ICEMA# 985966

❒ Cancelled ❒ AMA ❒ Transport ❒ Air _____ Date _____

Prim. Inc.# _____ Unit _____

Other provider _____ AMB OIA # _____

Location _____ (Do not write "SAME")

City _____ Zone _____

NAME _____

ADDRESS/P.O. BOX _____

City _____ State _____ Zip _____

Phone _____ Social Security No. _____

Age ____/ DOB ____/____/____ ❒ M ❒ F Approx. Weight Kg _____ Approx. Height _____

Patient _____ of _____ PATIENT'S PHYSICIAN/HOSP.

CHIEF COMPLAINT _____

MECH. OF INJ./SUBJECTIVE _____

MED. HISTORY: ❒ Asthma ❒ Cancer ❒ CVA ❒ Cardiac ❒ CHF ❒ COPD ❒ Diabetes ❒ HTN ❒ Psych ❒ Seizure

MEDICATION: _____

ALLERGIES: ❒ NKA _____

CARE PRIOR TO ARRIVAL	☐ YES ☐ NO	CARE GIVER TYPE	☐ CT. ☐ None ☐ Other	☐ Medical ☐ Law Enforce	☐ FD/BLS ☐ FD/ALS

	TIME	CODE	ODOMETER	
RECEIVED				
EN ROUTE		1 2 3		
ARRIVE				
PT. CONTACT				
DEPART		1 2 3		
ARRIV. DEST.				
AVAILABLE				

FAC. CONTACTED _____ CONTACT TIME _____

☐ BH ☐ VHF ☐ UHF ☐ Phone ☐ Cell ☐ 800 MHZ ☐ None

RECEIVING HOSPITAL _____

☐ Pt. Request ☐ Diversion ☐ Trauma ☐ RCF
☐ Peds Trauma ☐ Reroute ☐ Closest ☐ Other

TIME	BLOOD PRESSURE	PULSE Rate	PULSE Description	RESPIRATION Rate	RESPIRATION Lung Sounds	Pulse OX%

USE SUPPLEMENTAL

SECONDARY SURVEY	WNL	N/A	ABN	COMMENTS
NEURO	☐	☐	☐	
HEAD	☐	☐	☐	
NECK	☐	☐	☐	☐NO JVD
CHEST	☐	☐	☐	☐NEGATIVE BARREL HOOP
TRACHEA	☐	☐	☐	☐
ABD	☐	☐	☐	☐SOFT/SUPPLE
BACK-SPINE	☐	☐	☐	☐FULL SPINAL IMMOBILIZATION
PELVIS	☐	☐	☐	☐NEG NO INSTABILITY NOTED
EXTREM	☐	☐	☐	☐NO DISTAL EDEMA ☐F.R.O.M.

NARCOTIC GIVEN

Midazolam _____ mg
Morphine _____ mg

NARCOTIC WASTED

Midazolam _____ mg
Morphine _____ mg
Date _____ Time _____
Location _____
Nurse _____
Medic _____

SKIN COLOR	MOISTURE	SKIN TEMP.	Rt ... PUPILS ... Lt.		Rt ... PUPILS ... Lt.	
A B Normal	A B Normal	A B Hot	A B Normal	A B	A B Non-reactive	A B
A B Pale/Ashen	A B Dry	A B Warm	A B Constr.	A B	A B Sluggish	A B
A B Cyanotic	A B Moist	A B Cool	A B Dilated	A B		
A B Flushed	A B Profuse	A B Cold				

TIME A _____ TIME B _____

RESPIRATORY EFF.	CAPILLARY REFILL	EYE OPENING	VERBAL RESPONSE	MOTOR RESPONSE
A B Normal	A B Immediate	4 4 Spontaneous	5 5 Oriented	6 6 Obedient
A B Shallow/ Retract/None	A B Delayed	3 3 To voice	4 4 Confused	5 5 Purposeful
	A B None	2 2 To pain	3 3 Inappropriate	4 4 Withdrawal
		1 1 None	2 2 Incomprehensible	3 3 Flexion
			1 1 None	2 2 Extension
				1 1 None

