BASE HOSPITAL/RECEIVING FACILITY REPORT FORM

❑ ***BLS Report*** ❑ ***ALS Report***
❑ ***Initial Report*** ❑ ***Advisory Report*** ❑ ***Consultation Report***
❑ ***Base Hospital*** ❑ ***Receiving Facility***

PATIENT INFORMATION

Date:	***Time:***	Unit and #:	❑ Code 2 ❑ Code 3	ETA:	Pt ____ of ____
Age:	❑ Male ❑ Female	Weight (Kg)	***History of Incident:*** ❑ Medical ❑ Meets Trauma Triage Criteria		
Chief Complaint:			***Tr Alert Time:***	***Tr Activation Time:*** ***Level:*** ❑ L I ❑ L II ❑ ED Pt	

ASSESSMENT

LOC	*Pupils*	*Skin Signs*	*Lung Sounds*		*Abdomen*	*Extremities*
❑A & O X 4	❑PERRL	❑Pk, Wm, Dry	❑Rt: Clear	❑Lt: Clear	❑S,NT	❑CSM = WNL

V.S.	Time:	***V.S.***	Time:	***PMD***	***MEDICATIONS***
Bp		Bp			❑See List
P		P		***Specialist***	
R		R			
SaO2		SaO2		***PMHX***	
CM		CM		❑Cardiac ❑Resp	***ALLERGIES***
GCS		GCS		❑Diab ❑HTN ❑CA	❑NKDA
(F)BG		(F)BG		Other:	

TREATMENT

❑O2 ❑IV ❑CM ❑Spinal Precautions

RESPONSE TO TREATMENT

❑Patient has stabilized; no further orders needed

COMMENTS

ORDERS GIVEN TO PREHOSPITAL PROVIDER (MICN's/MD's ONLY)

Time:		Time:	
Time:		Time:	

Signature/Title:

Report given to: , RN / Physician

QI REVIEW

Forward this form to the Prehospital Care Coordinator if:

- ❑ The Base Hospital should have been contacted.
- ❑ The patient did not arrive at your this hospital as reported.
- ❑ You recommend the call to be reviewed at Field Care Audit Review

PATIENT IDENTIFICATION