REGION I EMERGENCY MEDICAL SERVICES

Standing Medical Orders and Policy Forms

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Airway Size Charts

Kings Airway Chart

Size	Patient Criteria	Color	Inflation Volume	NG Max Size
0	< 5 kg (12.5 lbs)	Clear	10 ml	10 F
1	5-12 kg (12.5-26.4 lbs)	White	20 ml	10 F
2	12-25 kg (26.4-55 lbs)	Green	35 ml	16 F
2.5	25-35 kg (55-77 lbs)	Orange	40-45 ml	16 F
3	4-5 ft	Yellow	45-60 ml	18 F
4	5-6 ft	Red	60-80 ml	18 F
5	> 6 ft	Purple	70-90 ml	18 F

I-GEL Airway Chart

Size	Patient Criteria	Color
1.0	Neonate – 2-5 kg	Pink
1.5	Infant - 5-12 kg	Blue
2.0	Small Pediatric – 10-25 kg	Grey
2.5	Large Pediatric – 25-35 kg	White
3	Small Adult – 30-60 kg	Yellow
4	Medium Adult – 50-90 kg	Green
5	Large Adult – 90+ kg	Orange

ADULT SEPSIS SCREENING TOOL

Is the patient's presentation suggestive of any of the following infections?			
	Pneumonia (cough/thick sputum)		Abdominal pain, distension and/or diarrhea
	Urinary tract infection		Wound infection, cellulitis
	Altered mental status		Skin/soft tissue infection
	Blood stream/catheter related		Device-related infection
Are any two of the following:			
	Temperature > 100.4◦F		
	Temperature < 96.8º F		
	Tachypnea > 20/m, PaCO2< 32 mmHg; SpO2 ≤ 92%		
	Adult Tachycardia > 90 bpm Pediatric Tachycardia (add chart) 0d – 3m >180		
	Systolic BP < 90 mm/Hg Pediatric Systolic BP 0d-3m - <50		
If presentation suggestive of infection and more than 2 the vital signs changes are positive, call a SEPSIS ALERT and follow SMO			

ADULT GLASGOW COMA SCORE

AREAS OF RESPONSE		
EYE OPENING	Eyes open ***Spontaneously***	4
	Eyes open in response to ***Voice***	3
	Eyes open in response to ***Pain***	2
	No eye opening response	1
VERBAL RESPONSE	***Oriented*** (e.g., to person, place, time)	5
	Confused, speaks but is disoriented	4
	Inappropriate but comprehensible words	3
	Incomprehensible sounds but no words are spoken	2
	None	1
MOTOR RESPONSE	***Obeys Commands*** to move	6
	Localized Painful stimuli	5
	Withdraws from painful stimulus	4
	Flexion, abnormal *decorticate* posturing	3
	Extension, abnormal *decerebrate* posturing	2
	No movement or posturing	1
TOTAL POSSIBLE SCORE		3 - 15
Severe Head Injury Moderate Head Injury Minor Head Injury		≤ 8 9 – 12 13 - 15

ADULT TRAUMA SCORE

The Trauma Score is a numerical grading system for estimating the severity of injury. The score is composed of the Glasgow Coma Scale (reduced to approximately one-third value) and measurements of cardiopulmonary function. Each parameter is given a number (high for normal and low for impaired function). Severity of injury is estimated by summing the numbers. The lowest score is 0, and the highest score is 12.

RESPIRATORY RATE (spontaneous patient-initiated inspirations/ minute)	10 - 29 / minute	4
	greater than 29	3
	6 - 9 minutes	2
	1 - 5 / minute	1
	None	0
SYSTOLIC BLOOD PRESSURE	Greater than 89	4
	76 - 89 mm Hg	3
	50 - 75 mm Hg	2
	1 - 49 mm Hg	1
	No pulse	0
GLASGOW COMA SCALE (see above)	13 – 15	4
	9 – 12	3
	6 – 8	2
	4 – 5	1
	3	0
TOTAL POSSIBLE SCORE		0 – 12

APGAR Score

APGAR SCORE:

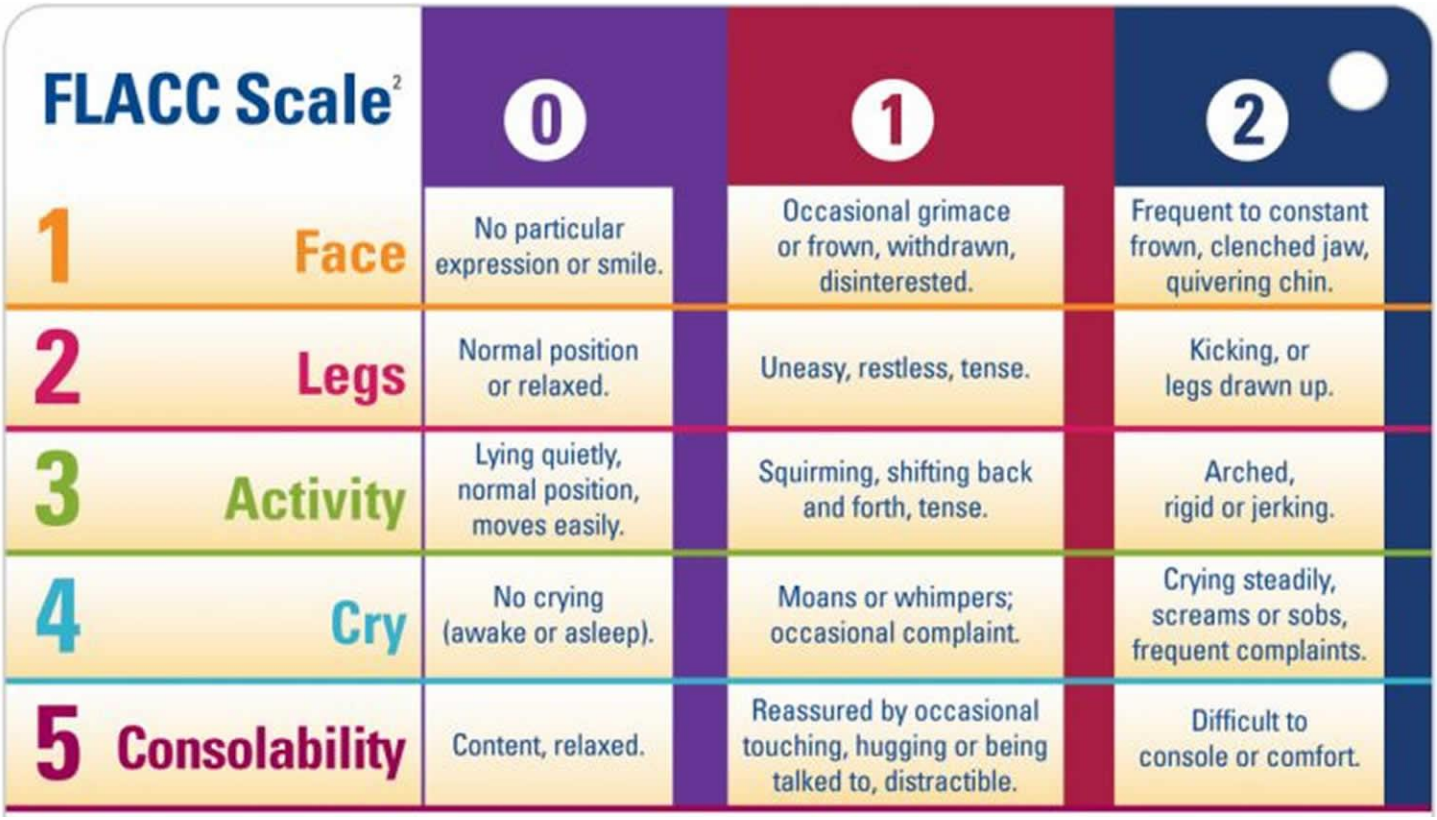
Appearance (skin color)	0=Body and extremities blue, pale	1=Body pink, extremities blue	2=Completely pink
Pulse	0=Absent	1=Less than 100/min	2=100/min and above
Grimace (Irritability)	0=No response	1=Grimace	2=Cough, sneeze, cry
Activity (Muscle tone)	0=Limp	1=Some flexion of the extremities	2=Active motion
Respirations	0=Absent	1=Slow and irregular	2=Strong cry

CPR/AED Guidelines

CPR GUIDELINES			
Component	Adults and Adolescents	Child (1 year to puberty)	Infant (under 1 year of age, excluding neonates)
Airway	Head tilt-chin lift. Jaw thrust if suspected cervical trauma		
Breathing: Without CPR	One breath every 6 seconds	One breath every 2-3 seconds (20-30 breaths /minute)	
Breathing: CPR with advanced airway	One breath every 6 seconds (10 breaths/min) About one second/breath. Visible chest rise.	One breath every 2-3 seconds (20-30 breaths/min) About one second/breath. Visible chest rise.	
Foreign Body: Conscious patient	Abdominal thrusts (*use chest thrusts in pregnant and obese patients)* or chest thrusts if abdominal thrusts are not effective		Five back slaps and five chest thrusts
Foreign Body: Unconscious patient	Lower victim to the floor. Begin CPR, starting with chest compressions. Do not check for a pulse. Before you deliver breaths, look into the mouth. If you see a foreign body that can easily be removed, remove it. Continue CPR.		
Compression landmarks **	Lower half of sternum between nipples		Just below nipple line (*lower half of sternum*)
Hand placement **	Heel of one hand, other hand on top	As for adults (*may use both hands or the heel of one hand depending on the size of the child*)	Two thumbs – encircling hands preferred for two rescuers
Compression depth **	At least 2 inches	Approximately one-third anterior/posterior depth of chest (*Approximately 2 inches in child/1 ½ inches in infant*)	
Compression rate **	100-120 per minute		
Compression – ventilation ratio without advanced airway	30:2 10:1 with continuous compressions	30:2 (single rescuer) 15:2 (two rescuers)	
AED GUIDELINES			
AED Defibrillation	Use adult pads	Use pediatric dose-attenuator system for children and infants if available. Use pediatric pads. If unavailable, use adult pads.	
NEONATAL GUIDELINES (*Less than 30 days old*)			
Assisted ventilation should be delivered at a rate of 40-60 breaths/minute to achieve or maintain a heart rate > 100 bpm. The ratio of compressions to ventilations should be 3:1 with 90 compressions and 30 breaths to achieve approximately 120 events per minute.			

