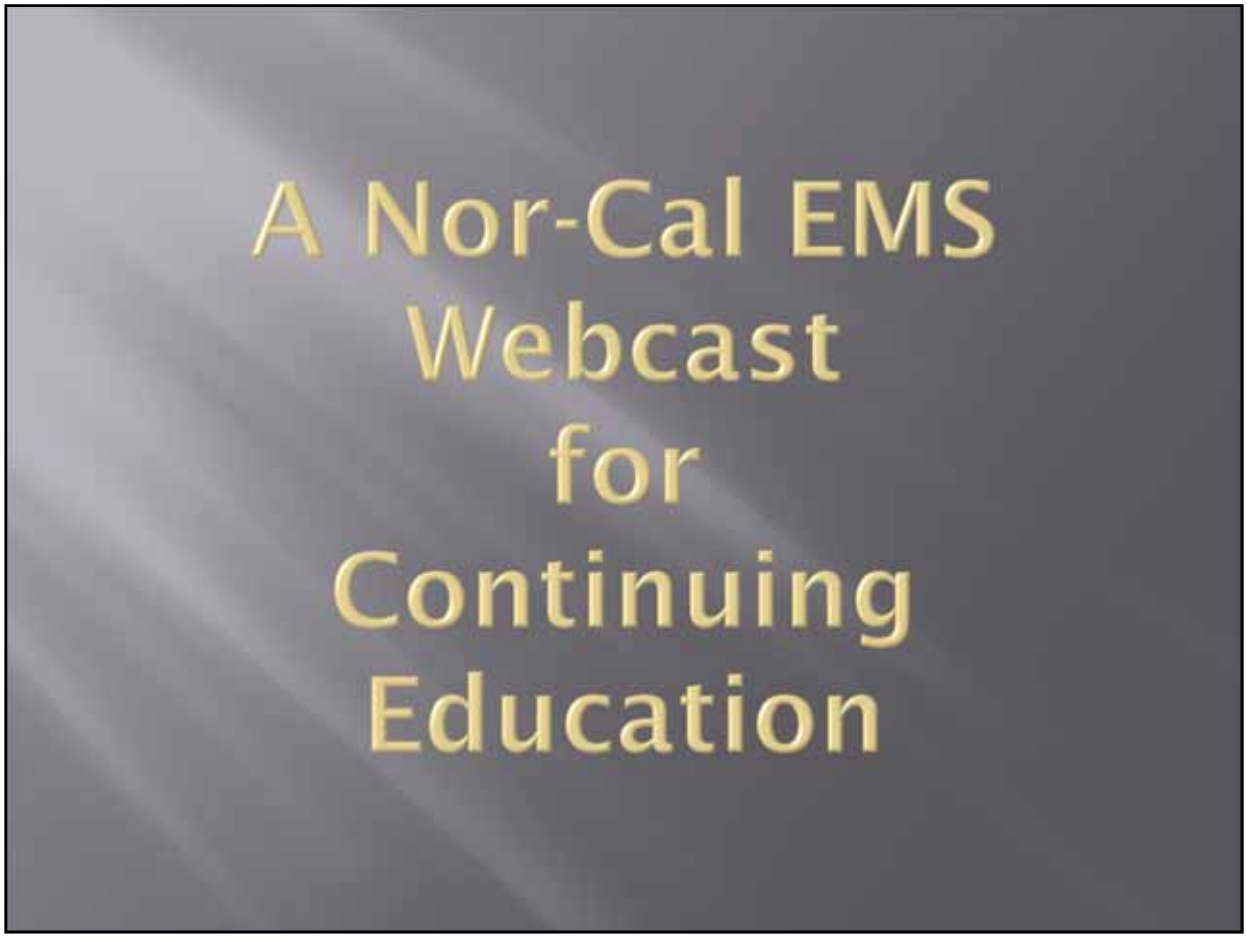

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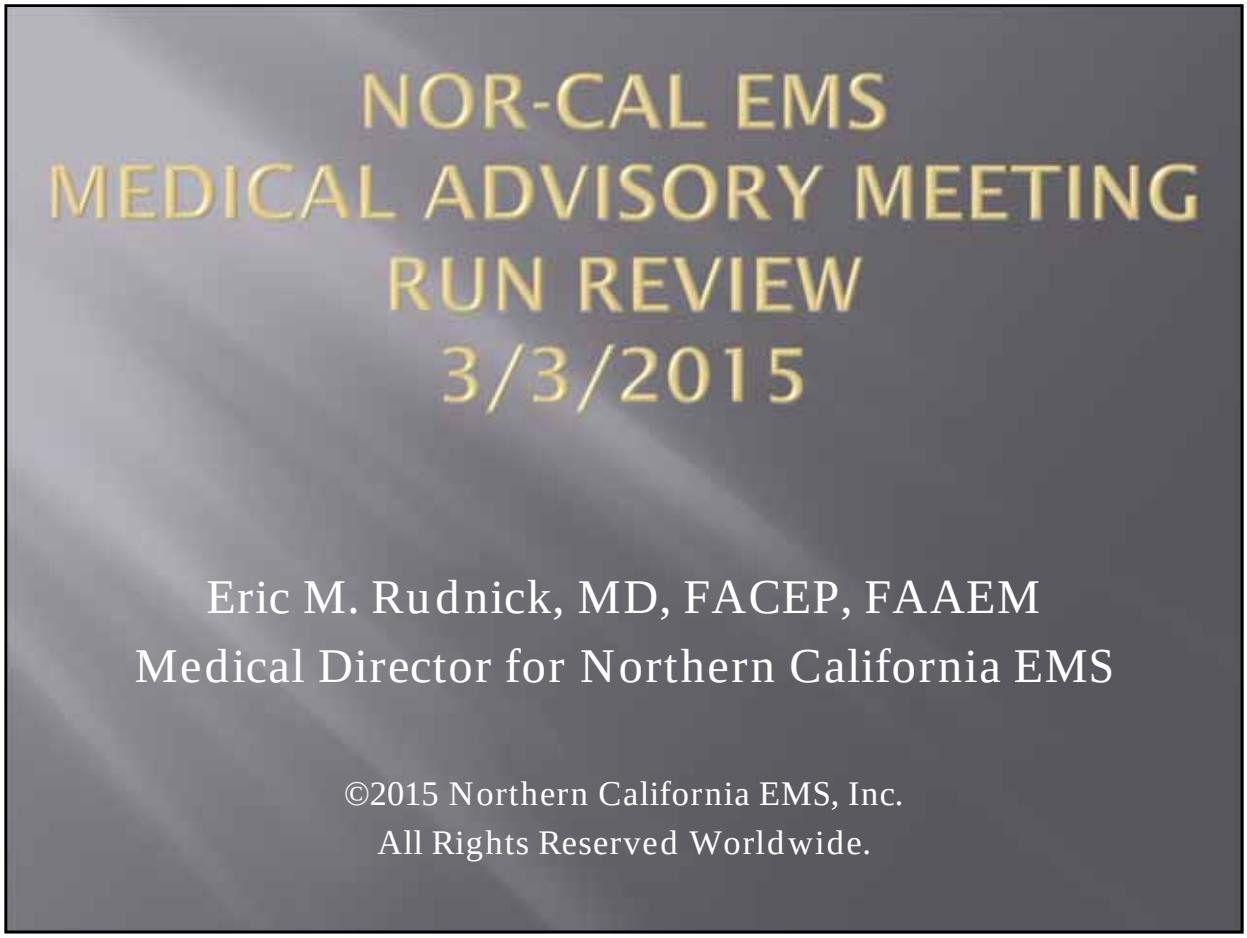

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Case #1

- Dispatched code 3 to a local Vet clinic.
- On arrival to the Veterinary Clinic to find a 39 year female out the front door in company of co-workers.
- Pt. presented A&OX4, GCS 15, pale, warm, and dry.
- Patient is complaining of chest tightness secondary to SVT.
- Patient reported having extensive history of reoccurring SVT.
- Pt. reported taking Lopressor approximately 10 minutes ago and calling her cardiologist who advised her to be transported to ED.
- Patient reported attempting vaso-vagal maneuvers and carotid massage with no change.

Case #1

- Patient reported having a pulse oximeter and getting readings in the 200's for her heart rate.
- Patient denies any C/P, SOB, or N/V.
- Patient did complain of dizziness.
- Patient reported onset at 12:48 today while sitting at rest.
- Patient reported last SVT episode required administration of Adenosine due to ineffective vagal maneuvers.
- Patient reported having her first SVT occurrence September of last year and having episodes reoccurring more frequently and lasting longer.

Case #1

- Patient reported being on a regular regimen of Lopressor 25 mg in the morning and 25 mg at night.
- Patient also reported being advised by her cardiologist to take additional 25 mg Lopressor when in SVT.

Case #1

- Assessment as noted and VS as noted.
- Vagal maneuvers attempted by having the patient blow into a syringe with no changes.
- IV 20g Left hand unsuccessful by paramedic intern, 12 lead EKG SVT with no ST elevation or depression.
- IV 20g unsuccessful Right hand.
- IV 18g Right wrist successful with 1000ml NS TKO.
- Patient transported code 2 ALS to Hospital.
- BG 134 mg / dl.

Case #1

- Just prior to administration of Adenosine patient self-converted.
- Patient reported chest tightness decreasing and dizziness subsiding.
- Patient continued to deny any other C/C.
- 12 lead obtained NSR with no ST segment changes.
- Both 12 leads transmitted to hospital successfully.
- Patient en route continued with VS wnl and NSR EKG.
- Patient report en route to hospital MICN via phone with no questions and reported to not follow chest pain protocol and not administer ASA or NTG for chest pressure.