PULSE:	FEMORAL	RADIAL	CAROTID
PRESENT	A B	A B	A B
ABSENT	A B	A B	A B

G C S _____

LOC	Y / N	SEATBELT	Y / N	STEERING WHEEL DAMAGE	Y / N
HELMET	Y / N	EJECTED	Y / N	WINDSHIELD DAMAGE	Y / N
AIRBAG	Y / N	ROLL OVER	Y / N	MOTORCYCLE DAMAGE	Y / N

BLOOD GLUCOSE ā D50 _____ ma/dl p̄ _____ ma/dl
Temperature _____ Route _____

Pulse Ox ā Intubation _____ % p̄ _____ % End - Tidal Co2 Detected Y / N

TIME ADM.	CARE RENDERED	RT/SIZE	DOSE	RESPONSE TX

USE SUPPLEMENTAL

TIME	RHYTHM	DEFIB	RHYTHM

USE SUPPLEMENTAL

P	Q	R	S	T

NARRATIVE/ASSESSMENT _____

THIS REPORT MAY NOT BE COMPLETE

_____ ❒ Patient Attendent ❒ Radio Attendent	_____ ❒ Patient Attendent ❒ Radio Attendent	_____ ❒ Patient Attendent ❒ Radio Attendent	☐ Valuables with Patient _____	☐ Meds: with Patient _____

Is patient a minor ☐ Yes Responsible Party _____

Primary Insurance _____ Policy # _____

Policy Holder Name _____ Policy # _____

Secondary Insurance _____ Policy # _____

	ITEM	CHARGE
	Oxygen	
	Mileage	
	Emergency	
	Night	
	Spinal Immobilization	
	Base Rate ☐ALS ☐BLS	

Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of Running Springs Fire Department Notice of Privacy Practices on this date.

Patient/Beneficiary Initial: _____ **Date:** _____

NOTICE TO MEDICARE/MEDI-CAL/HEALTH MAINTENANCE ORGANIZATION/AMBULANCE MEMBERSHIP BENEFICIARY

Medicare and some HMO's will only pay for services that they determine to be "reasonable and necessary" under Section 1862(a)(1) of the Social Security Act. Medicare or your HMO may deny payment for certain services provided to you OR about to be provided to you by Running Springs Fire Department, Ambulance Services. These services may include, but are not limited to, the following: Wheelchair Van Transportation, Non-emergency Ambulance Service (exceeding 100 miles), and Ancillary Outpatient Inter-facility Ambulance Service. Additionally, Medicare and some HMO's do not usually pay for ambulance service for a beneficiary unless certain diagnoses OR conditions are present, nor will they pay for ambulance service when the patient could be transported by other means.

I authorize the release of medical and/or information necessary to process this claim. I also authorize payment of medical benefits to Running Springs Fire Department. If I have Medi-Cal coverage and Medi-Cal deems the problem to NOT be an emergency and refuses coverage, I understand I am liable for payment.

BENEFICIARY AGREEMENT

I have been notified by Running Springs Fire Department, that under certain conditions, Medicare, Medi-Cal or, if applicable, my HMO may deny payment and that I will be fully responsible for payment.

_____
Patient/Beneficiary Name

_____
Patient/Beneficiary Signature

_____
Address

_____
City, State, Zip Code

☐Beneficiary Unable/Refused to Sign

☐Copy of Notice of Privacy Practices given to Patient/Beneficiary

_____
Caregiver's Signature

PHYSICIAN'S RESPONSIBILITY

DOCTOR. PLEASE READ CAREFULLY: IF YOU DESIRE TO TAKE CHARGE OF THE ACCIDENT/ILLNESS SCENE*, YOU MUST:

