

401

08-1026

Manitoba Health



# Ambulance Patient Care Report

Service No: 468 Date: 25 02 05 Day: Mo Yr: 05

Incident No: 08 Bin: 24 Veh: 3155 Operator: 5641 EMT 1: 5641 EMT 2:  Pickup Location: Hwy 59 c Perimeter

Pymt:  Billing Code:  Account No:  Sex:  M  F Date of Birth: 107371376 PHN:

Responsible for Payment

1  Blue Cross 10  Patient  
 2  D.V.A. 11  M.P.I.C.  
 4  Provincial Welfare 12  Employer  
 5  City Welfare 13  Estate  
 6  Fed. Med. Services 14  P.C.H.  
 7  Coroner 15  Other  
 9  Hospital

Ref. No. DAX 165-10-26

Support Agency:  Police 28  RCMP  To Scene  Transport  
 Fire 530  Scheduled N/A  
 Other 423 WPG  Non Emergency   
 Identify Ambulance  Emergency

Check for Billing

1 Address: [Redacted] Telephone: [Redacted]  
 City/Town: [Redacted]  
 Person Paying/other than Patient: [Redacted] Telephone: [Redacted]  
 City/Town: [Redacted] Province: [Redacted] Postal Code: [Redacted]

2 Address: [Redacted]

Next of Kin: [Redacted] Address: [Redacted]

Telephone: 519 Patient/Destination: 17-26 Family Physician: [Redacted]

Loaded Km:  Waiting Time:   
 Total Km:

Mechanism of Injury

Medical  
 MVA Traffic  
 MVA Non-Traffic  
 Struck by Vehicle  
 Machinery  Recreation  
 Fall  Fall > 3 meters  
 Environment  
 Drowning  
 Fire/Smoke  Violence  
 Hazardous Material (specify)  
 Other Trauma (in comments)

Call Category

Primary Response  
 Interfacility  
 Repatriation  
 Return leg  
 Airport Transfer  
 Non Resident of Manitoba  
 ALS

No Transport Call

Cancelled Prior to Arrival  
 No Patient/Incident Found  
 Handled by Other Agency  
 Patient Refusal  
 Treat and Release  
 Agency Standby  
 Special Event  
 Deceased at Scene

Location of Call

Home  
 Public Bldg  
 Industrial  
 Other Work Loc  
 Recreational  
 Highway  
 City/Town Street  
 Farm  
 School/Day Care  
 Health Facility  
 Other

Call Times

Call Rec'd: 07:17  
 Enroute: 07:20  
 Arr. Scene: 07:38  
 Arr. Patient:  est.  
 Dep't Scene: 07:56  
 Arr. Dest.: 08:36  
 Available: 08:36

Medical Assessment

Airway Obstruction  
 Respiratory Arrest  
 Respiratory Distress  
 Cardiac (Potential)  
 Cardiac Arrest  
 Allergic Reaction  
 Syncope  
 Nausea/Vomiting  
 Weak/Faint  
 Stroke/CVA  
 Shock  
 Seizure

Diabetic Related  
 General Illness/Malaise  
 Gastro-Intestinal Distress  
 Unconscious/Unresp  
 OB/GYN  
 Behavioral Disorder  
 Substance Abuse  
 Poisoning (Accidental)  
 Overdose (Acute) (specify in comments)  
 Heat Stroke/Exhaustion  
 Hypothermia  
 Other (spec. in comments)

Past Medical History

Nil/Unknown  Stroke  
 Hypertension  Diabetes  
 Seizures  Cardiac  
 Respiratory  Renal  
 Allergy  Psychiatric  
 Medication  Other

Position Found

Side Lying  
 Sitting  
 Prone  
 Supine  
 Ambulatory  
 Other (Specify)

Injury Locations

Physical Assessment

1 Fract./Dislocation  
 2 Sprains/Strains  
 3 Amputation / Avulsion  
 4 Trauma Blunt  
 5 Trauma Penetrating  
 6 Impaled Object  
 7 Crush Injury  
 8 Laceration  
 9 Bruise/Contusion  
 10 Soft Tissue Injury (other)  
 11 Burns Major (> 10%)  
 12 Burns Minor  
 13 Pain  
 Bleeding  
 14 Minor (<50 ml)  
 15 Moderate (50 - 500 ml)  
 16 Severe (>500 ml)  
 17 Other (Specify)