Case #1

- Patient on arrival to ED presented PWD with very minimal chest pressure and VS/EKG WNL.
- Pt. on arrival to ED report given and transfer of patient care.
- Copies EKG print outs provided and left with RN.

Case #1

- Medication Allergies: sulfa
- Patient medications: Lopressor (Metoprolol), B12, Multivitamins

Case #1

- PE 13:18
- Mental status: normal for patient
- Neuro: normal
- Eyes: reactive
- Skin: pale, warm, dry
- Head / Face: normal
- Neck: normal
- Chest / Lungs: normal chest assessment, clear and equal breath sounds

Case #1

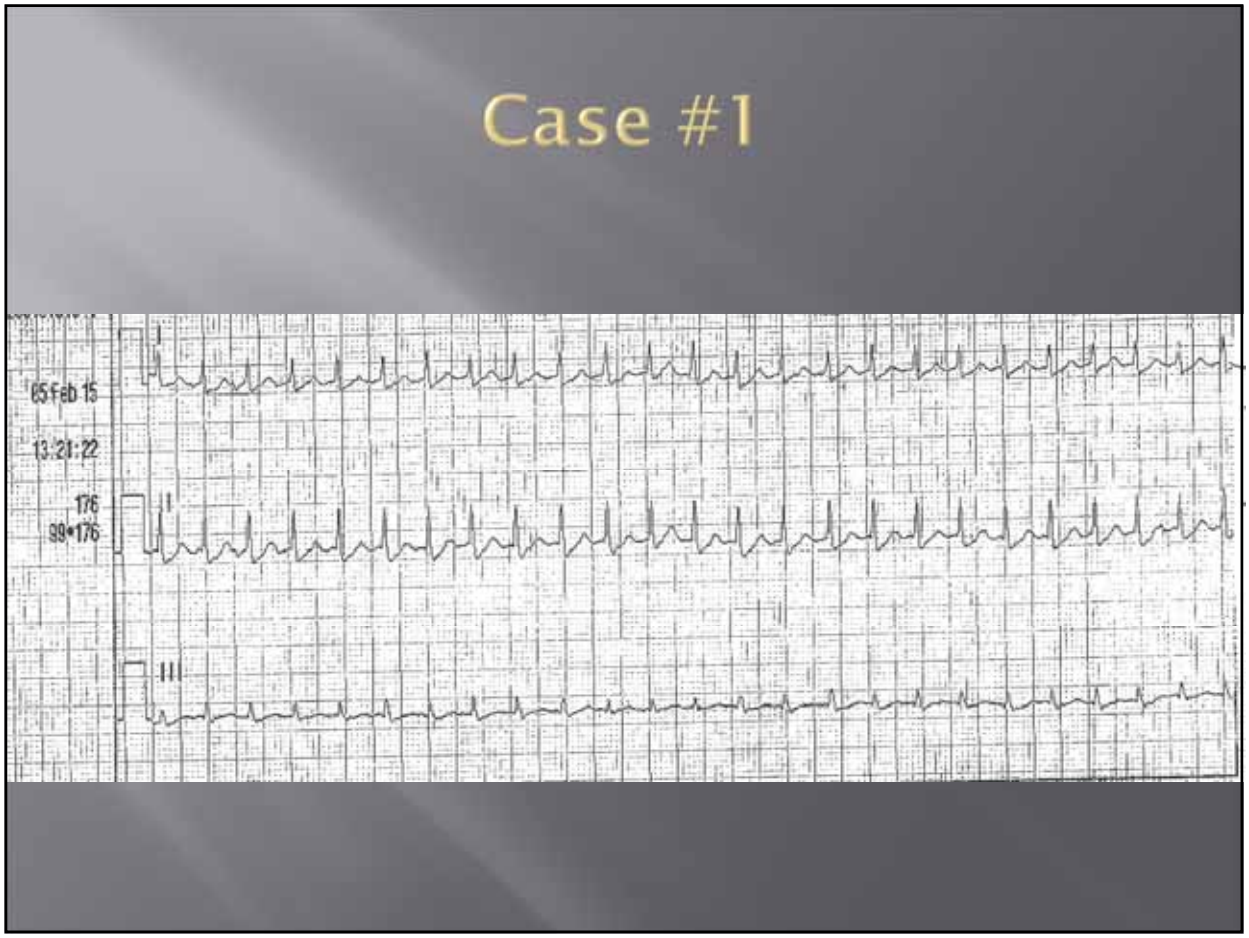
- Abdomen: LUQ, LLQ, RUQ, RLQ soft, non-tender
- GU: normal
- Cervical, thoracic, lumbar: normal, no deformities or pain
- Extremities: RU, RL, LU, LL: normal

Case #1

- Vital signs
- 13:21 BP 121 / 77, HR 184, RR 16, SaO2 99, GCS 15
- 13:31 BP 124 / 73, HR 189, RR 16, SaO2 99
- 13:35 BP 112 / 74, HR 80, RR 16
- 13:42 BP 119 / 60, HR 78, RR 16
- 13:50 110 / 80, HR 82, RR 16

Case #1

- 13:21 ECG monitor SVT
- 13:24 ECG monitor SVT
- 13:33 ECG NSR
- 13:40 ECG NSR
- 13:18 Adult ALS assessment
- 13:22 Valsalva 2 attempts no change
- 13:24 IV access saline lock
- 13:26 Oxygen 2 LPM
- 13:29 IV access saline lock
- 13:30 Blood glucose 134 mg / dl



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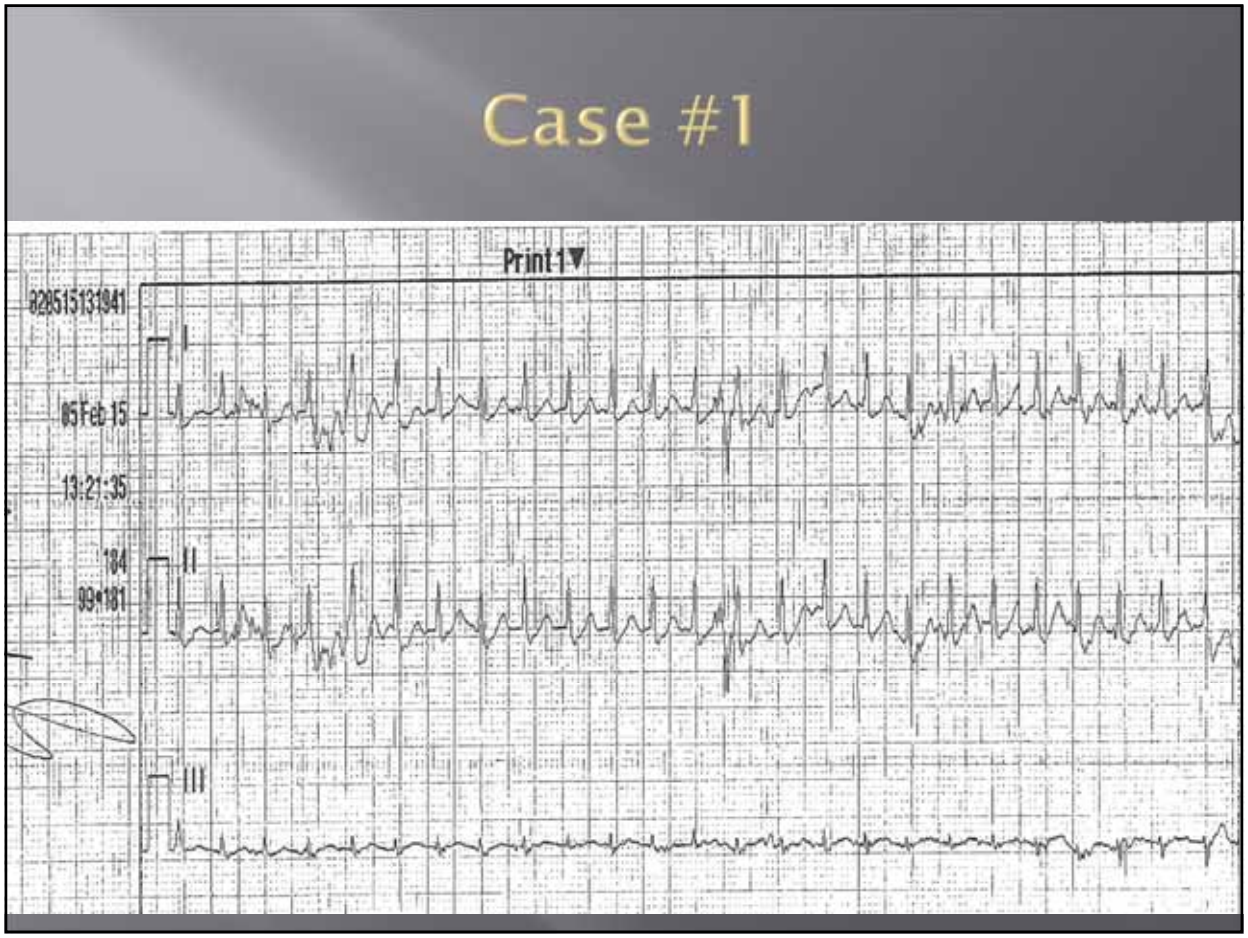

