Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13096

4 - ER URGENT

[redacted]

CALL DATE:	CALL TIME:	PATIENT GENDER:	PATIENT AGE:	PATIENT WEIGHT (Kg):
07 / 12 / 98	1002	F	37	160 KG

PATIENT NAME (Last, First, M.I.): [redacted]

CALL LOCATION (Incl. Address or Roadway Description; & City, Town, or Area): [redacted]

PATIENT ADDRESS (address, city, state, zip): [redacted]

Rx MEDICATIONS: NONE

HISTORY

CHIEF COMPLAINT: CARDIAC ARREST

Hx & ONSET: DOWN TIME APPX 20 MIN BEFORE CPR STARTED (HUS-

PAST MED/SURG Hx: NONE BAND LAST SAW PT 1/2 HR BEFORE HE FOUND HER IN FULL-ARREST)

	TIME	B/P	PULSE	RESP
1	1025	0	0	0
2		↓	↓	↓
3				
4				
5				
6				
7				

PHYSICAL EXAM

GENERAL APPEARANCE:

DISTRESS LEVEL:

CONSCIOUSNESS LEVEL: UNCONSCIOUS, APNEIC + PULSELESS

SKIN VITALS: PURPLE FROM JUST BELOW CLAVICLES + UP, COOL + DRY

HEENT: FIXED + DILATED, A-TRAUMATIC

NECK: NO JVD OR TRACH DEVIATION

CHEST/LUNGS: CLEAR + EQUAL BREATH SOUNDS AFTER INTUBATION

BACK: A-TRAUMATIC

ABDOMEN/PELVIS: DISTENDED + TIGHT

EXTREMITIES: FLACCID, COOL

CARDIOVASCULAR: NO PULSES, ASYSTOLE ALL LEADS

NEURO: N/A

SPINE IMMOBILIZATION:

- ○ Hard C-Collar SIZE:
- ○ Tape
- ○ Head Immob TYPE:
- ○ Bk Board/Scoop TYPE:
- ○ Short Bd/KED TYPE:

ACTION, TREATMENT, ASSESSMENT UPDATES (IN SEQUENCE):

FOUND PT ON FLOOR c̄ CPR IN PROGRESS BY [redacted] PT LAST SEEN @ APPX 0930 HRS. HUSBAND WENT TO CHECK ON HER + FOUND HER IN FULL ARREST. HE STARTED CPR IMMEDIATELY. UPON ARRIVAL OF [redacted] THEY TOOK OVER CPR + APPLIED AED. NO SHOCKS WERE ADMINISTERED. UPON OUR ARRIVAL PT FOUND AS ABOVE. INTUBATION c̄ 7.5 ET TUBE, CORDS VISUALIZED, TAPED @ 24 CM. GOOD BREATH SOUNDS BILAT. IV EST LAC FLUSH, 1 mg EPI + 1 mg ATROPINE GIVEN, NO RESPONSE. ECG STILL ASYSTOLE. GLUCOSE = 88 mg/dl. CPR CONT. LOG-ROLLED TO FLAT → AMB → CPR CONT → EPI + ATROPINE

EMT-P PROTOCOL USE: ○ NONE ○ LEVEL I ◉ LEVEL II

REASON FOR EMT-P PROTOCOL USE:

PHYSICIAN ASSESSMENT O[redacted]ROTOCOL USE:

PHYSICIAN: [redacted]

(print name) (Signature [redacted] Protocol Use Only)

ALLERGIES: NKA

DIAGNOSIS: CARDIO-PULMONARY ARREST

COMPLETED BY: ○ [redacted]

DELETED FORM INV #:

ORIGINAL — EMS
#1 COPY — PROVIDER
#2 COPY — RECEIVING FACILITY

INVOICE #: [redacted]

Complies with Privacy Act (Medical Record)

Page # 1 OF 2 [redacted]

000002

[redacted]

[redacted]

CALL DATE: 07 / 12 / 98 CALL TIME 1002

PATIENT ADDRESS (address, city, state, zip): [redacted]

PATIENT (last): [redacted] NAME (first): [redacted]

CALL LOCATION (Incl. Address or Roadway Description; & City, Town, or Area): [redacted]

ADDITIONAL NARRATIVE: This form is used for documentation of information that will not fit on the previous Narrative Form. Multiple sheets may be used as necessary for a single case. Each narrative form MUST be signed by the person completing the form (complete form, print name & sign). Diagnosis, Allergies, Physician Assessment, Reasons for Protocol Use, Physician Signature are all required on last Narrative Form completed.

NARRATION: (Print) GIVEN, NO RESPONSE. IV NO LONGER FLOWING WELL. NEW IV EST (R) EJ, FLOWING WELL, 1 AMP BICARB GIVEN; 2 mg NARCAN, PT IN VERY FINE V-FIB → SHOCKED @ 200 j, SHOCK @ 300 j, BACK TO TOTAL FLAT LINE. CPR CONTINUED → 1 mg EPI GIVEN, NO RESPONSE, [redacted] ON BOARD DURING TRANSPORT. ARRIVED @ HOSP W/O IMPROVEMENT IN PT STATUS. LEFT PT IN CARE OF STAFF, CPR IN PROGRESS.

EMT-P PROTOCOL USE: ○ NONE ○ LEVEL I ◉ LEVEL II

REASON FOR EMT-P PROTOCOL USE:

ALLERGIES: NKA

000003

PHYSICIAN ASSESSMENT OF EMT-P PROTOCOL USE:

DIAGNOSIS: CARDIO - PULMONARY ARREST

COMPLETED BY: ○ [redacted] ◉ [redacted]

PHYSICIAN: [redacted]

(print name) (Signature Level I/II EMT-P Protocol Use Only)

FORM INV #: [redacted]

Page # 2 OF 2

ORIGINAL – EMS
#1 COPY – PROVIDER
#2 COPY – RECEIVING FACILITY

[redacted]

[redacted]

[redacted]

EMERGENCY DEPARTMENT RECORD

Bed [redacted]

DATE ADMITTED 7.12.98 [redacted] TIME 1110

MODE OF ARRIVAL ☐ Ambulance ☐ Sheriff ☐ Private Auto ☒ Paramedic

CONDITION ☐ Good ☐ Fair ☐ Poor ☐ Serious ☒ Critical [redacted]

CHIEF COMPLAINT Full arrest

RT. 20/ N LT 20/

HISTORY

TETANUS

ALLERGIES Unknown

WEIGHT (kgs.) A

MEDICATIONS

L.M.P.

