RUN REPORT # | Date of Run (Mo. Day Century Year) | Ambulance Service # | Vehicle ID # | Ambulance Service Name

PATIENT INFORMATION

Last Name | First Name | M.I. | Date of Birth (Mo. Day Century Year) | AGE IN YEARS:

Street, Route, etc. | City

Phone | County | State | Zip

RACE: 1 Black 2 White 3 Hispanic 4 Other

SEX: 1 Male 2 Female

LOCATION OF PICKUP

Name of Hospital, Nursing Home, Clinic, or Street, Route, Highway #

City | County | State | Zip

PATIENT DESTINATION

Name of Hospital, Nursing Home, Clinic, Ambulance Service, Home, etc.

City | State

TYPE OF RUN

TO SCENE
1 Emergency response requested
2 Non-emergency response (routine) requested

FROM SCENE
01 Life threatening, transported
02 Urgent, transported
03 Routine, transported
04 Dry run, no transport

TIMES

Call Received | Unit Dispatched | Unit En Route | Arrive Location | Arrive Patient | Depart Location | Arrive Destination | Unit Available

PLACE OF INCIDENT

0 Home
1 Farm
2 Mine/Quarry
3 Industrial Place
4 Recreation/ Sport
5 Street or Highway
6 Public Building
7 Residential Institution (hospital)
8 Other
9 Unspecified

LICENSE NO.

Driver:
Att. #1:
Att. #2:

VITAL SIGNS

Systolic Blood Pressure
Respiratory Rate
Glasgow Coma Score

PROTECTIVE EQUIPMENT

1 None 4 Child Seat 7 Helmet
2 Unknown 5 Air Bag 8 Other
3 Seat Belt 6 Belt & Bag 9 Not Applicable

BILLING INFORMATION

Guarantor's Name (if different from patient) | Relationship

Address | Phone #

City | State | Zip Code

Patient Social Security # | Employer

Guarantor Social Security # | Employer

Insurance Company, Group & Policy Numbers | Worker's Comp. ☐ V.A. ☐

Advance Beneficiary Notice ☐

Medicare # | State | P.C.S. ☐ Private Pay ☐

Medicaid # | State

ACTUAL MILEAGE TO SCENE: _____ MILEAGE FROM SCENE TO DESTINATION: _____

FACTORS AFFECTING EMS

01 Adverse weather
02 Adverse road conditions
03 Vehicle problems
04 Unsafe scene
05 Language barrier
06 Extrication > 20 minutes
07 Hazardous materials
08 Crowd control
09 Med. control failure
10 Other
11 Not applicable

TREATMENT AUTHORIZATION

1 On-line (radio/telephone)
2 On-scene
3 Protocol
4 Written orders (patient specific)
5 Orders refused
6 Unknown
7 Not applicable

TRAUMA ASSESSMENT

	Amputation	Burn	Crush	Dislocation/FX	Blunt	Gunshot	Laceration	Puncture/Stab	Pain	Soft Tissue
Head	00	10	20	30	40	50	60	70	80	90
Face/Eye/Ear	01	11	21	31	41	51	61	71	81	91
Neck	02	12	22	32	42	52	62	72	82	92
Spine	03	13	23	33	43	53	63	73	83	93
Thorax	04	14	24	34	44	54	64	74	84	94
Abdomen/Pelvic Contents	05	15	25		45	55	65	75	85	95
Upper Arm/Shoulder	06	16	26	36	46	56	66	76	86	96
Lower Arm/Hand/Elbow	07	17	27	37	47	57	67	77	87	97
Upper Leg/Hip	08	18	28	38	48	58	68	78	88	98
Lower Leg/Foot/Knee	09	19	29	39	49	59	69	79	89	99

Cause of Injury | Time of Injury

ILLNESS ASSESSMENT

01 Abdominal pain/problems
02 Airway obstruction
03 Allergic reaction
04 Altered level of consciousness
05 Behavioral/psychiatric
06 Cardiac arrest
07 Cardiac rhythm disturbance
08 Chest pain/discomfort
09 Diabetic symptoms
10 Hyperthermia
11 Hypothermia
12 Hypovolemia/shock
13 Inhalation injury (toxic gas)
14 Poisoning/drug ingestion
15 Pregnancy/O.B. delivery
16 Respiratory arrest
17 Respiratory distress
18 Seizure
19 Smoke inhalation
20 Stroke/CVA
21 Syncope/fainting
22 Vaginal hemorrhage
23 Other
24 Unknown
25 Not applicable

DESTINATION DETERMINATION

01 Closest appropriate facility (if not, check one below)
02 Patient/family preference
03 Physician preference
04 Managed care
05 Law enforcement choice
06 Protocol
07 Specialty resource center
08 On-line medical direction
09 Diversion (name of hospital diverted from)
10 Other
11 Unknown
12 Not applicable

