



Short Form Patient Information Sheet

Jurisdiction: _____ Date: _____
 Incident # _____ Time Arrived at Hospital: _____
 Unit #: _____
 Age: _____ DOB: _____ Wt: _____ Kg Gender: M F
 Priority: 1 2 3 4 Trauma Category: A B C D
 Patient's Name: _____
 Patient's Address: _____
 City: _____ State: _____
 Point of Contact: _____ Phone Number: _____
 Chief Complaint: _____
 Time of Onset: _____ Past Medical History: (DNR/MOLST A1 A2 B)
 Cardiac CHF Hypertension Seizure Diabetes COPD Asthma
 Other: _____
 Current Meds: _____
 Allergies: Latex Penicillin/Ceph Sulfa Other: _____

Assessments

Vitals Time: _____ Temperature _____ B/P: _____ / _____ Pulse: _____ Respirations: _____ SAO2: _____ % Capnography: _____ Carbon Monoxide: _____ Repeat Vitals Time: _____ B/P: _____ / _____ Pulse: _____ Respirations: _____ SAO2: _____ % Capnography: _____ Carbon Monoxide: _____	Respiration <table border="1"> <tr> <th>Left</th> <th>Right</th> </tr> <tr> <td><input type="checkbox"/> Clear</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Rales</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Labored</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Stridor</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Rhonchi</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Wheezes</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Decreased</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Agonal</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Absent</td> <td><input type="checkbox"/></td> </tr> </table>	Left	Right	<input type="checkbox"/> Clear	<input type="checkbox"/>	<input type="checkbox"/> Rales	<input type="checkbox"/>	<input type="checkbox"/> Labored	<input type="checkbox"/>	<input type="checkbox"/> Stridor	<input type="checkbox"/>	<input type="checkbox"/> Rhonchi	<input type="checkbox"/>	<input type="checkbox"/> Wheezes	<input type="checkbox"/>	<input type="checkbox"/> Decreased	<input type="checkbox"/>	<input type="checkbox"/> Agonal	<input type="checkbox"/>	<input type="checkbox"/> Absent	<input type="checkbox"/>	Skin <input type="checkbox"/> Warm <input type="checkbox"/> Hot <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Clammy <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Cyanotic	GCS Eyes (4): _____ Motor (6): _____ Verbal (5): _____ TOTAL: _____ Pupils <input type="checkbox"/> PERRL <input type="checkbox"/> Unequal <input type="checkbox"/> Fixed/Dilated
	Left	Right																					
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<input type="checkbox"/> Absent	<input type="checkbox"/>																						
	Pulse <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> JVD <input type="checkbox"/> Peripheral Edema Cap Refill: _____ seconds	Neuro <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U																					

Assessment

Procedures

Cardiac Rhythm: _____ Perform 12 Lead Yes <input type="checkbox"/> No <input type="checkbox"/> 12 Lead Transmit Yes <input type="checkbox"/> No <input type="checkbox"/> Glucometer: _____ <input type="checkbox"/> IV1 <input type="checkbox"/> IV2 Time Started _____ <input type="checkbox"/> IO <input type="checkbox"/> EJ Amount Infused: _____	Cincinnati Stroke Scale <i>Normal/Abnormal</i> Facial Droop Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Arm Drift Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Speech Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Last Known Well Time/Date: _____																												
CPR Performed Yes <input type="checkbox"/> No <input type="checkbox"/> ROSC Yes <input type="checkbox"/> No <input type="checkbox"/> Induced Hypothermia Yes <input type="checkbox"/> No <input type="checkbox"/>	Los Angeles Motor Scale (LAMS) <table border="1"> <tr> <th><i>Facial Droop</i></th> <th></th> <th><i>Grip Strength</i></th> <th></th> </tr> <tr> <td>Absent</td> <td>0</td> <td>Normal</td> <td>0</td> </tr> <tr> <td>Present</td> <td>1</td> <td>Weak Grip</td> <td>1</td> </tr> <tr> <td><i>Arm Drift</i></td> <td></td> <td>No Grip</td> <td>2</td> </tr> <tr> <td>Absent</td> <td>0</td> <td></td> <td></td> </tr> <tr> <td>Drifts Down</td> <td>1</td> <td></td> <td></td> </tr> <tr> <td>Falls Rapidly</td> <td>2</td> <td>Score:</td> <td>_____</td> </tr> </table>	<i>Facial Droop</i>		<i>Grip Strength</i>		Absent	0	Normal	0	Present	1	Weak Grip	1	<i>Arm Drift</i>		No Grip	2	Absent	0			Drifts Down	1			Falls Rapidly	2	Score:	_____
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	Oxygen <input type="checkbox"/> NRB Mask <input type="checkbox"/> King Airway <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> CPAP <input type="checkbox"/> NPA/OPA <input type="checkbox"/> NDT <input type="checkbox"/> BVM <input type="checkbox"/> Ventilator <input type="checkbox"/> ET <input type="checkbox"/> NT <input type="checkbox"/> NGT <input type="checkbox"/> Easy Tube																												

Treatment:

Jurisdictional Additions:

Print Provider Name: _____