

Dispatch:
 AGENCY NAME _____
 INCIDENT#: _____ RESPONSE #: _____ UNIT#: _____
 DATE: _____ RESPONDING FROM: _____

Alaska Ambulance Run Report

INCIDENT INFORMATION:
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 REASON FOR DISPATCH: _____
 LOCATION PATIENT FOUND: _____

(CIRCLE DRIVER OR ATT) CREW MEMBERS (ADDITIONAL CREW LISTED IN NARRATIVE) CERT NUMBER
 DRIVER/ ATT 1: _____
 DRIVER/ATT 2 _____
 DRIVER/ATT 3: _____

MODE OF RESPONSE TO SCENE: Lights Siren None

TYPE OF RESPONSE:
 SCH. TRANSFER
 UNSCH. TRANSFER
 STAND-BY
 INTERCEPT/ASSIST
 SCENE - N/A
 EMS DNR PRESENT

TYPE OF SCENE/PICK-UP LOCATION:
 HOSPITAL
 HOME
 FARM
 MINE/QUARRY
 INDUSTRIAL
 SPORT/RECREATION
 STREET/HIGHWAY
 PUBLIC BUILDING
 RESIDENTIAL INST.
 EDUCATIONAL INST.
 OTHER HEALTH CARE FACILITY
 OTHER
 UNKNOWN/UNSPEC.

RESPONSE: Circumstances affecting Resp.:	TIME (MILITARY)			
	<input type="checkbox"/> ADVERSE WEATHER	CALL RECEIVED		
<input type="checkbox"/> CROWD CONTROL	DISPATCH/NOTIF			
<input type="checkbox"/> EXTRICATION >20 MIN.	EN ROUTE			
<input type="checkbox"/> HAZ-MAT	ON SCENE			
<input type="checkbox"/> INFECTIOUS	AT PATIENT			
<input type="checkbox"/> EXPOSURE	PATIENT MOVED			
<input type="checkbox"/> LANGUAGE BARRIER	DEPARTED SCENE			
<input type="checkbox"/> ROAD CONDITIONS	ARRIVAL AT DEST.			
<input type="checkbox"/> UNSAFE SCENE	RETURN TO SERVICE			
<input type="checkbox"/> VEHICLE COLLISION				
<input type="checkbox"/> VEHICLE PROBLEMS				
<input type="checkbox"/> OTHER: _____				
<input type="checkbox"/> NONE				

PATIENT DEMOGRAPHIC INFORMATION:
 PATIENT NAME: _____ SEX: M ___ F ___
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 PHONE: _____ DOB: _____ AGE: _____
 RACE: WHITE BLACK AMERICAN INDIAN ALASKAN NATIVE
 ASIAN/PI OTHER UNKNOWN
 ETHNIC ORIGIN: HISPANIC NON-HISPANIC UNKNOWN

AID BEFORE ARRIVAL BY:
 NA UNKNOWN
 BYSTANDER/FAMILY
 BLS FIRST RESPONSE
 ALS FIRST RESPONSE
 OTHER

OTHER RESPONDERS:
 EMS AGENCY (BLS) NONE
 EMS AGENCY (ALS) MEDICAL RESP.
 AIR AMB (ALS) HAZ-MAT TEAM
 FIRE DEPARTMENT CORONER
 RESCUE SQUAD LAW ENFORCEMENT AGENCY
 OTHER: _____

RESTRAINTS USED? YES NO (REASON _____)

PATIENT HISTORY: PATIENT'S PHYSICIAN _____
 CHIEF COMPLAINT _____
 ONSET DATE/TIME _____ / _____ WORK RELATED? YES ___ NO ___
 ALLERGIES _____
 MEDICATIONS _____