Time	Blood Pressure	Temp	Pulse	Resp.	OXIM. FIO2	Time	Blood Pressure	Temp	Pulse	Resp.	OXIM. FIO2
1110	0	—	0	24 ASSIST							

DR. ORDERS

LAB

- CBC
- 7 PANEL
- U/A
- CARDIAC W/U
- ABG ___ FI02
- EKG

X-RAY

- CHEST
- ABDOMEN
- SKULL
- SPINE

MISC

- PULSE OX.
- O2
- MONITOR
- ORTHOSTATICS

MEDICATIONS/PROCEDURES

CHIEF COMPLAINT 37 y/o ♀ - arrived by ambulance in full arrest -

HISTORY: TIME epi - atropine + bicarb given on way in -

Agonal Asystole rhythm in 2 leads -

PAST High dose epi 5mg given IV +

FAMILY shock c̄ 360 j. x2 no response -

SOCIAL A total of 4 amps of bicarb + 4 high

PHYSICAL EXAM: dose epi given c̄ intervening

defib at 360 - no response -

Pupils fixed + dilated on arrival

Has face - neck + chest venous stasis

+ (2) leg - on arrival - ET tube

aerating both lungs - blood gas

pH 6.909 pO2 57 O2 sat 66% PCO2 99

HCO3 9.9 Base -22 - K 1.6 others out of range

Arrived 11:10 & code called at 11:35 -

Patient never had any pulse or spontaneous

electrical activity - attempts at electrical

pacing - no pulse c̄ electrical activity

at end frothy red material from ET tube -

Husband found her in bathroom without pulse

RE EXAM: TIME or breathing for unknown length of time -

TREATMENT:

[redacted] case # [redacted]

PLAN:

CONSULT/REFERRAL: Time Issued | Time Responded:

DIAGNOSIS D.O.A. R/O P.E.

PHYSICIAN SIGNATURE [redacted]

REVIEW OF SYSTEMS
Check appropriate square & describe abnormal or pertinent findings

SYSTEM	NOR	AE
Skin		
E.N.T.		
Eyes		
Head		
Neck		
Chest		
Heart		
Lungs		
Abd.		
Ext.		
Rectal		
Genital		
Neuro		
Back		

DISPOSITION OF PATIENT:

- ☐ RELEASED
- ☐ REFUSED TREATM
- ☐ REFERRED TO PHYSICIAN'S OFFIC
- ☐ PATIENT TRANSFER
- ☐ PATIENT ADMITTED

CONDITION OF DISCHA

- ☐ GOOD ☐ FAIR
- ☐ POOR ☐ CRIT
- ☐ SERIOUS ☐ DEAT
- ☒ D.O.A.
- ☐ UNDETERMINED

DATE & TIME D/C [redacted]

TRANSFERRED TO: T

6/4

000004

OCT 2 6 1998

MEDICAL RECORDS

[redacted]

[redacted]

EMERGENCY DEPARTMENT RECORD

Bed [redacted]

DATE ADMITTED	[redacted]	TIME	MODE OF ARRIVAL	CONDITION	PMD
7.12.98	[redacted]	1110	☐ Private Auto ☐ Ambulance ☑ Paramedic ☐ Sheriff	☐ Good ☐ Fair ☐ Poor ☐ Serious ☑ Critical	

CHIEF COMPLAINT: Full arrest

RT. 20/ ___ LT 20/ ___

HISTORY

TETANUS: 1/

ALLERGIES: Unknown

WEIGHT (kgs.): A

MEDICATIONS

L.M.P.

Time	Blood Pressure	Temp	Pulse	Resp.	OXIM. FIO2	Time	Blood Pressure	Temp	Pulse	Resp.	OXIM. FIO2
1110	Ø		Ø	Ø	/		/				/
	/				/		/				/

NEUROLOGICAL

EYE OPENING: 4 ☐ Spontaneous, 3 ☐ To voice, 2 ☐ To pain, 1 ☑ None, ☐ PERL, ☐ Unequal

MOTOR RESPONSE: 6 ☐ Obedient / Active, 5 ☐ Purposeful, 4 ☐ Withdrawal, 3 ☐ Flexion, 2 ☐ Extension, 1 ☑ None

VERBAL RESPONSE: 5 ☐ Oriented / Appropriate, 4 ☐ Confused, 3 ☐ Inappropriate, 2 ☐ Incomp, 1 ☑ None

GLASCOW COMA SCALE TOTAL: 3

MOVEMENT: ☐ Equal ☐ Weak ☐ Unequal ☐ Absent Location: none

CARDIOVASCULAR

4 – Bounding, 3 – Normal, 2 – Weak, 1 – Absent

PULSES: none Radial: L ___ R ___ Pedal: L ___ R ___

MONITOR: Time. Rhythm:

EDEMA: ☐ JVD ☐ Pedal ☐ Dependent ☐ Location:

RESPIRATORY

BREATH SOUNDS: present and = ☐ Normal ☐ Rales ☐ Retractions ☐ Wheezes ☐ Rhonchi ☐ Stridor Location:

RESP: none ☐ Regular ☐ Shallow ☐ Irregular ☐ Labored

OXYGEN: ☐ Cannula Time: ___ ☐ Mask L/min.: ___

INTUBATION: in field TIME ___ # ET TUBE ___

INTEGUMENTARY

COLOR: ☐ Normal ☐ Flushed ☐ Pale ☐ Jaundiced ☑ Cyanotic

TEMP: ☐ Warm ☐ Hot ☑ Cool

MOISTURE: ☑ Dry ☐ Moist

WOUND DESCRIPTION: Location: none ☐ Laceration ☐ Puncture ☐ Rash ☐ Other ☐ Abrasion ☐ Burn

