

GENERIC RUN REPORT

Prehospital Patient Care Chart

INCIDENT NUMBER		UNIT ID		INCIDENT DATE	
INCIDENT ADDRESS		INCIDENT CITY		INCIDENT STATE	
INCIDENT COUNTY		INCIDENT LOCATION TYPE See Ref. Sheet			
COMPLAINT REPORTED BY DISPATCH See Ref. Sheet		PRIMARY PAYMENT See Ref. Sheet		EMERGENCY MEDICAL DISPATCH PERFORMED <input type="checkbox"/> No <input type="checkbox"/> Yes w/pre-arrival instructions <input type="checkbox"/> Yes w/out pre-arrival instructions	
INCIDENT/PATIENT DISPOSITION <input type="checkbox"/> Treated, Transport EMS <input type="checkbox"/> No Patient Found <input type="checkbox"/> Treated, Transport EMS <input type="checkbox"/> No Treatment Required <input type="checkbox"/> Treated & Released <input type="checkbox"/> Dead at Scene		<input type="checkbox"/> Treated, Transferred care <input type="checkbox"/> Pt Refused Care <input type="checkbox"/> Treated, Transported Private Vehicle		<input type="checkbox"/> Treated, Transported Law Enforcement LEVEL OF SERVICE <input type="checkbox"/> BLS, Emergency <input type="checkbox"/> ALS, Level 1 Emergency <input type="checkbox"/> ALS, Level 2 <input type="checkbox"/> Specialty Care Transport <input type="checkbox"/> Helicopter <input type="checkbox"/> Not Applicable	
NUMBER OF PATIENTS ON SCENE <input type="checkbox"/> Single <input type="checkbox"/> None <input type="checkbox"/> Multiple		MASS CASUALTY <input type="checkbox"/> Yes <input type="checkbox"/> No		TYPE OF SERVICE REQUESTED <input type="checkbox"/> Scene Response <input type="checkbox"/> ED to ED Transfer <input type="checkbox"/> Mutual Aid <input type="checkbox"/> Intercept	
PRIMARY ROLE OF THE UNIT <input type="checkbox"/> Transport <input type="checkbox"/> Non-transport <input type="checkbox"/> Supervisor <input type="checkbox"/> Rescue					
TYPE OF DELAY (S) DISPATCHER <input type="checkbox"/> None-N/A <input type="checkbox"/> Not known <input type="checkbox"/> Caller Uncooperative <input type="checkbox"/> High Call Volume <input type="checkbox"/> Language Barrier <input type="checkbox"/> Location (difficulty to obtain) <input type="checkbox"/> No Unit Available <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Technical Failure <input type="checkbox"/> Other		RESPONSE <input type="checkbox"/> None-N/A <input type="checkbox"/> Crowded <input type="checkbox"/> Directions <input type="checkbox"/> Distance <input type="checkbox"/> Diversion <input type="checkbox"/> Hazmat <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Staff Delay <input type="checkbox"/> Traffic <input type="checkbox"/> Ambulance Crash <input type="checkbox"/> Ambulance Failure <input type="checkbox"/> Weather <input type="checkbox"/> Other		SCENE <input type="checkbox"/> None-N/A <input type="checkbox"/> Crowded <input type="checkbox"/> Directions <input type="checkbox"/> Distance <input type="checkbox"/> Diversion <input type="checkbox"/> Extinction > 20 Min <input type="checkbox"/> Hazmat <input type="checkbox"/> Language Barrier <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Staff Delay <input type="checkbox"/> Traffic <input type="checkbox"/> Ambulance Crash <input type="checkbox"/> Ambulance Failure <input type="checkbox"/> Weather <input type="checkbox"/> Other	
		TRANSPORT <input type="checkbox"/> None-N/A <input type="checkbox"/> Crowded <input type="checkbox"/> Directions <input type="checkbox"/> Distance <input type="checkbox"/> Diversion <input type="checkbox"/> Hazmat <input type="checkbox"/> Safety Conditions <input type="checkbox"/> Staff Delay <input type="checkbox"/> Traffic <input type="checkbox"/> Ambulance Crash <input type="checkbox"/> Ambulance Failure <input type="checkbox"/> Weather <input type="checkbox"/> Other		RETURN <input type="checkbox"/> None-N/A <input type="checkbox"/> Clean up <input type="checkbox"/> Decontamination <input type="checkbox"/> Documentation <input type="checkbox"/> ED Overcrowding <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Equipment Replenishment <input type="checkbox"/> Other <input type="checkbox"/> Staff Delay <input type="checkbox"/> Ambulance Failure	
