

# Alaska Ambulance Run Report for First Responders

## 1. Patient Information

Patient Name: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: \_\_\_\_\_ M \_\_\_\_\_ F

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_

## 2. Unit Information

Agency Name: \_\_\_\_\_ Agency Number: \_\_\_\_\_

Responder Name \_\_\_\_\_ Level: \_\_\_\_\_

Responder Name \_\_\_\_\_ Level: \_\_\_\_\_

## 3. Dates and Times

Date
PSAP Call
Unit Notified
Arrived on Scene
Transfer Time
Left Scene

## 4. Situation

Location/Address of Call or Incident \_\_\_\_\_ (Same as Patient) \_\_\_\_\_

Chief Complaint: \_\_\_\_\_ Onset Date/Time \_\_\_\_\_

## 5. Narrative


## 6. Vital Signs

Time	BP	HR	RR	GLUCOSE	C02	SaO2	Temp	GCS	Cardiac Rhythm	<b>Glasgow Coma Score Legend</b> <b>Eye</b> 1. None    2. Pain 3. Verbal    4. Spontaneous <b>Verbal</b> 1. None 2. Incomprehensible 3. Inappropriate words 4. Disoriented 5. Oriented <b>Motor</b> 1. No response to pain 2. Extends to pain 3. Flexes to pain 4. Withdraws from pain 5. Localizes pain 6. Obeys Commands

<b>7. Stroke Screen</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done	<b>8. Reperfusion Check Sheet</b>	<input type="checkbox"/> No Contraindicators <input type="checkbox"/> Contraindicators <input type="checkbox"/> Not Done
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## 9. Procedures and Medications

Time	Procedure	Size	Tech ID	Time	Medication	Dose/Route	Tech ID

## 10. Disposition

Patient Transferred by: _____	Patient Received by: _____
Agency Name: _____	Agency Name: _____
Date & Time: _____	Date & time: _____

## 11. Signatures


**This is a Preliminary Document - This is not the final EMS Patient Care Report**