Commonwealth of Virginia

EMS Medical Record - Short Form

Patient and Response Information

Agency: | **Agency #:** | **Unit #:** | **Date:** D D / D D / Y Y

Location: | **ZIP** | **Incident #:**

Name: _____ **Age:** _____ **Gender:** ☐ Male ☐ Female

Address: _____ **Apt/Rm** _____ **Telephone:** _____

City: _____ **State:** _____ **ZIP:** _____

Next of Kin **Name:** _____ **Rel.** _____ **Tel.#:** _____

SSN/DL # | | | | | | | | | | | **DL State** | | **DOB** M M D D Y Y Y Y

Times (24hr Format)

PSAP Time				
Unit Disp.				
Enroute				
Arrive Scene				
Arrive Patient				
Leave Scene				
Arrive Dest.				

Patient History

Chief Complaint and Duration	Secondary Complaint and Duration	Symptoms

Past Medical Surgical History

☐ None	☐ COPD	☐ GU/GI	☐ Hypotension	☐ Seizures	☐ Tuberculosis
☐ Asthma	☐ Develop Delayed	☐ High Cholesterol	☐ Neuro	☐ Stroke/CVA	☐ Other:
☐ Cancer:_____	☐ Diabetes	☐ HIV/AIDS	☐ Psych Disorder	☐ Substance Abuse	
☐ Cardiac:_____	☐ Endocrine	☐ Hypertension	☐ Renal Failure	☐ TIA	

Allergies:

Medications:

Assessment/Vital Signs

Time	LOC	B/P	Pulse	Resp.	SpO2	Pain	ECG	Time	LOC	B/P	Pulse	Resp.	SpO2	Pain	ECG
Gluc.	☐ A ☐ V ☐ P ☐ U ☐ n/a	/ ☐ Palp ☐ Unable ☐ N/O	☐ Regular ☐ Reg-Irreg ☐ Irreg-Irreg	☐ Regular ☐ Reg-Irreg ☐ Irreg.-Irreg.	☐ RA ☐ 1-6 L ☐ 7-9 L ☐ 10-25 L	CO2	Defib Joules	Gluc.	☐ A ☐ V ☐ P ☐ U ☐ n/a	/ ☐ Palp ☐ Unable ☐ N/O	☐ Regular ☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ Regular ☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ RA ☐ 1-6 L ☐ 7-9 L ☐ 10-25 L	CO2	Defib Joules
Gluc.	☐ A ☐ V ☐ P ☐ U ☐ n/a	/ ☐ Palp ☐ Unable ☐ N/O	☐ Regular ☐ Reg-Irreg ☐ Irreg-Irreg	☐ Regular ☐ Reg-Irreg ☐ Irreg.-Irreg.	☐ RA ☐ 1-6 L ☐ 7-9 L ☐ 10-25 L	CO2	Defib Joules	Gluc.	☐ A ☐ V ☐ P ☐ U ☐ n/a	/ ☐ Palp ☐ Unable ☐ N/O	☐ Regular ☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ Regular ☐ Reg.-Irreg. ☐ Irreg.-Irreg.	☐ RA ☐ 1-6 L ☐ 7-9 L ☐ 10-25 L	CO2	Defib Joules

Treatment

Medication Administration

Time	Medication	Dose	Route	Resp.	Crew #	Time	Medication	Dose	Route	Resp	Crew #

Airway/Intravenous Procedures

Time	Size	Type	Loc.	Fluid/Lock	ATT.	Succ.	Crew #

Airway

☐ None		☐ Nasal Airway	Sz. _____	☐ Intubated (ETT)	
☐ Asst Vent.	RPM _____	☐ Oral Airway	Sz. _____	☐ Ventilator	
☐ O2 Cannula	LPM _____	☐ Suction		☐ Crichothyrotomy	
☐ O2 Mask	LPM _____	☐ Supraglottic Airway		☐ NG Tube	
☐ O2 Neb/BB	LPM _____	☐ CPAP		☐ Chest Decomp	

Cardiac

☐ ECG Monitoring
☐ External Pacing
R _____ M _____
☐ Defib/Cardioversion
☐ CPR

IV/Medications

☐ IV Access
☐ IO Access
☐ IV Fluids
☐ Medications

Basic Life Support

☐ Bleeding Control	☐ Splint Extremety
☐ Burn Care	☐ Splint Traction
☐ Glucose Check	☐ Spinal Immob.
☐ OB Care	☐ Other

Narrative

Signatures

Physician Note:

Func.	Printed Name	Signature	VA. Certification No.
AIC			FR EMT Enh. Int. P

Physician's Signature/Printed Nan **DEA#**

Drug Box #1		Drug Box #2	
Old		Old	
New		New	

Narcotics Accounted For:

*** This form is not intended for use as a full EMS medical record**