VITAL SIGNS

TIME	RESP	PULSE	S.P.	VERBAL	MOTOR	EYES	GCS	SKIN	R PUPILS	L R GRIP
07:20	Rate: <u>16</u> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Shallow <input type="checkbox"/> Labored <input type="checkbox"/> Noisy	Rate: <u>90</u> <input checked="" type="checkbox"/> Reg <input type="checkbox"/> Irreg <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready	/	<input type="checkbox"/> 1 Nil <input type="checkbox"/> 2 Incomp Sounds <input type="checkbox"/> 3 Inprop Words <input type="checkbox"/> 4 Confused <input checked="" type="checkbox"/> 5 Oriented Alert	<input type="checkbox"/> 1 Nil <input type="checkbox"/> 2 Extends <input type="checkbox"/> 3 Abnor Flex <input type="checkbox"/> 4 Withdraws <input type="checkbox"/> 5 Localizes <input checked="" type="checkbox"/> 6 Obeys	<input type="checkbox"/> 1 Nil <input type="checkbox"/> 2 Pain <input type="checkbox"/> 3 Voice <input checked="" type="checkbox"/> 4 Spont	<u>15</u>	<input checked="" type="checkbox"/> Unremarkable <input type="checkbox"/> Cool <input type="checkbox"/> Pale <input type="checkbox"/> Warm <input type="checkbox"/> Cyanotic <input type="checkbox"/> Moist <input type="checkbox"/> Flushed <input type="checkbox"/> Dry <input type="checkbox"/> Jaundiced	<input checked="" type="checkbox"/> Size <input checked="" type="checkbox"/> <input type="checkbox"/> Normal <input type="checkbox"/> Absent <input type="checkbox"/> Sluggish <input type="checkbox"/> Normal <input type="checkbox"/> No React <input type="checkbox"/> Weak	<input type="checkbox"/> Absent <input type="checkbox"/> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> <input type="checkbox"/> Weak <input type="checkbox"/>
:	Rate: <u></u> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Shallow <input type="checkbox"/> Labored <input type="checkbox"/> Noisy	Rate: <u></u> <input type="checkbox"/> Reg <input type="checkbox"/> Irreg <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready		<input type="checkbox"/> 1 Nil <input type="checkbox"/> 2 Incomp Sounds <input type="checkbox"/> 3 Inprop Words <input type="checkbox"/> 4 Confused <input type="checkbox"/> 5 Oriented Alert	<input type="checkbox"/> 1 Nil <input type="checkbox"/> 2 Extends <input type="checkbox"/> 3 Abnor Flex <input type="checkbox"/> 4 Withdraws <input type="checkbox"/> 5 Localizes <input type="checkbox"/> 6 Obeys	<input type="checkbox"/> 1 Nil <input type="checkbox"/> 2 Pain <input type="checkbox"/> 3 Voice <input type="checkbox"/> 4 Spont		<input type="checkbox"/> Unremarkable <input type="checkbox"/> Cool <input type="checkbox"/> Pale <input type="checkbox"/> Warm <input type="checkbox"/> Cyanotic <input type="checkbox"/> Moist <input type="checkbox"/> Flushed <input type="checkbox"/> Dry <input type="checkbox"/> Jaundiced	<input type="checkbox"/> Size <input type="checkbox"/> <input type="checkbox"/> Normal <input type="checkbox"/> Absent <input type="checkbox"/> Sluggish <input type="checkbox"/> Normal <input type="checkbox"/> No React <input type="checkbox"/> Weak	<input type="checkbox"/> Absent <input type="checkbox"/> <input type="checkbox"/> Normal <input type="checkbox"/> <input type="checkbox"/> Weak <input type="checkbox"/>
:	Rate: <u></u> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Shallow <input type="checkbox"/> Labored <input type="checkbox"/> Noisy	Rate: <u></u> <input type="checkbox"/> Reg <input type="checkbox"/> Irreg <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready		<input type="checkbox"/> 1 Nil <input type="checkbox"/> 2 Incomp Sounds <input type="checkbox"/> 3 Inprop Words <input type="checkbox"/> 4 Confused <input type="checkbox"/> 5 Oriented Alert	<input type="checkbox"/> 1 Nil <input type="checkbox"/> 2 Extends <input type="checkbox"/> 3 Abnor Flex <input type="checkbox"/> 4 Withdraws <input type="checkbox"/> 5 Localizes <input type="checkbox"/> 6 Obeys	<input type="checkbox"/> 1 Nil <input type="checkbox"/> 2 Pain <input type="checkbox"/> 3 Voice <input type="checkbox"/> 4 Spont		<input type="checkbox"/> Unremarkable <input type="checkbox"/> Cool <input type="checkbox"/> Pale <input type="checkbox"/> Warm <input type="checkbox"/> Cyanotic <input type="checkbox"/> Moist <input type="checkbox"/> Flushed <input type="checkbox"/> Dry <input type="checkbox"/> Jaundiced	<input type="checkbox"/> Size <input type="checkbox"/> <input type="checkbox"/> Normal <input type="checkbox"/> Absent <input type="checkbox"/> Sluggish <input type="checkbox"/> Normal <input type="checkbox"/> No React <input type="checkbox"/> Weak	<input type="checkbox"/> Absent <input type="checkbox"/> <input type="checkbox"/> Normal <input type="checkbox"/> <input type="checkbox"/> Weak <input type="checkbox"/>