** Apply a mechanical compression device (LUCAS, AutoPulse) per manufacturers' instructions if available.

FLACC Scale



FLACC Scale[2]	0	1	2
1 Face	No particular expression or smile.	Occasional grimace or frown, withdrawn, disinterested.	Frequent to constant frown, clenched jaw, quivering chin.
2 Legs	Normal position or relaxed.	Uneasy, restless, tense.	Kicking, or legs drawn up.
3 Activity	Lying quietly, normal position, moves easily.	Squirming, shifting back and forth, tense.	Arched, rigid or jerking.
4 Cry	No crying (awake or asleep).	Moans or whimpers; occasional complaint.	Crying steadily, screams or sobs, frequent complaints.
5 Consolability	Content, relaxed.	Reassured by occasional touching, hugging or being talked to, distractible.	Difficult to console or comfort.

H's and T's

Consider	Definition	Potential Causes	Treatment
Hydrogen Ions	Improper PH level caused by too much acid (lactic acidosis)	• Respiratory • Metabolic	Respiratory - ventilate Metabolic – Sodium Bicarb
Hyperkalemia	Too much potassium in the body	• Kidney disease/failure • Diuretics • DKA	Calcium Gluconate 1 Gram – may repeat every 5 min up to 3 Grams Sodium Bicarb 1 meq/kg; may repeat half dose in 10 minutes
Hypokalemia	Too little potassium in the body	• Kidney disease/failure • Diuretics • DKA	
Hypothermia	When the body loses the ability to keep itself warm (body temperature below 95° F)	Extreme/prolonged exposure to cold weather and/or water	Apply active and passive warming measures
Hypovolemia	Sudden and significant decrease in the volume of blood and fluids in the body	• Blood loss (internal and external) • Inadequate intake of fluids • Excessive vomiting or diarrhea	IV/IO fluid bolus Rapid Transport; possible surgical intervention
Hypoxia	When the body is deprived of a sufficient supply of oxygen	• Lack of oxygen • Lung disease • Chemical or gas poisoning	• Increase O_2 intake • Ventilate • Advanced airway
Tamponade (pericardial tamponade)	Build-up of blood or fluid in the pericardial space	• Chest Trauma • Myocardial rupture • Pericarditis	• IV/IO fluids • Rapid Transport
Tension Pneumothorax			Pleural decompression
Thrombosis – (acute coronary syndrome)	Blockage of the heart's coronary artery/arteries	• Blood clot(s) • Myocardial infarction	Rapid transport; consider Cath Lab capable hospital
Thrombosis (pulmonary embolus)	Blockage of the lung's main artery	• Blood clot(s) • Pulmonary embolism	
Toxins	Overdose, either intentional or accidental	• Street drugs • Prescription or OTC drugs • Chemical exposure	Opiate – Naloxone Beta Blocker OD – Glucagon TCA – Sodium Bicarb Organophosphate OD - Atropine

Resuscitation Checklist - Adult

TREATMENT: Cardiac Arrest

	Priority of patient care:	Notes:
	▪ High quality compressions	
	▪ AED/cardiac monitor/defibrillation	
	▪ Ventilation	
	Provide high quality continuous chest compressions with:	
	▪ Full recoil.	
	▪ At a rate of 100-120 per minute (consider metronome).	
	▪ At a depth of at least two inches.	
	▪ Minimizing any pauses to < 10 seconds.	
	▪ Switching providers (if available) every two minutes.	
	Apply AED/cardiac monitor as soon as possible.	
	Ventilate the patient:	
	▪ Without advanced airway at a rate of 30:2.	
	▪ Consider supraglottic airway or ETT when possible without interruption of chest compressions.	
	○ Ventilate at a rate of every six (6) seconds/10 per minute. Stop with chest rise.	
	○ Confirm advanced airway with multiple methods.	
	Attach appropriate capnography sensor:	
	▪ Monitor $EtCO_2$ level, respiratory rate, and waveform. If waveform capnography is not available use colormetric with advanced airway.	
	▪ If $EtCO_2$ is below 10 ensure high quality CPR is being performed.	
	▪ Continuously monitor $EtCO_2$ throughout arrest. A sudden increase may indicate ROSC.	
	Apply mechanical compression device if available and indicated:	
	▪ AutoPulse Device:	
	○ 18 years and older (may consider use in a large, younger patient)	
	○ Not for use in patients who do not fit in device	
	○ Not for use in patients with traumatic arrest	
	▪ LUCAS Device:	
	○ 12 years and older (may consider use in a large, younger patient)	
	○ Not for use in patients who do not fit in device	
	For Ventricular Fibrillation/Ventricular Tachycardia:	
	▪ Defibrillate at dose listed below or 360 j for monophasic.	
	▪ **Region 1 EMS Medical Directors recommend starting and continuing at maximum energy, if possible. Below are the recommended manufacturer settings:**	

Defibrillation Settings*	**1st**	**2nd**	**3rd**	**4th +**
Zoll Biphasic	120	150	200	200
Phillips MRX	150	170	200	200
Lifepak/Medtronic	200	300	360	360
Tempus	150	170	200	200

	▪ *If other manufacturer refer to their specific settings*	
	▪ Obtain IV/IO access without pausing compressions:	

	▪ Medications as listed below. Medication Administration Chart:	
	○ Epinephrine 1 mg (1mg/10ml) – repeat every 3-5 minutes as long as CPR continues.	
	○ If Polymorphic VT – Magnesium Sulfate – 2 Grams over 5-10 minutes	
	○ Amiodarone OR Lidocaine (Select one medication – do not use both)	
	• Amiodarone V-Fib/Pulseless VT 300 mg /repeat at 150 mg	
	• Lidocaine (refer to weight-based dosing)	
	○ Consider H's or T's (see below)	
	Resource: H's and T's: - Hypoxia (ventilate/O2) - Tamponade, cardiac (IV boluses) - Hypothermia (core warm) - Tension Pneumothorax (plural decompression) - Hypovolemia (IV boluses) - Thrombosis – coronary/pulmonary - Hypokalemia - * Toxins (opiate-Naloxone/TCA-Sodium Bicarb/Beta Blocker overdose – Glucagon/ Organophosphate overdose - Atropine) - * Hydrogen ion (acidosis) * (ventilate for respiratory/Sodium Bicarbonate for metabolic) - * Hyperkalemia - Calcium Gluconate 1 Gram – may repeat every 5 minutes up to 3 Grams/ * Sodium Bicarbonate 1 meq/kg; may repeat at half dose in 10 minutes	
	For Asystole/PEA:	
	▪ Obtain IV/IO access without pausing compressions:	
	▪ Medications as listed below:	
	○ Epinephrine 1 mg (1mg/10 ml) – repeat every 3-5 minutes as long as CPR continues	
	○ Consider H's or T's (see above)	

TREATMENT: Cardiac Arrest – POST RESUSCITATION

	Obtain 12 Lead as soon as possible. Evaluate/transmit for potential STEMI.	
	Titrate oxygen to the lowest level required to achieve Spo2 ≥ 94-99%.	
	Monitor EtCo2.	
	▪ Do not hyperventilate	
	▪ Optimal EtCo2 is 35-45 (may need to adjust ventilation rate)	
	If hypotensive (systolic <90 mmHG) consider Cardiogenic Shock:	
	▪ Treat underlying dysrhythmias	
	▪ Fluid bolus of 250 ml for patients with clear lungs	
	Consider anti-dysrhythmic given if not given in resuscitation noted above and patient was in V-Fib/V-Tach:	
	▪ Amiodarone (150 mg over 10 minutes)	
	▪ Lidocaine (refer to weight-based dosing)	
	Provide sedation or Pain Management as indicated:	
	▪ Fentanyl – weight-based dosing	
	▪ Morphine – weight-based dosing	
	▪ Midazolam (light dose) – dosing chart	
	Check blood glucose level. Use caution as glucose level may be inaccurate. Administer Dextrose if indicated. Medication Administration Weight-Based Chart.	

PROCEDURE: In-Field Termination

	AHA Guidelines recommends resuscitation for a minimum of 20 minutes.	
	At 20 minutes consider transporting the patient, continuing treatment, or discontinuing treatment.	
	When termination or transport is being considered:	
	▪ Availability of local resources (e.g., time for coroner to arrive if care is terminated vs time of transport)	
	▪ Trauma codes	
	▪ Scene is unsafe	
	▪ Family members present	
	▪ Age/condition of patient	
	▪ $EtCO_2$	
	▪ Obvious death at a crime scene	
	Contact Medical Direction for termination.	
	Any/all equipment that was used to treat the patient such as ET tubes, airway adjuncts, IVs, IOs etc should not be removed from the patient and be left in position that they were in at the time the patient was pronounced.	
	If termination is approved contact Coroner in the county of patient death. The Coroner should be contacted for all out of hospital deaths:	
	▪ Note time of death and confirm signs. Remain on scene until coroner, law enforcement, or other appropriate professional arrives.	
	▪ Do not transport patient who is dead at the scene unless other directed by the coroner.	
	▪ If termination occurs during transport do not cross county lines without approval of the coroner.	