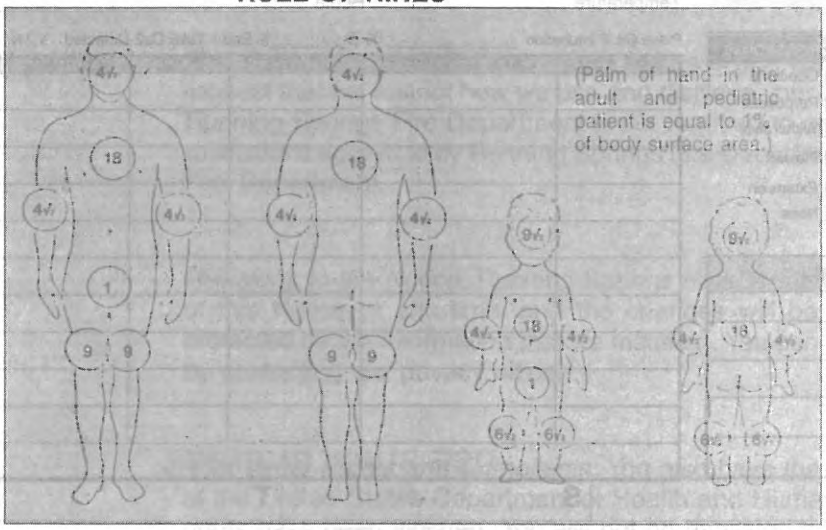
1. Show your current California Medical Dr. License to the Emergency Medical Personnel on the scene.
2. Agree to take full responsibility for the care & treatment of the patient(s) involved in the incident.
3. Accompany the patient(s) in the ambulance/rescue unit to the medical facility most appropriate to receive the patient(s).

_____
Physician's Signature

_____ _____
Professional License Number Date

***The Base Hospital must be notified that a physician is taking charge of the Patient.**

RULE OF NINES



Burn Patient Reminders

Protect the burned area.

- Don't break blisters
- Remove restrictive clothing
- Cover w/dry sterile dressing for Burns ≥ 15% BSA
- Cover w/moist sterile dressing for Burns <15% BSA
- Don't remove adherent materials

NARCOTIC GIVEN	
Midazolam	mg
Morphine	mg
NARCOTIC WASTED	
Midazolam	mg
Morphine	mg
Date	Time
Location	
Nurse	
Medic	

Normal Saline Hourly Rate for Burn Victims

Kilograms x % Burned Surface Area (BSA) ÷ 8

For Patients with Evidence of Shock: Give 500cc fluid challenge, may repeat if systolic BP greater than 90 mmHg

Sign	0	1	2	1 min.	5 min.
Heart Rate	Absent	Below 100	Over 100		
Respiration (effort)	Absent	Slow and irregular	Normal; crying		
Muscle Tone	Limp	Some flexion-extremities	Active; good motion		
Irritability	No response	Crying; some motion	Crying; vigorous		
Skin Color	Bluish or Paleness	Pink or typical newborn color; hands and feet are blue	Pink or typical newborn color; entire body		
			TOTAL APGAR SCORE		

ICEMA# 985966

❒ Cancelled ❒ AMA ❒ Transport ❒ Air _____ Date _____

Prim. Inc.# _____ Unit _____

Other provider _____ AMB OIA # _____

Location _____ (Do not write "SAME")

City _____ Zone _____

NAME _____

ADDRESS/P.O. BOX _____

City _____ State _____ Zip _____

Phone _____ Social Security No. _____

Age ____ DOB ___/___/___ ❒ M ❒ F Approx. Weight Kg _____ Approx. Height _____

Patient _____ of _____ PATIENT'S PHYSICIAN/HOSP.

CHIEF COMPLAINT _____

MECH. OF INJ./SUBJECTIVE _____

MED. HISTORY: ❒ Asthma ❒ Cancer ❒ CVA ❒ Cardiac ❒ CHF ❒ COPD ❒ Diabetes ❒ HTN ❒ Psych ❒ Seizure

MEDICATION: _____

ALLERGIES: ❒ NKA _____

CARE PRIOR TO ARRIVAL	☐ YES ☐ NO	CARE GIVER TYPE	☐ CT. ☐ None ☐ Other	☐ Medical ☐ Law Enforce	☐ FD/BLS ☐ FD/ALS

	TIME	CODE	ODOMETER	
RECEIVED				
EN ROUTE		1 2 3		
ARRIVE				
PT. CONTACT				
DEPART		1 2 3		
ARRIV. DEST.				
AVAILABLE				

FAC. CONTACTED _____ CONTACT TIME _____

☐ BH ☐ VHF ☐ UHF ☐ Phone ☐ Cell ☐ 800 MHZ ☐ None

RECEIVING HOSPITAL _____

☐ Pt. Request ☐ Diversion ☐ Trauma ☐ RCF
☐ Peds Trauma ☐ Reroute ☐ Closest ☐ Other