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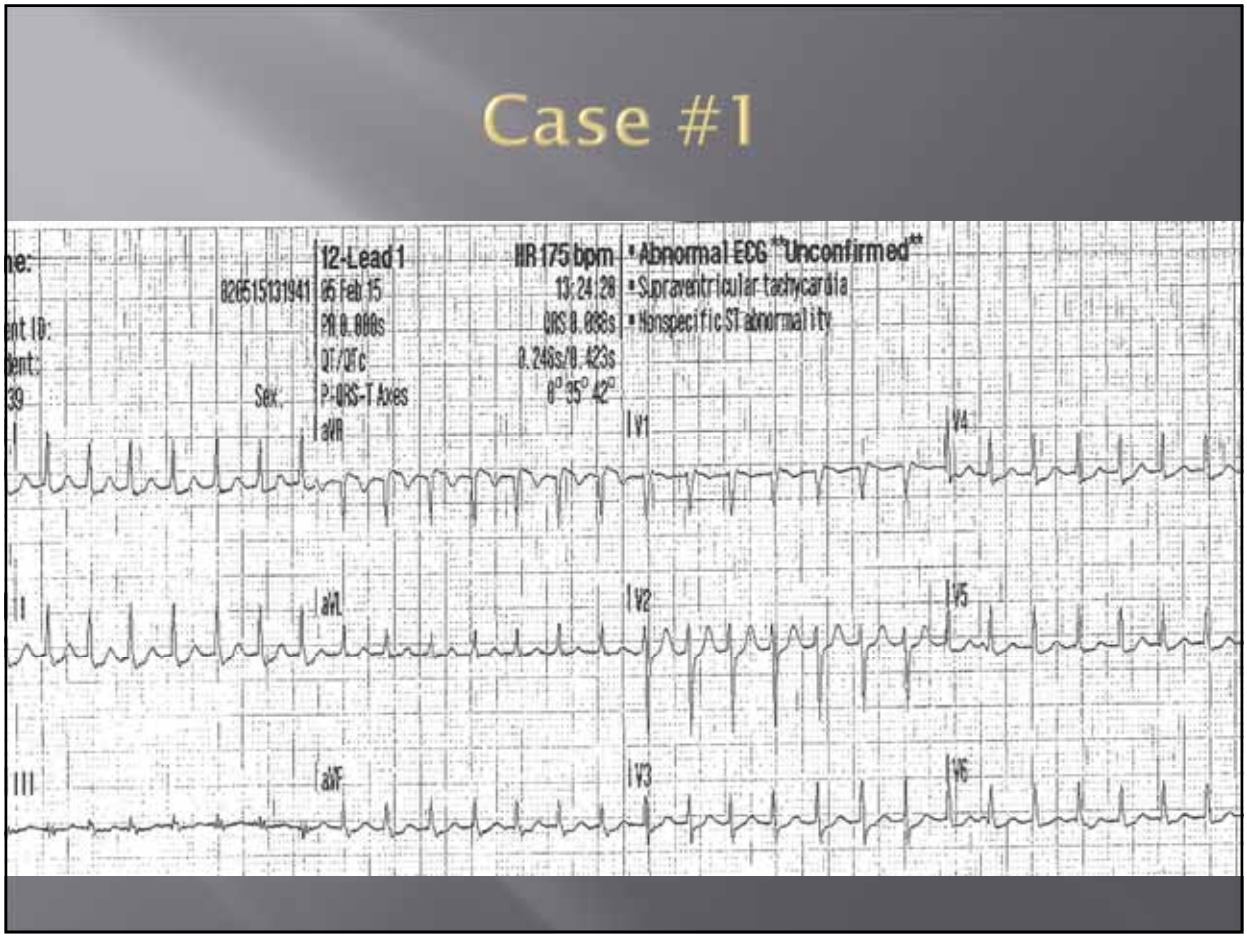

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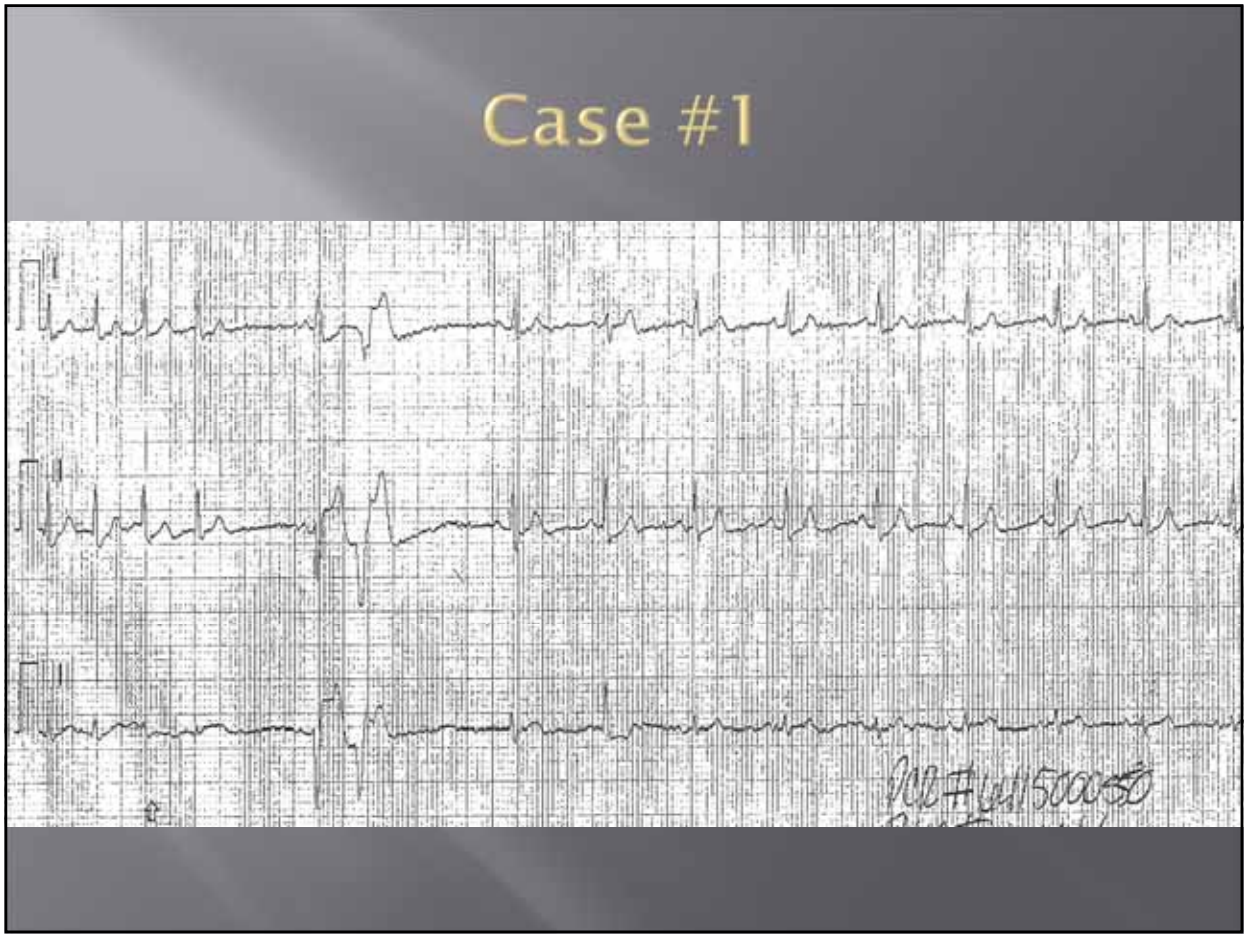

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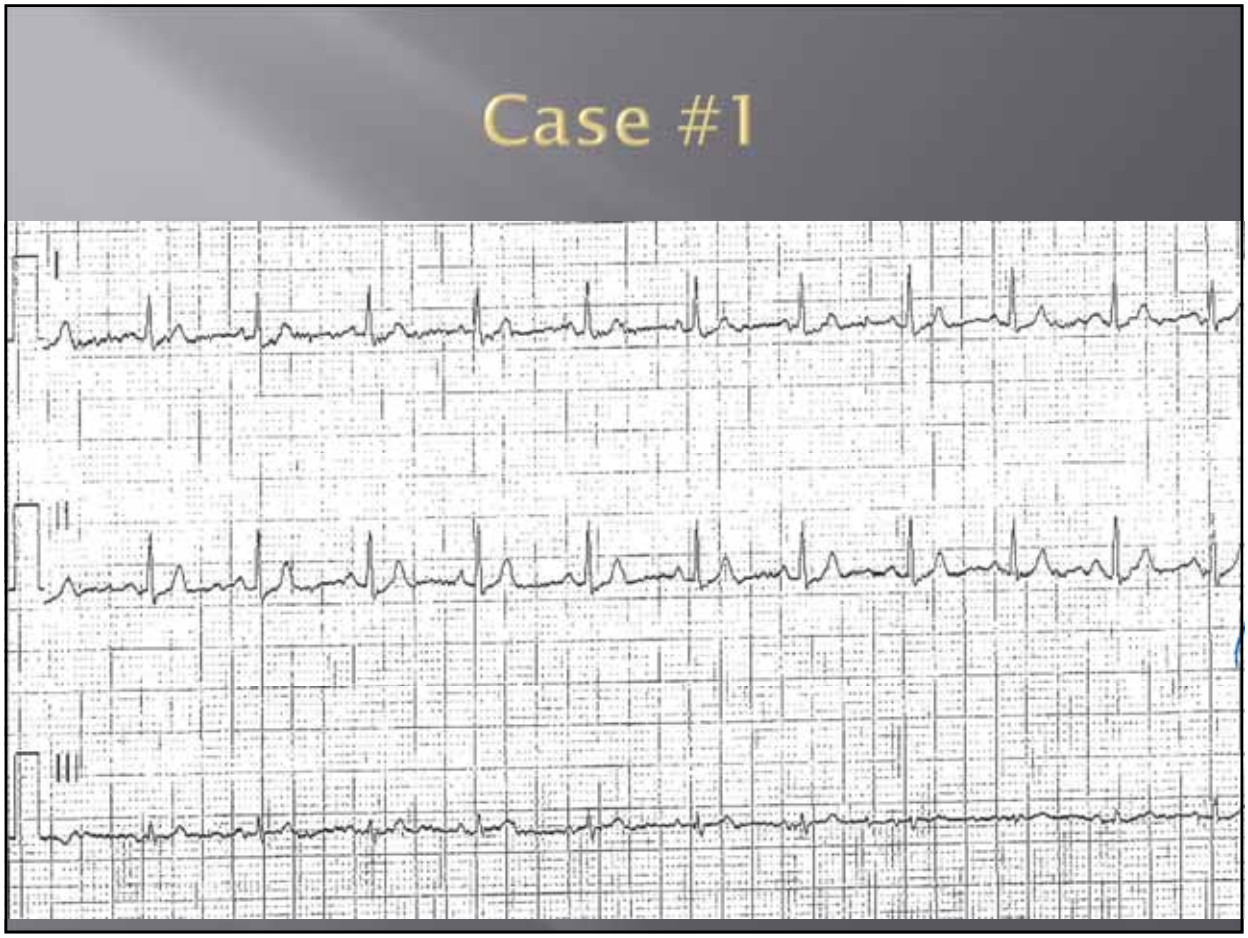

