

Genesee County Medical Control Authority

Short Form

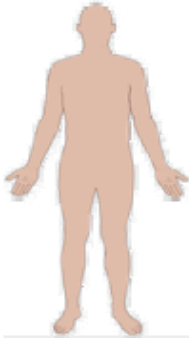
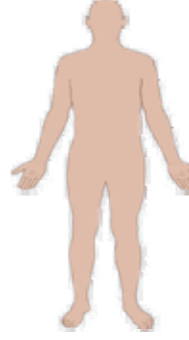
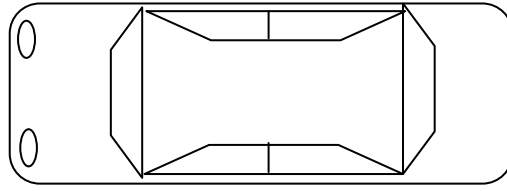
RUN # _____	ROOM #: _____	DATE: _____
EMS UNIT NUMBER: _____		PATIENT PRIORITY: _____
AGENCY NAME: _____		
LOCATION: _____		
PRIMARY COMPLAINT: _____		
VITALS:	TIME OF VITALS	MEDICATIONS
LEVEL OF RESPONSIVENESS:		
BLOOD PRESSURE		
PULSE RATE / RHYTHM		
RESPIRATIONS		
BREATH SOUNDS		
PUPILS		
SKIN PERFUSION		ALLERGIES
BLOOD SUGAR		
SPO2		
TEMPERATURE		
GLASGOW		
PAIN SCALE		

MEDICAL HISTORY	_____

SCENE CONDITIONS:

MEDICAL ONLY: _____			
ACCIDENT: _____			
DRIVER / PASSENGER	ROLLOVER ?	Y / N	HELMET: Y / N
ENTRAPMENT ?	Y / N	EXTRICATION TIME :	_____
SEATBELT	Y / N	AIRBAG DEPLOYMENT	Y / N

TREATMENT(S):	_____
EKG:	_____

Front	Back	Vehicle
		Intrusion: _____ <div style="text-align: center;">  </div> Front Back Speed: _____

CREW NAMES:

_____	EMT B	PARAMEDIC
_____	EMT B	PARAMEDIC
_____	EMT B	PARAMEDIC
_____	EMT B	PARAMEDIC

Patient Name: _____
 Call Time: _____
 Enr Time: _____
 Arrival Time: _____
 Pt. Contact Time: _____
 Transport Time: _____
 Arrival Hosp: _____
 Address: _____
 Phone: _____
 DOB: _____