GASTRO-INTESTINAL

ABDOMEN: ☐ Soft ☐ Firm ☐ Obese ☑ Distended ☐ Rebound ☐ Guarding

BOWEL SOUNDS: N/A ☐ Normal ☐ Absent ☐ Hypo ☐ Hyper

STOOL: ☐ Normal ☐ Black ☐ Red ☐ Loose ☐ Constipated Last BM:

GUIAC STOOL: ☐ + ☐ –

LOCATION OF PAIN: N/A

NG/LAVAGE: Time: ___ Size: ___ ☐ NS: ___ cc In ___ cc Out ☐ Suction Color: ___ Heme: ☐ + ☐

GENITO-URINARY

URINE COLOR: HEME ☐ + ☐ –

FOLEY: ☐ Yes ☐ No Time: ___ Amount: ___ cc

GYN

TYPE OF DISCHARGE: / DURATION: /A

PREG / E.D.C. [redacted] GRAVIDA PARA AB PELVIC

BY

ASSESSMENT PERFORMED BY [redacted] TIME 1110

MEDICATIONS

Time	Medication/Dose	Route	Signature
	See Code Sheet		

IV FLUIDS

Time	Site	Size	Solution/Medication	Rate
1 route	(R) jugular	NS	1L	WO
1114	(L) jugular	NS	1L	WO

[redacted]

000005

DATE	TIME	TITLE	NOTES
7/12	1110	[redacted]	Down approx. 45 min prior to EMS arrival. RT bagging c̄ 100% O2. CPR in progress. Pt cyanotic. No pulse or spontaneous respirations. Asystole
	1112		Asystole in 2 leads. ABG drawn. CPR continues
	1115		Possible fine V-Fib. Defib X2 c̄ 360 joules [redacted]

DISCHARGE EVALUATION: [redacted] office removed pt [redacted]

DISPOSITION OF PATIENT: ☐ ADMIT ☐ RELEASED ☐ REFUSED TREATMENT ☐ TRANSFER ☐ REFERRED TO PHYS. OFF. ☐ IN CUSTODY

CONDITION ON DISCHARGE: ☐ GOOD ☐ FAIR ☐ POOR ☐ SERIOUS ☐ CRITICAL ☐ UNDETERMINED ☑ D.O.A. ☒ DEATH - ED

DATE & TIME D/C: 7-12-98 AM PM

[redacted]

[redacted]

ACCT [redacted]

[redacted]

PATIENT'S PROGRESS RECORD
Continued Sheet

Time	Signs	Trauma Score	Medications - Treatment	Ass
1118	Asystole. CPR continued. Lab drawn			[redacted]
1121	Pupils fixed and dilated. Monitor shows asystole. Pt defibrillated x 2 @ 360 joules. Remains unchanged and in asystole			[redacted]
1122	#18 NG ~~tube~~ inserted. Placement confirmed.			[redacted]
1125	External pacer applied. MA 40, rate 70 c good capture. No pulse. CPR continued & RT [redacted] ventilating @ 100% O2			[redacted]
1128	Pt remains cyanotic and pulseless. ACLS continued			
1134	Defib x 2 @ 360 joules. Monitor shows asystole			
1135	Asystole. No pulse. Code called by Dr [redacted]			

[redacted]

[redacted]

ADDRESSOGRAPH

[redacted]

CARDIOPULMONARY RESUSCITATION FORM

Approximate Time of Arrest: approx 10

Time CPR Started: 1110 IN [redacted]

Prehospital Care
☐ None ☐ BCLS @ ____
☑ ACLS @ ____; Meds, I.V.'s etc.:
intubated by paramedics
atropine x2
Bicarb x 1

CPR Team:
MD in Charg[redacted]
[redacted]

Notification of: By:
Family @ husband present
Physician @
Chaplain @

Precordial Thump: ☐ No ☐ Yes Time: unknown Response: ____

Defibrillation or Cardioversion (Attach representative EKG strips to back.)

Dysrhythmia	Asystole	Asystole	Asystole	Asystole	Asystole	Asystole	
Time	1110	1115	1121	1125	1134	1135	
Watts/Sec		360j x1	360j x2	Pacer capture	360j x2		
Response		none	none	none	none		

Medications

Epinephrine	Dose/Rt	5mg IV	5mg IV	5mg IV	5mg IV	5mg IV	5mg IV		
	Time	1112	1118	1118	1130	1134	1138		
Sodium Bicarb	Dose/Rt	1 amp	1 amp	1 amp					
	Time	1126	1130	1131					
Calcium Chloride	Dose/Rt								
	Time								
Atropine	Dose/Rt								
	Time								
Isoproterenol	Dose/Rt								
	Time								
Lidocaine Bolus	Dose/Rt								
	Time								
Lidocaine Drip	Dose/Rt								
	Time								
Bretylium Bolus	Dose/Rt								
	Time								
Pronestyl	Dose/Rt								
	Time								
Dopamine Drip	Dose/Rt								
	Time								
Dobutamine	Dose/Rt								
	Time								
Levophed	Dose/Rt								
	Time								
Verapamil	Dose/Rt								
	Time								
	Dose/Rt								
	Time								
	Dose/Rt								
	Time								

Outcome:
☐ Survived
Disposition: ____
Time of Transfer: ____
Condition @ Transfer ____
Disposition of Valuables: ____
Total Time of Resuscitation: 25 minutes

Time CPR Stopped: 1135

☒ Expired @: 1135
Autopsy Requested: ☐ Yes ☐ No
Medical Examiner Notified:
☐ No ☒ Yes Time: ____
By: ____
Signature [redacted]

000007

NAME _____ RM _____ ADMIT DX _____

PRESENT THERAPY:

SUBJECTIVE: ( ) Could not obtain

DYSPNEA: ( ) None ( ) At rest ( ) Exercise ( ) At night

COUGH: ( ) Dry ( ) Sputum

PFT:

OBJECTIVE:

( ) Clear

CXR: Date

SPUTUM: ( ) Mucoid ( ) Purulent Amount

Description:

AUSCULTATION: ( ) Clear ( ) Wheezes ( ) Rales ( ) Rhonchi ( ) Other

ABG'S:	Date	Conditions	PH	PCO_2	PO_2	HCO_3

VITAL SIGNS: Pulse Resp. Rate

COMMENTS:

RECOMMENDATIONS & THERAPEUTIC OBJECTIVES:

Date Dr. Therapist Signature

RESPIRATORY SERVICES, S.O.A.P.