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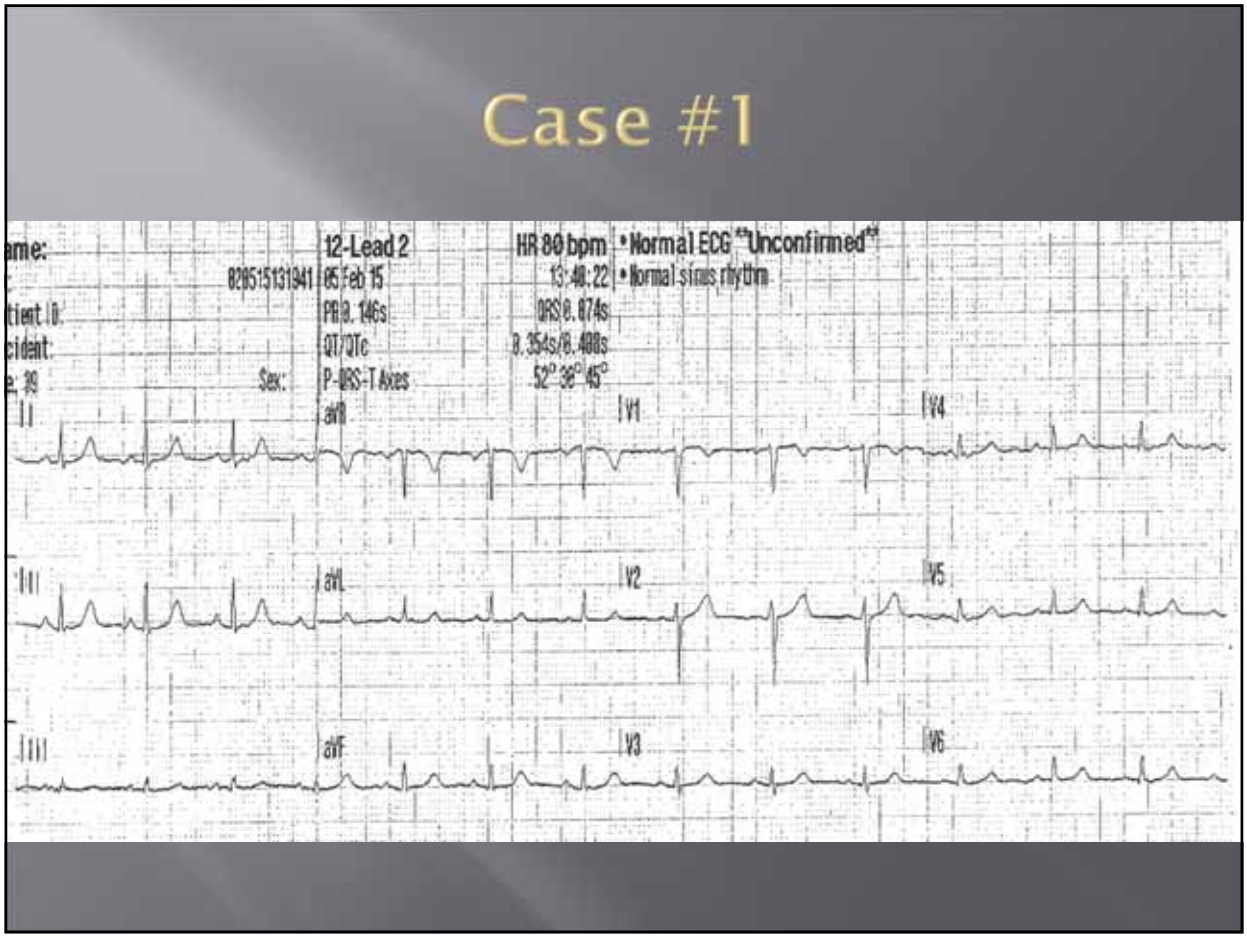

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Case #2

- Responded code 2 for a female with a possible stroke.
- At scene to Board and Care to be greeted by caregivers.
- The caregiver went to the kitchen and returned to find the patient slumping to the right drooling, slurred speech, and right facial droop and the right hand contracted up.
- Patient was last seen normal at 16:20 hours.
- Patient was found sitting in a chair in her bedroom with the caregiver and neighbor in attendance.
- Patient had positive stroke assessment.

Case #2

- Patient denies CP, SOB, , or N / V.
- The caregiver provided the DNR and current medication list.
- POA could not be reached due to the caregiver not having the POA's phone number.
- Patient was able to speak however the words were slurred.

Case #2

- Patient was A&OX1 to person only.
- GCS 14 with reduction due to confusion.
- Patient's skin signs were pale, warm, and dry.
- HEENT was clear with right sided gaze and dilated pupil on the right with sluggish reaction.
- Trachea midline without JVD.
- Equal chest rise and fall with clear LS.
- Abdomen SNT.
- Pelvis intact and stable.

Case #2

- Good CSM on the left with flaccid motor function on the right.
- Patient was loaded onto stretcher and into the ambulance.
- Patient was transported code 2 to hospital.
- In the ambulance vitals and pulse ox were obtained.
- Patient was placed on the cardiac monitor with A-fib showing.
- A 12 lead EKG was obtained.
- Phone report was given to the hospital with orders to upgrade to code 3 and the was a stroke alert.
- Bilateral IVs were started in the wrists.

Case #2

- Blood sugar levels were obtained with a reading of 103mg / dl.
- Patient given oxygen via nasal cannula at 4 LPM.
- The patient vomited and the oral pharynx was cleared with a hand towel.
- Arrived at hospital ER without further complications.
- While wheeling the patient into the hospital patient vomited again.
- Patient was turned on the left lateral position.

Case #2

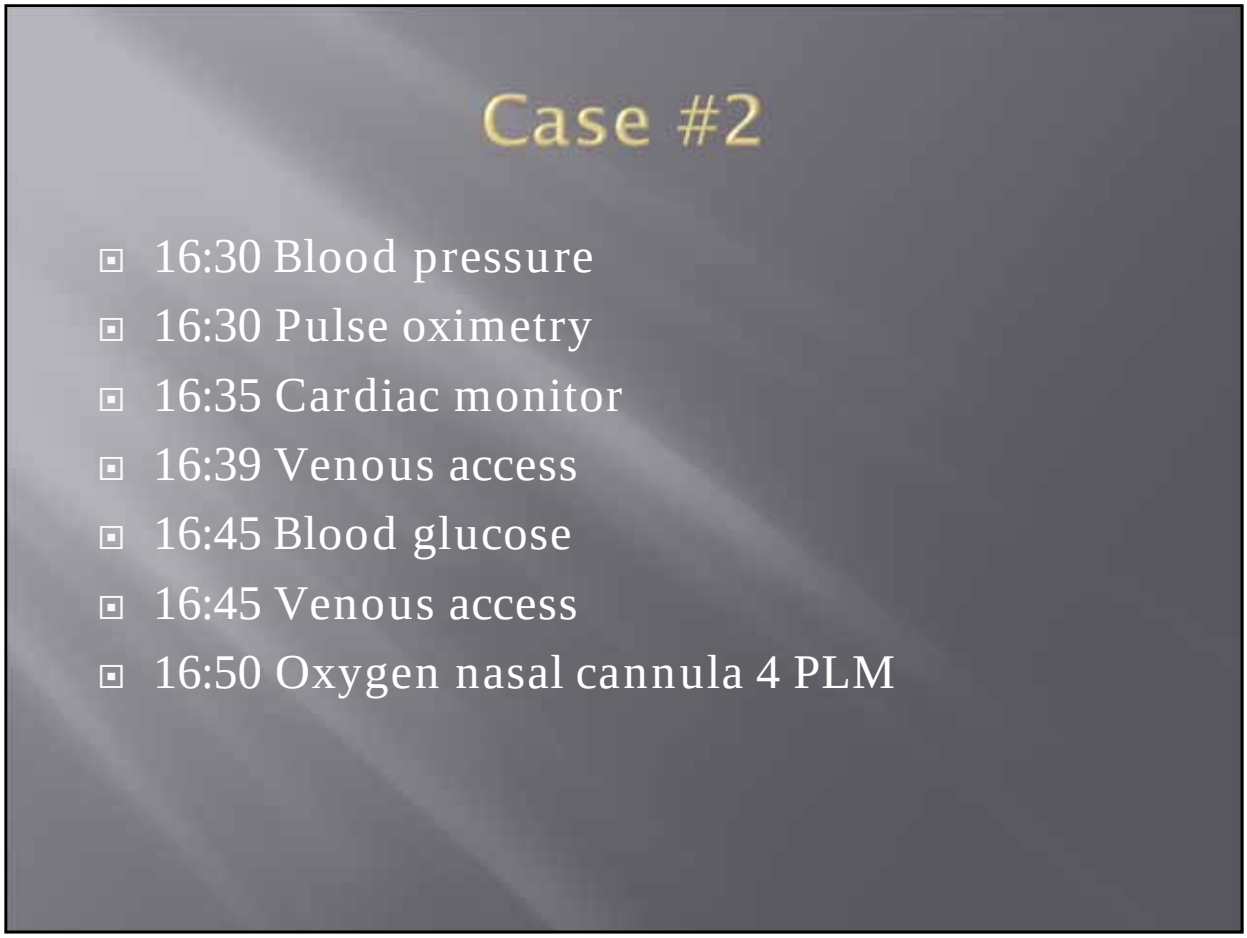
- 16:28 PE:
- Mental status: confused, oriented-person
- Neuro: normal
- Eyes: R: sluggish L:Reactive
- Skin: normal
- Head / Face: Asymmetric smile or droop
- Neck: normal
- Chest / lungs: normal chest assessment, clear and equal BS