Resuscitation Checklist – Pediatric

	Priority of patient care:	Notes:
	▪ High quality compressions	
	▪ AED/cardiac monitor/defibrillation	
	▪ Ventilations	
	Provide high quality continuous chest compressions with:	
	▪ Full recoil	
	▪ At a rate of 100-120 per minute (consider metronome).	
	▪ Compression depth at approximately one-third anterior/posterior depth of chest	
	○ Approximately two inches in child/1 ½ inches for infant	
	▪ Minimizing any pauses to < 10 seconds.	
	▪ Switching providers (if available) every two minutes.	
	Apply AED/cardiac monitor as soon as possible.	
	▪ Use pediatric dose-attenuator system for children and infants if available. Use pediatric pads. If unavailable, use adult pads.	
	▪ For manual defibrillation use appropriate weight-based energy as appropriate	
	Ventilate the patient:	
	▪ Without advanced airway at a rate of 30:2 for single rescuer/15:2 for two rescuers	
	▪ Consider supraglottic airway when possible without interruption of chest compressions or ETT when other measures are ineffective. Ventilate at a rate of once every 2-3 seconds until chest rise.	
	Attach appropriate capnography sensor:	
	▪ Monitor $EtCO_2$ level, respiratory rate, and waveform. If waveform capnography is not available use colormetric with advanced airway. If patient is under 15 kg use pediatric colormetric.	
	▪ If $EtCO_2$ is below 10 ensure high quality CPR is being performed.	
	▪ Continuously monitor $EtCO_2$ throughout arrest. A sudden increase may indicate ROSC.	
	Apply mechanical compression device if available and indicated:	
	▪ AutoPulse Device:	
	○ 18 years and older (may consider use in a large, younger patient)	
	○ Not for use in patients who do not fit in device	
	○ Not for use in patients with traumatic arrest	
	▪ LUCAS Device:	
	○ 12 years and older (may consider use in a large, younger patient)	
	○ Not for use in patients who do not fit in device	
	For Ventricular Fibrillation/Ventricular Tachycardia:	
	▪ Defibrillate at 2 J/kg. Repeat at 4 J/kg if ineffective. Subsequent doses greater than or equal to 4 J/kg to a max of 10 J/kg or adult dose.	
	▪ Obtain IV/IO access without pausing compressions:	

	▪ Medications as listed below. It is recommended that the Broselow tape or Medication Administration Chart is utilized for dosing pediatric patients.	
	○ Epinephrine– Weight-based dosing. Repeat every 3-5 minutes as long as CPR continues.	
	○ Amiodarone OR Lidocaine **(Select one medication – do not use both)**	
	• Amiodarone V-Fib/Pulseless VT 5 mg/kg - repeat at 5 mg/kg to a max of 15 mg/kg	
	• Lidocaine 1 mg/kg	
	○ Magnesium Sulfate is not recommended for pediatric patients without the use of a pump. Contact Medical Direction for potential orders.	
	○ Consider H's or T's (see below)	
	Resource: H's and T's: - Hypoxia (ventilate/O2) - Tamponade, cardiac (20 ml/kg) - Hypothermia (core warm) - Tension Pneumothorax (plural decompression) - Hypovolemia (20 ml/kg) - Thrombosis – coronary/pulmonary - Hypokalemia - * Toxins (opiate-Naloxone/TCA-Sodium Bicarb/Beta-Blocker overdose – Glucagon/ Organophosphate overdose - Atropine) - * Hydrogen ion (acidosis) * (ventilate for respiratory/Sodium Bicarbonate for metabolic) - * Hyperkalemia - Calcium Gluconate 60 mg/kg weight-based dosing ○ * Sodium Bicarbonate 1 meq/kg weight-based dosing	
	For Asystole/PEA:	
	Obtain IV/IO access without pausing compressions:	
	▪ Medications as listed below:	
	▪ Epinephrine Weight-based dosing. Repeat every 3-5 minutes as long as CPR continues.	
	○ Consider H's or T's (see above)	

TREATMENT: Cardiac Arrest – POST RESUSCITATION

	Obtain 12 Lead as soon as possible. Evaluate/transmit for potential STEMI.	
	Titrate oxygen to the lowest level required to achieve Spo2 ≥ 94-99%.	
	Monitor $EtCo_2$.	
	▪ Do not hyperventilate	
	▪ Optimal $EtCo_2$ is 35-45	
	If hypotensive consider Cardiogenic Shock:	
	▪ Treat underlying dysrhythmias	
	▪ Fluid bolus of 10 ml/kg for patients with clear lungs	
	Consider anti-dysrhythmic given if not given in resuscitation noted above and patient was in V-Fib/V-Tach:	
	▪ Amiodarone V-Fib/Pulseless VT 5 mg/kg – may repeat at 5 mg/kg to a max of 15 mg/kg	
	▪ Lidocaine (refer to weight-based dosing)	
	Provide sedation or Pain Management as indicated:	
	▪ Fentanyl – weight-based dosing	
	▪ Morphine – weight-based dosing	
	▪ Midazolam (light dose) – dosing chart	
	Check blood glucose level. Administer Dextrose if indicated. Use caution as glucose level may be inaccurate. Medication Administration Weight-Based Dosing Chart.	

PROCEDURE: In-Field Termination

	AHA Guidelines recommends resuscitation for a minimum of 20 minutes.	
	At 20 minutes consider transporting the patient, continuing treatment, or discontinuing treatment.	
	When termination or transport is being consider:	
	▪ Availability of local resources (e.g., time for coroner to arrive if care is terminated vs time of transport)	
	▪ Trauma codes	
	▪ Scene is unsafe	
	▪ Family members present	
	▪ Age/condition of patient	
	▪ $EtCO_2$	
	▪ Obvious death at a crime scene	
	Contact Medical Direction for termination.	
	Any/all equipment that was used to treat the patient such as ET tubes, airway adjuncts, IVs, IOs etc should not be removed from the patient and be left in position that they were in at the time the patient was pronounced.	
	If termination is approved contact Coroner in the county of patient death. The Coroner should be contacted for all out of hospital deaths:	
	▪ Note time of death and confirm signs. Remain on scene until coroner, law enforcement, or other appropriate professional arrives.	
	▪ Do not transport patient who is dead at the scene unless other directed by the coroner.	
	▪ If termination occurs during transport do not cross county lines without approval of the coroner.	

Pediatric Normal Vital Signs

NORMAL VITAL SIGNS

Respiratory Rates

Age	Breaths/min
Infant (< 1 year)	30 – 60
Toddler (1-3 years)	24 – 40
Preschool (4-5 years)	22 – 34
School age (6-12 years)	18 – 30
Adolescent (13-18 years)	12 – 16

Heart rates

Age	Awake Pulse/min	Mean	Sleeping Pulse/min
Newborn-3 months	85-205	140	80-160
3 months-2 years	100-190	130	75-160
2-10 years	60-140	80	60-90
> 10 years	60-100	75	50-90

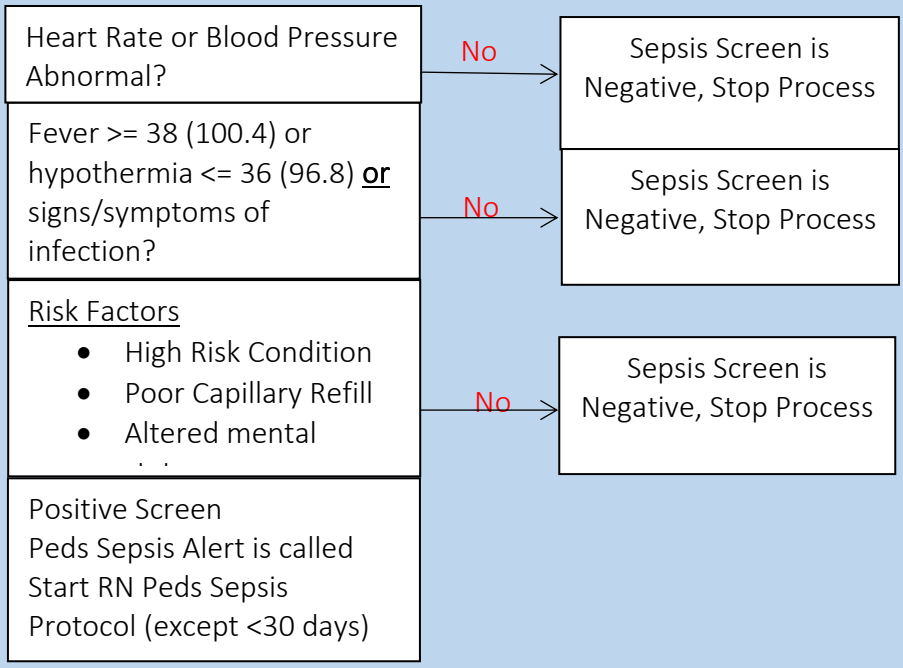
Blood pressure

Age	Systolic		Diastolic	
	Female	Male	Female	Male
1 day	60-76	60-74	31-45	30-44
4 days	67-83	68-84	37-53	35-53
1 month	73-91	74-94	36-56	37-55
3 months	78-100	81-103	44-64	45-65
6 months	82-102	87-105	46-66	48-68
1 year	68-104	67-103	22-60	20-58
2 years	71-105	70-106	27-65	25-63
7 years	79-113	79-115	39-77	38-78
Adolescent (15 years)	93-127	95-131	47-85	45-85

DEGREE OF DEHYDRATION ASSESSMENT

Clinical Parameters	Mild	Moderate	Severe
Body weight loss			
Infant	5% (50 ml/kg)	10% (100 ml/kg)	15% (150 ml/kg
Child	3% (30 ml/kg)	6% (60 ml/kg)	9% (90 ml/kg)
Fontanelle	Flat or depressed	Depressed	Significant depression
Mucous Membranes	Dry	Very dry	Parched
Skin Perfusion	Warm / normal color	Cool extremities / pale	Cold extremities
Heart Rate	Mild tachycardia	Moderate tachycardia	Extreme tachycardia
Peripheral Pulse	Normal	Diminished	Absent
Blood Pressure	Normal	Normal	< 70 + 2x age in years
Sensorium	Normal-irritable	Irritable-lethargic	Unresponsive

Pediatric Sepsis Screening Tool



Did the patient screen positive for Sepsis? (circle one): YES NO

Was a Pediatric Sepsis Alert called? (circle one): YES NO

Vital Sign Limits		
Age	Heart Rate	Systolic BP
0d-3m	>180	<50
3m-1Y	>170	<70
1Y-4Y	>150	<75
4Y-12Y	>130	<80
>=12Y	>120	<85

PEDIATRIC GLASGOW COMA SCORE

AREAS OF RESPONSE	>1 year	< 1 year	GCS
EYE OPENING	Spontaneously	Spontaneously	4
	To ***Verbal Command***	To ***Shout***	3
	To ***Pain***	To ***Pain***	2
	No eye opening response	No eye opening response	1
MOTOR RESPONSE	***Obeys Commands*** to move	***Obeys Commands*** to move	6
	Localized Painful stimuli	***Localized Painful*** stimuli	5
	Withdraws from painful stimulus	***Flexion—normal***	4
	Flexion, abnormal *decorticate* posturing	***Flexion,*** abnormal *decorticate* posturing	3
	Extension, abnormal *decerebrate* posturing	***Extension***, abnormal *decerebrate* posturing	2
	No movement or posturing	No movement or posturing	1

