Genesee County Medical Control Authority

Short Form

RUN # _____	**ROOM #:** _____	**DATE:** _____
EMS UNIT NUMBER: _____		**PATIENT PRIORITY:** _____
AGENCY NAME: _____		
LOCATION :		
PRIMARY COMPLAINT: _____		

VITALS:	**TIME OF VITALS**		**MEDICATIONS**
LEVEL OF RESPONSIVENESS:			
BLOOD PRESSURE			
PULSE RATE / RHYTHM			
RESPIRATIONS			
BREATH SOUNDS			
PUPILS			
SKIN PERFUSION			**ALLERGIES**
BLOOD SUGAR			
SPO2			
TEMPERATURE			
GLASGOW			
PAIN SCALE			

MEDICAL HISTORY _____

SCENE CONDITIONS:

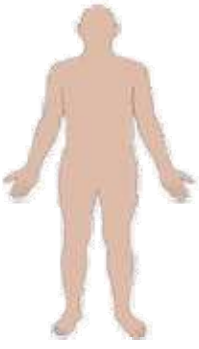
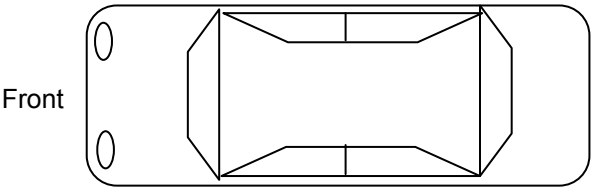
MEDICAL ONLY: _____

ACCIDENT: _____

DRIVER / PASSENGER	ROLLOVER ? Y / N	HELMET: Y / N
ENTRAPMENT ? Y / N	EXTRICATION TIME : _____	
SEATBELT Y / N	AIRBAG DEPLOYMENT Y / N	

TREATMENT(S): _____

EKG: _____

Front	Back	Vehicle
		Intrusion:_____  Front Back Speed: _____

CREW NAMES: _____ EMT B PARAMEDIC

_____ EMT B PARAMEDIC

_____ EMT B PARAMEDIC

_____ EMT B PARAMEDIC

Call Time: _____ Enr Time: _____ Arrival Time: _____ Pt. Contact Time: _____ Transport Time : _____ Arrival Hosp: _____

Patient Name: _____ DOB : ____ - ____ - ____ Address: _____ Phone: _____