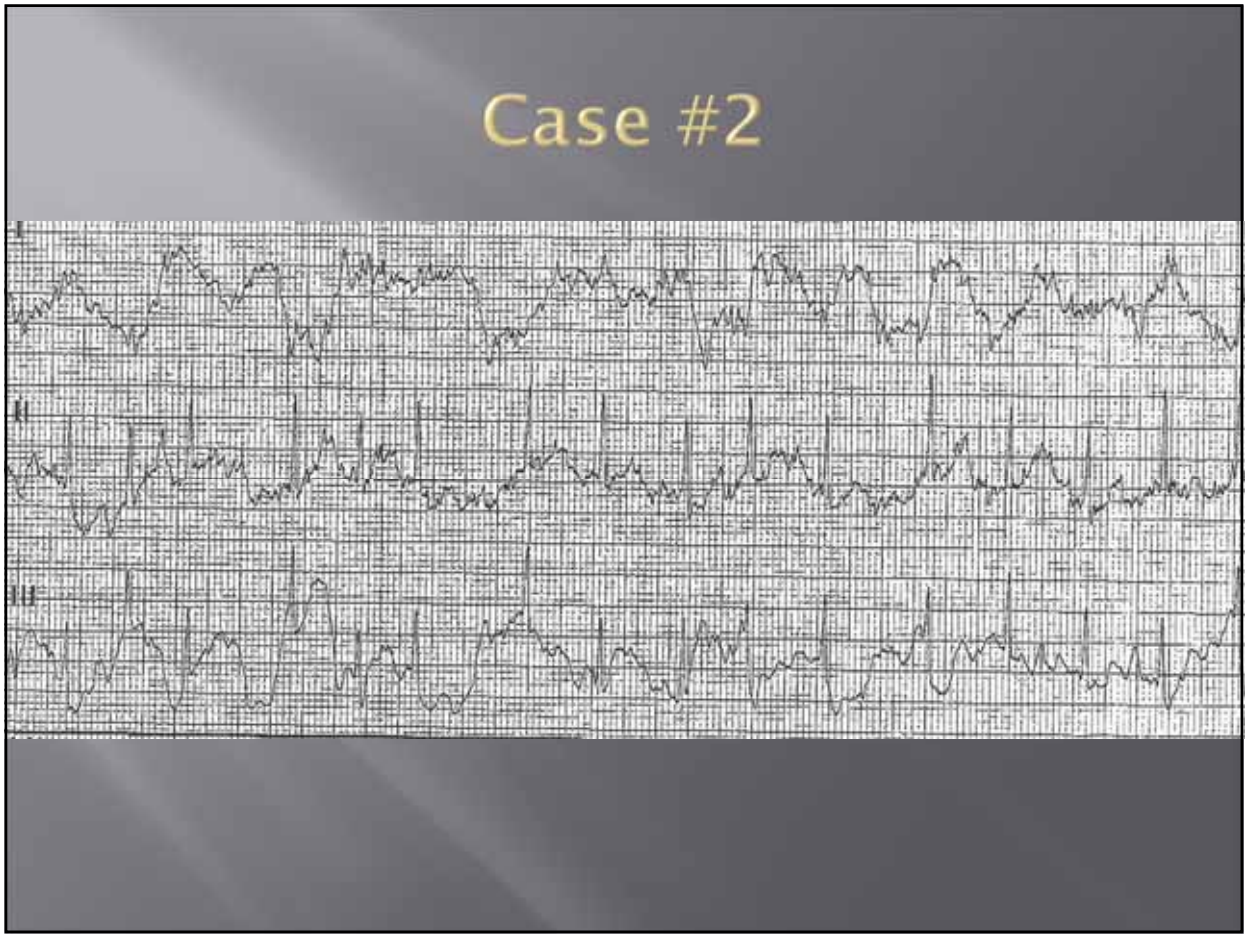
Case #2

- Heart: normal
- Abdomen: LUQ, LLQ, RUQ, RLQ: soft, non-tender
- GU: normal
- Cervical, Thoracic, Lumbar: non-tender, no pain
- Extremities: RU weakness abnormal CSM, LU normal, RL weakness, abnormal CSM, LL normal

Case #2

- 16:30 BP 200 / 105, HR 78, RR 16, SaO2 92
- 16:35 BP 210 / 108, HR 68, RR 16, SaO2 98
- 16:40 BP 201 / 101, HR 75, RR 16
- 16:45 BP 217 / 107, HR 88, RR 16
- 16:50 BP 214 / 109, HR 68, RR 16
- 16:55 BP 209 / 110, HR 78, RR 16
- 17:00 BP 215 / 106, HR 65, RR 16





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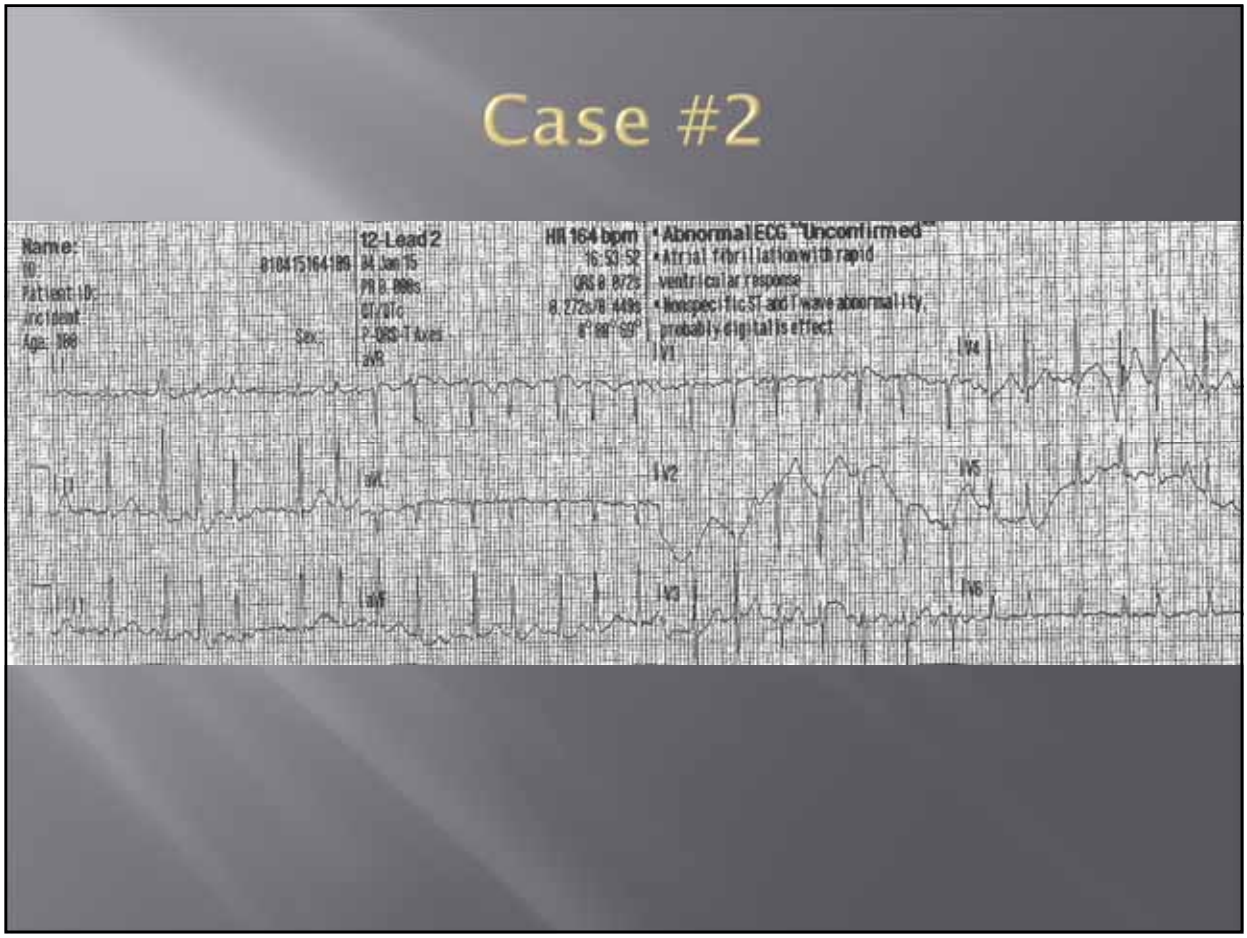

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Case #2

- Documentation?
- Quality of care delivered?
- Other issues and concerns?
- Care appropriate?
- Overall impression?
- Protocol changes required?
- Teaching / Take home points

Case #3

- Chief Complaint: N / V / Back pain in a 55 female
- Dispatched for a female with abdominal pain.
- Responded code 3.
- On arrival finds patient walking down stairs to her front room with fire and her husband in attendance.
- Patient states that at approximately 12:30 today she began to have abdominal pain.
- Patient states that her pain is in her right quadrant and in her thoracic area.

