NATIONAL SET & EVENT MEDICS

Patient Care Report

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REALITY MEDIC REMOTE ACTION RESCUE

DATE	INCIDENT LOCATION	Incident # Leave Blank

PATIENT NAME	FIRST	M.I.	LAST	Patients:______of______

ADDRESS	SEX M☐ F☐	D.O.B. / /

CITY	STATE	ZIP	S.S. NUMBER *(Last 4)* XXX — XX —	AGE

HOME PHONE ( )	PARENT/GUARDIAN NAME	RELATION TO PATIENT

HISTORY

PMH: □AMI □CHF □Diabetes □CVA □HTN □Seizures □COPD □Asthma □Cardiac

Other:________________

Pt. Medications:________________

Allergies:________________

ASSESSMENT

Breathing: □Normal □Shallow □Retractions □Labored □Absent □Rapid

Lungs: □Clear □Wheezes □Rales □Diminished □Absent □Rhonchi

□Left □Right □Upper □Lower □Bilateral

Circulation: Cap Refill: □Normal □Delayed

Skin: □Normal □Pale □Flushed □Warm □Cyanotic □Dry □Moist □Cool □Cold □Hot

Head:

Eyes: □Perl □Pinpoint □Dilated □Reactive □Nonreactive □R>L □L>R MM

Chest:

Abdomen:

Pelvis:

Extremities:

CHIEF COMPLAINT

____

PATIENT STATUS

Alert and Oriented to:

□Person □Place

□Time □Event

VITALS

Time			
BP	/	/	/
P			
R			
SPO_2			

TREATMENT

□NC

□NRM

□BVM

□Suction

□Dstick_____mg/dL

Time___________

O_2 ________L/min

AED INFORMATION

Witnessed Arrest? **Y / N**

Bystander CPR? **Y / N**

Was Pt. shocked? **Y / N**

Time CPR started:_______

By whom:_______________

Number of shocks:_______

NARRATIVE:

GLASGOW

Time				
Eyes Open	4-Spontaneously 3-To Speech 2-To Pain 1-None			
Best Verbal Resp.	5-Oriented 4-Confused 3-Inappropriate 2-Incomprehensible 1-None			
Best Motor Resp.	6-Obeys Orders 5-Localizes Pain 4-Withdraw to Pain 3-Flex to Pain 2-Exten. to Pain 1-None			

PATIENT OUTCOME

□TREATED AND RELEASED

□REFUSAL-SIGNED BELOW

□PRIVATE TRANSPORT

□NO PATIENT CONTACT

□TRANSPORTED BY_________

EMT/Medic: **Signature**

I have been advised that NSM Medical personnel are unable to determine, beyond initial examination, if I have a life-threatening illness or injury which could potentially result in death. I have also been advised by NSM Medical personnel to seek medical attention immediately. I fully understand my condition and the potential consequences for refusing to seek further treatment or transport to a medical facility. I do not hold NSM Medical liable for any treatments that I have received.

Patient Signature/Authorized Signature Witness Signature Date