CONFIDENTIAL MEDICAL INFORMATION COVERED UNDER WISCONSIN STATUTE 146.81-84

CASE NO.

DATE — MONTH / DAY / YEAR

EMS REPORT

AMB. PROVIDER NO.

DISPATCH LEVEL ○ ALS ○ BLS

ALS Unit Special Call? ○ Yes ○ No

INCIDENT NUMBER — BLS/PFR — ALS

EMERG. LOCATION — CITY — ZIP — CO.

TYPE OF LOCATION: ○ Airport ○ Clinic/Med. ○ Educ. Inst. ○ Farm ○ Home/Resid. ○ Hospital ○ Industrial ○ Nursing Home ○ Public Building ○ Public Outdoors ○ Recreational/Sport ○ Residential Inst. ○ Restaurant/Bar ○ Street/HWY ○ Waterway ○ Other

WORK RELATED INJURY? ○ Yes ○ No

UNIT Letter	UNIT Number	ENTRY TIME	DISPATCH TIME	TIME UNIT RESP.	AT SCENE	AT PATIENT (Est.)	DEPART SCENE	AT HOSPITAL	IN SERVICE	IN QTRS	CALLED OFF
○BLS or ○PFR											○
○ALS											○

1ST EMS UNIT ARRIVING ____________

OTHER UNITS RESPONDING: ○ E - Engine Co. ○ R - FD Squad ○ L - Ladder Co. ○ M-ALS Unit ○ A - Private Amb. ○ Chief Officer ○ EMS Officer ○ Helicopter ○ Police____________ ○ Other____________

PATIENT NAME — LAST — FIRST — M.I. — SEX ○M ○F — WT.(lbs) — AGE — DOB MO. DAY YR

ADDRESS ○ Same as above — CITY — STATE — ZIP

PRIMARY INSURANCE CO. ○ — ○Medicare ○T19 ○BCBS ○UHC ○Compcare ○Self Pay — POLICY # ○ Same as SS# — GROUP — PHONE ( )

RACE: ○White ○Black ○Asian ○Native Amer. ○Hispanic ○Other

FIN Sheet? ○ Yes ○ No

SECONDARY INSURANCE CO. ○ — ○T19 ○Aetna ○BCBS ○Compcare ○Humana ○WPS — POLICY # ○ Same as SS# — GROUP

Social Security # ___ - __ - ____

PRESENT HISTORY

DISPATCH CODE

CHIEF COMPLAINT — BLS\PFR — ALS

PRIM. WORKING ASSESSMENT / Standard of Care (Select One Code): BLS/PFR — ALS

C.C. ONSET: Min. Hrs. Days — ○ Unknown Onset

CARDIAC ARREST DATA

N/A ○

Time of Cardiac Arrest:

Witnessed? ○ No ○ Yes If yes, by

Time CPR Started: by

PRIOR Rx BY: (○N/A)	1st Aid / O2	IV	Meds	Adv. Airway	Extrication	CPR	Defib	WITN Arrest
Bystander	○	○	○	○	○	○	○	○
1st Responder	○	○	○	○	○	○	○	○
Police	○	○	○	○	○	○	○	○
Med. Facility	○	○	○	○	○	○	○	○
EMT	○	○	○	○	○	○	○	○
Paramedic	○	○	○	○	○	○	○	○

WORKING ASSESSMENT (Fill in all circles that apply)

(BLS/PFR ○ ALS ○)

- A1- Angina(chest pain) / MI
- A2- Arrhythmia / Palpitations
- A3- Cardiac Arrest
- A4- CHF
- K1- Non-Cardiac Chest Pain
- B1- Airway Obstruction
- B3- Asthma
- B2- COPD
- B4- Inhalation Injury
- B5- Respiratory Arrest
- B6- Respiratory Distress
- B7- Cough
- C1- Poison / Overdose
- C2- Substance Abuse
- C3- Allergic Rx
- D3- Hypertension
- D1- Hypotension / Shock
- D2- Other Vascular
- E1- Altered Consciousness
- E2- CVA / TIA
- E3- Seizure
- E4- Syncope
- F1- Trauma-Blunt
- F2-Trauma-Penetrating
- F6- Trauma-Lacerating
- F3- Burns
- F4- Drowning
- F7- Electrocution
- F5- Hanging
- G - Diabetic
- H - OB / GYN
- I1 - GI / Abdominal
- I2 - GI Bleed
- I3 - Diarrhea
- J - Psychological
- K2- Diaphoresis
- K3- Dizziness
- K4- Fever / Hyperthermia
- K5- Headache
- K6- Hypothermia
- K7- Nausea / Vomiting
- K8- Numbness
- K9- Weakness
- K - Other____________