Case #3

- Patient states that it has been increasingly getting worse and approximately 13:30 she began to have nausea.
- Patient states that she has not vomited, nor had a bowel movement today.
- Patient states that she no longer has her appendix or gallbladder.
- Patient denies any chest pain, shortness of breath, headache, or dizziness.
- Patient has a port-a-cath in upper right chest, she states that she is extremely hard to get an IV established and wishes to wait to have the port accessed.

Case #3

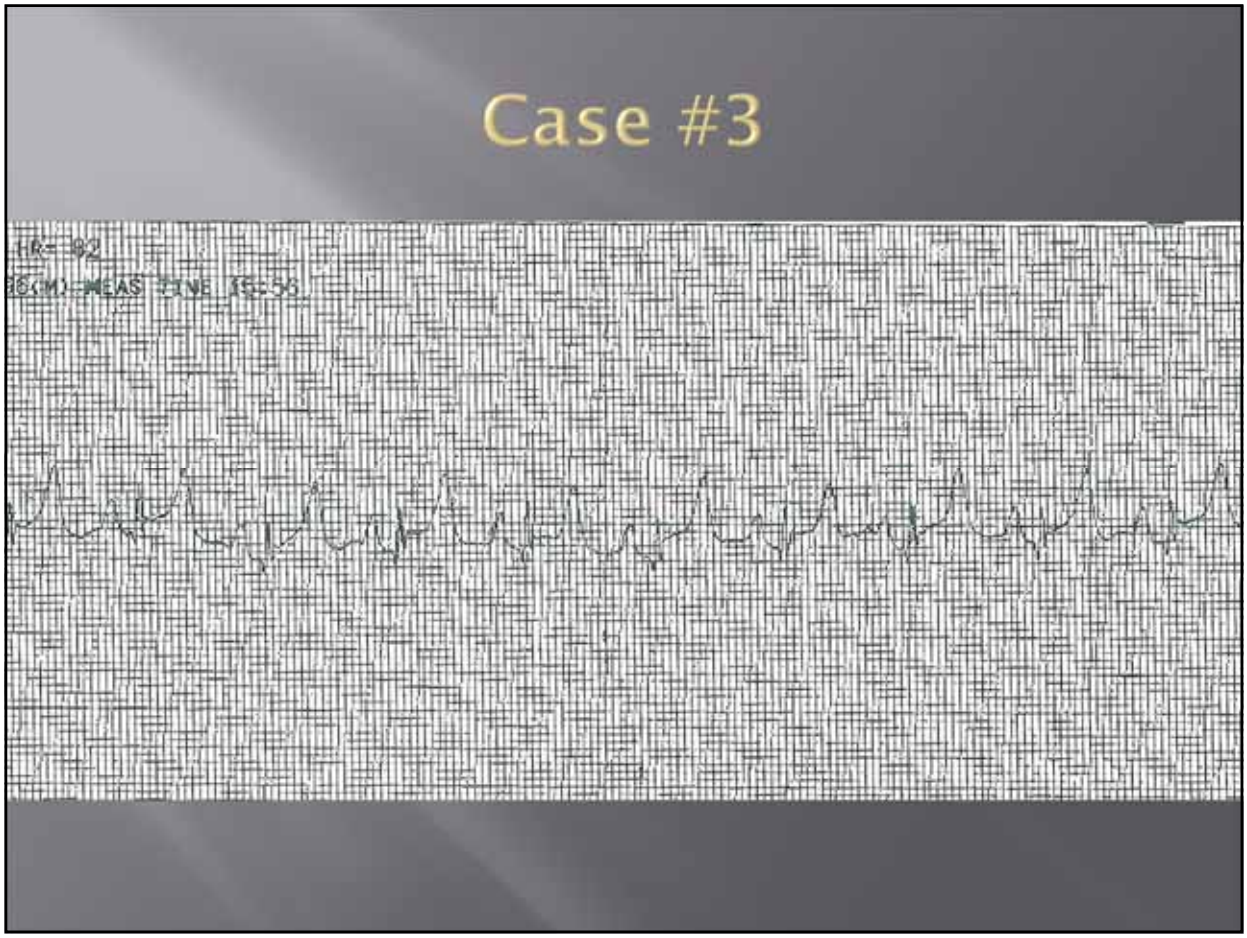
- Patient assisted to gurney and to the ambulance.
- C/C abdominal pain
- TX: patient placed on cardiac monitor and vitals obtained as noted.
- 12 Lead EKG obtained as noted.
- O2 placed as noted.
- Zofran administered as noted with no relief.
- PE: HEENT: clear PERRL
- Skin: pale, warm, clammy

Case #3

- Neck: intact
- Lungs: clear with equal chest rise bilaterally.
- Abdomen: soft, non-tender in all four quadrants, non-distended, active bowel sounds in all four quadrants.
- Pelvis: intact
- CSM intact in all extremities
- During transport no acute changes.

Case #3

- Allergies: Toradol
- Medications: Alprazolam, ASA, Carvediolol, Estradiol, Famotidine, HCTZ, Losartan, Progesterone, Omeprazole, Paroxetine, Prednisone, Promethazine, trazadone
- PMH: HTN, Cardiac Stent, GI/GU conditions, Psychological/Depression, Anxiety



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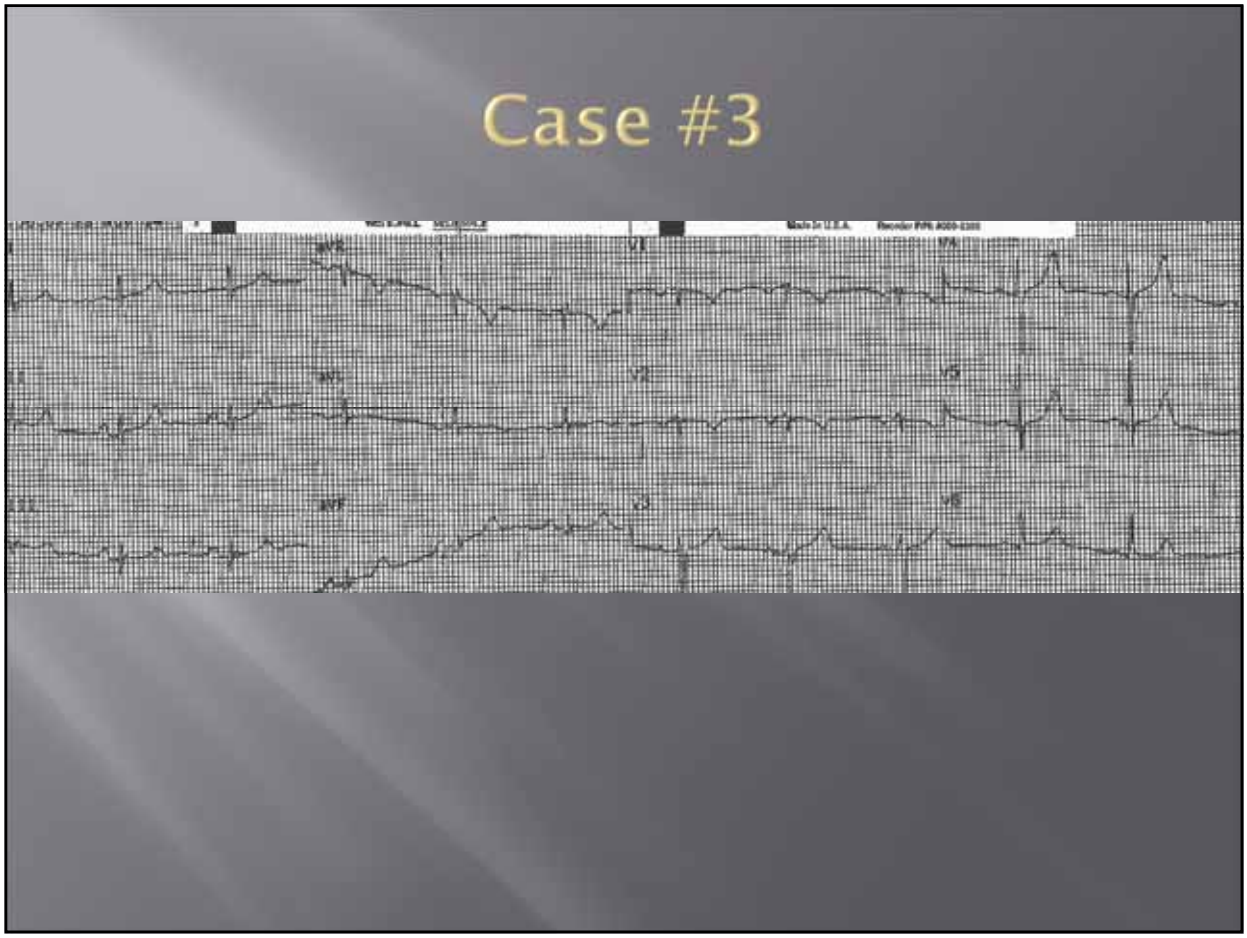

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Case #3

- Documentation?
- Quality of care delivered?
- Other issues and concerns?
- Care appropriate?
- Overall impression?
- Protocol changes required?
- Teaching / Take home points

Case #4

- Dispatched code 2 to a private residence for chest discomfort and elevated heart rate.
- On arrival to rural residence, personnel unable to gain access into residence.
- Med Com advised patient will be opening door.
- Upon patient contact to be greeted by a 78 year old male who was just requesting a BP evaluation.
- Patient presented A&OX4, GCS 15, PWD, speaking full sentences without difficulty and no slurred speech.