VERBAL RESPONSE	> 5 years	< 2 – 5 years	0 - 23 months	
	Oriented and converses	Appropriate words & phrases for age	Smiles, coos, cries appropriately	5
	Disoriented but converses	Inappropriate words	Cries	4
	Inappropriate words	Cries and/or screams	Inappropriate crying and/or screaming	3
	Incomprehensible	Grunts	Grunts	2
	No response	No response	No response	1
TOTAL POSSIBLE SCORE				**3 - 15**

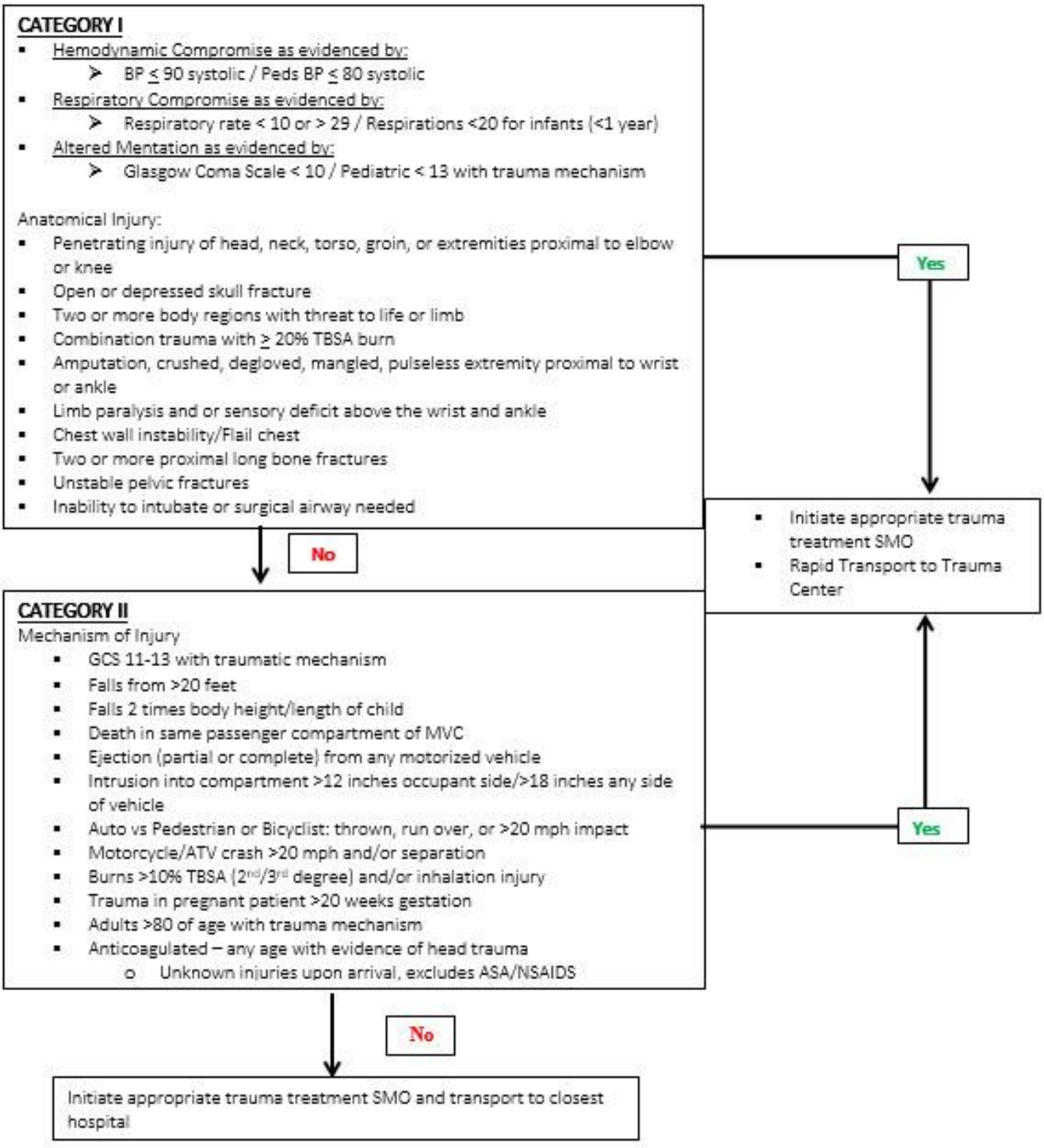
PEDIATRIC TRAUMA SCORE

	VALUES		
COMPONENT	**+2**	**+1**	**-1**
Size	≥ 20 kg	10 – 20 kg	≤ 10 kg
Airway	Normal	Maintainable	Unable to maintain
CNS	Awake	Obtunded	Coma
Systolic BP	≥ 90 mm Hg	50 – 90 mm Hg	≤ 50 mm Hg
Open wound	None	Minor	Major
Skeletal Injuries	None	Closed fracture	Open or multiple fractures

Revised Trauma Score

Glasgow Coma Scale (GCS)	Systolic Blood Pressure (SBP)	Respiratory Rate (RR)	Coded Value
13-15	>89	10-29	**4**
9-12	76-89	>29	**3**
6-8	50-75	6-9	**2**
4-5	1-49	1-5	**1**
3	0	0	**0**

Trauma – In-Field Trauma Triage Guideline



Shock Considerations

	Hypovolemic Shock		Non-hemorrhagic Shock	
	Compensated Shock	De-compensated Shock	Neurogenic Shock	Obstructive (Cardiogenic) Shock
Skin temperature/quality	White, cool, moist	White, cold, waxy	Warm, dry	Cool, clammy
Skin color	Normal to Pale	Pale, cyanotic	Pink	Pale, cyanotic
Blood Pressure	Normal	Decreased	Decreased	Decreased
Pulse	Tachycardia	Tachycardia, that can progress to bradycardia	Bradycardia	Tachycardia
Level of consciousness	Unaltered or slightly anxious	Altered-anxiety, confusion, or unresponsive	Unaltered, can be altered in head injury	Altered
Capillary Refill Time	Normal	Delayed	Normal	Delayed
Pulse Pressure	Normal or narrowed	Decreased	Decreased	Decreased

Region 1 EMS Stroke Screening Checklist:

Date: _____
Time Stroke Report sent via radio/phone from EMS to Receiving Hospital: _____
Signs and Symptoms at time of event:
____Sudden Numbness or weakness of face, arm, leg, especially one side
____Sudden confusion, trouble speaking or understanding
____Sudden trouble walking, dizziness, loss of balance or coordination
____Sudden severe headache with no known cause
____Sudden trouble with vision or seeing in one or both eyes
AND:
____BGM/Glucose Level Checked: RESULT: _____

DATE AND TIME PATIENT LAST KNOWN WELL: _____

DATE AND TIME SYMPTOMS STARTED: _____

CONTACT PERSON AND PHONE NUMBER: _____

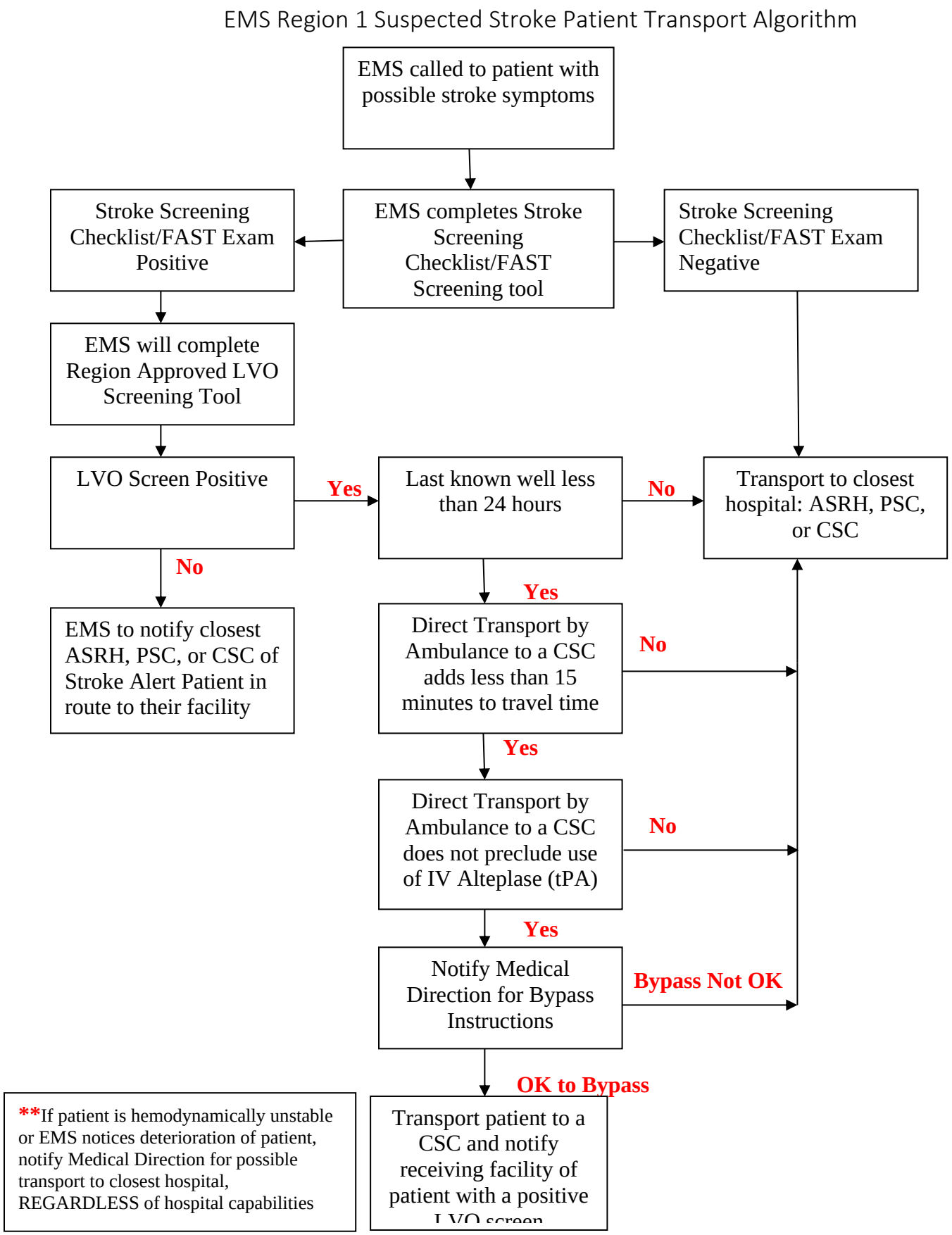
G-FAST Screen:
GAZE DEVIATION: Does the person stare to one side and cannot move their eyes back to center
_____Normal: Patient able to move eyes from side to side and back to midline
_____ABNORMAL: Patient stares to one side and cannot move eyes back to midline or to look elsewhere
FACIAL DROOP: Ask the person to smile and/or show their teeth
_____Normal: Both sides of the face are equal, there is no droop noted to one side
_____ABNORMAL: One side the mouth or face is drooping, drooling or does not look the same
ARM DRIFT: Ask the person to hold both arms out in front of them for the count of 10
_____Normal: Both arms move equally
_____ABNORMAL: One arm drifts down or does not move at all, the other is normal
SPEECH: Have the person say a sentence (example: You can't teach an old dog new tricks.)
_____Normal: Sentence sounds normal, no slurring words and person uses correct words
_____ABNORMAL: Patient unable to speak (mute), words are slurred, incorrect words used
TIME: If the time of Last Known Well is GREATER than 24 hours, then a stroke alert is NOT paged because the patient is outside of acute treatment window.