INITIAL PHYSICAL EXAM

MENTAL STATUS (BLS/PFR, ALS): ○ A- Alert ○ V- Resp. Verbal ○ P- Resp. Pain ○ U- Unresponsive

BEHAVIOR (BLS/PFR, ALS) ○N/A: ○ Normal ○ Acute Confusion ○ Usually Confused ○ Incoherent ○ Interm. Consc. ○ Combative

BREATH SOUNDS (BLS/PFR Yes No, ALS Yes No) Ⓤ — Assisted? — Lt. Rt.: Clear, Wet, Decreased, Absent, Wheeze, Congested

RESPIRATORY EFFORT (BLS/PFR, ALS) Ⓤ: ○ Normal ○ Inc. Effort (Labored, Retractions, Accessory muscles) ○ Dec. Effort (Fatigued, Dec. rise & fall of chest) ○ Absent

PUPILS Ⓤ (BLS/PFR, ALS) — PERL ○

- LEFT: Yes No Blind — Reactive; Mid Dil Pin — Size
- RIGHT: Yes No Blind — Reactive; Mid Dil Pin — Size

SKIN TEMP. (BLS/PFR, ALS) Ⓤ: ○ Normal ○ Warm ○ Hot ○ Cool ○ Cold

SKIN COLOR (BLS/PFR, ALS) Ⓤ: ○ Normal ○ Pale ○ Cynanotic ○ Flushed ○ Cherry ○ Jaundice

SKIN MOISTURE (BLS/PFR, ALS) Ⓤ: ○ Normal ○ Dry ○ Moist ○ Diaphoretic

CAPILLARY REFILL (BLS/PFR, ALS) Ⓤ: ○ ≤ 2 Seconds ○ > 2 Seconds

B. GLUCOSE ○ N/A — 1st ___ TIME: — 2nd ___ TIME:

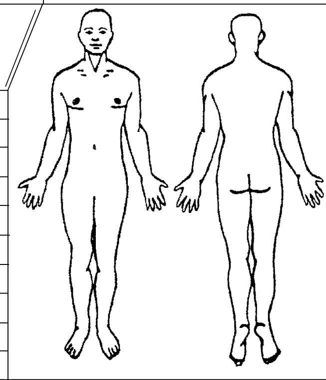
PAIN QUALITY: ○ Sharp ○ Dull ○ Cramp ○ Crushing ○ Constant ○ Radiate — ○ N/A

PAIN SEVERITY (0 TO 10) ○N/A — Initial — Final

PHYSICAL EXAMINATION - CHECK ONLY WHEN ABNORMAL

○N/A

INJURY / PAIN LOCATION	PAIN- NO TRAUMA	BLUNT	BURNS	DISLOC./FX/ AMPUTATION	GUNSHOT	LACERATION ABRASION	PUNCTURE STAB	SOFT TISSUE SWELLING	WEAKNESS PARALYSIS
Head / Face	○	○	○	○	○	○	○	○	○
Neck	○	○	○	○	○	○	○	○	○
Chest / Axilla	○	○	○	○	○	○	○	○	○
Abdomen	○	○	○	○	○	○	○	○	○
Back / Flank	○	○	○	○	○	○	○	○	○
Pelvis / Hip	○	○	○	○	○	○	○	○	○
L Arm Ⓤ Ⓛ Ⓙ	○	○	○	○	○	○	○	○	○
R Arm Ⓤ Ⓛ Ⓙ	○	○	○	○	○	○	○	○	○
L Leg Ⓤ Ⓛ Ⓙ	○	○	○	○	○	○	○	○	○
R Leg Ⓤ Ⓛ Ⓙ	○	○	○	○	○	○	○	○	○



GLASGOW COMA SCALE ○ N/A

EYES (BLS/PFR, ALS): ○ 4-Opens spontan. ○ 3-Opens to command ○ 2-Opens to pain ○ 1-None

VERBAL (BLS/PFR, ALS): ○ 5-Oriented ○ 4-Confused ○ 3-Inappropriate ○ 2-Incomprehensible sounds ○ 1-None

MOTOR (BLS/PFR, ALS): ○ 6-Moves spontan. ○ 5-Localizes ○ 4-Withdraws ○ 3-Flexor posturing ○ 2-Extensor posturing ○ 1-None

PAST MEDICAL HISTORY

ALLERGIES: ○ None ○ Unknown ○ Yes ○ Latex — Allergic Meds:

CARDIAC: ○ None ○ Unknown ○ Angina ○ Arrhythmia ○ Cardiomyopathy ○ CHF ○ Congenital ○ Implanted Defib. ○ MI ○ Other__________

SURGERY: ○ None ○ Unknown ○ Abdominal ○ Heart ○ Lung ○ Neurological ○ Other

CHRONIC PROBLEMS: ○ None ○ Unknown ○ Asthma ○ Bleeding Disor. ○ Cancer ○ COPD ○ CVA / TIA ○ Dev. Delay / MR ○ Diabetes ○ Dialysis / Renal ○ Other ○ Gastrointestinal ○ Headaches ○ Hepatitis ○ HIV+ ○ Hypertension ○ Paralysis ○ Psychiatric ○ Seizures ○ Substance Abuse ○ Tuberculosis

PERSONAL PHYSICIAN:

CURRENT MEDS ○ Yes ○ No ○ Unknown

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CASE NO.

Overflow form used ○
Transfer of Care form used ○

TREATMENT

ROUTINE EQUIPMENT / PROCEDURE ○ N/A

○ Nasal Airway
○ Oral Airway
○ Suction Airway
○ Backboard
○ CPR
○ C-Spine Immobilization
○ MAST Inflated
○ MAST Not Inflated
○ O2 Liters________ (○ Nasal ○ Mask)
○ OB Care
○ Splinting
○ Traction Splint
○ Wound Care
○ Other________________

Rx AUTHORIZATION (BLS/PFR)
○ On-Line Physician
○ On Scene Physician
○ Protocol Only

BASE DOCTOR NO. BLS ALS

TRANSPORTED TO: CODE #

TRANSPORT MODE ○ N/A
○ FD ALS
○ FD BLS
○ Private Ambulance
○ Air-Medical
○ Other

CHOICE ○ N/A
○ Closest Hospital
○ Specialty Center
○ Patient / MD Request
○ Diversion
○ On-Line Medical Direction

FLUID	TIME	GAUGE	SITE	UNSUC	RATE	TOTAL VOLUME	PERFORMED BY
IV #1 NORMAL SALINE			○ IV ○ IO	○ ○		CCS	Ⓐ ① ② ③ Ⓑ ④ ⑤
IV #2 NORMAL SALINE			○ IV ○ IO	○ ○		CCS	Ⓐ ① ② ③ Ⓑ ④ ⑤

AIRWAY	TIME	AIRWAY TYPE	SIZE	UNSUC	PERFORMED BY
ADVANCED AIRWAY #1		○ Combitube ○ Oral ET ○ Nasal ET		○ ○	Ⓐ ① ② ③ Ⓑ ④ ⑤
ADVANCED AIRWAY #2		○ Combitube ○ Oral ET ○ Nasal ET		○ ○	Ⓐ ① ② ③ Ⓑ ④ ⑤

TIME	DRUG / PROCEDURE	DOSE / JOULES	ROUTE	PERFORMED BY	EKG RHYTHM	ECTOPICS BLOCKS	MENTAL STATUS	BLOOD PRESSURE Systolic	Diastolic	PULSE	Reg. or Irreg.	RESP.	PULSE OX	END TIDAL CO2	RESPONSE (+ Improved - Worse 0 Same)
				Ⓐ①②③ Ⓑ④⑤			Ⓐ x __ ⓋⓅⓊ				Ⓡ Ⓘ				⊕ ⊖ ⓪
				Ⓐ①②③ Ⓑ④⑤			Ⓐ x __ ⓋⓅⓊ				Ⓡ Ⓘ				⊕ ⊖ ⓪
				Ⓐ①②③ Ⓑ④⑤			Ⓐ x __ ⓋⓅⓊ				Ⓡ Ⓘ				⊕ ⊖ ⓪
				Ⓐ①②③ Ⓑ④⑤			Ⓐ x __ ⓋⓅⓊ				Ⓡ Ⓘ				⊕ ⊖ ⓪
				Ⓐ①②③ Ⓑ④⑤			Ⓐ x __ ⓋⓅⓊ				Ⓡ Ⓘ				⊕ ⊖ ⓪
				Ⓐ①②③ Ⓑ④⑤			Ⓐ x __ ⓋⓅⓊ				Ⓡ Ⓘ				⊕ ⊖ ⓪
				Ⓐ①②③ Ⓑ④⑤			Ⓐ x __ ⓋⓅⓊ				Ⓡ Ⓘ				⊕ ⊖ ⓪
				Ⓐ①②③ Ⓑ④⑤			Ⓐ x __ ⓋⓅⓊ				Ⓡ Ⓘ				⊕ ⊖ ⓪
				Ⓐ①②③ Ⓑ④⑤			Ⓐ x __ ⓋⓅⓊ				Ⓡ Ⓘ				⊕ ⊖ ⓪
				Ⓐ①②③ Ⓑ④⑤			Ⓐ x __ ⓋⓅⓊ				Ⓡ Ⓘ				⊕ ⊖ ⓪

