UNIVERSITY EMERGENCY MEDICINE STUDENT ASSOCIATION
MEDICAL RESPONSE UNIT — PATIENT CARE REPORT

THIS DOCUMENT IS NOT A FULL EMS REPORT. IT MUST BE RETAINED BY THE RESPONDER

Dispatch

Incident Number (YYMMDD##)	Time	Crew (Fl. Last Name, Rank)

Incident Location (Building / location name / event / room number / address)

Assisting Units	Patient Disposition	Transporting Agency	Transport Destination

Demographics

First name	MI
Last Name	Sex

DOB	Phone

Address	Apt

City	State	Zip

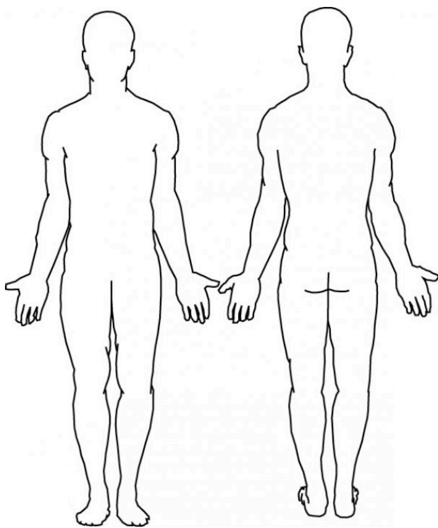
History

Allergies
Medical History
Medications

Medication Treatments

O_2	Time	Device	Flow Rate LPM	Response

Medication			
Time	Medication	Dose (units)	
Route	Effect		



Vitals

Response	Alert Verbal Painful Unresponsive
Orientation	x4 Person Place Time Event

GCS	Eyes	Verbal	Motor
	4 Spontaneous 3 To voice 2 To pain 1 No response Total: /15	5 Orientated 4 Confused 3 Inappropriate 2 Incomprehensible 1 No response	6 Obeys command 5 Localizes pain 4 Withdraws to pain 3 Decorticate 2 Decerebrate 1 No response

Pupils	PERRL Dilated Constricted | Both Left Right
Skin	Color: Temp: Condition:
Lung Sounds	Clear Wheezes Rales Rhonchi Location: x4 | Upper Bases | Bilateral L R

BGL	Time	Value	Temp	Time	Value

#	Time	Blood Pressure	Pulse	SpO2	RR
1		/			
2		/			
3		/			

Assessment

DCAP-BTLS & OPQRSTI

Chief complaint:

Narrative & Treatments	Incident Number #

Supplies / Medications Used

Signature for Services Rendered

Section I – Patient	Section II – Authorized Representative
I acknowledge that I have received assessment and/or treatment from UEMSA personnel for my medical complaint. I acknowledge that I have been advised to discuss my medical complaint with my regular health care provider or seek additional medical care on my own accord for follow-up or continued care for my medical complaint. Patient signature Date If the patient makes any mark other then a signature, it is recommended that someone sign as a witness. This can be a crewmember. Witness printed name Date Witness Signature	1. Complete this section only if: ☐ The patient is physically or mentally incapable of signing ☐ The patient is a minor ☐ There is no authorized representative willing or able to sign on behalf of the patient at the time of service 2. I am: ☐ Patient's legal guardian ☐ Patient's Health Care Power of Attorney ☐ Person who receives government benefits on behalf of the patient ☐ Person who arranges treatment of handles the patient's affairs. ☐ Representative of an agency or institution that furnished care, service, or assistance to the patient ☐ UEMSA personnel / crewmember Printed name Date Signature

Refusal of Services

Check the applicable box for each service refused.

☐ I refuse to accept ☐ all or ☐ specific (as noted below) treatment at the recommendation of UEMSA personnel. I have been advised that medical assistance on my behalf is necessary and that refusal of said assistance could be hazardous to my health, and under any certain circumstance include disability and/or death. I have been advised to discuss my medical complaints with my regular health care provider or seek alternative medical care on my own accord.

☐ I acknowledge that I may or may not have a medical condition that may require additional medical assessment. I elect to defer any assessment that has been offered to me at the present time. I elect to seek alternative medical care on my own accord.

☐ I am refusing to have Emergency Medical Services (911) called on my behalf at the recommendation of UEMSA personnel.

I accept all responsibility connected with this refusal and hereby release UEMSA, the USF System, and any connected officers or agents of any liability or medical claim resulting from my decision to refuse. By signing below, I certify that I have read and understand the above information.

Indicated treatment or assessment: ____________________

Patient Signature: ____________________ Date: __________ ☐ Is a minor (Use Section II for signature)

Witness Signature: ____________________ Date: __________ Relation to patient: __________

Witness Printed Name: ____________________ Phone: __________