TREATMENT

D	Att.		D	Att.		D	Att.		D	Att.	
01	02	Bag mask/demand valve ____ lpm	19	20	Drug administered	39	40	I.V. administered # ____	59	60	Oxygen by mask ____ lpm
03	04	Bleeding controlled	21	22	Endotracheal intubation	41	42	I.V. failed # ____	61	62	P.C.P.D. applied
05	06	Blood specimen drawn	23	24	Oral or nasal tracheal tube failed # ____ attempts	43	44	I.V. maintained	63	64	Pulse oximetry
07	08	C.P.R.	25	26	Other airway	47	48	Intraosseous infusion # ____	65	66	Spinal immobilization
09	10	Cardiac pacing	27	28	EKG monitor	53	54	N.G. tube	67	68	Restraints
11	12	Cardioversion # ____ attempts	29	30	Extremity splint	55	56	O.B. delivery	69	70	Suction airway
13	14	Cricothyrotomy	31	32	Extrication ____ time	57	58	Oxygen by cannula ____ lpm	71	72	Chest Decompression
15	16	Defibrillation ____ watts/sec. # ____ attempts	35	36	Glucose test ____ mg/dl				75	76	Other ____

REVISED 05-07-03

MID-AMERICA REGIONAL COUNCIL EMERGENCY RESCUE (MARCER)

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TRIP NO. | WAIT TIME

☐ Hospital to hospital for testing/treatment, specify _____

Supp. Medical Info.: A ___ B(1) Y☐ N☐ B(2) Y☐ N☐ C Y☐ N☐

Weight: ___ (kgs)

Pri. | Sec. | Sec. | Sec.

CREW

EMT: | Paramedic #1: | Att. #2:

EMT: X | Paramedic #1: X | Att. #2: X

ODOMETER

At dispatch | At scene | At destination

Dispatch Code: | Dispatch Nature: | Chief Complaint:

Patient was preferentially routed due to: ☐ Trauma ☐ Cardiac Patient's Physician _____

HPI/MOI/TxPTA:

PERTINENT POSITIVES & PERTINENT NEGATIVES

Dyspnea - Pos. Neg. | Chest discomfort - Pos. Neg. | Extremity numbness - Pos. Neg. | Extremity tingling - Pos. Neg. | Nausea - Pos. Neg. | LOC - Pos. Neg. | Head discomfort - Pos. Neg. | Neck discomfort - Pos. Neg. | Back discomfort - Pos. Neg. | Weakness - Pos. Neg. | Other, specify:

PRE-EXISTING CONDITIONS (Check those that apply)

☐ Pt. Denies ☐ Unk. ☐ Cardiac | ☐ HTN ☐ CHF ☐ CABG | ☐ Behavioral/psych ☐ ETOH/Subst. abuse ☐ Dialysis/renal failure | ☐ Cancer ☐ Seizures ☐ CVA | ☐ Hemiparesis ☐ Paraplegic ☐ Quadriplegic | ☐ Comm. disease ☐ Diabetes ☐ -Ostomy? specify: | ☐ Amputee?, specify where: _____ ☐ Prosthesis?, specify where: _____ | ☐ Shunt?, specify where: _____ | ☐ Other: _____

ALLERGIES ☐ NKDA List:

PERSONAL EFFECTS ☐ None ☐ Specify:

AIRWAY: ☐ Self maintained ☐ Partial obstruction ☐ Closed, interv. req'd

BREATHING: ☐ Non-labored ☐ Labored ☐ Normal depth ☐ Shallow ☐ Absent

CIRCULATION: ☐ Strong ☐ Weak ☐ Absent | ☐ Radial ☐ Femoral ☐ Carotid

GCS: 1°/2° E = ___/___ V = ___/___ M = ___/___ Time = ___/___ 2nd Glucose: _____ mg/dl _____ Time

Medical control name/hospital _____ Person receiving patient X _____

Medications:

HEENT	☐ PERRL ☐ Pink mucosa ☐ Not examined
Neck	☐ No JVD ☐ Trachea midline ☐ Not examined
Chest	☐ CEBBS ☐ Not examined
Heart	☐ Regular rate & rhythm ☐ Not examined
EKG	☐ NSR, no ectopy ☐ Lead(s) used, specify: ☐ Not examined
Back	☐ Not examined
Abdomen	☐ Soft, not-tender ☐ Not examined
Extremity	☐ No pedal edema ☐ Nail beds pink ☐ Not examined
Pelvis	☐ Intact to stress ☐ Not examined
Gen/Rect	☐ No incontinence ☐ No bleeding ☐ Not examined
Skin	☐ Normal color, warm, dry ☐ Not examined
Neuro	☐ MAE ☐ SAE ☐ Not examined **CPSS** ☐ No slurred speech ☐ No facial droop ☐ No arm drift

Additional notes or treatment:

Patient Received NPP ☐ Yes ☐ No Impression:

Time	B.P.	Pulse	Resp.	SaO2	Time / PM#	Intervention / Medication	Route	Fluid Infusion / Dosage	Rhythm	Time / PM#	Intervention / Medication	Route	Fluid Infusion / Dosage	Rhythm

AMBULANCE SERVICE COPY

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