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:_____

Sample Ambulance Signature/Claim Submission Authorization Form – Version 2.2

Patient Name: _____ **Transport Date:** _____

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that Wood River Rescue provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. ***A copy of this form is valid as an original****

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.
NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Wood River Rescue now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by Wood River Rescue 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 agree to immediately remit to Wood River Rescue any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Wood River Rescue . I authorize Wood River Rescue to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to Wood River Rescue and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Wood River Rescue, now, in the past, or in the future. I also authorize Wood River Rescue to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

If the patient signs with an "X" or other mark, a witness should sign below.

X_____ _____ X_____ _____
Patient Signature or Mark | Date | Witness Signature | Date

_____
Witness Address

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if the patient is physically or mentally incapable of signing.

Describe the circumstances that make it impractical for the patient to sign: _____

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by Wood River Rescue now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **only** the following individuals:

- ☐ Patient's legal guardian
- ☐ Relative or other person who receives social security or other governmental benefits on behalf of the patient
- ☐ Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs
- ☐ Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient

X_____ _____ _____
Representative Signature | Date | Printed Name of Representative

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section **only** if: (1) the patient was physically or mentally incapable of signing, **and**
(2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

Describe the circumstances that make it impractical for the patient to sign: _____

Name and Location of Receiving Facility: _____ Time: _____

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by Wood River Rescue.

A. Ambulance Crew Member Statement (*must* be completed by crew member at time of transport)
My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. **My signature is not an acceptance of financial responsibility for the services rendered.**

X_____ _____ _____
Signature of Crewmember | Date | Printed Name and Title of Crewmember

B. Receiving Facility Representative Signature
The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered.**

X_____ _____ _____