursing Facility ____ Hospital ____ Nursing Home ____ Other

Destination: _____
____ Patient's Home ____ Skilled Nursing Facility ____ Hospital ____ Nursing Home ____ Other

If you transported more than one patient, name(s)_____

PRIVACY AWARENESS ☐ REFUSED PRIVACY POLICY

WOOD RIVER RESCUE UNIT has a HIPAA Notice of Privacy Practices. My signature affirms that WOOD RIVER RESCUE UNIT has offered me a written copy of their privacy policy.

RELEASE OF PAYMENT

I request that payment of authorized Medicare/State Medicaid/Blue Cross/Third Party/Automobile/Workers' Compensation/ Liability insurance and my Medigap benefits be made on my behalf to WOOD RIVER RESCUE UNIT for any services furnished me by that provider, now or in the future. I agree to immediately remit to WOOD RIVER RESCUE UNIT any payments that I receive directly from any source for the services provided to me and I assign all rights to such payments to WOOD RIVER RESCUE UNIT. I understand that I am financially responsible for the services provided to me by WOOD RIVER RESCUE UNIT, regardless of my insurance coverage and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I authorize WOOD RIVER RESCUE UNIT to appeal payment denials or other adverse decisions on my behalf without further authorization.

RELEASE OF MEDICAL / BILLING INFORMATION

I authorize and direct *any holder of medical information* or documentation about me to release such information to the WOOD RIVER RESCUE UNIT and its billing agents, and/or the Centers for Medicare and Medicaid Services and its MAC and agents, and/or any other payors or insurers as may be necessary to determine these or other benefits payable for any services provided to me by WOOD RIVER RESCUE UNIT, now or in the future.
This is a lifetime authorization for any services provided to me by WOOD RIVER RESCUE UNIT. A copy of this form shall be the same force and effect as an original.

Patient's Signature: _____ Date: _____

IF PATIENT IS UNABLE TO SIGN ABOVE DUE TO PHYSICAL OR MENTAL INABILITY, signature of Authorized Signer:
Signing on behalf of the patient does not make me financially responsible for these services.

*__Signature:__**_____ ☐ Spouse ☐ Legal Guardian ☐ POA
☐ Blood Relative _____ ☐ Originating Facility ☐ Other_____
(RELATIONSHIP)

Printed Name: _____

Reason patient could not sign_____Date:_____

FOR EMERGENCY TRANSPORTS ONLY: ***Signing on behalf of the patient does not make me financially responsible for these services.***

I was a crew member on this trip and this patient was transported to the above named facility on this date_____ and time _____.

Patient was unable to sign for the following reason _____ and no "AUTHORIZED SIGNER" was available at the time of transport.

***EMT SIGNATURE**_____

As a representative of the receiving facility, I certify the patient was received by our facility on the date and time above.

***RECEIVING FACILITY SIGNATURE**_____**Title:**_____

Printed Name: _____