



Hospital Admission Sticker

Your agency logo
Inserted Here

PATIENT FIELD REPORT

TO BE TURNED IN TO HOSPITAL WITH PATIENT
THIS DOES NOT REPLACE YOUR PPCR/PCR/ELECTRONIC PCR

DATE: ___/___/___ EMS AGENCY: (Your agency name)

Provider Name: Agency Phone #

PT NAME: AGE:

PT ADDRESS

PT PHONE

SSN: - - RACE: SEX: DOB: / /

LOCATION OF CALL:

Mechanism of Injury / Nature of Illness:

CHIEF COMPLAINT: PAST MEDICAL HISTORY:

ALLERGIES: N.K.A. / PCN / SULFA/ ASA/ OTHER:

MEDS:

PATIENT EXAM:

Medication Wasted Nurse or Pharmacist

Old Drug Box # New Drug Box # Controlled Substances present:
Fentanyl 50 mcg/ml x 2 Yes No Midazolam 5 mg/ml x 2 Yes No
Pharmacist or Pharmacy Technician signature

TIMES: On Scene: Enroute to ED Arrival at ED

AVPU PUPILS: PERL Dilated Constricted

BASELINE VITALS: Time BP: Resp:

Pulse: Skin: Hot Warm Cool Cold

2nd VITALS: Time BP: Resp: Pulse:

SKIN: Hot Warm: Cool: Cold:

MED: Amount: Route: Time:

MED: Amount: Route: Time:

IV #1: GAUGE: SITE: FLUID: RATE:

ESTIMATED TOTAL IV FLUID INFUSED

OXYGEN: LPM: NC NRB BVM

SPO2 END-TIDAL CO2 GLUCOSE

CARDIAC ARREST: Un-Witnessed Witnessed Start Time

Total Time without CPR Total Time of CPR

SHOCKS TIMES #1 #2 #3 #4

Onset of Chest Pains Onset of Stroke Signs

12 Lead Rhythm if available (Please Attach) Onset of Symptoms

Initial Rhythm: STEMI ALERT: Yes No

GCS Score: Eyes Verbal Motor Total

DOCTOR'S SIGNATURE

See the complete Patient Care Report for further details