Northeast Michigan MCA

EMS INTERIM FIELD NOTES

Date_____ Agency_____ Unit_____ Run # _____

Incident Location_____ Dispatch _____

Patient Name _____ At Scene _____

Patient DOB _____ Lv Scene _____

Complaint _____ At Hosp _____

Related Past Medical Hx _____

☐Asthma ☐Cancer ☐Cardiac ☐CHF ☐COPD ☐DM ☐Substance Use ☐HTN ☐Renal ☐Seizures ☐ Blood Thinners

Meds_____

Allergies _____

Initial Assessment/Injuries:
(Physical Findings/Pertinent Negatives)

_____

_____

_____

Cap Refill	LOC (initial)	Skin	
☐ Normal	☐Alert	☐ Pink	☐ Hot
☐ Delayed	☐Confused	☐ Ashen	☐ Warm
☐ None	☐Verbal	☐ Flush	☐ Cool
	☐Pain	☐ Mottled	☐ Dry
	☐Unresponsive	☐ Pale	☐ Moist

Airway Management		
☐Suctioned	☐ETT	☐OPA sz____
☐02 @___lpm	☐COMBI	☐NPA sz____
☐N/C	☐KING	☐Simple Mask
☐NRB	☐I-GEL	☐CPAP
☐BVM		☐Nebulizer

Cardiac Arrest Information		
Witnessed	First CPR	AED/Defib
☐ No	☐by lay person	☐ Yes
☐by lay person	☐by RN/MD	☐ No
☐by EMS/FF	☐EMS/FF/LAW	1st Shock
Time _____	Time_____	Time_____

Primary EMT/Paramedic _____

Time	Pulse	Resp	B/P	Interventions
			/	
			/	
			/	
			/	

History of Present Illness / Mechanism of Injury

Time	Intervention/Notes/Meds administered (time, dose, etc)	
	12-Lead:	Time Sent:
	Rhythm:	Blood Glucose:
	IV (ga, site):	Total Fluid Infused cc

Place patient sticker here

Transporting EMS agencies: This form is only to be used as a temporary patient care record – A complete electronic patient care report must also be sent to the hospital. ER Fax 989-356-7257/MCA Fax 989-356-8148