TIME	BLOOD PRESSURE	PULSE Rate	PULSE Description	RESPIRATION Rate	RESPIRATION Lung Sounds	Pulse OX%

USE SUPPLEMENTAL

SECONDARY SURVEY	WNL	N/A	ABN	COMMENTS
NEURO	☐	☐	☐	
HEAD	☐	☐	☐	
NECK	☐	☐	☐	☐NO JVD
CHEST	☐	☐	☐	☐NEGATIVE BARREL HOOP
TRACHEA	☐	☐	☐	☐
ABD	☐	☐	☐	☐SOFT/SUPPLE
BACK-SPINE	☐	☐	☐	☐FULL SPINAL IMMOBILIZATION
PELVIS	☐	☐	☐	☐NEG NO INSTABILITY NOTED
EXTREM	☐	☐	☐	☐NO DISTAL EDEMA ☐F.R.O.M.

NARCOTIC GIVEN

Midazolam _____ mg
Morphine _____ mg

NARCOTIC WASTED

Midazolam _____ mg
Morphine _____ mg
Date _____ Time _____
Location _____
Nurse _____
Medic _____

SKIN COLOR	MOISTURE	SKIN TEMP.	Rt . . . PUPILS . . . Lt.	Rt . . . PUPILS . . . Lt.
A B Normal	A B Normal	A B Hot	A B Normal A B	A B Non-reactive A B
A B Pale/Ashen	A B Dry	A B Warm	A B Constr. A B	A B Sluggish A B
A B Cyanotic	A B Moist	A B Cool	A B Dilated A B	
A B Flushed	A B Profuse	A B Cold	TIME A _____ TIME B _____	

RESPIRATORY EFF.	CAPILLARY REFILL	EYE OPENING	VERBAL RESPONSE	MOTOR RESPONSE
A B Normal	A B Immediate	4 4 Spontaneous	5 5 Oriented	6 6 Obedient
A B Shallow/ Retract/None	A B Delayed	3 3 To voice	4 4 Confused	5 5 Purposeful
	A B None	2 2 To pain	3 3 Inappropriate	4 4 Withdrawal
		1 1 None	2 2 Incomprehensible	3 3 Flexion
			1 1 None	2 2 Extension
				1 1 None

PULSE:	FEMORAL	RADIAL	CAROTID
PRESENT	A B	A B	A B
ABSENT	A B	A B	A B

G C S _____

LOC Y / N SEATBELT Y / N STEERING WHEEL DAMAGE Y / N
HELMET Y / N EJECTED Y / N WINDSHIELD DAMAGE Y / N
AIRBAG Y / N ROLL OVER Y / N MOTORCYCLE DAMAGE Y / N

BLOOD GLUCOSE ā D50 ma/dl p̄ ma/dl
Temperature _____ Route _____

Pulse Ox ā Intubation _____ % p̄ _____ % End - Tidal Co2 Detected Y / N

TIME	RHYTHM	DEFIB	RHYTHM

USE SUPPLEMENTAL

TIME ADM.	CARE RENDERED	RT/SIZE	DOSE	RESPONSE TX

USE SUPPLEMENTAL

P	Q	R	S	T

NARRATIVE/ASSESSMENT _____

THIS REPORT MAY NOT BE COMPLETE

Name (Print)	❒ Patient Attendent ❒ Radio Attendent ❒ Completed Form	Name (Print)	❒ Patient Attendent ❒ Radio Attendent ❒ Completed Form	Name (Print)	❒ Patient Attendent ❒ Radio Attendent ❒ Completed Form
Cert/Acc#	❒ EMT-1 ❒ EMT-P	Cert/Acc#	❒ EMT-1 ❒ EMT-P	Cert/Acc#	❒ EMT-1 ❒ EMT-P

☐ Valuables with Patient _____ ☐ Meds: with Patient _____

☐ F.D. PATIENT FOLLOW-UP _____

PT RECEIVED BY:

Distribution: White-Provider • Green-Medical • Yellow-ICEMA • Pink-QI • White • Provider