TREATMENT

Obstetrical

Baby Delivered @ Time:  APGAR 1 Min   
 Alive  Stillborn  Male  Female Score 5 Min   
 \* Complete Additional Patient Care Report

Ventilation

Mouth to Mask  
 Bag and Valve  
 Powered Ventilator

Treatment Before Arrival

Nil  CPR  First Aid  Medical

Bleeding

Pressure  
 Elevation  
 Dressing Applied  
 Tourniquet

Cardiac Arrest

Witnessed by:   
 Est Time of Collapse:   
 CPR Started by:   
 Police  
 Fire  
 Bystander (Time)   
 1 Man CPR  2 Man CPR

Patient Positioning

Side Lying  
 Supine  
 Sitting  
 Fowler's  
 Semi Fowler's

AIRWAY

TR & LIP  
 Jaw Thrust  
 Suction  
 Oropharyngeal  
 Nasopharyngeal

Oxygen

Nasal  lpm  
 Non Rebreath  lpm  
 Rebreath  lpm

Splitting and Immobilization

Rigid  
 Traction  
 Cervical Collar  
 KED/Short Board  
 Scoop/Long Board

Other

Burn Care  
 Oral Glucose

Comments

**Chief Complaint**  
*1612 @ calf*

**Mechanism of Injury**  
*MVA*

**History of Present Illness/Injury**  
*PT involved in 3 car MVA, rear ended, rear ended - stranded vehicle into other car*

**Past Medical History**  
*NI*

**Medications**  
*NI*

**Allergies**  
*NI*

**Observations:**  
*Unit 29 - cc: MVA 1/4 found 31 y/o pt in care of WSP Police Truck, pt amb after MVA (abs. of) pat, @ nor @ SR cuts / noc - 3 splens / skin - pink - ulcers / dry / P/R / G/L / S / P / S / a pain to @ calf / muck / P / small / a / b / @ / skin @ / can / long / dry / blood on nose / P / smelled of liquor / P / swollen, co-operative / Fa - 4s taken / P / refused tx - signal 10-36 / Advise / pt to expect stiffness, pain, consult dr. if needed /*

*AR*

Advanced Procedures

INTUBATION	Pulse Oximetry	I.V. THERAPY		LINE 1	LINE 2
Double Lumen ETT/NTT <input type="checkbox"/> Already in Situ <input type="checkbox"/> Successful <input type="checkbox"/> Unsuccessful <input type="checkbox"/> No. of Attempts <input type="checkbox"/> 1 <input type="checkbox"/> 2 Tube Size _____ mm Time _____ CM's at Lip _____ Time of Extub _____ EMT Lic. No. _____	SAO <sub>2</sub> _____ SAO <sub>2</sub> _____ SAO <sub>2</sub> _____ SAO <sub>2</sub> _____ SAO <sub>2</sub> _____ EMT Lic. No. _____ <b>Blood Sugar</b> _____ mmol/l _____ mmol/l _____ mmol/l EMT Lic. No. _____ <b>Air Entry Check</b> Left + <input type="checkbox"/> - <input type="checkbox"/> Right + <input type="checkbox"/> - <input type="checkbox"/> Stomach + <input type="checkbox"/> - <input type="checkbox"/>	I.V. Solution Line 1 Line 2 N/S <input type="checkbox"/> <input type="checkbox"/> D5W <input type="checkbox"/> <input type="checkbox"/> Ringers Lactate <input type="checkbox"/> <input type="checkbox"/> Other (Specify) _____ I.V. Site Line 1 Line 2 ACF <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L Other (Specify) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L	Already in Situ <input type="checkbox"/> <input type="checkbox"/> Successful <input type="checkbox"/> <input type="checkbox"/> Unsuccessful <input type="checkbox"/> <input type="checkbox"/> No. of Attempts _____ Catheter Size _____ GA _____ GA Flow Rate _____ Time Started _____ Pressure Infuser Used <input type="checkbox"/> <input type="checkbox"/> Pre-Heop Vol. Intused _____ ml _____ ml Time Discontinued _____ EMT Lic. No. _____		
		Core Temperature _____ °C _____ °C EMT Lic. _____	Advance Directive <input type="checkbox"/> Do Not Resuscitate Orders <input type="checkbox"/> Received From: _____ Title/Relationship to Patient: _____		

Time	Treatment Drug; D.C. Shock; Procedure	Med Dose	Med Route	Med Discard	Procedure Code	Patient Response	EMT Lic. No
<i>114</i>							

**Physician/RN Comments**

Condition at Destination:  Unchanged  Improved  Deteriorated

Medical Control On Line Orders:  Yes  No

Dr. Name: \_\_\_\_\_

Facility Escort: \_\_\_\_\_ Second EMT: \_\_\_\_\_

Veh. Operator: \_\_\_\_\_ Primary EMT: *[Signature]* Receiving Nurse or MD: \_\_\_\_\_ Time: \_\_\_\_\_