PREHOSPITAL RUN REPORT

Pt /	Date	Call recvd from: ☐ 911 ☐ PVT Other:	Agency:	Response Location:	Incident #:

Incident Location City Zip

Call Type: ☐ BLS ☐ ALS ☐ Dry Run/Cancelled ☐ IFT
Pt. Type: ☐ Medical ☐ Trauma ☐ Burn Pt.

Patient Name	Sex	WT (Kg):	Age	DOB:

Mailing Address City: Zip

Chief Complaint

History of Incident

Medications ☐ See attached list

Med Hx:
☐ Kidney
☐ AMI ☐ HTN ☐ Diabetes
☐ COPD ☐ Stroke ☐ CA

PMD: / Specialist

	Time	Code	Odometer
Incident Occurred			
Received Call			
Enroute			
Arrival At Scene			
Patient Contact			
Depart Scene			
Destination			
Available		Ttl Mi:	

Allergies
☐ NKDA ☐ PCN ☐ ASA ☐ Sulfa ☐ MS ☐ Iodine

Hlmt:
Stblt:
Drv Arbg?
Pass Arbg?

CARE PRIOR TO ARRIVAL: FR Agency or Unit #
☐ FD/BLS ☐ FD/ALS ☐ Law ☐ Ctz ☐ Med

Report Called to: ☐ Phone ☐ Radio ☐ RCF Time:
☐ Standardized Procedure

Disposition: ☐ Transported ☐ Expired ☐ AMA ☐ Other
Receiving Facility:
☐ Pt. Reqst ☐ Diversn ☐ Closest ☐ Trma Ctr ☐ Special

AED Information		Trauma Information	Trauma Triage Criteria
Witnessed Arrest?	Time CPR Started:	Trauma Alert Called:	☐ Physiologic Factors
Bystandander CPR?	Intl. Rhythm: ☐ VT ☐ VF ☐ Unkn	☐ Intentional ☐ Unintentional ☐ Unkn	☐ Anatomic Factors
Was Patient Shocked?	Number of Shocks:	Time of Injury: ☐ Unkn	☐ Mechanism of Injury w/CoMorbid
Pulse after shock?	Other:	Position: ☐ Drvr ☐ Pass ☐ Frnt ☐ Back	☐ Clinical Suspicion
DC from Hospital?		Est. Speed:	Other:

Skin Color	Temperature	Moisture	Cap Refill
☐ ***Pk/Nml***	☐ ***Warm***	☐ ***Dry/Nml***	☐ ***Normal***
☐ Pale/Ash	☐ Cool	☐ Moist	☐ Delayed
☐ Flushed	☐ Cold	☐ Diaph.	☐ None
☐ Cyanotic	☐ Hot		Blood Sugar (mg/dl)
☐ Mottled			

Pupils	L	R
Normal	☐	☐
Constricted	☐	☐
Dilated	☐	☐
Sluggish	☐	☐
Non-Reactive	☐	☐
Size (mm)	___	___

Glasgow Coma Scale

Eye Opening (1st / 2nd)		Verbal (1st / 2nd)		Motor	
☐ ☐ ***Spont***	4	☐ ☐ ***Oriented***	5	☐ ☐ ***Obeys***	6
☐ ☐ To Voice	3	☐ ☐ Confused	4	☐ ☐ Purposeful	5
☐ ☐ To Pain	2	☐ ☐ Inapprop	3	☐ ☐ Withdraw	4
☐ ☐ None	1	☐ ☐ Incomp	2	☐ ☐ Flexion	3
		☐ ☐ None	1	☐ ☐ Extension	2
				☐ ☐ None	1

Time (1st)	Total GCS	Time (2nd)	Total GCS

Time	BP	Pulse Rate	Pulse Description	Resp. Rate	SpO_2	$ETCO_2$	Lung Sounds Left	Lung Sounds Right	PAIN Scale	Cardiac Rhythm (attach rhythm strip/EKG)	Defib (joules)
									/10		
									/10		
									/10		
									/10		

P	Q	R	S	T

Time	Medication/Procedure	Size / Dose	Route	By Whom?	Remarks/Response

Narrative:

Team Member #1 - Pt Care	Team Member #2 - Transport	Team Member #3	Receiving Facility
Signature, Cert. Level & Number	Signature, Cert. Level & Number	Title:	Received by: ☐ Report on Arrival

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SUPPLEMENTAL NARRATIVE

Patient Name:

Agency Name:

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Form Completed by: **Cert #:**

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