PATIENT INSURANCE TYPE CODE:	CARDIAC ARREST:	EVENT	TIME
MEDICAL HISTORY: <input type="checkbox"/> ASTHMA <input type="checkbox"/> NONE/UNK <input type="checkbox"/> BEHAVIORAL DIS. <input type="checkbox"/> SEIZURES <input type="checkbox"/> CANCER <input type="checkbox"/> STROKE/CVA <input type="checkbox"/> CARDIAC DIS. <input type="checkbox"/> SUBSTN. ABUSE <input type="checkbox"/> DIABETES <input type="checkbox"/> TOBACCO USE <input type="checkbox"/> EMPHYS/COPD <input type="checkbox"/> TRACHEOSTOMY <input type="checkbox"/> HYPERTENSION <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> RENAL DISORDER <input type="checkbox"/> OTHER (LIST)	Witnessed By: <input type="checkbox"/> NA <input type="checkbox"/> UNK <input type="checkbox"/> BLS <input type="checkbox"/> ALS <input type="checkbox"/> BY-STANDER CPR Provided By: <input type="checkbox"/> NA <input type="checkbox"/> UNK <input type="checkbox"/> BLS <input type="checkbox"/> ALS <input type="checkbox"/> BY-STANDER	ARREST CPR. INT. 1ST DEFIB. 2ND DEFIB. 3RD DEFIB. RESUSIT. TERMINATED	

PHYSICAL: AIRWAY: PATENT OBSTRUCTED
BREATHING EFFORT: NORMAL INCR. DECR. ABSENT
SKIN COLOR: NORMAL PALE CYAN. FLUSH
SKIN CONDITION: NORMAL COOL DRY MOIST
NEUROL: ALERT VOICE PAIN UNRESPONSIVE
PUPILS: L NORM. DILAT. CONST. NON-REACT
R NORM. DILAT. CONST. NON-REACT
NECK: JVD CAROTID L PRESENT DECRS. ABSENT
 PAIN PULSE: R PRESENT DECRS. ABSENT

SUSPECTED USE/ABUSE: ALCOHOL DRUGS BOTH NONE UNKNOWN
BREATH L NORMAL DESCRS. ABSENT RALES RHONCHI WHEEZES
SOUNDS: R NORMAL DESCRS. ABSENT RALES RHONCHI WHEEZES
CHEST WALL: ABNORMAL SYMMETRY CREPITUS FLAIL CHEST UNKNOWN
ABDOMEN: DISTEND TENDER **SOUNDS:** INCRS. DECRS. ABSENT
EXTREM.: R-UP ROM ROM PULSE SENS. CAP REFILL <2S >2S
L-UP ROM ROM PULSE SENS. CAP REFILL <2S >2S
R-LO ROM ROM PULSE SENS. CAP REFILL <2S >2S
L-LO ROM ROM PULSE SENS. CAP REFILL <2S >2S

BLS PROCEDURE CODES: 05 - C-C-COLLAR APPLIED 10 - SHORT BD/SCOOP 15 - MAST/PASG 20 - OXYGEN, CANNULA
 01 - ASST. VENTILATION 06 - CPR 11 - SPLINT, ARM 16 - IV MAINTEN. 21 - AIRWAY, ORAL
 02 - BLEEDING CONTROL 07 - COLD/HOT APPLIED 12 - SPLINT, LEG 17 - OB CARE/DELIV. 22 - AIRWAY, NASAL
 03 - BANDAGE/DRESSING 08 - EXTRICATION 13 - SPLINE, TRACTION 18 - SUCTION 23 - DEFIB. AUTOMATIC
 04 - BURN CARE 09 - LONG BED / KED 14 - POSITION/ELEV. 19 - OXYGEN MASK 24 - OTHER BLS PROC.

PRIMARY IMPRESSION CODE _____
 USE NUMBER FROM SIGNS BELOW

TIME	CERT. #	PULSE	RESP.	SBP/DBP	TEMP.	EYE	VERB.	MOT	G.C.S	R.T.S	PROC	ATT.	SUC	AMOUNT

SIGNS/SYMPOMS/IMP.: (CHECK ALL WHICH APPLY)
 01 ABDOMINAL PAIN 22 SMOKE INHALATION
 02 AIRWAY OBSTR. 23 STING/BITE
 03 ALLERGIC REACT. 24 STROKE/CVA
 04 ALTERED L.O.C. 25 SYNCOPE/FAINTING
 05 BEHAVIOR/PSYCH. 26 TRAUMA (PAGE 2)
 06 CARDIAC ARREST 27 VAGINAL HEMMOR.
 07 CARD. RHYT. DIST. 28 NOT APPLICABLE
 08 CHEST PAIN 29 UNKNOWN
 09 DIABETIC EMERG. BACK PAIN
 10 ELECTROCUTION BLOODY STOOL
 11 HYPERTHER./FEVER DIARRHEA
 12 HYPOTHERMIA DIZZINESS
 13 HYPOVOL./SHOCK EAR PAIN
 14 INHALATION INJURY EYE PAIN
 15 OBVIOUS DEATH HEADACHE
 16 POISON/DRUG HYPERTENSION
 17 PREG./OB DELIVERY NAUSEA/VOMIT.
 18 RESP. ARREST PALPITATIONS
 19 RESP. DISTRESS PARALYSIS
 20 SEIZURE UNRESPONSIVE
 21 SEXUAL ASSAULT WEAKNESS