PATIENT LAST NAME		PATIENT FIRST NAME		MI	
PATIENT ADDRESS <input type="checkbox"/> SAME AS INCIDENT		PATIENT CITY		PATIENT STATE	
				PATIENT ZIP CODE	
AGE		DATE OF BIRTH		GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male	
				RACE	
				ETHNICITY	
CURRENT MEDICATIONS		ALLERGIES		PERTINENT HISTORY	
INJURY PRESENT <input type="checkbox"/> Yes <input type="checkbox"/> No		CAUSE OF INJURY See Ref. Sheet		TYPE OF INJURY <input type="checkbox"/> Blunt <input type="checkbox"/> Penetrating <input type="checkbox"/> Burn <input type="checkbox"/> Not Known	
				ALCOHOL/DRUG USE INDICATORS <input type="checkbox"/> None <input type="checkbox"/> Smell of alcohol on breath <input type="checkbox"/> Alcohol and/or drug paraphernalia at scene	
CHIEF COMPLAINT				CONDITION CODE See Ref. Sheet	
CHIEF COMPLAINT ANATOMICAL LOCATION <input type="checkbox"/> Abdomen <input type="checkbox"/> Extremity Lower <input type="checkbox"/> Chest <input type="checkbox"/> Back <input type="checkbox"/> Head <input type="checkbox"/> Neck		<input type="checkbox"/> General/Global <input type="checkbox"/> Extremity Upper <input type="checkbox"/> Genitals		CHIEF COMPLAINT ORGAN SYSTEM <input type="checkbox"/> CNS/Neuro <input type="checkbox"/> OB/GYN <input type="checkbox"/> Global <input type="checkbox"/> Renal <input type="checkbox"/> Psych <input type="checkbox"/> Skin <input type="checkbox"/> Pulmonary <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Musculoskeletal	
CARDIAC ARREST <input type="checkbox"/> Yes, Prior to Arrival <input type="checkbox"/> Yes, After Arrival <input type="checkbox"/> No		RESUSCITATION <input type="checkbox"/> Defibrillation <input type="checkbox"/> Ventilation <input type="checkbox"/> Chest Compressions		CAUSE OF CARDIAC ARREST <input type="checkbox"/> Presumed Cardiac <input type="checkbox"/> Trauma <input type="checkbox"/> Drowning <input type="checkbox"/> Respiratory <input type="checkbox"/> Electrocution <input type="checkbox"/> Other	
USE OF SAFETY EQUIPMENT <input type="checkbox"/> N/A <input type="checkbox"/> Not Known <input type="checkbox"/> Child Restraint		<input type="checkbox"/> Lap Belt <input type="checkbox"/> Helmet Worn <input type="checkbox"/> Eye Protection		<input type="checkbox"/> Shoulder Belt <input type="checkbox"/> Protective Non-Clothing Gear <input type="checkbox"/> Personal Floatation Device <input type="checkbox"/> Protective Clothing <input type="checkbox"/> Other <input type="checkbox"/> None	
BARRIERS TO STANDARD PATIENT CARE <input type="checkbox"/> Development Impaired <input type="checkbox"/> Physical Restraint		<input type="checkbox"/> Physically Impaired <input type="checkbox"/> Unconscious		<input type="checkbox"/> Unattended/Unsupervised <input type="checkbox"/> Language <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Speech Impaired	
RESPONSE MODE <input type="checkbox"/> Lights/Sirens <input type="checkbox"/> No Lights/No Sirens <input type="checkbox"/> Initial Lights/Sirens Downgraded to no Lights/Sirens <input type="checkbox"/> Initial No Lights/Sirens Upgraded to Lights/Sirens		TRANSPORT MODE <input type="checkbox"/> Initial Call for Help <input type="checkbox"/> Unit Notified <input type="checkbox"/> Unit En Route <input type="checkbox"/> Arrive on Scene <input type="checkbox"/> Arrived at PT		<input type="checkbox"/> Unit Left Scene <input type="checkbox"/> Patient arrived at Destination <input type="checkbox"/> Incident Completed <input type="checkbox"/> Available for Next Incident	
PRIOR AID See Ref. Sheet		PRIOR AID OUTCOME <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Worse <input type="checkbox"/> Unknown			
PERFORMED BY		MEDICATIONS/PROCEDURES		PERFORMED BY	

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AW Chickering

A red circular graphic with a gradient, appearing as a partial circle or a thick arc, located to the right of the 'AW Chickering' text.

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