6/03

FORWARD FORM TO EMS/QI COORDINATOR FOR REVIEW

SKILLS EVALUATION FORM

AIRWAY

Acquire: Head Tilt ☐ Jaw Thrust ☐ Unable ☐ Reason: _____

Protect: Cricoid Pressure ☐

Adjunct ☐ if yes: OPA ☐ NPA ☐ ETAD ☐ size: _____

Mask Ventilation: Chest Rise ☐ Air Trapping ☐ Auto Vent ☐

Abdominal Distension: yes ☐ no ☐ if yes: Prior to Arrival ☐ During Treatment ☐

Emesis: yes ☐ no ☐ if yes: Prior to Arrival ☐ During Treatment ☐

Intubation: Chest Rise ☐ Air Trapping ☐ Auto Vent ☐

Abdominal Distension: yes ☐ no ☐ if yes: Prior to Arrival ☐ During Treatment ☐

Emesis: yes ☐ no ☐ if yes: Prior to Arrival ☐ During Treatment ☐

CHECK, OR FILL-IN THE REQUESTED INFORMATION *ICEMA RUN#* _____

AIRWAY

INTUBATION:	SIZE	# OF ATTEMPTS	SUCCESSFUL*
ADULT ☐ ORAL ☐ NASAL			☐ YES ☐ NO
☐ ETAD ☐ OTHER			☐ YES ☐ NO
PEDIATRIC ORAL			☐ YES ☐ NO
NEEDLE CRIC DEVICE			☐ YES ☐ NO

How was placement verified: ☐ Auscultation _____

☐ Pulse Ox Initial _____ Post Treatment _____

☐ End-title CO2 Color Post Intubation _____

OPTIONAL SKILLS

	SIZE	# OF ATTEMPTS	SUCCESSFUL*
INTRAOSSEOUS INFUSION			☐ YES ☐ NO

How was placement verified: _____

TRANSCUTANEOUS CARDIAC PACING: Initial Rhythm _____ Fluid Bolus Given ☐ YES ☐ NO

Capture ☐ YES ☐ NO at _____ Rate _____ Milli Amps

NASO/OROGASTRIC TUBE	SIZE	# OF ATTEMPTS	SUCCESSFUL*
			☐ YES ☐ NO

How was placement verified: ☐ Auscultation over Lungs

☐ Auscultation over Stomach

☐ Aspiration of Stomach Contents

*IF ABOVE SKILL/PROCEDURE WAS SUCCESSFUL, EXPLAIN PATIENT RESPONSE

*IF ABOVE SKILL/PROCEDURE WAS UNSUCCESSFUL, EXPLAIN POSSIBLE REASON

☐ Anatomical Constraints ☐ Environmental Constraints ☐ Equipment Failure ☐ Other

PROCEDURE PERFORMED: ☐ Prior To Contact ☐ Radio Communication Failure ☐ Base Hospital Order