Date	Time	Title	NOTES
7/12/98	1110	Rcp	Rt previously Alerted - to tehachapi in paramedics full arrest - ACLS - Compressions - bagged in [redacted] 100% Amber bag 7.5 ET tube approx 24cm @ lip bs are equal by auscultation noted throughout CPR - ABL done reported to ER physician - ACLS continued - Drugs - Ox compression - defib - external pacemaker - bloody froth pee from ET tube mod/lg Amts 1130 Sx. No Response from ACLS pupils are fixed + dilated pronounced. @ 1135 AM [redacted]

PATIENT I.D. # [redacted]

NAM[redacted]

SEX F AGE 57 SS #

BIRTH DATE [redacted] MED REC # FIN CLASS

DOCTOR [redacted] ADMIT DATE

[redacted]

000008

[redacted]

PATIENT: [redacted] PHYSICIAN: [redacted]
MED REC # SEX: F BIRTHDATE: [redacted]

LOCATION: [redacted]
SPECIMEN NUMBER: [redacted] COLLECTED: 07/12/98 TIME 12:05PM
COMMENTS:

TEST NAME:	RESULTS		NORMALS		UNITS	TECH
PANEL 7						
SODIUM		SEE COMML	135	145	mmol/L	
POTASSIUM		1.6L	3.6	5.2	mmol/L	
CHLORIDE		SEE COMML	101	111	mmol/L	
TOTAL CO2		SEE COMML	21	31	mmol/L	
GLUCOSE		240H	70	110	mg/dl	
BUN	8.0		7.0	18.0	mg/dl	
CREATININE	0.9		0.8	1.3	mg/dl	

RESULT OUT OF INSTRUMENT RANGE---QUANITY NOT SUFFICIENT TO REPEAT OR RECHECK.

Reported 1125

PATIENT NAME [redacted] UNIT NO. ROOM [redacted]

AGE 39 SEX F TEST REQUESTED ABG

DIAGNOSIS Cardiac Arrest PHYSICIAN [redacted] DATE 7/12/98

% OR CONC. O_2 100% Res Bag TIME REPORTED 1118 / 1119

REPORT

pH 6.909 pCO_2 49 [redacted]

pO_2 57 HCO_3 9.9

O_2 Sat 66% Base -22.4 [redacted]

ARTERIAL BLOOD GAS

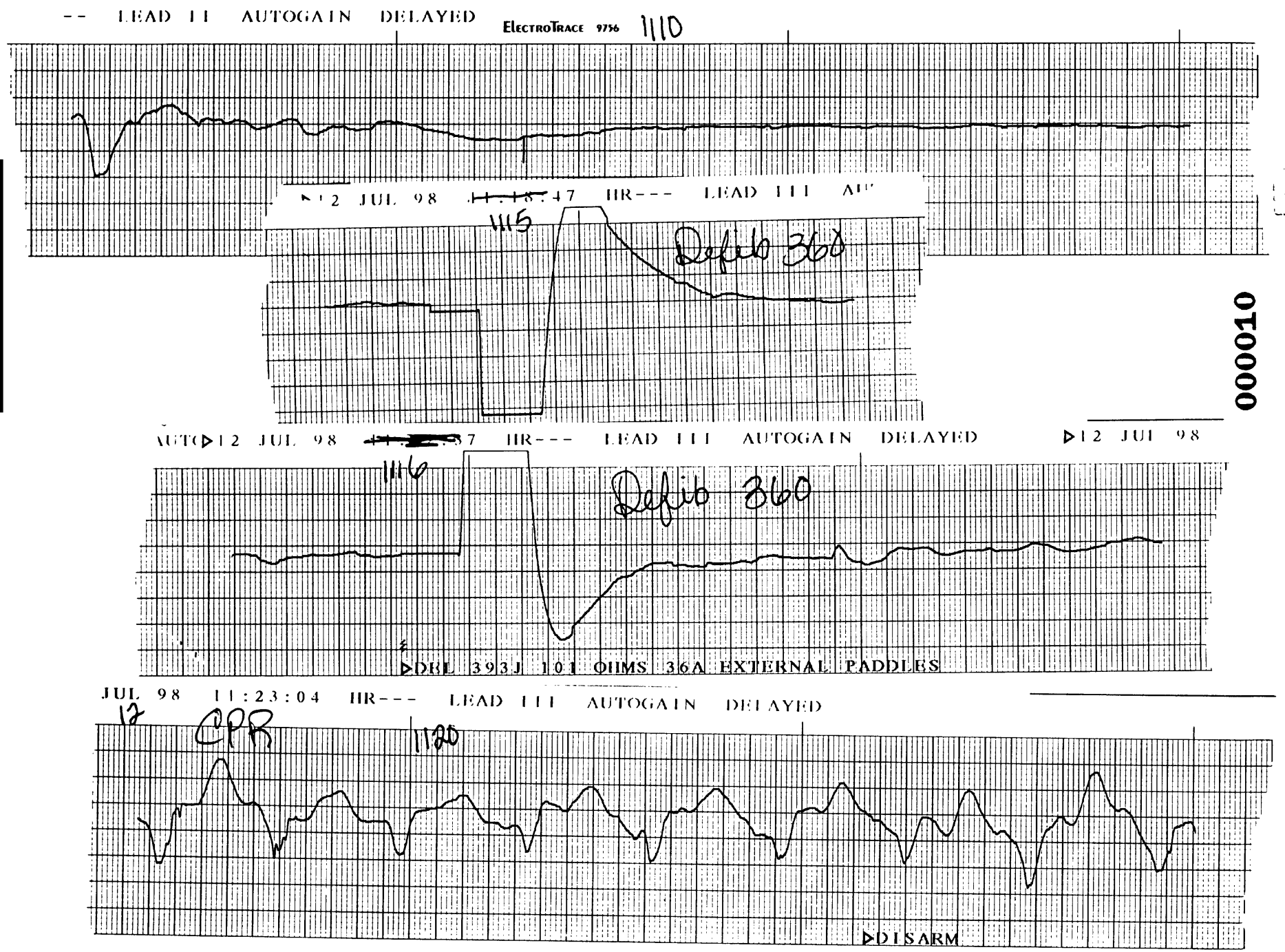
[redacted]

