Ph: 715-889-4491

Patient Care Worksheet

ALS ☐ BLS ☐ NT ☐

Action Sports EMS / Great Lakes E.M.S.

Incident Location _____ **Rider #**_____ **Date**_____

Patient Name:		**Date of Birth:**	
Gender:	Male ☐ Female ☐	**Patient Age:**	Minor?
Phone Number:	( )	**Guardian Name:**	
Patient Address:		**Guardian Relation:** Allowed to make decisions?	Father ☐ Mother ☐ Other ☐ Implied Consent ☐
		Patient Social Security:	
Allergies:		**Medications:**	
Chief Complaint:			Onset:
Crew Members:	#1. #2. #3.		

Base Line Vitals / Pain Scale

Time	BP	HR	RR	SpO2	Pain 0-10
:					
:					
:					
:					
:					

Required Vitals & Assessments

A&O x 4	Denies LOC	CMS x 4	Witnessed	Glucose
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	MOI? ☐ Yes ☐ No	_____ Time:

Glasgow Coma Score

Eyes 4-1	Verbal 5-1	Motor 6-1	**Total 3-15**

Skin Condition (Check all that apply)

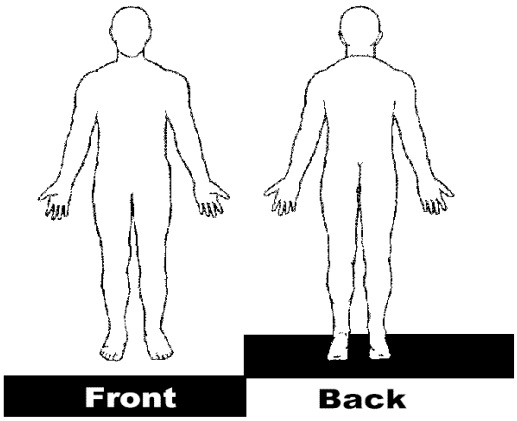
Warm	Dry	Moist	Cold	Flush	Pale

Eyes (Check all that apply) ☐ Right ☐ Left ☐ Both

PERL	Constricted	Dilated	Non-reactive

Oxygen Given: ☐ **Yes** ☐ **No**

Flow Rate _____ ☐ NRB ☐ Cannula ☐ BVM ☐ Nebulizer



Traumatic ☐
LOC ☐
ALOC ☐
Medical ☐
Exhaustion ☐
Wound Care ☐
First Aid ☐

Procedures Performed *(Enter crew member number from above)*

Skill Performed	EMT #	Skill Performed	EMT #
ALS Assessment		Vitals	
BLS Assessment		**Cardiac Monitor**	
C-Collar		Suction Airway	
Long Board		OP/NP Airway	
Splint Extremity		Advanced Airway	
Traction Splint		**Blood Glucose**	
Wound Care		**IV Access**	
Helmet Removal		Med Administration	

Medications Administered

Time	EMT #	Medication	Dose	Route	Reactions / Improvements
:					
:					
:					
:					
:					

Narrative located on back of this sheet.

Narrative

EMT Signature:		Date:	
Transferred To:		Transfer Time:	