***If any of the FAST questions is scored abnormal, the chances are high that a stroke may be occurring. If the G for gaze is abnormal, chances are high the patient has a severe stroke with a Large Vessel Occlusion in the brain. Follow the EMS Region 1 Suspected Stroke Patient Transport Algorithm for ED Destination

---

EMS Personnel Signature: _____ Date: _____ Time: _____
Ambulance: _____

Stroke Transport Algorithm



Toxidrome Table

Toxidrome Table			
Toxidrome	**Examples**	**Symptoms**	**Antidotes/Treatment**
ACE Inhibitors	Captopril Enalapril Lisinopril Quinapril	Hypotension	Supportive treatment IV fluids
Anticholinergic	Atropine Jimson Weed Scopolamine Diphenhydramine	Delirium Hyperthermia Tachycardia Warm, dry skin	Supportive treatment
Anti-Psychotic	**Typical:** Chlorpromazine (Thorazine) Haloperidol (Haldol) Trifluoperazine (Stelazine) **Atypical:** Aripiprazole (Abilify) Clozapine (Clozaril) Quetiapine (Seroquel) Risperidone (Risperdal) Ziprasidone (Geodon)	Hypotension Tachycardia QRS prolongation Arrhythmias Flushed skin Altered mental status	Supportive treatment Midazolam (heavy dose)
Blister Agents	Lewisite Nitrogen Mustard Sulfur Mustard Phosgene Oxime	Upper airway irritation Laryngospasm Hypovolemic shock Nausea/Vomiting Erythema with burning	Supportive Treatment Pulmonary Edema Seizure Airway Management Shock
Biological Agents	**Category A** Anthrax Botulism Plague **Category B** Ricin Cholera T2 Mycotoxin **Category C** Viruses that cause: Encephalitis Hantavirus Influenza	Respiratory distress Hypotension Hypoxemia Chest pain Tachycardia Confusion Vomiting Seizures GI bleed Shock Sepsis Diaphoresis	Supportive Treatment Seizure Airway Management CPAP Shock Sepsis

Toxidrome Table			
Toxidrome	**Examples**	**Symptoms**	**Antidotes/Treatment**
Cardiotoxic Drugs	**Beta-blockers:** Metoprolol (Lopressor) Nadolol (Corgard) Propranolol (Inderal) **Calcium channel blockers:** Amiodipine (Norvasc) Verapamil (Verelan) Nifedipine (Procardia) Cardizem (diltiazem)	Bradycardia Conduction issues Hypotension	Supportive Treatment For bradycardia and/or hypotension high dose Glucagon. Atropine Calcium Gluconate IV or IO for symptomatic calcium channel blocker overdose
Cholinergic (Anti-cholinesterase)	**Pesticides:** Carbamates Organophosphates **Nerve Agents:** Sarin Soman Tabun VX	**Muscarinic *** **Nicotinic **** **Central *****	Supportive Treatment Atropine – repeat every 2-5 minutes until airway symptoms subside Pralidoxime (2-PAM) Chem-Pak
Cyanide Agents *Consider: combustible materials from house fires (plastics/furniture*)	**Hydrogen Cyanide (AC):** Formonitrile **Cyanogen Chloride (CK):** Chlorine cyanide	Respiratory arrest Hypotension Nausea/vomiting Chemical conjunctivitis	Supportive treatment Early notification to hospital for cyanide kit
Hallucinogens	PCP LSD Mescaline	Hyperthermia Tachycardia Hypertension	Supportive Treatment Midazolam (heavy dose)
Hydrofluoric Acid	Found in batteries of electric cars	Dermal/Skin Exposure Eye Inhalation Injury	**Calcium Gluconate Gel?**
Opioid	Fentanyl Heroin Hydromorphone Methadone Oxycodone	Depressed mental status Hypoventilation Constricted pupils	Supportive Treatment Naloxone (IN, IM, IV)

*Muscarinic	**Nicotinic	***Central
Diarrhea, Urination, Miosis, Bradycardia, Bronchospasm, Bronchorrhea, Emesis, Lacrimation, Salivation, Sweating	Mydriasis, Tachycardia, Weakness, Hypertension, Hyperglycemia, Fasciculations	Confusion, Convulsions, Coma

Toxidrome Table			
Toxidrome	**Example**	**Symptoms**	**Antidotes/Treatment**
Pulmonary Agents	Phosgene Diphosgene Chlorine Anhydrous Ammonia	Pharyngitis Hypovolemia Shock Chemical Burns	Supportive Treatment CPAP Shock Pulmonary Edema
Riot Control	Tear gas Mace Pepper Spray	Increased heart rate Increased blood pressure	Supportive Treatment Irrigate as appropriate Airway Management CPAP Shock
Sedative – Hypnotic	Amobarbital Barbiturates Benzodiazepines GHB Pentobarbital Rohypnol	Depressed mental status Hypotension Hypothermia	Supportive Treatment
Sodium Channel Blockade	Tricyclic antidepressants ▪ Type 1A – quinidine, procainamide Type 1C – felcainide, propafenone	Altered mental status Hypotension Seizures Wide-Complex Tachycardia	Support Treatment Sodium Bicarbonate for hypotension, seizure, and/or QRS widening > 0.10 seconds. Midazolam (heavy dose) for Seizures
Sympathomimetic	Adderall Cocaine Methamphetamine	Agitation Diaphoresis Hypertension Hyperthermia Dilated pupils Tachycardia	Supportive Treatment Midazolam (heavy dose)

Delayed Sequence Airway Management/Intubation (DSI)

Region I Quality Improvement Form

This form will be completed whenever DSI is utilized by an approved provider and submitted to the Medical Director at your Resource Hospital with a copy of the run sheet attached within 48 hours of drug utilization.

PLEASE PRINT

Patient Name: _____

Date: _____

Ambulance / Rescue Agency: _____ Run #: _____

Induction Agent and Dosage: _____ Number of Times: _____

Paralytic Agent and Dosage: _____ Number of Times: _____

Indications: _____

Allergies: _____

Contraindications: _____

Any complications encountered: _____

_____

Outcome of Patient: _____

Additional Comments: _____

_____

_____

Name of Paramedic administering medication: _____

Send this completed form your EMS Medical Director at your Resource Hospital within 48 hours of DSI event.

HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

State of Illinois
Illinois Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ❑ M ❑ F	
Address (street/city/state/ZIPcode)		

A — CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

Check One

❑ **Attempt Resuscitation/CPR** ❑ **Do Not Attempt Resuscitation/DNR**

(*Selecting CPR means* **Full Treatment** *in Section B is selected*)

When not in cardiopulmonary arrest, follow orders B and C.

B — MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

Check One *(optional)*

❑ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

❑ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

❑ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Optional Additional Orders _____

C — MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.

Check One *(optional)*

❑ Long-term medically administered nutrition, including feeding tubes.

❑ Trial period of medically administered nutrition, including feeding tubes.

❑ No medically administered means of nutrition, including feeding tubes.

Additional Instructions (e.g., length of trial period)

_____

_____

D — DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

❑ Patient ❑ Agent under health care power of attorney

❑ Parent of minor ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature *(required)*	Name (print)	Date

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature *(required)*	Name (print)	Date

E — Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Authorized Practitioner Name *(required)*	Phone
	( ) _____ - _____
Authorized Practitioner Signature *(required)*	Date *(required)*

Form Revision Date - April 2016 (Prior form versions are also valid.)

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2016

IDPH POLST

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THIS SIDE FOR INFORMATIONAL PURPOSES ONLY

Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

❑ Health Care Power of Attorney ❑ Living Will Declaration ❑ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- **The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time.**
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a POLST Form

This POLST form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another, or
- or there is a substantial change in the patient's health status, or
- or the patient's treatment preferences change, or
- or the patient's primary care professional changes.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at
http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Please note: as per the Region 1 Emergency Incident Rehabilitation Policy symptomatic department members will be transported to the hospital.

Emergency Incident Rehabilitation Report

Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ______
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ______
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ______
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ______
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ______
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ______
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ______
Out										

Incident: ______

Location: ______

Date: ______

Printed name of care provider(s) ______ Incident Commander: ______

EMS Coordinator Signature: ______ Date received: ______

Region 1 Medication Restocking Form

State of Illinois
Department of Human Services - Division of Mental Health

PETITION FOR INVOLUNTARY/JUDICIAL ADMISSION

PETITION FOR INVOLUNTARY/JUDICIAL ADMISSION

STATE OF ILLINOIS

CIRCUIT COURT FOR THE _____ JUDICIAL CIRCUIT

_____COUNTY

IN THE MATTER OF

)
)
)
)
)
)

Docket No. _____

_____
(name of respondent)

Who is asserted to be a person subject to _____ In-patient admission to a facility and for whom
(judicial/involuntary)

this petition is being initiated by reason of: (Select one or more, if applicable)

☐ Emergency inpatient admission by certificate; (405 ILCS 5/3-600). The Respondent is currently detained in a mental health facility or hospital; name of facility where detained: _____ .