000009

PATIENT: [redacted] MED REC # [redacted] REPORT DATE: 07/12/98 12:08PM

MEDICAL RECORDS

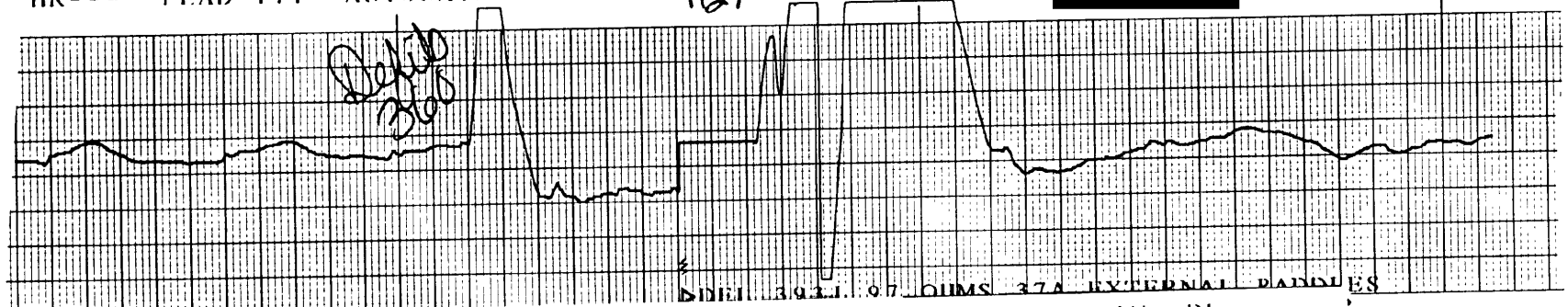
[redacted]


-- LEAD II AUTOGAIN DELAYED
ELECTROTRACE 9756
1110
12 JUL 98 11:18:47 HR--- LEAD III AU
1115
Defib 360
AUTO 12 JUL 98 11:18:57 HR--- LEAD III AUTOGAIN DELAYED 12 JUL 98
1116
Defib 360
DBL 393J 101 OHMS 36A EXTERNAL PADDLES
JUL 98 11:23:04 HR--- LEAD III AUTOGAIN DELAYED
12
CPR
1120
DISARM

000010

[redacted]

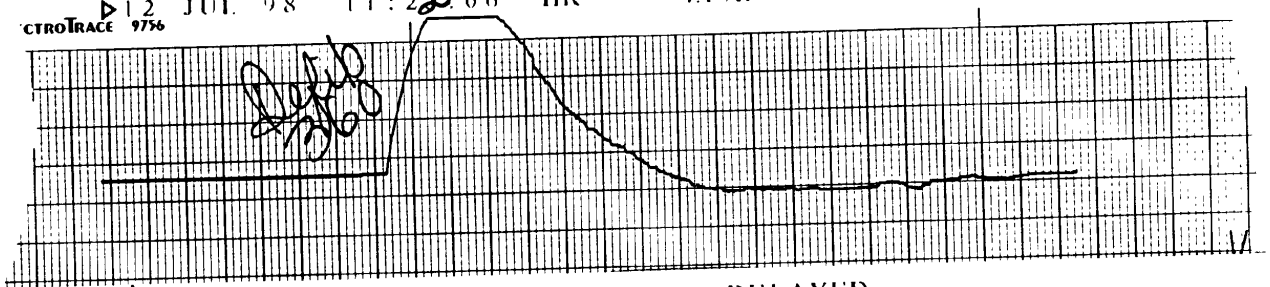
HR--- LEAD III AUTOGAIN DELAYED 1121 [redacted] ▷12 JUL 98



