MWLC EMSS Patient Care Report Short Form

Date	Time of Patient Contact	Agency	

Name	Address	DOB
		Gender

Chief Complaint / history of presenting illness / mechanism of injury

Medication (list):	Allergies (list)
☐ None ☐ Unknown ☐ Anticoagulants	☐ Unknown ☐ None

Past Medical History

☐None ☐Unknown ☐Asthma ☐Cancer ☐COPD ☐Cardiac ☐DM ☐HF ☐HTN ☐Psych/BHE ☐Renal ☐ Seizures ☐Smoker/tobacco use
☐Stroke ☐Other

Treatment/Procedures

☐ SMR ☐ IV_____ ☐ Wound Care ☐ O2 _____ ☐12 Lead _____

☐ Other

Medication	Dose	Controlled Substance Med	Dose	Waste

Time	BP	Pulse	RR	Temp	ECG	Glucose	Sp02	ETCO2	GCS	Pain Scale