☐ Inpatient admission by court order; (405 ILCS 5/3-700).

☐ Voluntary admittee submitted written notice of desire to be discharged and two Certificates are attached to/submitted with this petition; (405 ILCS 5/3-403).

☐ Voluntary admittee failed to reaffirm a desire to continue treatment and two Certificates are attached to/submitted with this petition; (405 ILCS 5/3-404).

☐ Person continues to be subject to involuntary admission on an inpatient basis; (405 ILCS 5/3-813).

☐ Emergency admission of the developmentally disabled; (405 ILCS 5/4-400).

☐ Judicial admission of the developmentally disabled; (405 ILCS 5/4-500).

☐ Developmentally disabled person or an interested person on behalf of a person submitted written objection to admission; (405 ILCS 5/4-306).

☐ Administrative person; (or person who executed application) failed to authorize continued residence; (405 ILCS 5/4-310).

☐ Person continues to meet standard for judicial admission; (405 ILCS 5/4-611).

State of Illinois
Department of Human Services - Division of Mental Health

PETITION FOR INVOLUNTARY/JUDICIAL ADMISSION

I assert that _____ is: (check all that apply)

☐ a person with mental illness who: because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed;

☐ a person with mental illness who: because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or others, unless treated on an inpatient basis;

☐ a person with mental illness who: refuses treatment or is not adhering adequately to prescribed treatment; because of the nature of his or her illness is unable to understand his or her need for treatment; and if not treated on an inpatient basis, is reasonably expected based on his or her behavioral history, to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph one or paragraph two above.

☐ an individual who: is developmentally disabled and unless treated on an in-patient basis is reasonably expected to inflict serious physical harm upon himself or herself or others in the near future, and/or

☐ in need of immediate hospitalization for the prevention of such harm.

I base the foregoing assertion on the following (State in detail the signs and symptoms of mental illness displayed by the Respondent. Include prior diagnosis, treatment and hospitalizations. Describe any threats, behavior or pattern of behavior which support your complaint. Include personal observations that lead to your belief the Respondent is subject to involuntary admission): If additional space needed please attach a separate page or pages.

Below is a list of all witnesses by whom the facts asserted may be proven (include addresses and phone numbers):

Listed below are the names and addresses of the spouse, parent, guardian, or substitute decision maker, if any, and close relative or, if none, a friend of the respondent whom I have reason to believe may know or have any of the other names and addresses. If names and addresses are not listed below, I made a diligent inquiry to identify and locate these individuals and the following describes the specific steps taken by me in making this inquiry (additional pages may be attached as necessary):

☐ I do ☐ I do not have a legal interest in this matter.

☐ I do ☐ I do not have a financial interest in this matter.

☐ I am ☐ I am not involved in litigation with the respondent.

☐ Although I have indicated that I have a legal or financial interest in this matter or that I am involved in litigation with the respondent, I believe it would not be practicable or possible for someone else to be the petitioner for the following reasons:

PETITION FOR INVOLUNTARY/JUDICIAL ADMISSION

☐ No certificate was attached with this petition because no physician, qualified examiner or clinical psychologist was immediately available or it was impossible after diligent effort to obtain a certificate. However: I believe, as a result of my personal observation, that the respondent is subject to Involuntary inpatient admission. A diligent effort was made to obtain a certificate; but no physician, qualified examiner or clinical psychologist could be found who has examined or could examine the respondent; and
a diligent effort has been made to convince the respondent to appear voluntarily for examination by a physician, qualified examiner or clinical psychologist, or I reasonably believe that effort would impose a risk of harm to the respondent or others.

☐ One Certificate of Examination is attached.

☐ Two Certificates of Examination are attached.

Did a peace officer detain respondent, take him/her into custody, and/or transport him/her to the mental health facility?

☐ No ☐ Yes; If yes, the peace officer **MAY** complete the petition or if the petition IS NOT COMPLETED by the peace officer transporting the person, the following information MUST be entered:

Transporting Officer's Name: _____ Badge Number: _____

Employer: _____

The petitioner can request to be notified if the facility director approves the recipients's request for voluntary or informal admission prior to adjudication. The petitioner may also request to be notified of the recipient's discharge under section 3-902 (d) of the Mental Health and Developmental Disabilities Code. Failure to indicate a choice will be treated as a decision NOT to be notified.

☐ if the individual requests and is approved for voluntary or informal admission prior to adjudication, I wish to be notified using the contact information supplied below. (Hospital staff use form IL462-2203 for notification purposes).

☐ if the individual is committed or discharged by court, I wish to be notified using the contact information supplied below. (Hospital staff use form IL462-2208M for notification purposes).

☐ I do not wish to be notified in either of the two situations described above.

The petitioner has made a good faith attempt to determine whether the recipient has executed a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act and to obtain copies of these instruments if they exist.
I have read and understood this petition and affirm that the statements made by me are true to the best of my knowledge.
I further understand that knowingly making a false statement on this Petition is a Class A Misdemeanor.

_____ _____
Date Signed

_____ _____
Time Printed Name

_____
Relationship to Respondent

Address

_____
Telephone Number

State of Illinois
Department of Human Services - Division of Mental Health

PETITION FOR INVOLUNTARY/JUDICIAL ADMISSION

Within 12 hours of admission to the facility under this status and/or completion of a new petition, I gave the respondent a copy of this Petition (IL462-2005). I have explained the Rights of Admittee to the respondent and have provided him or her with a copy of it. I have also provided him or her with a copy of Rights of Individuals Receiving Mental Health and Developmental Services (IL462-2001) and explained those rights to him or her (405 ILCS 5/3-609).

Date/Time of Admission _____ Signed: _____

To Mental Health Facility/Psychiatric Unit

Printed Name: _____

Date/Time
Petition Completed: _____ Title: _____

RIGHTS OF ADMITTEE

1. If you have been brought to this facility on the basis of this petition alone, you will not be immediately admitted, but will be detained for examination. You must be examined by a qualified professional within 24 hours or be released.

2. When you are first examined by a physician, clinical psychologist, qualified examiner, or psychiatrist, you do not have to talk to the examiner. Anything you say may be related by the examiner in court on the issue of whether you are subject to involuntary or judicial admission.

3. At the time that you have been certified you will be admitted to the facility and a copy of the petition and certificate will be filed with the court. A copy of the petition shall also be given to you.

4A. If you are alleged to be subject to involuntary admission (mentally ill) you must also be examined within 24 hours excluding Saturdays, Sundays, and holidays by a psychiatrist (different from the first examiner) or be released. If you are alleged to be subject to involuntary admission the court will set the matter for a hearing.

4B. If you are alleged to be subject to judicial admission (developmentally disabled) the court will set a hearing upon receipt of the diagnostic evaluation which is required to be completed within 7 days.

5A. If you are alleged to be subject to involuntary admission (mentally ill) and if the facility director approves, you may be admitted to the facility as a voluntary admittee upon your request any time prior to the court hearing.

The court may require proof that voluntary admission is in your best interest and in the public interest.

5B. If you are alleged to be subject to judicial admission (developmentally disabled) and if the facility director approves, you may decide that you prefer to admit yourself to the facility rather than have the court decide whether you ought to be admitted. You may make the request for administrative admission at any time prior to the hearing. The court may require proof that administrative admission is in your best interest and the public interest.

6. You have the right to request a jury.

7. You have the right to request an examination by an independent physician, psychiatrist, clinical psychologist, or qualified examiner of your choice. If you are unable to obtain an examination, the court may appoint an examiner for you upon your request.

8. You have the right to be represented by an attorney. If you do not have funds or are unable to obtain an attorney, the court will appoint an attorney for you.

9. You have the right to be present at your court hearing.

10. As a general rule, you do not lose any of your legal rights, benefits, or privileges simply because you have been admitted to a mental health facility (see your copy of the "Rights of Individuals"). However, you should know that persons admitted to mental health facilities will be disqualified from obtaining Firearm Owner's Identification Cards, or may lose such cards obtained prior to admission.

11. Information about the health care services you receive at a mental health or developmental disabilities facility is protected by privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.O. 104-191) at 45 CFR 160 and 164. Your personally identifiable health information will only be used and/or released in accordance with HIPAA and the Illinois Mental Health and Development Disabilities Confidentiality Act [740 ILCS 110].

PETITION FOR INVOLUNTARY/JUDICIAL ADMISSION

I certify that I provided respondent with a copy of this form. (pages 1-5) on _____

☐ English ☐ Spanish ☐ Other Specify language: _____ Time: _____

Signature: _____

Title: _____

Printed Name: _____

A Guardianship and Advocacy Commission has been created which consists of three divisions: Legal Advocacy Services, Human Rights Authority and the Office of the State Guardian. The Commission is located at:

Chicago Regional Office
160 N. La Salle Street
Suite S500
Chicago, IL 60601
Phone: (312) 793-5900
Fax: (312) 793-4311
TTY: (866) 333-3362

Springfield Regional Office
830 S. Spring Street
Springfield, IL 62704
Phone: (217) 785-1540
Fax: (217)524-0088
TTY: (866) 333-3362

Equip for Equality, Inc. is an independent, not-for-profit organization that administers the federal protection and advocacy system to people with disabilities in Illinois. Equip for Equality, Inc., provides self-advocacy assistance, legal services, education, public policy advocacy, and abuse investigations. The office is located at: **Website:** www.equipforequality.org

Main/Chicago Office
20 N. Michigan, Ste 300
Chicago, Illinois 60602
(800) 537-2632 or
(312) 341-0022
TTY: (800) 610-2779
Fax: (312) 800-0912

The information you provide on this form is protected by privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) ([PL 104-191] at 45 CFR 160 and 164). Your personally identifiable health Information will only be used and/or released in accordance with HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

I have explained these rights to the individual (or the guardian of the individual, if applicable) and have provided him or her a copy of it. A copy of this form has been filed in the individual's clinical record.