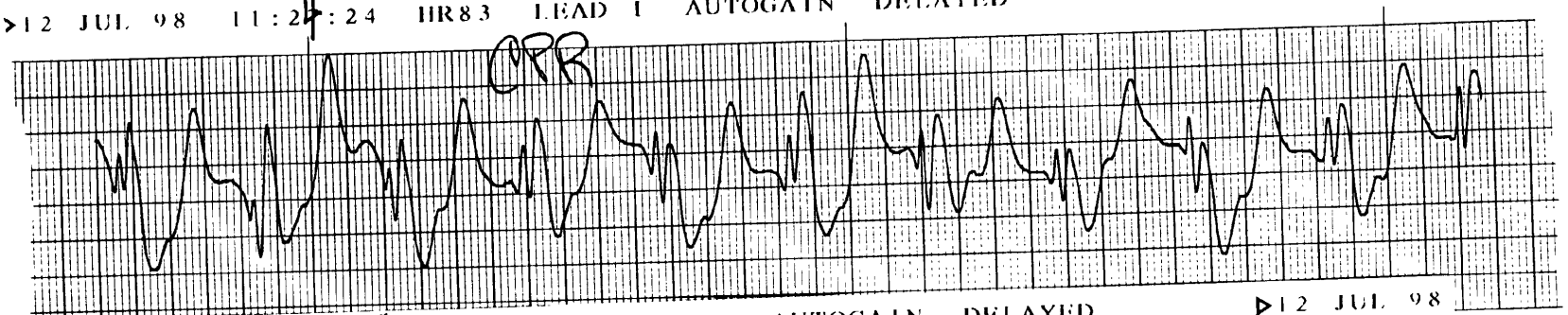
▷DEL 3931 97 OHMS 37A EXTERNAL PADDLES

▷12 JUL 98 11:22:06 HR--- LEAD I AUTOGAIN DI

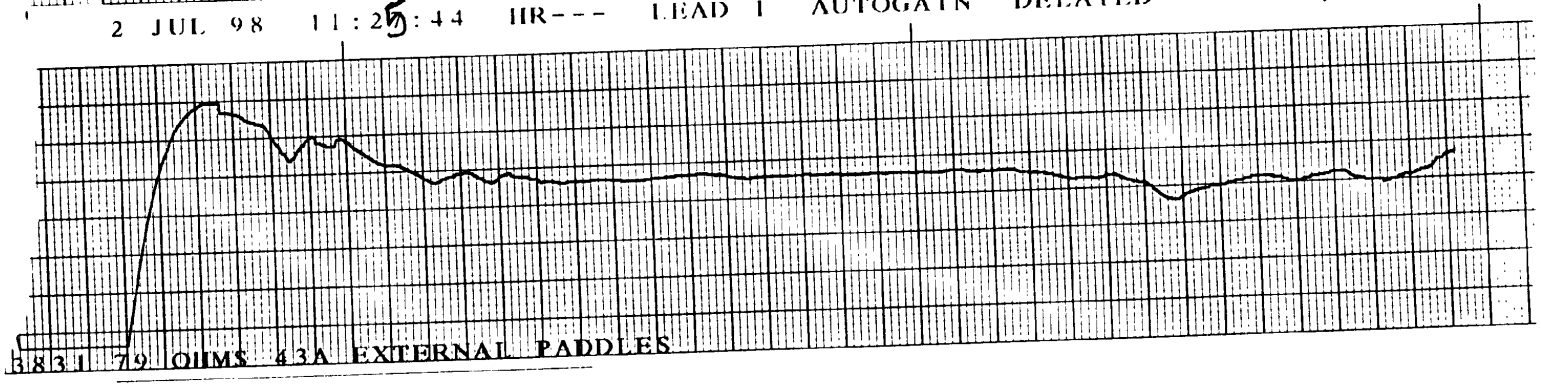
CTROTRACE 9756



▷12 JUL 98 11:24:24 HR83 LEAD I AUTOGAIN DELAYED



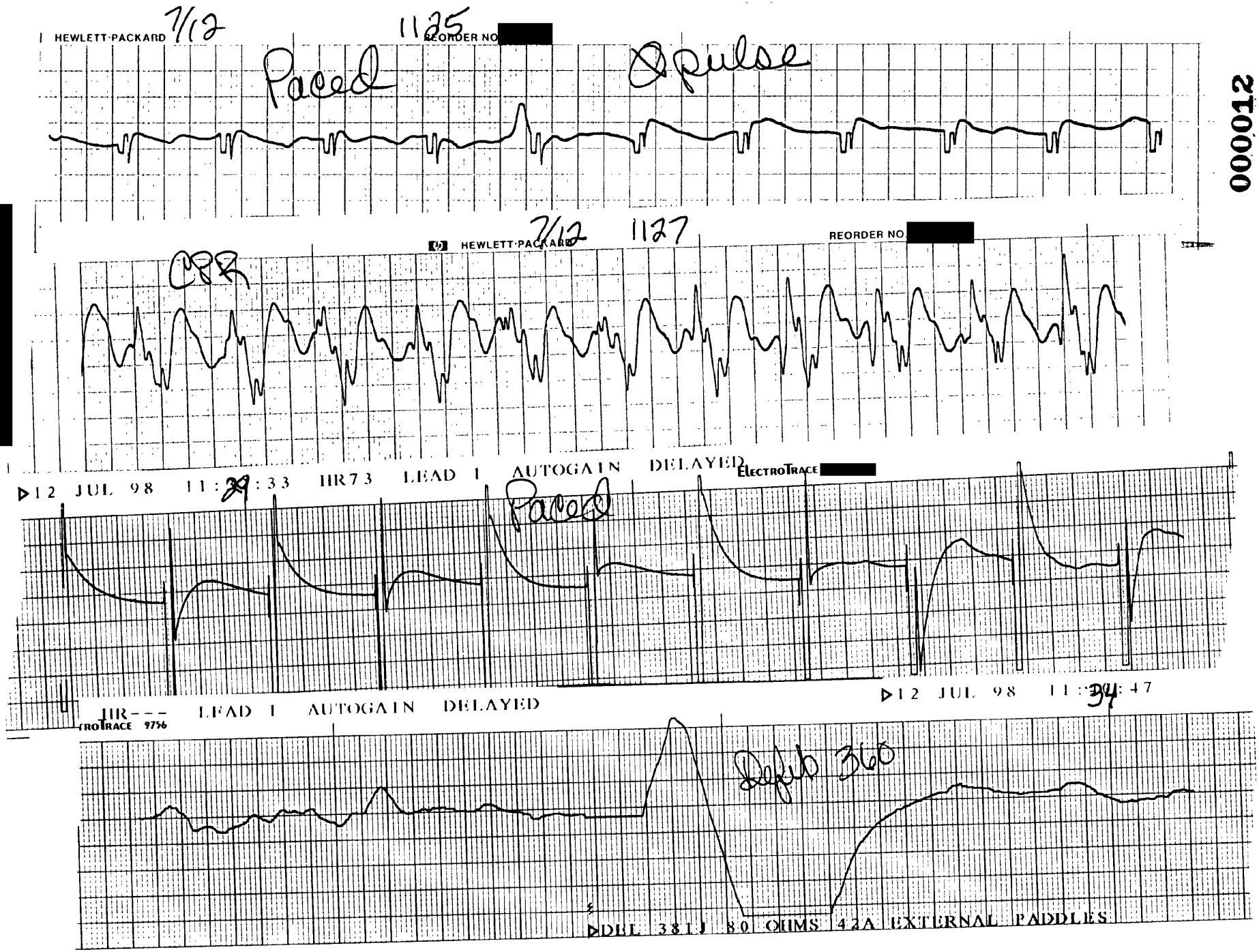
2 JUL 98 11:25:44 HR--- LEAD I AUTOGAIN DELAYED ▷12 JUL 98