PERSONNEL

ALS VEHICLE	Skill Level BLS	ALS	PENSION / EMPLOYEE #	CODE #	Hx	PHYS EXAM
A1 Report Writer	○	○			○	○
A2	○	○			○	○
A3	○	○			○	○
A4	○	○			○	○
A5	○	○			○	○

BLS/PFR VEHICLE	Skill Level BLS	ALS	PENSION / EMPLOYEE #	CODE #	Hx	PHYS EXAM
B1 Report Writer	○	○			○	○
B2	○	○			○	○
B3	○	○			○	○
B4	○	○			○	○
B5	○	○			○	○

MOTOR VEHICLE CRASH ○ N/A

REAR / FRONT

Fill in Patient Location in Vehicle
X = Location of Impact to Vehicle

CRASH TYPE # of Vehicles: ○ 1 ○ ≥2
○ Car ○ Semi-Truck
○ Motorcycle ○ Snowmobile
○ Aircraft ○ Truck
○ ATV ○ Van
○ Bus ○ Watercraft

CRASH REPORT NUMBER

EXTERIOR DAMAGE
○ None
○ Minor
○ Moderate
○ Major

INTERIOR DAMAGE
○ None
○ Spidered Windshield
○ Steering Wheel Bent
○ Compartment Intrusion>12"

OTHER CRASH INFO
○ Death Same Vehicle
○ Patient Ejected or Thrown
○ Impact Speed 40+ mph
○ Prolonged Extrication
○ Rollover

RESTRAINTS

	Obs.	Rprt.
None	○	○
Airbag	○	○
Lap Belt	○	○
Shoulder Belt	○	○
Child Seat	○	○

PATIENT SAFETY EQUIPMENT ○ N/A
○ None
○ Helmet
○ Eye Protection
○ Clothing Protection
○ Flotation Device
○ Unknown

HISTORY / RESULTS OF Rx: (Situation, Assessment, Treatment, Response)

COMPLAINT REPORTED BY DISPATCH:

BLS/PFR

ALS

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CAUSE OF INJURY (Select One) ○ N/A

○ Air Pressure Mishap (scuba diving)	○ Drowning	○ Motor Vehicle (Traffic)	○ Suffocation-Mechanical, Hanging
○ Aircraft Related	○ Electrocution (non-lightning)	○ Overexertion / Strenuous Activity	○ Venomous Stings & Bites (plant/animal/insect)
○ Athletic Event	○ Excessive Cold	○ Pedestrian vs Motor Vehicle	
○ Bicycle Crash (exclude MVC)	○ Excessive Heat	○ Physical Assault (with object or punch, kick, push, **human bite**)	○ Water Transport Incident
○ Bicycle vs Motor Vehicle	○ Explosion		○ Unknown Cause
○ Bite (nonvenomous animal only)	○ Fall	○ Poison, Drug Ingestion, Alcohol	○ Other____________________
○ Burns - Fire/Flames	○ Fall Down Stairs	○ Poison, Not Drugs	
○ Burns - Hot Liquids	○ Fall From Height > 9'	○ Radiation Exposure	
○ Burns - Hot Object	○ Firearm	○ Sexual Assault	
○ Chemical Exposure	○ Legal Intervention Injury	○ Smoke Inhalation	
○ Child Battering (suspected)	○ Lightning	○ Stabbing / Cutting	
○ Crushed Between Objects	○ Machine Injury	○ Striking Against, Struck by Object (includes sledding accidents)	
○ Diving Injury (strike bottom)	○ Motor Vehicle (Non-Traffic, off road)		

INTENT OF INJURY
○ Intentional
○ Unintentional
○ Undetermined

SOURCE OF INJURY
○ Self ○ Unknown
○ Other Person
○ Other

RESPONSE TYPE

BLS/PFR	ALS	
○	○	Response to Scene (Incl. Still Alarm)
○	○	Intercept
○	○	Mutual Aid
○	○	Scheduled Interfacility Transfer
○	○	Standby
○	○	Unscheduled Interfacility Transfer
○	○	Unknown

LIGHTS & SIREN TO SCENE

BLS/PFR	ALS	
○	○	Lights and Siren
○	○	No Lights or Siren
○	○	Initial Lights and Siren, Downgrade to No Lights or Siren
○	○	Initial No Lights or Siren, Upgrade to Lights and Siren

