

KEMSA EMT-B Observation Form	Student Name: _____ ID # _____	Shift Date: _____
	Field Preceptor Name: _____ ID # _____	Service Name: _____ TIME IN: _____ TIME Out: _____

DISPATCH	RACE/SEX	M	F	INITIALS/AGE	DISPOSITION/CALL OUTCOME	
NON-EMERGENT <input type="checkbox"/>	AFRICAN AMERICAN <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PT. INITIALS	<input type="checkbox"/> TRANSPORT ROUTINE	<input type="checkbox"/> D.O.A
NONEMBERGENT <input type="checkbox"/>	AMERICAN INDIAN <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AGE IN YEARS	<input type="checkbox"/> TRANSPORT EMERGENCY	<input type="checkbox"/> FALSE CALL
TRANSFER <input type="checkbox"/>	ASIAN <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> REFUSAL – TREATMENT	<input type="checkbox"/> CANCELLED
EMERGENT <input type="checkbox"/>	CAUCASIAN <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AGE IN MONTHS	<input type="checkbox"/> TREATED– RELEASED	<input type="checkbox"/> STANDBY
ARREST/CRITICAL <input type="checkbox"/>	HISPANIC <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> TRANSFER TO ANOTHER UNIT	
	OTHER <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> TREATED - REFUSED TRANSPORT	

CHIEF COMPLAINT: _____

PRIMARY AND SECONDARY FIELD IMPRESSION (What you think is wrong with the patient)

MEDICAL		MEDICAL		TRAUMA		MECHANISM OF INJURY	
Primary	Secondary	Primary	Secondary	Primary	Secondary		
<input type="checkbox"/> ABDOMINAL/GI	<input type="checkbox"/>	<input type="checkbox"/> OD – POISON	<input type="checkbox"/>	<input type="checkbox"/> ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/> NONE	<input type="checkbox"/> AUTO-PEDESTRIAN
<input type="checkbox"/> RESPIRATORY	<input type="checkbox"/>	<input type="checkbox"/> PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/> CHEST	<input type="checkbox"/>	<input type="checkbox"/> STEERING WHEEL DEFORMED	<input type="checkbox"/> MOTORCYCLE
<input type="checkbox"/> CARDIAC	<input type="checkbox"/>	<input type="checkbox"/> SEIZURE	<input type="checkbox"/>	<input type="checkbox"/> EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/> DASHBOARD DEFORMED	<input type="checkbox"/> PENETRATING INJURY
<input type="checkbox"/> CVA/TIA	<input type="checkbox"/>	<input type="checkbox"/> SEPSIS/INFECTION	<input type="checkbox"/>	<input type="checkbox"/> MUSCULOSKELETAL	<input type="checkbox"/>	<input type="checkbox"/> WINDSHIELD SPIDERWEBBED	___ Gunshot wound
<input type="checkbox"/> DIABETIC	<input type="checkbox"/>	<input type="checkbox"/> OTHER MEDICAL	<input type="checkbox"/>	<input type="checkbox"/> HEAD/FACE	<input type="checkbox"/>	<input type="checkbox"/> EJECTION	___ Knife
<input type="checkbox"/> DOA – NO CPR	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> NECK-BACK	<input type="checkbox"/>	<input type="checkbox"/> ENTRAPMENT	<input type="checkbox"/> BLUNT T INJURY
<input type="checkbox"/> OB – BIRTH/DELIVERY	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> PELVIC	<input type="checkbox"/>	<input type="checkbox"/> PINNED IN VEHICLE	<input type="checkbox"/> FALL/JUMP _____
<input type="checkbox"/> GYN	<input type="checkbox"/>	<input type="checkbox"/> OTHER NEURO	<input type="checkbox"/>	<input type="checkbox"/> MULTI-SYSTEMS	<input type="checkbox"/>	<input type="checkbox"/> DOA SAME VEHICLE	<input type="checkbox"/> DRIVER – MVA
<input type="checkbox"/> OB-LABOR	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/> ROLLOVER	<input type="checkbox"/> PASSENGER – MVA _____
<input type="checkbox"/> PREGNANCY PROBLEMS	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> AIRBAG _____
							<input type="checkbox"/> SEATBELT _____

MEDICAL HISTORY

MEDICATION _____ ALLERGIES _____	PAST HISTORY _____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th colspan="3">REVISED TRAUMA SCORE</th> </tr> <tr> <td>GCS Points</td> <td>13-15</td> <td>4</td> </tr> <tr> <td></td> <td>9-12</td> <td>3</td> </tr> <tr> <td></td> <td>6-8</td> <td>2</td> </tr> <tr> <td></td> <td>4-5</td> <td>1</td> </tr> <tr> <td></td> <td>0-3</td> <td>0</td> </tr> </table>	REVISED TRAUMA SCORE			GCS Points	13-15	4		9-12	3		6-8	2		4-5	1		0-3	0
REVISED TRAUMA SCORE																				
GCS Points	13-15	4																		
	9-12	3																		
	6-8	2																		
	4-5	1																		
	0-3	0																		

VITAL SIGNS

VITAL SIGNS				INITIAL GLASGOW COMA SCALE					
TIME	BP	PULSE	RESP	LOC – AVPU	EYES OPEN	BEST VERBAL	BEST MOTOR	Systolic BP	
				<input type="checkbox"/> ALERT	<input type="checkbox"/> SPONTANEOUS– 4	<input type="checkbox"/> ORIENTED-5	<input type="checkbox"/> OBEYS COMMANDS-6	>89 mmHg	4
				<input type="checkbox"/> VERBAL	<input type="checkbox"/> TO VOICE – 3	<input type="checkbox"/> CONFUSED-4	<input type="checkbox"/> PAIN/LOCAL-5	76-89 mmHg	3
				<input type="checkbox"/> PAINFUL	<input type="checkbox"/> TO PAIN- 2	<input type="checkbox"/> INAPPROPRIATE.-3	<input type="checkbox"/> PAIN/WITHDRAWAL-4	50-75 mmHg	2
				<input type="checkbox"/> UNRESPONSIVE	<input type="checkbox"/> NONE –1	<input type="checkbox"/> GARBLED-2	<input type="checkbox"/> PAIN/FLEXION-3	1-49 mmHg	1
						<input type="checkbox"/> NONE-1	<input type="checkbox"/> PAIN/EXTENSION-2	NONE	0
							<input type="checkbox"/> NONE-1	Respiratory Rate	10-29/min
									>29/min
									6-9/min
									1-5/min
									NONE
									0
Total Adult Score									

ALS PROCEDURES *Please designate all procedures observed.

AIRWAY					ALS IV/IO ACCESS					MEDICATIONS				
ATTEMPTS	SUCCESS	ET SIZE	O		ATTEMPTS	SUCCESS	SITE	GAUGE	O	DRUG	DOSE	ROUTE	O	
			<input type="checkbox"/>						<input type="checkbox"/>				<input type="checkbox"/>	
			<input type="checkbox"/>						<input type="checkbox"/>				<input type="checkbox"/>	
			<input type="checkbox"/>						<input type="checkbox"/>				<input type="checkbox"/>	
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			<input type="checkbox"/>						<input type="checkbox"/>				<input type="checkbox"/>	
			<input type="checkbox"/>						<input type="checkbox"/>				<input type="checkbox"/>	

ASSESSMENT-BASED MANAGEMENT/PLAN/TREATMENT NARRATIVE