_____
Staff signature

_____
Staff Name and Title

_____
Date and Time

_____
Signature of Individual Receiving Services

☐ Check here if individual refuses to sign

_____
Witness' Name (required only if individual refuses to sign)

_____
Witness' Signature (required only if individual refuses to sign)

EMS REGION 1

ON-SITE PHYSICIAN RESPONSIBILITY ACKNOWLEDGMENT

Thank you for your offer of assistance. Be advised the attending EMS Region 1 personnel are operating under the authority of Illinois law. No physician or other person may intercede in patient care without the EMS Region 1 Medical Director, or his or her appropriate designee, relinquishing responsibility of the scene or otherwise giving approval in accordance with EMS Region 1 SMOs.

If YOU ARE A PHYSICIAN AND DESIRE TO ACCEPT RESPONSIBILITY FOR AND DIRECTION OF THE CARE OF THE PATIENT(S) AT THE SCENE:

1. You **MUST** show your medical license wallet card to the EMT and state your specialty.

2. You **MUST** accompany any patient whose care you direct to the medical facility in the ambulance or other attending medical vehicle.

3. Your direction of a case **MUST** be approved by the EMS Region 1 Medical Director or his or her appropriate designee.

Please print except for your signature:

I, _____ M.D. / D.O., assume full responsibility for the pre-hospital direction of medical care of the patient(s) identified below during this ambulance call, and I will accompany the patient(s) to the medical facility. I understand that the Region 1 EMS Medical Director, or his or her appropriate designee, retains the right to resume responsibility for the medical care of such patient(s) at his or her discretion in accordance with Region 1 EMS SMOs at any time, and that the care of the patient(s) will be relinquished to the appropriate Region 1 personnel upon arrival at the medical facility.

Patient Identification (*please initial and provide information as appropriate*):

_____ All patients at the scene, **OR**

_____ The following patients: _____

_____

_____

_____ _____/_____/_____

Physician Signature (M.D. / D.O.) Date

Region 1 EMS Provider to complete: Date _____/_____/_____ Run Identification _____ EMS Provider Initials _____

Region One Prehospital Refusal

Date: ___/___/___ Location of Call: _____ Type of Call: _____

Time: _____ Dispatched: _____ Enroute: _____ Arrived:_____ Completed:_____

Agency: _____ Unit #:_____ Call #:_____

Patient Information

Name: _____ Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

D.O.B.:___/___/___ Age: _____ Gender: ☐ Male ☐ Female

Assessment of Patient

Medical Hx: _____ ___ Allergies: _____

Medications: _____

BP: ____/____ Pulse: _____ Resp.: _____ Skin: _____ Pupils: R-_____ / L-_____ ☐ Refused V/S

Check appropriate response: ***Draw an "X" through the most appropriate box – Y is yes and N is no***

Is the patient oriented to: **Person** **Y** **N** **Place** **Y** **N** **Time** **Y** **N** **Situation** **Y** **N**

*****NOTE: Any "No" answer from above requires contact of Medical Control***

Suspicion of intoxication? **Y** **N**

***** NOTE: A "YES" answer requires contact of Medical Control***

Medical Direction Contacted? **Y** **N** M.D. / ECRN Name: _____

Patient left in care of: _____ Phone Number: (____) _____

Release from Medical Responsibility

I, _____ hereby release the Hospital, EMS System and it's physicians, nurses and employees and the EMS Service and it's EMTs of any responsibility and liability for the worsening of my condition. I acknowledge that I have been informed of the risks and I voluntarily assume all responsibilities in making this decision.

Adult Patient or Guardian initial next to the box(es) with the most appropriate statement(s)

_____ ☐ I do not consider myself to be injured or ill and do not wish to receive medical services, treatment, or transport.
_____ ☐ I have been advised to seek first aid or medical treatment, which I am refusing.
_____ ☐ I have received emergency medical treatment and am now refusing further care or transport to a medical facility.
_____ ☐ I have received emergency medical treatment and am consenting to transport to a medical facility but, I am refusing the following: _____
_____ ☐ I am refusing transport to the nearest hospital.
_____ ☐ I am requesting transport to _____ Hospital. I have been informed that this facility lies outside the responding agency's territorial range of transport. I am refusing transport to a hospital within this territorial range.

RISKS

All refusals of treatment have the inherent risks of threatening the health, medical safety and possible survival of the patient. All transfers have the inherent risks of traffic delays, accidents during transports, inclement weather, rough terrain, and the limitations of equipment and personnel present in the vehicle, all of which may be the potential threat to the health, medical safety and possible survival of the patient. Transfers to a more distant hospital may increase these risks. The following risks have been explained to the patient, the patient's guardian and/or power of attorney for healthcare.

_____ ☐ Deterioration of Medical Condition, up to and including death
_____ ☐ Deterioration of Medical Condition of Pregnant and/or unborn Child/Delivery
_____ ☐ I have received a "Refusal / Discharge Instruction" form.

_____ X_____ ___/___/___
Printed name of patient / person authorized to consent for patient — Signature of patient / person authorized to consent for patient — Date

_____ X _____ ___/___/___
Printed name of witness — Signature of witness — Date

Comments:_____

_____

X _____ X _____
Signature of Crewmember #1/License # — Signature of Crewmember #2 License #

Refusal / Discharge Instructions

UNIVERSAL INSTRUCTIONS:

• YOU HAVE NOT RECEIVED A COMPLETE MEDICAL EVALUATION. SEE A PHYSICIAN AS SOON AS POSSIBLE.

• IF AT ANY TIME AFTER YOU HAVE TAKEN ANY MEDICATION, YOU HAVE TROUBLE BREATHING, START WHEEZING, GET HIVES OR A RASH, OR HAVE ANY UNEXPECTED REACTION, CALL 911 IMMEDIATELY.

• IF YOUR SYMPTOMS WORSEN AT ANY TIME, YOU SHOULD SEE YOUR DOCTOR, GO TO THE EMERGENCY DEPARTMENT OR CALL 911.

ABDOMINAL PAIN:

- Abdominal pain is also called belly pain. Many illnesses can cause abdominal pain and it is very difficult for EMS to identify the cause.
- Take your temperature every 4 hours.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- Your pain gets worse or is now only in 1 area
- You vomit (throw up) blood or find blood in your bowel movement
- You become dizzy or faint
- Your abdomen becomes distended or swollen
- You have a temperature over 100° F
- You have trouble passing urine
- You have trouble breathing

BACK PAIN:

- Apply heat to the painful area to help relieve pain. You may use a warm heating pad, whirlpool bath, or warm, moist towels for 10 to 20 minutes every hour.
- Stay in bed as much as possible the first 24 hours.
- Begin normal activities when you can do them without causing pain.
- When picking things up, bend at the hips and knees. Never bend from the waist only.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- You have shooting pain into your buttocks, groin, legs, or arms or the pain increases.
- You have trouble urinating or lose control of your stools or urine.
- You have numbness or weakness in your legs, feet, arms, or hands.

FEVER:

- Always take medication as directed. Tylenol and Ibuprofen can be taken at the same time.
- If you are taking antibiotics, take them until they are gone, not until you are feeling better.
- Drink extra liquids (1 glass of water, soft drink or Gatorade per hour of fever for an adult)
- If the temperature is above 103° F, it can be brought down by a sponge bath with room temperature water. Do not use cold water, a fan, or an alcohol bath.
- Temperature should be taken every 4 hours.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- Temperature is greater than 101° F for 24 hours
- A child becomes less active or alert.
- The Temperature does not come down with Acetaminophen (Tylenol) or Ibuprofen with the appropriate dose.

HEAD INJURY:

- Immediately after a blow to the head, nausea, and vomiting may occur.
- Individuals who have sustained a head injury must be checked, and if necessary awakened, every 2 hours for the first 24 hours.
- Ice may be placed on the injured area to decrease pain and swelling.
- Only drink clear liquids such as juices, soft drinks, or water the first 12 hours after injury..
- Acetaminophen (Tylenol) or Ibuprofen only may be used for pain.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- The injured person has persistent vomiting, is not able to be awakened, has trouble walking or using an arm or leg, has a seizure, develops unequal pupils, has a clear or bloody fluid coming from the ears or nose, or has strange behavior.

INSECT BITE/STING:

- A bite or sting typically is a red lump which may have a hole in the center. You may have pain, swelling and a rash. Severe stings may cause a headache and an upset stomach (vomiting).
- Some individuals will have an allergic reaction to a bite or sting. Difficulty breathing or chest pain is an emergency requiring medical care.
- Elevation of the injured area and ice (applied to the area 10 to 20 minutes each hour) will decrease pain and swelling.
- Diphenhydramine (Benadryl) may be used as directed to control itching and hives.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- You develop any chest pain or difficulty breathing.
- The area becomes red, warm, tender, and swollen beyond the area of the bite or sting.
- You develop a temperature above 101° F.

RESPIRATORY DISTRESS:

- Respiratory Distress is also known as shortness of breath or difficulty breathing.
- Causes of Respiratory Distress include reactions to pollen, dust, animals, molds, foods, drugs, infections, smoke, and respiratory conditions such as Asthma and COPD. If possible avoid any causes which produce respiratory distress.
- If you have seen a physician for this problem, take all medication's as directed.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- Temperature is greater than 101° F.
- The cough, wheezing, or breathing difficulty becomes worse or does not improve even when taking medications.
- You have Chest Pain.
- Sputum (spit) changes from clear to yellow, green grey, or becomes bloody.
- You are not able to perform normal activities.

EXTREMITY INJURY:

- Extremity Injuries may consist of cuts, scrapes, bruises, sprains, or broken bones (fractures).
- Apply ice on the injury for 15 to 20 minutes each hour for the first 1 to 2 days.
- Elevate the extremity above the heart as possible for the first 48 hours to decrease pain and swelling.
- Use the extremity as pain allows.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- Temperature is greater than 101° F.
- The bruising, swelling, or pain gets worse despite the treatment listed above.
- Any problems listed on the **Wound Care instructions** are noted.
- You are unable to move the extremity or if numbness or tingling is noted.
- You are not improved in 24 to 48 hours or you are not normal in 7 to 10 days.