PATIENT DISPOSITION: NA UNKNOWN
 TREATED, TRANSPORT TREATED, RELEASED OBVIOUSLY DECEASED
 TREATED, TRANSF. CARE NO TREATMENT REQ. NO PATIENT FOUND
 TREATED, TR BY P.O.V. TREATMENT REFUSED CALL CANCELED

PATIENT CONDITION AT LAST DEST.:
 UNCHANGED EXPIRED
 BETTER UNKNOWN
 WORSE NA

MODE OF TRANSPORT: LIGHTS SIREN NONE **DESTINATION**

DESTINATION DETERMINED BY: PATIENT PROTOCOL CLOSEST LAW ENFORCEMENT MANAGED CARE
 PATIENT'S DR. DR. ON SCENE MED CTRL. OTHER UNKNOWN / NA

REPRESENTATIVE OF FACILITY ASSUMING CARE: _____ E.M.S. CARE PROVIDER: _____

Reimbursement Information

GUARANTOR NAME				DATE OF BIRTH	TELEPHONE (HOME)			TELEPHONE (WORK/OTHER)	
STREET				CITY	STATE		ZIP		
NEXT OF KIN/GUARDIAN				RELATIONSHIP		TELEPHONE			
STREET				CITY	STATE		ZIP		
PRIMARY INSURANCE									
POLICY NUMBER		GROUP NUMBER			INSURED NUMBER				
SECONDARY INSURANCE									
POLICY NUMBER		GROUP NUMBER			INSURED NUMBER				
MILEAGE			MILES	EMPLOYER					
AT START								MEDICARE	MEDICAID
AT SCENE									
AT DESTINATION								PATIENT SOCIAL SECURITY NUMBER	PATIENT VALUABLES AND DISPOSITION
RETURN TO SERV.									

Release for Medical Billing and Insurance and Notice to Medicare Patients

I hereby authorize the release of any medical records or other information that is necessary to process any claims for medical or other insurance benefits. I understand that I have an obligation to pay for services and supplies provided, regardless of any deductibles, co-payments, or other variations in individual insurance programs. If I have Medicare of AK, Medical Assistance agrees to accept assignment, and I authorize

to bill my carrier for whatever benefits I am entitled to cover these charges and services. To Medicare Patients: Federal law requires that we notify you when services to be provided may not be covered by Medicare. In our opinion, the ambulance transport on this date may not be covered by Medicare because it may not meet their guidelines. We are, hereby, giving you notice that if Medicare denies payment for this service, we will hold you responsible for payment. I further authorize the release of any medical information to enable proper completion of the quality improvement process for this service.

Signature of Patient, Legal Guardian, or Healthcare Surrogate

Release of Liability/Refusal to Consent to Treatment

I, the undersigned, have been advised that medical assistance on my behalf is necessary and that my refusal to allow such assistance may result in death or endanger my health. I have been advised of, and fully understand, the nature of the risks I am taking by refusing medical assistance. I assume all responsibility for the consequence of my decision. I hereby release any and all persons employed by or responding with them from any and all liability which arises now or may arise in the future from the consequences of this refusal of emergency medical care and/or transportation to a hospital.

- ____ Refused medical care offered to me or the patient
- ____ Refused transport to a medical facility which was offered to me or the patient
- ____ Refused transport to the nearest hospital after being advised that the welfare of the patient required prompt emergency care
- ____ No treatment was necessary or requested

Signature of Witness

Signature of Patient, Legal Guardian, or Healthcare Specialist

____ Refused to Sign

Signature of EMS Staff

Date

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