MEDICATION EVALUATION

☐ Magnesium Sulfate Dose _____ Patient Response to Medication _____

☐ Verapmil Dose _____ Patient Response to Medication _____

☐ Other _____ Dose _____ Patient Response to Medication _____

REVIEW OF PROCEDURE

RECEIVING HOSPITAL _____ BASE HOSPITAL: _____

RECEIVING PHYSICIAN SIGNATURE: _____ DATE: _____

PARAMEDIC SIGNATURE: _____ DATE: _____

CONDITION UPON ARRIVAL AT HOSPITAL: _____

EMS/QI/PLN REVIEW

EMS/QI/PLN SIGNATURE: _____ DATE: _____

PATIENT OUTCOME

COMPLETE FOLLOWING ONLY IF INFORMATION IS AVAILABLE

☐ **DECEASED** ☐ **ADMITTED** ☐ **OTHER** _____

☐ **TRANSFERRED** TO _____

PEDIATRIC DRUG DOSE SCALE

***All numbers shown are in Milligram or Gram Doses.**

DRUG/kg	3	4	5	6	7	8	10	12	14	16	18	20	22	24	26	28	30	32	34
Adenosine 0.1 mg (1st)	0.3	0.4	0.5	0.6	0.7	0.8	1.0	1.2	1.4	1.6	1.8	2.0	2.2	2.4	2.6	2.8	3.0	3.2	3.4
Adenosine 0.2 mg (2nd)	0.6	0.8	1.0	1.2	1.4	1.6	2.0	2.4	2.8	3.2	3.6	4.0	4.4	4.8	5.2	5.6	6.0	6.4	6.8
Atropine 0.02 mg	.10	.10	.10	.12	.14	.16	.20	.24	.28	.32	.36	.40	.44	.48	.52	.56	.60	.64	.68
Benadryl 1 mg IV	3	4	5	6	7	8	10	12	14	16	18	20	22	24	A	D	U	L	T
Benadryl 2 mg IM	6	8	10	12	14	16	20	24	28	32	36	40	44	48	A	D	U	L	T
Charcoal 1 G	3	4	5	6	7	8	10	12	14	16	18	20	22	24	26	28	30	32	34
Dex. 25% 0.5 G	1.5	2	2.5	3	3.5	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Epinephrine 0.005 mg post arrest	.015	.02	.025	.03	.035	.04	.05	.06	.07	.08	.09	.10	.11	.12	.13	.14	.15	.16	.17
Epinephrine 0.01 mg IV/IO	.03	.04	.05	.06	.07	.08	.10	.12	.14	.16	.18	.20	.22	.24	.26	.28	.30	.32	.34
Epinephrine 0.1 mg ET	0.3	0.4	0.5	0.6	0.7	0.8	1.0	A	D	U	L	T		D	O	S	A	G	E
Glucagon 0.025 mg	.075	.1	.125	.15	.175	.2	.25	.3	.35	.4	.45	.5	.55	.6	.65	.7	.75	.8	.85
Lasix 1 mg	3	4	5	6	7	8	10	12	14	16	18	20	22	24	26	28	30	32	34
Lidocaine 1 mg	3	4	5	6	7	8	10	12	14	16	18	20	22	24	26	28	30	32	34
Narcan 0.01 mg	.03	.04	.05	.06	.07	.08	.10	.12	.14	.16	.18	.20	.22	.24	.26	.28	.30	.32	.34
Narcan 0.1 mg repeat	0.3	0.4	0.5	0.6	0.7	0.8	1.0	1.2	1.4	1.6	1.8	2.0	A	D	U	L	T	-	-
Morphine 0.1 mg	0.3	0.4	0.5	0.6	0.7	0.8	1.0	1.2	1.4	1.6	1.8	2.0	2.2	2.4	2.6	2.8	3.0	3.2	3.4
Versed 0.1 mg IV/IO	0.3	0.4	0.5	0.6	0.7	0.8	1.0	1.2	1.4	1.6	1.8	2.0	2.2	2.4	2.6	2.8	3.0	3.2	3.4
Versed 0.2 mg IM	0.6	0.8	1.0	1.2	1.4	1.6	2.0	2.4	2.8	3.2	3.6	4.0	4.4	4.8	5.2	5.6	6.0	6.4	6.8

MEDICATION INFORMATION

NARCAN REVERSES	PSYCH MEDS	HYPERTENSION MEDS	CHF/CARDIAC MEDS	DIABETIC MEDS	SEIZURE MEDS
CODEINE	CELEXA	ATENOLOL	ALDACTONE	AMARYL	DEPAKOTE
DEMEROL	ELAVIL	COZAAR	DIGOXIN	AVANDIA	DILANTIN
HEROIN	HALDOL	HCTZ	INDEROL	DIABINESE	KLONOPIN
HYDROCODONE	PAXIL	LOTENSIN	ISOSORBIDE	DIABETA	LAMICTAL
METHADONE	PROZAC	LOPRESSOR	LASIX	GLUCOPHAGE	NEURONTIN
MORPHINE	RISPERDAL	NORVASC	MEXITIL	GLUCATROL	PHENOBARBITOL
NUBAIN	THORAZINE	PROCARDIA	NITRO'S (ALL)	INSULINS (ALL)	TEGRETOL
OXYCODONE	XANAX	VASOTEC	QUINIDINE	ORINASE	TOPAMAX
TALWIN	ZOLOFT	VERAPAMIL	PROCAINAMIDE	TOLINASE	VALIUM