

INCIDENT#:	SERVICE NAME:	DATE:
AMBULANCE/ VEHICLE #:	LOCATION OF EVENT:	ASSISTANT NAMES: <input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> FIRE <input type="checkbox"/> MEDEVAC <input type="checkbox"/> CHA/CHAP <input type="checkbox"/> OTHER _____
<input type="checkbox"/> TRANSPORT <input type="checkbox"/> TREATMENT GIVEN, NO TRANSPORT <input type="checkbox"/> REFUSAL (ATTACH FORM) <input type="checkbox"/> MEDEVAC ASSIST	NATURE OF CALL:	TIME DISPATCHED
	PATIENT CHIEF COMPLAINT:	TIME ENROUTE
		TIME ARRIVE SCENE
		TIME LEFT SCENE
		TIME ARRIVE DESTINATION
		TIME LEFT DESTINATION
		TIME BACK IN SERVICE

PATIENT NAME (FIRST, MI, LAST, SUFFIX)		PARENT/GUARDIAN NAME:	
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH:	AGE:	PHONE:
PATIENT ADDRESS (PHYSICAL & MAILING)		CITY:	STATE: ZIP:

**SUBJECTIVE REPORT**

SYMPTOMS - "WHAT YOU ARE TOLD":

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ALLERGIES: <input type="checkbox"/> NO KNOWN	MEDICATIONS/OVER THE COUNTER/HERBAL REMEDY/VITAMINS/DRUGS/ALCOHOL: <input type="checkbox"/> NO KNOWN
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PAST/PERTINENT MEDICAL HISTORY:

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LAST ORAL INTAKE/OUTPUT & WHEN:

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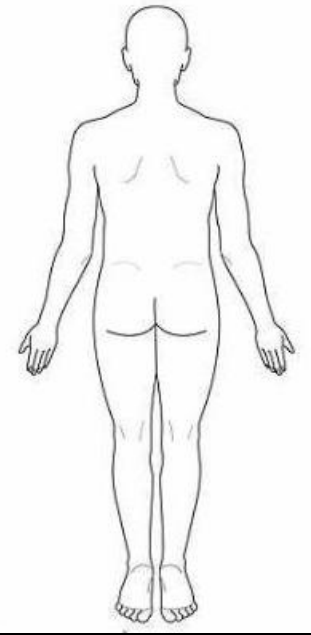
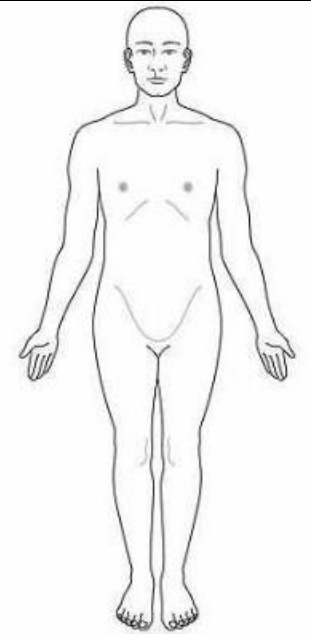
EVENTS LEADING UP TO:

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**OTHER NOTES**

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