Case #4

- Patient provided documentation of 6 blood pressures he had obtained with his home automatic cuff and was concerned by his high blood pressure results and so he reportedly called 911.
- Patient denied any C/C, patient denied CP, SOB, HA, blurred vision, or N/V.
- Patient reported not taking his blood pressure medications as prescribed and only taking it occasionally.
- Patient reported taking his metoprolol approximately 30 minutes PTA of EMS.

Case #4

- Assessment as noted and unremarkable, negative stroke scale, + CSMX4, no pedal edema noted.
- Vital as noted with an initial manual BP of 280/140 mm Hg, HR 92 irregular, RR 16, SpO2 97% on RA.
- CM SR with occasional PVCs.
- Patient was advised of the need to be transported and the rik of complications associated with HTN.
- Patient agreed to be transported.
- After extended time securing patient's residence as requested by patient, patient to LSU without changes and or incident.

Case #4

- Patient transported code 2 to hospital.
- 12 Lead obtained with no ST segment, SR with PVCs as noted, O2 via NC with no changes, IV left FA successful X1,
- BG 197 mg/dl
- VS en route as noted with continuous HTN.
- Patient report via phone with no questions or orders.
- Patient en route continued to deny any C/C.

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Case #4

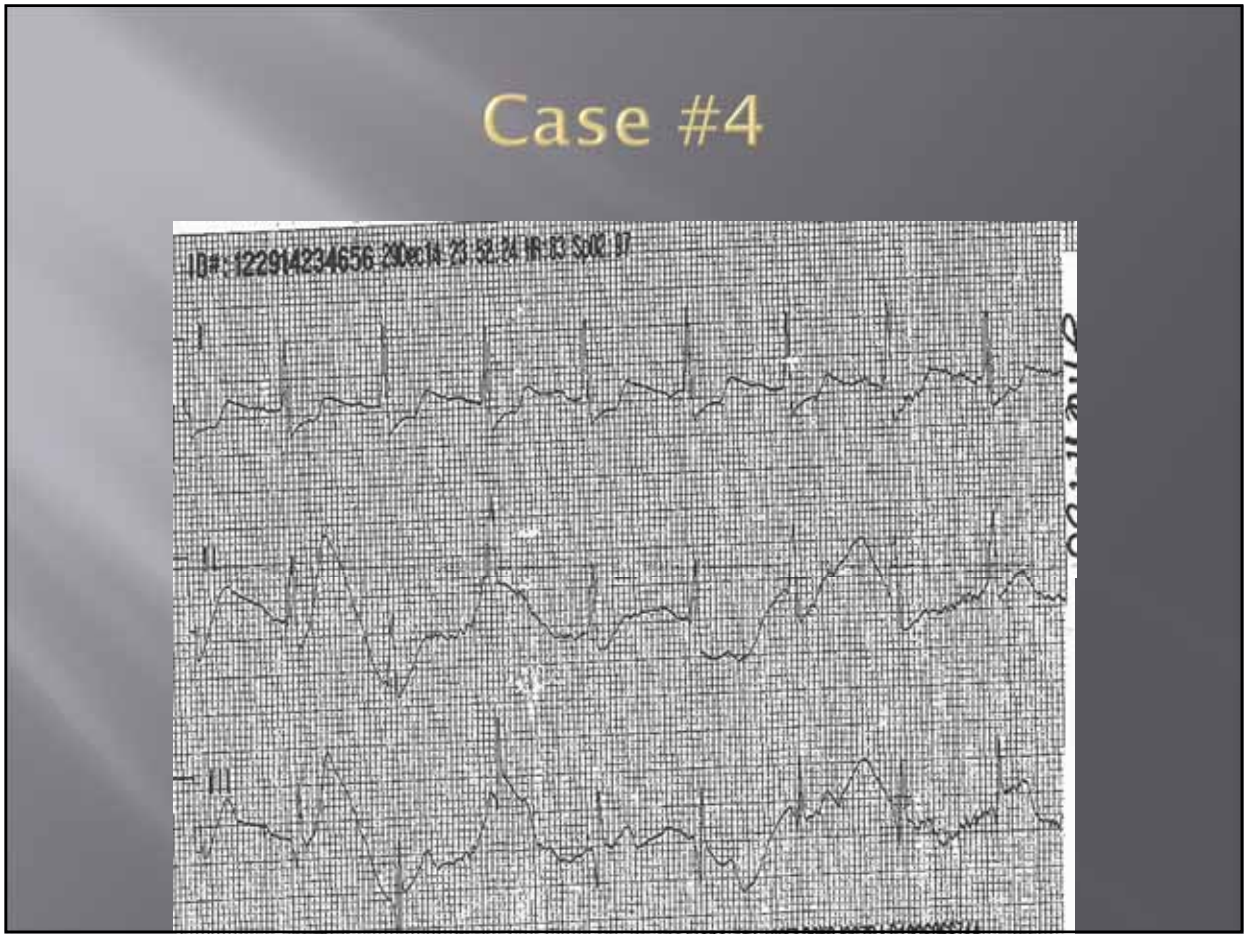
- PE:
- Mental status: normal for patient
- Neuro: normal
- Eyes: reactive
- Skin: normal
- Head / Face: normal
- Neck: normal
- Chest / lungs: normal chest assessment, clear and equal BS

Case #4

- Abdomen LUQ, RUQ, LLQ, RLQ: soft and non-tender
- GU: normal
- Cervical, Thoracic, Lumbar: normal, no pain or deformities
- Extremities: RU, LU, RL, LL: normal

Case #4

- 23:50 BP 280 / 140, HR 92, RR 16, SpO2 98%
- 00:18 BP 198 / 106, HR 78, RR 16
- 00:30 250 / 110, HR 88, RR 16
- 23:45 Assessment- adult
- 00:15 Venous access- saline lock
- 00:16 BG 197 mg / dl
- 00:10 Oxygen per NC 4LPM



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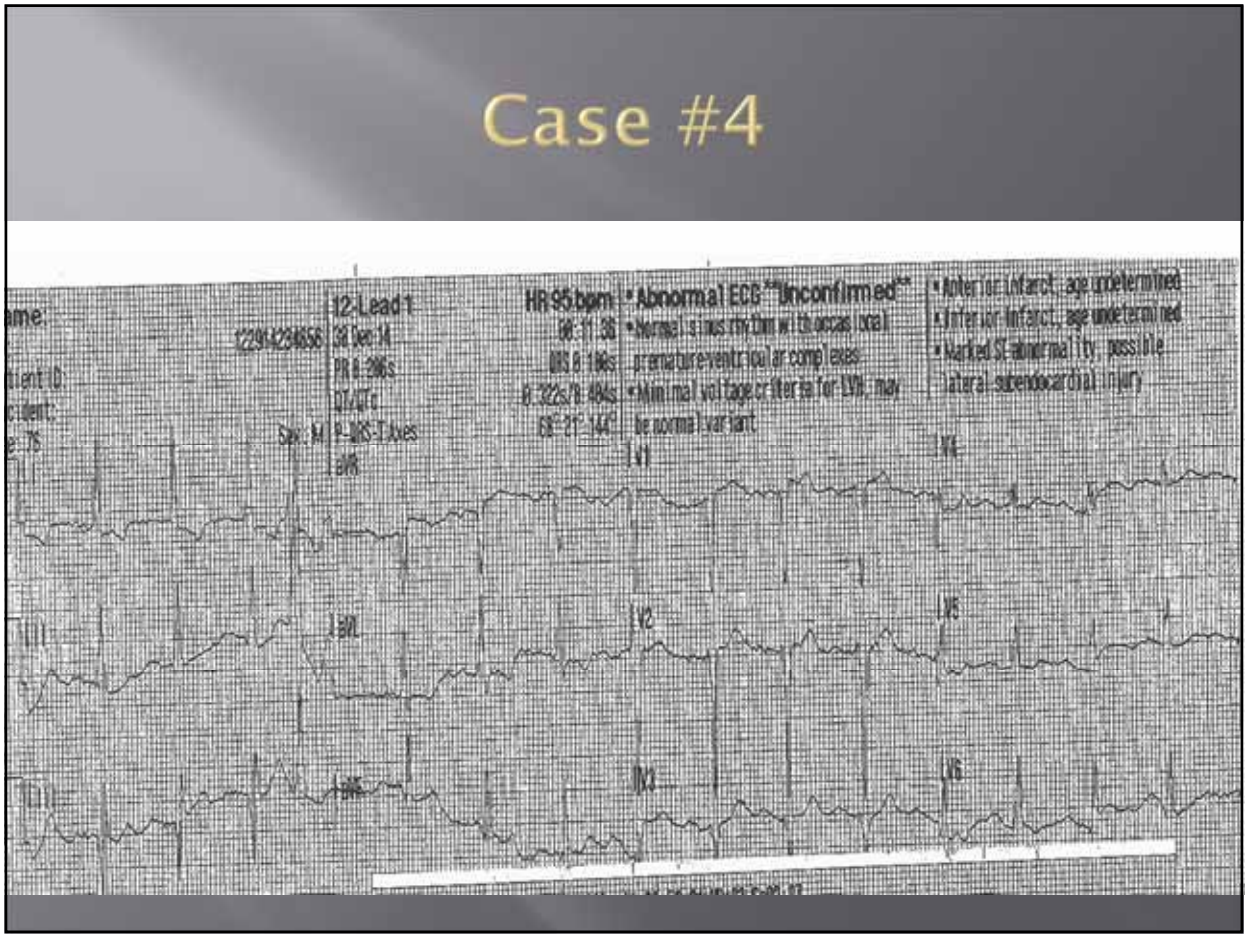

