OSF SAINT FRANCIS MEDICAL CENTER

PEORIA AREA EMS

Hello everyone,

We have added the stroke assessment tools to the PAEMS *Preliminary Field Medical Report Form*, more commonly called "*Short Form*." You will find this new information listed under the *Present Illness* section. If you suspect that your patient is having a stroke please check "YES" and then check all the items underneath that apply. After checking all that apply; note the time that the patient was seen without having the symptoms in the blank provided.

Also take note on the short form that there is now a place to note the patient's weight as well as blood sugar. If you suspect possible stroke blood sugar and patient weight need to be noted.

The level of consciousness and possible stroke areas are now in the light gray color and are mandatory to complete for each patient.

Possible Stroke Definitions:

***Aphasia – Difficulty finding the right words (also described as word salad), or mute. Not just slurred speech alone.***

***Dysarthria – difficult or unclear articulation of speech that is otherwise linguistically normal.***

***Gaze palsy – eyes deviated to one side or unable to cross midline***

***Neglect – not able to pay attention to one side (right or left)***

Thank you for your corporation in implementing this new version of the short form.

-PAEMS Staff

**Peoria Area Emergency Medical Services System**
304 E. Illinois Ave, Peoria, IL 61603 Phone (309) 655-2113 Fax (309) 655-2090 www.paems.org

Patient Label

OSF
SAINT FRANCIS MEDICAL CENTER
Peoria, IL

**Preliminary Field Medical Report Form**
H0060-82501-08-1365-1 (Rev. 03/17)
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H0060-1365

Provider Agency: _____ Unit: _____
Log #: _____ Time: _____

# Peoria Area EMS System

Light Gray Sections are MANDATORY!

SIGNIFICANT BODY EXPOSURE: ☐ YES ☐ NO

| DATE OF CALL | DISPATCH NUMBER |
|---|---|
| | |

**TIMES (NOT VERIFIED)**

| Alarm | At Scene | At Hospital | Available | Cleared |
|---|---|---|---|---|
| | | | | |

**SERVICES PROVIDED**
☐ ALS ☐ ILS ☐ BLS

**RECEIVING HOSPITAL**

**PATIENT INFORMATION**
NAME (LAST) (FIRST) (MI)
HOME ADDRESS
CITY / STATE / ZIP AGE GENDER M F

**LOCATION OF CALL**

**PT MOVED / AMBULATING PTA**
☐ YES ☐ NO

**PATIENT FOUND**
☐ LYING ☐ STANDING
☐ SITTING ☐ ENTRAPPED

**PAST HISTORY**
☐ CARDIAC ☐ HTN ☐ SEIZURE
☐ DIABETIC ☐ ASTHMA ☐ COPD

**FAMILY MD**

**PATIENT COMPLAINT / ONSET**

**MEDS**
☐ None ☐ Unknown

OTHER MEDICAL HX:

PT. WEIGHT_____

**PRESENT ILLNESS**

**LEVEL OF CONSCIOUSNESS**
☐ ALERT
☐ VERBAL
☐ PAINFUL
☐ UNRESPONSIVE
☐ LOC
☐ BLOOD SUGAR_____

**POSSIBLE STROKE?** ☐ YES ☐ NO
MARK ALL THAT APPLY
☐ DROWSY ☐ DIZZY
☐ DOUBLE VISION ☐ DYSARTHRIA
☐ APHASIA ☐ GAZE PALSY
☐ NEGLECT
☐ WEAKNESS (FACE, ARM, LEG)
☐ LOSS OF SENSATION (FACE, ARM, LEG)
☐ LOSS OF VISION (ONE OR BOTH EYES)
RECORD TIME LAST SEEN WITHOUT SYMPTOMS_____
*If symptoms <6 hours call stroke alert to receiving hospital.*

**CARDIAC / RESPIRATORY**
☐ CHEST PAIN
☐ RADIATION_____
☐ PAIN SHARP / DULL
☐ PAIN WORSE
☐ INSPIRATION
☐ EXPIRATION
☐ DYSPNEA
☐ OTHER:_____

**GI / GU**
☐ PAIN: _____
☐ NAUSEA / VOMITING
☐ COFFEE GROUND EMESIS
☐ TARRY STOOLS
☐ DIARRHEA
☐ VAGINAL DISCHARGE / BLEEDING

**ALLERGIES**
☐ None ☐ Unknown

**PHYSICAL EXAM**

**SKIN COLOR**

| INITIAL | | LAST |
|---|---|---|
| ☐ | NORMAL | ☐ |
| ☐ | PALE | ☐ |
| ☐ | CYANOTIC | ☐ |
| ☐ | FLUSHED | ☐ |
| ☐ | JAUNDICED | ☐ |
| ☐ | MOTTLED | ☐ |
| ☐ | ASHENED | ☐ |

**SKIN TEMP**

| INITIAL | | LAST |
|---|---|---|
| ☐ | NORMAL | ☐ |
| ☐ | COOL | ☐ |
| ☐ | COLD | ☐ |
| ☐ | HOT | ☐ |
| ☐ | WARM | ☐ |

**SKIN MOISTURE**

| INITIAL | | LAST |
|---|---|---|
| ☐ | NORMAL | ☐ |
| ☐ | MOIST | ☐ |
| ☐ | DRY | ☐ |
| ☐ | WET | ☐ |

**NEURO**
PUPILS
REACT: ☐ YES ☐ NO
EQUAL: ☐ YES ☐ NO
SIZE: R: _____ L: _____
OTHER: _____

**LUNG SOUNDS**

| LEFT | | 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 |

DISTRESS: ☐ MILD ☐ MODERATE ☐ SEVERE

**GI / GU**
☐ TENDERNESS
☐ GUARDING
☐ RIGIDITY
☐ OTHER:

**PELVIS**
STABLE ☐ YES ☐ NO
PAIN ☐ YES ☐ NO
INCONTINENT? ☐ YES ☐ NO

**EXTREMITIES**
MAEW ☐ YES ☐ NO
EDEMA ☐ YES ☐ NO
TRAUMA ☐ YES ☐ NO

**GLASGOW COMA SCALE**

**EYE OPENING**
☐ SPONTANEOUS
☐ TO SPEECH
☐ TO PAIN
☐ NONE

**VERBAL RESPONSE**
☐ ORIENTED
☐ DISORIENTED
☐ INCOHERENT
☐ MOANS
☐ NONE

**MOTOR RESPONSE**
☐ OBEYS
☐ LOCALIZES
☐ WITHDRAWS
☐ DECORTICATE
☐ DECEREBRATE
☐ NONE

| TIME | PULSE | RESP | BP | AVPU | RHYTHM | 02 SAT | TREATMENT | DOSE | ROUTE | RESPONSE |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

Comments - _____

**SIGNATURE OF PERSON RECEIVING PATIENT**
X_____

☐ CODE SUMMARY ATTACHED ☐ RHYTHM STRIPS ATTACHED ☐ TRAUMA SUPPLEMENT / CONTINUUM ATTACHED

**CREW SIGNATURES**
PRIMARY PROVIDER: _____ ID: _____
SECONDARY PROVIDER: _____ ID: _____