INTERIM PATIENT CARE REPORT

Incident Number	

Provider Name	Unit #	Date

Last Name	First Name	Age	Weight LB (KG)	Sex	DOB
				M	

Patient Address:

Incident Location (Address):	Time of Incident AM

Chief Complaint:

Mechanism of Injury:

Vitals Time	BP	Pulse	Resp Rate/Quality	SPO2	GCS				Rhythm
					Eyes	Verbal	Motor	Total	
								0	
								0	
								0	

Time	Treatment/Medications				Response
	Oxygen ☐ Cannula ☐ Mask ☐ BVM Flow Rate:				
	☐ IV ☐ I/O	Gauge	Location	Rate	

Pt. Condition Upon Arrival to Receiving Hospital: ☐ Improved ☐ Maintained ☐ Deteriorated

Medical History: ☐ Cardiac ☐ Stroke ☐ HTN ☐ CA ☐ Psych ☐ Diabetes ☐ COPD ☐ Other:

Medications:

Allergies:

Pertinent Physical Findings:

Receiving Hospital:	Person Accepting Care:

Crew:

1. _____ **2.** _____ **3.** _____