LIGHTS & SIREN FROM SCENE ○ N/A

BLS/PFR	ALS	
○	○	Lights and Siren
○	○	No Lights or Siren
○	○	Initial Lights and Siren, Downgrade to No Lights or Siren
○	○	Initial No Lights or Siren, Upgrade to Lights and Siren

LOADED MILEAGE (Start=at scene, End=at hospital) End-Start=Trans.Miles
Start Odom. [ ][ ].[ ] End Odom. [ ][ ].[ ] Trans. Miles [ ][ ].[ ]

MISCELLANEOUS

TREATMENT PROVIDED
○ Treated
○ Not Treated (includes examine only)
○ Patient Refused Treatment

BASE EKG ACTIVITY ○ N/A
○ Rhythm Strip Done - Not Sent
○ Rhythm Strip Done - Sent
○ 12 Lead Done - Sent & Received
○ 12 Lead Done - Sent & Not Rec'd or Not Sent

	Yes	No	N/A
Smoke Detector?	○	○	○
Operational?	○	○	○

STUDY? ○ Yes ○ No
6 ○ 7 ○ 8 ○ 9 ○ 10 ○

 # PATIENTS ON SCENE ○ Single ○ Multiple

MASS CASUALTY? ○ Yes ○ No (overwhelmed existing EMS resources)

CARDIAC ARREST OUTCOME ○ N/A
Any Return of Pulses? ○ Yes ○ No

Resuscitation Type (select one)
○ Successful (Pulses at ED)
○ Unsuccessful (No Pulses at ED or Terminated in Field)
○ DNR Order (Do Not Resuscitate)
○ None, DOA - Trauma
○ None, DOA - NonTrauma

PNB Outcome (select one)
○ Terminated in Field/DNR
○ DOA at ED
○ Expired in ED
○ Admit to ED

TIME OF EXPIRATION [ ][ ][ ][ ]

PATIENT CONDITION AT END OF CALL
○ Unchanged
○ Improved
○ Worse
○ DOA
○ Unknown

PPE USED

BLS/PFR	ALS	
○	○	Gloves
○	○	Gown
○	○	Goggles
○	○	Mask
○	○	Other______

FACILITY NOTIFIED BY ○ N/A
○ Radio
○ Phone
○ Direct
○ Unable*
*Explain:_____________

DIFFICULTIES ENCOUNTERED ○ N/A
○ Dispatch ○ Unsafe Scene
○ Extrication ○ Vehicle Problems
○ Hazardous Material ○ Weather
○ Language Barrier ○ Other_____________
○ Road _________________

CONSENT (Pt. to initial all that apply) | **EMS PROVIDER**

______ I refuse treatment / transport against medical advice and understand / accept risks. →

______ I request that payment of authorized Medicare or insurance benefits be made on my behalf to the Milwaukee County EMS Provider/municipal Fire Department EMS Provider attending me for any services furnished me by that Provider. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services and its carriers and agents, as well as to the EMS Provider and its billing agents and any other payers or insurers, any information or documentation needed to determine these benefits payable for related services, now or in the future. I understand that I am financially responsible for the services provided to me by the EMS Provider, regardless of insurance coverage. This authorization is in effect until I choose to revoke it.

I also acknowledge that I have received a copy of the Milwaukee County EMS Provider and/or municipal Fire Department EMS Provider's Notice of Privacy Practices. →

Patient Signature:

X____

○ Patient unable to sign. Reason:______________________________
If patient unable to sign, ask witness to sign and document relationship to patient. The witness signature validates that patient care was provided by EMS personnel, it does not imply any financial responsibility.

Witness Signature:

X ______________________________ Relationship:______________

Witness Address:______________________________ ○ Address same as receiving hospital

City: ________________ State: __________ Zip: __________

REFUSAL ○ N/A
The Refusal of Care flowchart has been followed per the Standard of Care.

EMS Personnel Initials: __________

○ **EQUIPMENT FAILURE / OUT OF SERVICE** ○ N/A
Type: ______________________________________

○ **COMPLICATION / SIGNIFICANT EXPOSURE** ○ N/A
Type: ______________________________________

PRIVACY NOTICE DELIVERED?
○ Yes (incl. prior pts) ○ No, explain why not:________________
If not patient,
Notice given to: ________________

ER Doctor Name:

Signatures of Persons Writing Report
BLS/PFR ______________________________ Reviewed By:__________
ALS ______________________________ Reviewed By:__________