VOMITING/DIARRHEA:

- Vomiting (throwing up) can be caused by many things. It is common in children, but should be watched closely.
- Diarrhea is most often caused by either a food reaction or infection.
- Dehydration is the most serious problem associated with vomiting or diarrhea.
- Drink clear liquids such as water, apple juice, soft drinks, or Gatorade for the first 12 hours or until things improve. Adults should drink 8 to 12 glasses of fluids per day with diarrhea. Children should drink 1 cup of fluid for each loose bowel movement.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- Temperature is greater than 101° F.
- Vomiting or Diarrhea lasts longer than 24 hours, gets worse, or blood is noted.
- You cannot keep fluids down or no urination is noted in 8 hours.

WOUND CARE:

- Wounds include cuts, scrapes, bites, abrasions, or puncture wounds.
- If the wound begins to bleed, apply pressure over the wound with a clean bandage and elevate the wound above the heart for 5 to 10 minutes.
- Unless instructed otherwise, clean the wound twice daily with soapy water, and keep the wound dry. It is safe to take a shower but do not place the wound in bath or dish water.
- See a physician for a tetanus shot if it has been 10 years or more since your last one.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- See the **Extremity Injury instructions**.
- Temperature is greater than 101° F.
- Bruising, swelling, or pain gets worse or bleeding is not controlled as directed above.
- Any signs of infection, such as redness, drainage of yellow fluid or pus, red streaks extending from the wound, or a bad smell is noted.

Refusal / Discharge Instructions

UNIVERSAL INSTRUCTIONS:

• YOU HAVE NOT RECEIVED A COMPLETE MEDICAL EVALUATION. SEE A PHYSICIAN AS SOON AS POSSIBLE.

• IF AT ANY TIME AFTER YOU HAVE TAKEN ANY MEDICATION, YOU HAVE TROUBLE BREATHING, START WHEEZING, GET HIVES OR A RASH, OR HAVE ANY UNEXPECTED REACTION, CALL 911 IMMEDIATELY.

• IF YOUR SYMPTOMS WORSEN AT ANY TIME, YOU SHOULD SEE YOUR DOCTOR, GO TO THE EMERGENCY DEPARTMENT OR CALL 911.

Chest Pain:

- There are many causes of chest pain.
- Some of the causes include: heart problems, heartburn, esophagus disorders, pneumonia, pleurisy, pulmonary embolism, panic attacks or inflammation in your chest.
- Some of these problems can be serious and life threating.
- Chest Pain should be evaluated by a physician.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- If increase in pain or pressure in chest.
- Sweating
- Unexplained weakness, dizziness, lightheadedness
- Shortness of breath
- Nausea or vomiting
- Fast or irregular heart beat

Syncope - Fainting :

- Fainting is a temporary loss of consciousness.
- There are many causes for fainting.
- Fainting usually occurs when your blood pressure drops suddenly and a decrease in blood flow to the brain results.
- Some of the causes include: heart problems, drop in blood sugar, certain medication, emotional distress, standing up too quickly, heat or dehydration.
- Syncope/Fainting should be evaluated by a physician.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- Unexplained weakness, dizziness, lightheadedness continues.
- Shortness of breath
- Nausea or vomiting
- Pain or pressure in the chest
- Fast or irregular heart beat

Hypertension – High Blood Pressure:

- High blood pressure is a common condition that may cause health problems, such as heart disease.
- You can have high blood pressure for years without any symptom.
- Uncontrolled high blood pressure increases your risk of serious health problems including heart attack and stroke.
- High blood pressure is generally defined as a pressure over 140/90.
- Have you blood pressure checked regularly and see a physician if it is high.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- You have other symptoms such as headache, dizziness, shortness of breath, chest pain or nosebleeds.

Low Blood Sugar:

- Causes of low blood sugar: too little food, too much insulin or diabetes pills and/or more active than usual.
- The onset is often sudden.
- Some Symptoms include: shaky, sweating, fast heartbeat, blurry vision, headache, irritable, weakness or fatigue.
- If you feel like your blood sugar is low, check your blood glucose. If you can't check your glucose, treat anyway.
- Treat by eating glucose tablets, candies, fruit juice or regular soda pop.
- Check blood glucose again.
- Eat something in addition to the sugar. Eat something with protein and/or carbohydrates to last longer.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- If symptoms do not improve or stop.

High Blood Sugar:

- Causes of high blood sugar: too much food, too little insulin or diabetes's pills, illness or stress.
- The onset often starts slowly.
- Some Symptoms include: extreme thirst, ,need to urinate often, dry skin, hungry, drowsy, slow healing of wounds.
- Check blood glucose.
- If your blood glucose is higher than your goal and you don't know why call your healthcare provider.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- If symptoms do not improve or stop.

Unsafe Situation:

- Are you currently in a relationship / situation where you feel unsafe or threatened?

Information about shelter and alternatives is available 24 hours a day by contacting the Domestic Violence Hotline at:

- **Illinois hotline 877-863-6338**
- **National hotline 800-799-7233 / TTY 800-787-3224**
- **http://www.ilcadv.org/**

Narcan:

- You have received Narcan for an apparent Narcotic overdose. You were unconscious and breathing was compromised. Narcan was administered to save your life.
- **We strongly recommend that you go to the hospital for additional medical care.** The Narcan may wear off before the Narcotic is out of your system. If that happen you could die
- We cannot take you against your will.
- We recommend that you do not do any more drugs or alcohol.

Local Phone Numbers

Refusing against EMS advice:

Patients that have apparent decision making capacities have the right to refuse. We recommend the following:

- You seek medical care.
- You stay with a responsible adult who will observe you and call 911 if needed.
- **Please call 911 or seek medical attention if you change your mind.**

Region One Multiple Patient Prehospital Refusal Form

Date: ___/___/___ Location of Call: _____

Time: Dispatched: _____ Enroute: _____ Arrived: _____ Completed: _____

Agency: _____Unit #:_____Call #:_____

Type of Incident: _____

_____

Medical Control Contacted? Y N M.D. / ECRN Name: _____

RELEASE FROM RISKS OF MEDICAL RESPONSIBILITY

I, ***listed below,*** hereby release the Hospital, EMS System and its physicians, nurses, and employees and the EMS agency and its' Personal of any responsibility and liability for the worsening of medical condition of multiple victims involved in this incident. I acknowledge that I have been informed of the risks and I voluntarily assume all responsibility. I acknowledge that all refusals carry the inherent risks of deterioration of medical condition up to and including death.

Print Name **Signature** **DOB**

1. _____ _____ _____

Address_____

2. _____ _____ _____

Address_____

3. _____ _____ _____

Address_____

4. _____ _____ _____

Address_____

5. _____ _____ _____

Address_____

6. _____ _____ _____

Address_____

7. _____ _____ _____

Address_____

_____ _____

Signature of EMS crew #1 **Signature of EMS crew #2**

If School Bus Accident, signature of authorized school designee: _____

Region 1 Request for Clarification Form
(formerly Unusual Occurrence Form)

All information contained within this form is private and confidential pursuant to the Illinois Medical Studies Act and is for official use only.

Incident Information:

Date of Report: Date of Incident: Time of Incident:

Incident Location:

Type of Incident (Check all the apply):

☐ Medications	☐ Procedure	☐ Patient Injury	☐ Other Patient Related
☐ Equipment	☐ SMO/SOP Deviation	☐ Provider Injury	☐ ED Staff Related
☐ Communication	☐ Assessment/Intervention	☐ Other Provider Related	☐ Other

Agency / Organization Involved: Receiving Hospital:

EMS Report Number: ECRN Log Number:

EMS System Personnel Involved (List All):

Non-EMS Personnel Involved

Report Initiated By:

Incident Description/Details:

STOP Do not write below this line. For Administrative use only.

EMS System Review:

Disposition:

☐ Unfounded ☐ Re-Education ☐ Verbal Warning ☐ Written Warning ☐ Suspension ☐ Other

Region 1 EMS Coordinator Contacted: ☐ Yes ☐ No Date:

EMS Coordinator Signature: Date:

EMS Medical Director Signature: Date:

Region 1- Patient Care Report-Short/Non-Transport Form

Company _____ Unit # _____ Date _____

Receiving Facility _____ Time _____

Patient Name _____

Address: _____

Age _____ DOB _____

Vital Signs: HR _____ RR _____ B/P _____ O2 Sat _____

Chief complaint /Mechanism of Injury _____

Crew Telephone Contact # _____

Crew Member #1 _____

Crew Member #2 _____

LOC
Alert ☐
Verbal ☐
Pain ☐
Unresponsive ☐

Glascow Coma Scale: _____

Lung Sounds
Clear ☐
Bilateral ☐
Wheezes ☐
Rales/Crackles ☐
Ronchi ☐
Diminished ☐

Gluco Check: _____

Treatments
IV/IO Rate _____ TKO ☐
Monitor On: Yes ☐ No ☐
Time: _____

12 Lead: Yes ☐ No ☐ Time: _____
STEMI: Yes ☐ No ☐
Transmitted: Yes ☐ Time: _____ No ☐
Interpretation:
NSR ☐ Brady ☐ Tach ☐ Other _____

Stroke Assessment
G - + -
F - + -
A - + -
S - + -
T - _____
Last seen normal

Skin
Normal ☐
Pale ☐
Flushed ☐
Moist ☐
Diaphoretic ☐

Pain
Yes ☐
No ☐
Severity (1-10)
On Arrival _____
At Hospital _____

Oxygen
liters/Minute _____
Nasal Cannula ☐
NRB ☐
ETT ☐
King Airway ☐
CPAP ☐

Immobilization
Yes ☐ No ☐
Long Board ☐
Cervical Collar ☐
HIM ☐

Time	BP	Pulse	Resp	02 Sat	Temp

Time	Rhythm	Time	Rhythm

Medications

Med	Time/Dose	Time/Dose	Time/Dose

Defibrillation X _____

Medical History:

Patient's Meds: None ☐

Allergies: None ☐
List:

Other Information:

Final Report Completed-Date _____ Time: _____

Final Report Faxed To Rec Hosp. Date _____ Time _____