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Case #4

- Documentation?
- Quality of care delivered?
- Other issues and concerns?
- Care appropriate?
- Overall impression?
- Protocol changes required?
- Teaching / Take home points

Case #5

- Dispatched code 3 to a MVA.
- Arrived @ scene to find a 41 year old male walking toward the ambulance.
- Patient C/O neck/back/LT arm pain positive rollover.
- Patient reports driving home to Redding from UC Davis Medical Center, when he fell asleep while driving.
- Patient reports to driving with cruise control set at 70 mph.
- Patient was driving full sized Dodge truck and was unsure how many times the truck rolled.

Case #5

- Patient's truck went through a wire fence coming to rest at the current location upside right.
- Patient reports to wearing shoulder and lap belt and was self extracted PTA.
- Patient's truck has major damage all over with right rear tire torn off, deformity to roof with intrusion into passengers compartment with approximately 12-18 intrusion to passenger's side.
- Starring of windshield with partial ejection of windshield observed.
- No steering wheel or dashboard deformities observed.
- No airbags deployed.

Case #5

- Exam: Patient was pale, cool, and moist. CA&OX3, negative to time and unable to recall recent Thanksgiving Holiday.
- HEENT: Approximately 1 inch lac to LT side head, 1-2 mm wide and no active bleeding.
- No crepitus / deformity / depression noted.
- PERRL, no oral trauma noted.
- Neck: Trachea midline, No JVD observed no pain with palp but did c/o pain while being c-spine.
- Chest: Equal rise and fall, no crepitus or bruising observed.

Case #5

- No subcutaneous emphysema noted.
- L/S are clear and equal in all fields with good tidal volume.
- Swelling noted to left armpit area.
- Abdomen: S&NT X4, no masses felt upon palpation.
- Back: No trauma/deformities felt upon palpation.
- C/O of high back pain during c-spine.
- Pelvis: stable and intact, no incontinence observed.
- Extremities: Deformity noted to left shoulder joint with soft tissue swelling. No crepitus noted.

Case #5

- Capillary refill at 3 seconds and difficulty palpating radial pulse.
- Patient c/o unable to move arm and decreased sensation.
- Abrasion noted to left elbow, rt 2nd and 3rd metacarpals, abrasion to bilateral shins just above ankles, all with no active bleeding.

Case #5

- Treatment: Patient examined with TTA.
- Patient placed in full c-spine, placed on stretcher and load to ambulance.
- En route to hospital code 3.
- 4X4 placed on abrasion to left elbow.
- Left arm positioned to patient's thoracic area.
- IV X 2 started as noted.
- CM attached not due marked artifact unable to determine rhythm.

Case #5

- Skin prep done without any change to CM.
- O2 applied and BG obtained.
- Patient report given to hospital before drive to Sacramento and further denies any other recreational drug or prescription use.
- Patient denies ETOH with CHP reporting the patient blew zero on breathanalyzer machine.
- Base contact made with no further orders.
- Arrived hospital without incident.

Case #5

- NKDA
- Medications: Medical THC
- PHM: chronic knee pain

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Case #5

- PE:
- Mental status: normal
- Neuro: normal
- Eyes: reactive
- Skin: cold, clammy, pale
- Head / Neck: normal
- Neck: normal
- Chest / lungs: normal chest assessment, clear and equal

Case #5

- Heart: normal
- Abdomen: LUQ, RUQ, LLQ, RLQ: soft, non-tender
- GU: normal
- Cervical: normal
- Thoracic: normal
- Lumbar: normal
- Extremities: LU, LL, RU, RL: normal

Case #5

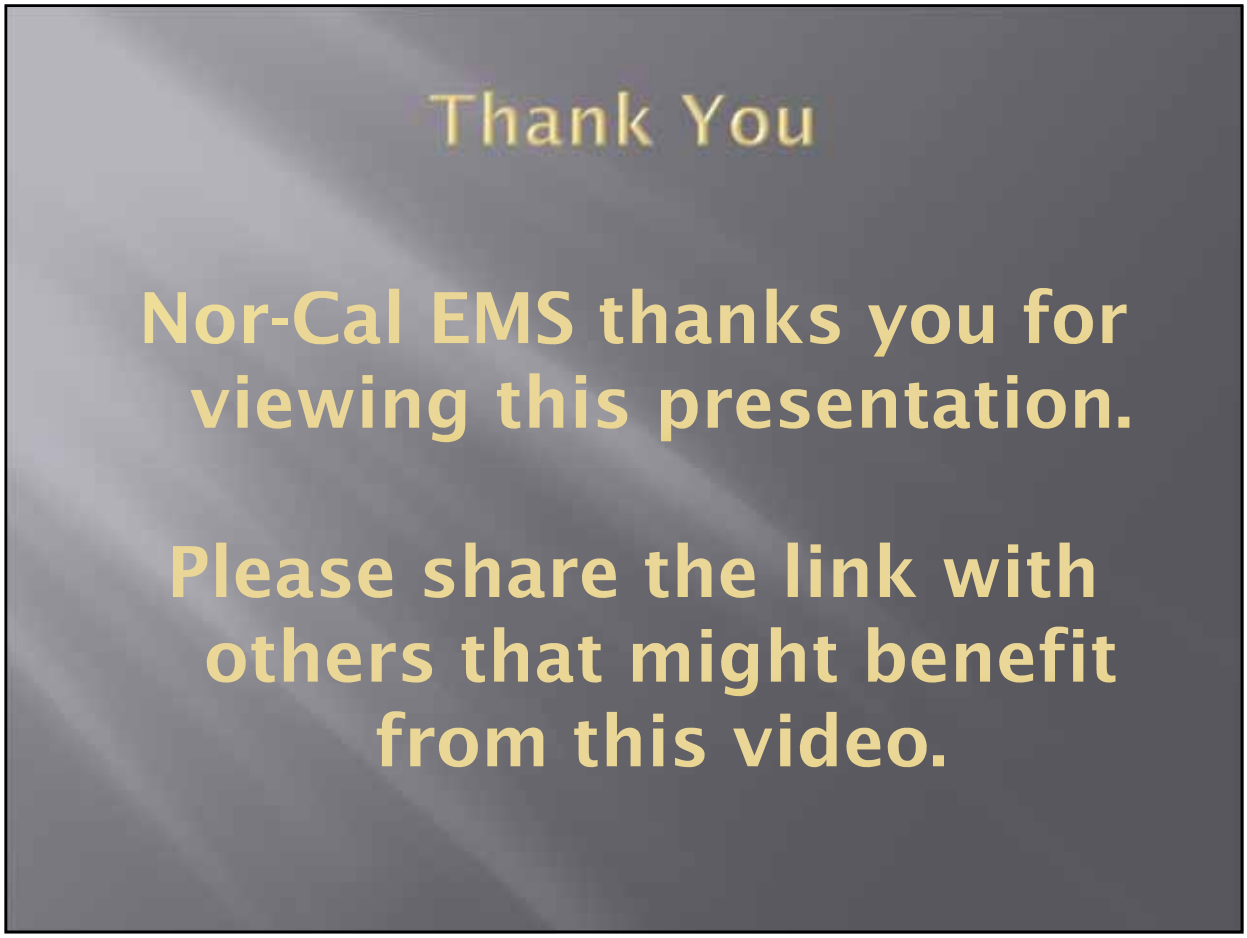
- 03:31: BP 127/79, HR 61, RR 16, SpO2 99%, GCS 15
- 03:35: BP 131/89, HR 61, RR 16
- 03:50: BP 139/113, HR 55, RR 16
- 03:59: BP 134/85, HR 55, RR 16
- 03:23: spinal immobilization
- 03:36: Venous access
- 03:37: Blood glucose 204 mg/dl
- 03:40: bleeding/ hemorrhage control Arm left
- 03:46: Venous access

Case #5

- 03:33 Oxygen by nasal cannula 6 LPM
- 03:36 Normal Saline at KVO

Case #5

- Documentation?
- Quality of care delivered?
- Other issues and concerns?
- Care appropriate?
- Overall impression?
- Protocol changes required?
- Teaching / Take home points



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