3831 79 OHMS 43A EXTERNAL PADDLES

000011

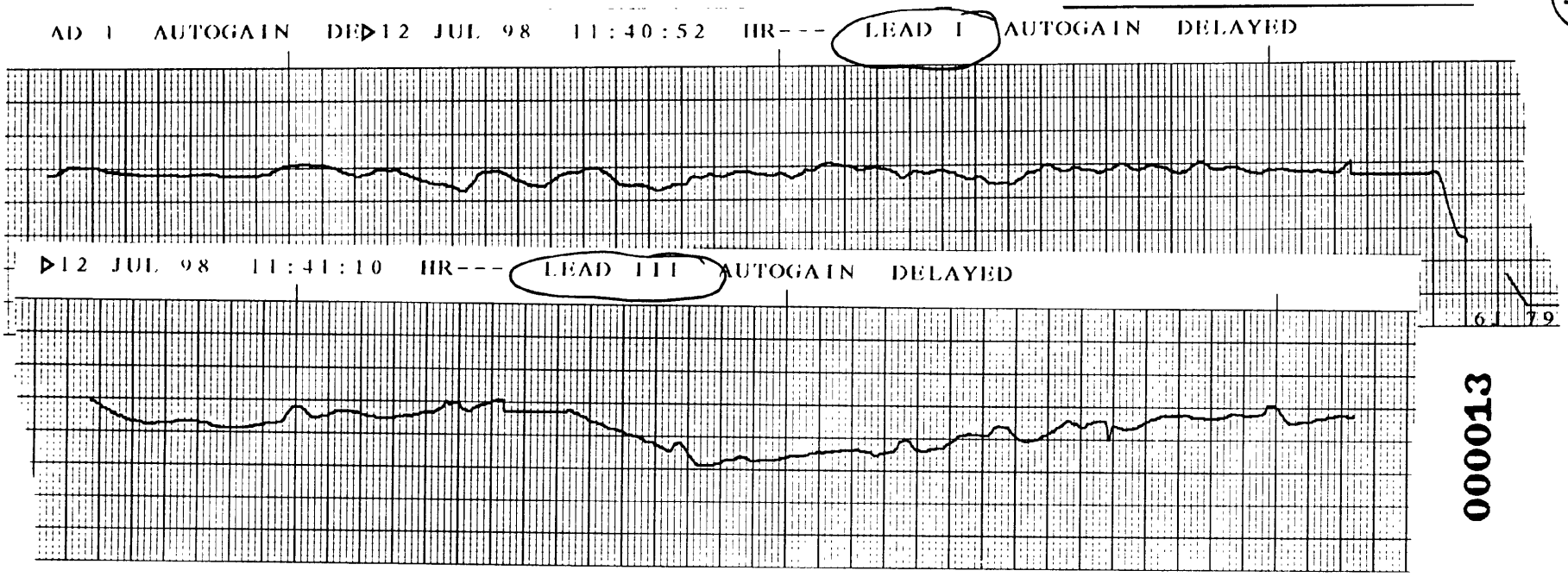
(8)


HEWLETT-PACKARD
7/12
1125
REORDER NO
Paced
Pulse
HEWLETT-PACKARD
7/12
1127
REORDER NO
CBR
12 JUL 98 11:39:33 HR73 LEAD I AUTOGAIN DELAYED
ELECTROTRACE
Paced
HR--- LEAD I AUTOGAIN DELAYED
12 JUL 98 11:39:47
ELECTROTRACE 9756
Defib 360
DBL 381J 80 OHMS 42A EXTERNAL PADDLES

000012

(3)

4


AD 1 AUTOGAIN DE▷12 JUL 98 11:40:52 HR--- LEAD I AUTOGAIN DELAYED
▷12 JUL 98 11:41:10 HR--- LEAD III AUTOGAIN DELAYED

000013

OTHER ER VISITS

[redacted]

EMERGENCY DEPARTMENT RECORD

[redacted]

DATE ADMITTED 7-1-98 | SEX/AGE F/C 34yr | TIME 0810 | MODE OF ARRIVAL ☒ Private Auto ☐ Ambulance ☐ Paramedic ☐ Sheriff | CONDITION ☐ Good ☐ Fair ☐ Poor ☒ Serious ☐ Critical | [redacted]

CHIEF COMPLAINT: Sore throat x 2 days

HISTORY: pt. male

ALLERGIES: None

MEDICATIONS: Tylenol (BCP)

HT 20/ ____ LI 20/ ____

TETANUS: N/A

WEIGHT (kgs)

LMP

Time	Blood Pressure	Temp	Pulse	Resp	OXIM FIO_2	Time	Blood Pressure	Temp	Pulse	Resp	OXIM FIO_2
0810	130/90	98.9	104	20							

DR ORDERS

LAB
- CBC
- 7 PANEL
- U/A
- CARDIAC W/U
- ABG FIO2
- EKG

X-RAY
- CHEST
- ABDOMEN
- SKULL
- SPINE

MISC
- PULSE OX
- O2
- MONITOR
- ORTHOSTATICS

MEDICATIONS/PROCEDURES

CHIEF COMPLAINT: S/T x 2d

HISTORY: TIME: No fever
Throat cough
sick 2 days

PAST:

FAMILY:

SOCIAL:

PHYSICAL EXAM: Ears TMs OK
throat - erythema
neck - supple & adenopathy

RE EXAM: TIME: Rx Augmentin 500mg tid x 10d

TREATMENT: Tylenol [redacted] 2d prn

PLAN:

CONSULT/REFERRAL: Time Issued ____ Time Responded ____

DIAGNOSIS: Pharyngitis

PHYSICIAN SIGNATURE: [redacted]

REVIEW OF SYSTEMS
Check appropriate squares & describe abnormal or pertinent findings

SYSTEM	NOR	ABN
Skin		
E.N.T.		
Eyes		
Head		
Neck		
Chest		
Heart		
Lungs		
Abd		
Ext		
Rectal		
Genital		
Neuro		
Back		

DISPOSITION OF PATIENT:
- ☒ RELEASED
- ☐ REFUSED TREATMENT
- ☐ REFERRED TO PHYSICIAN'S OFFICE
- ☐ PATIENT TRANSFERRED
- ☐ PATIENT ADMITTED

CONDITION OF DISCHARGE:
- ☐ GOOD ☐ FAIR
- ☐ POOR ☐ CRITICAL
- ☐ SERIOUS ☐ DEATH
- ☐ DOA
- ☐ UNDETERMINED

DATE & TIME D/C: A P

TRANSFERRED TO: TIME

[redacted]

[redacted]

[redacted]

ERGENCY DEPARTMENT RECORD

E ADMITTED	SEX/AGE	TIME	MODE OF ARRIVAL	CONDITION	PMD
			☒ Private Auto ☐ Ambulance ☐ Paramedic ☐ Sheriff	☒ Good ☐ Fair ☐ Poor ☒ Serious ☐ Critical	

EF COMPLAINT

ORY

ERGIES

DICATIONS

RT 20/ ____ LT 20/ ____

TETANUS

WEIGHT (kgs.)

L.M.P.

ime	Blood Pressure	Temp	Pulse	Resp.	OXIM FIO2	Time	Blood Pressure	Temp	Pulse	Resp	OXIM FIO2

IEUROLOGICAL

EYE OPENING: 4 ☒ Spontaneous; 3 ☐ To voice; 2 ☐ To pain; 1 ☐ None; ☒ PERL; ☐ Unequal

MOTOR RESPONSE: 6 ☒ Obedient; 5 ☐ Purposeful; 4 ☐ Withdrawal; 3 ☐ Flexion; 2 ☐ Extension; 1 ☐ None

VERBAL RESPONSE: 5 ☒ Oriented; 4 ☐ Confused; 3 ☐ Inappropriate; 2 ☐ Incomp; 1 ☐ None

GLASCOW COMA SCALE TOTAL 15

MOVEMENT: ☒ Equal; ☐ Unequal; ☐ Weak; ☐ Absent; Location:

RDIOVASCULAR

4 – Bounding; 3 – Normal; 2 – Weak; 1 – Absent

PULSES: Radial: L 3 R 3 Pedal: L ___ R ___

MONITOR: Time: NA Rhythm

EDEMA: ☐ JVD ☐ Pedal ☐ Dependent ☐ Location: [redacted]

RESPIRATORY

BREATH SOUNDS: ☒ Normal; ☐ Rales; ☐ Retractions; ☐ Wheezes; ☐ Rhonchi; ☐ Stridor; Location:

RESP: ☒ Regular; ☐ Irregular; ☐ Shallow; ☐ Labored

OXYGEN: NA ☐ Cannula Time: ___ ☐ Mask L/min: ___

INTUBATION: NA TIME ___ # ET TUBE ___

NTEGUMENTARY

COLOR: ☒ Normal; ☐ Flushed; ☐ Pale; ☐ Jaundiced; ☐ Cyanotic

TEMP: ☒ Warm; ☐ Hot; ☐ Cool

MOISTURE: ☒ Dry; ☐ Moist

WOUND DESCRIPTION: Location: [redacted] ☐ Laceration; ☐ Puncture; ☐ Rash; ☐ Other; ☐ Abrasion; ☐ Burn

GASTRO-INTESTINAL

ABDOMEN: ☒ Soft; ☐ Firm; ☐ Obese; ☐ Distended; ☐ Rebound; ☐ Guarding

BOWEL SOUNDS: ☒ Normal; ☐ Absent; ☐ Hypo; ☐ Hyper

STOOL: ☒ Normal; ☐ Black; ☐ Red; ☐ Loose; ☐ Constipated; Last BM:

GUIAC STOOL: ☐ + NA ☐ –

LOCATION OF PAIN: None

NG/LAVAGE: Time: ___ Size: NA ☐ NS ___ cc In ___ cc Out ☐ Suction Color: ___ Heme: ☐ + ☐

GENITO-URINARY

URINE COLOR: N/A

HEME: ☐ + ☐ –

FOLEY: ☐ Yes ☐ No Time: ___ Amount: ___ cc

GYN

TYPE OF DISCHARGE / DURATION

PREG WEEKS / F.D.C.

GRAVIDA | PARA | AB | PELVIC

BY

ASSESSMENT PERFORMED [redacted] RN RN TIME 0810

MEDICATIONS

Time	Medication/Dose	Route	Signature

IV FLUIDS

Time	Site	Size	Solution/Medication	Rate	Signature

NOTES

DATE	TIME	TITLE	
1 95	0810	RN	Closed throat x 2 days c? fever clonaco [redacted] congestion

[redacted]

DISCHARGE EVALUATION [redacted] Rx by MD

DISPOSITION [redacted] ☐ ADMIT ☒ RELEASED ☐ REFUSED TREATMENT ☐ REFERRED TO PHYS. OFF ☐ PATIENT TRANSFER TO

CONDITION ON DISCHARGE: ☒ GOOD ☐ FAIR ☐ POOR ☐ SERIOUS ☐ CRITICAL ☐ UNDETERMINED ☐ DOA ☐ DEATH - ED

DATE & TIME D/C: 0830 AM PM

TRANSFER/ADMIT TO [redacted]