Maryland Institute for
Emergency Medical Services Systems

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: _____

Assessment

Respiration

Left		Right
❑	Clear	❑
❑	Rales	❑
❑	Labored	❑
❑	Stridor	❑
❑	Rhonchi	❑
❑	Wheezes	❑
❑	Decreased	❑
❑	Agonal	❑
❑	Absent	❑

Pulse
❑ Regular ❑ Irregular
❑ JVD ❑ Peripheral Edema
Cap Refill: _____ seconds

Skin
❑ Warm
❑ Hot
❑ Cool
❑ Dry
❑ Clammy
❑ Diaphoretic
❑ Cyanotic

GCS
Eyes (4): _____
Motor (6): _____
Verbal (5): _____
TOTAL: _____

Pupils
❑ PERRL
❑ Unequal
❑ Fixed/Dilated

Neuro
❑ A ❑ V
❑ P ❑ U

Procedures

Cardiac Rhythm:
_____

Perform 12 Lead Yes ❑ No ❑
12 Lead Transmit Yes ❑ No ❑

Glucometer:
_____

❑ IV1 ❑ IV2 Time Started _____
❑ IO ❑ EJ

Amount Infused:
_____

CPR Performed Yes ❑ No ❑
ROSC Yes ❑ No ❑

Cincinnati Stroke Scale
Normal/Abnormal

Facial Droop Normal ❑ Abnormal ❑
Arm Drift Normal ❑ Abnormal ❑
Speech Normal ❑ Abnormal ❑
Last Known Well Time/Date: _____

Los Angeles Motor Scale (LAMS)

Facial Droop		*Grip Strength*	
Absent	0	Normal	0
Present	1	Weak Grip	1
Arm Drift		No Grip	2
Absent	0		
Drifts Down	1		
Falls Rapidly	2	Score:	_____

Airway	Oxygen	Other
❑ NPA/OPA	❑ NRB Mask	❑ NDT
❑ EGA/SGA	❑ Nasal Cannula	❑ NGT
❑ ET ❑ NT	❑ CPAP	
❑ BVM	❑ Ventilator	

❑ **Abuse Suspected** *(Reported Directly to Law Enforcement / Social Services)*

Treatment:

Jurisdictional Additions:

Print Clinician Name: _____

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