Peoria Area EMS System

NARRATIVE

SERVICE NAME	SERVICE #	TODAY'S DATE M M D D Y Y Y Y
INCIDENT LOCATION	HOSPITAL DESTINATION	

PATIENT INFO

PATIENT LAST NAME	FIRST	M.I.	HOME PHONE #	AGE	DATE OF BIRTH M M D D Y Y Y Y
STREET ADDRESS					
CITY	STATE	ZIP CODE	LEGAL GUARDIAN		

ALLERGIES (MEDS) ○ NONE KNOWN

CURRENT MEDICATIONS ○ NONE KNOWN ○ BROUGHT W/PT.

CHIEF COMPLAINT

NARRATIVE

TIME	P	R	B/P	TEMP	BS	RHYTHM	TREATMENT	DOSE	ROUTE	O2 SAT.	COMMENTS

LEFT	LUNG SOUNDS	RIGHT
I L	CLEAR	I L
I L	RHONCHI	I L
I L	RALES	I L
I L	WHEEZES	I L
I L	DIMINISHED	I L
I L	ABSENT	I L

SKIN TEMP	Initial	Last
NORMAL	☐	☐
COOL	☐	☐
COLD	☐	☐
HOT	☐	☐
WARM	☐	☐

SKIN MOISTURE	Initial	Last
NORMAL	☐	☐
MOIST	☐	☐
DRY	☐	☐
WET	☐	☐

SKIN COLOR	Initial	Last
NORMAL	☐	☐
PALE	☐	☐
CYANOTIC	☐	☐
FLUSHED	☐	☐
JAUNDICED	☐	☐
MOTTLED	☐	☐
ASHENED	☐	☐

ABDOMEN	Initial	Last
NORMAL	☐	☐
SOFT	☐	☐
RIGID	☐	☐
DISTENDED	☐	☐
TENDER	☐	☐

SIGNATURE OF PERSON RECEIVING PATIENT

X _____

ENTER NUMBER FROM 3-PART FORM/DATA SHEET

CREW SIGNATURES

	DRIVER	COMPLETED REPORT
CREW MEMBER 1 _____	D	R
CREW MEMBER 2 _____	D	R
CREW MEMBER 3 _____	D	R
CREW MEMBER 4 _____	D	R

(Signatures should correspond with license numbers on back of data sheet.)

White - Service/Provider Copy Pink - Receiving Facility Copy Yellow - EMS Resource Hospital Copy