**ILLINOIS MEDICAL EMERGENCY RESPONSE TEAM**

**PATIENT RECORD**

Location:

Tracking number:

DATE: \_\_\_\_\_\_\_\_\_\_\_ TIME: \_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_ M / F

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_

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| **CHIEF COMPLAINT:** | **PMH**: |
| **MEDICATION:** |
| **ALLERGIES**:  | **LNMP**: | **WEIGHT**: |
| **VITAL SIGNS FLOW SHEET** |
| **TIME** | **B/P** | **PULSE** | **RESP** | **SPO2** | **TEMP** | **GCS** | **Glucose** |
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**Nurse/Medic Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **TIME** | **COMMENTS / TREATMENT / PROCEDURES FLOW SHEET** |
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| **TIME** | **MEDICATION DOSE / ROUTE** | **TIME GIVEN** | **STAFF SIGNATURE** |
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| **Physician Signature:**  | **Date/Time:**  |

**Physician/Provider Notes Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**General Appearance**: Alert\_\_\_\_\_\_ Drowsy\_\_\_\_\_\_ Arousable\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_

**Pupils**: PERRL\_\_\_\_\_\_ Unequal\_\_\_\_\_ Left Side\_\_\_\_\_\_\_\_\_\_ Right Side\_\_\_\_\_\_\_\_\_\_

**Neuro:**  A&Ox3 \_\_\_\_\_\_\_\_ **ENT**: \_\_\_\_\_\_\_\_\_\_

**Pulmonary**: Clear\_\_\_\_\_\_\_ Wheezing\_\_\_\_\_\_\_ Rales\_\_\_\_\_\_\_ Rhonchi\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_

**CV**: Reg. Rhythm\_\_\_\_\_\_\_ Irreg. Rhythm\_\_\_\_\_\_\_ Normal Rate\_\_\_\_\_\_\_ Tachy\_\_\_\_ Brady\_\_\_\_\_\_\_

**Abdomen**: Soft, NT\_\_\_\_\_\_\_ Tenderness\_\_\_\_\_\_\_\_\_ Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin**: Normal\_\_\_\_\_\_\_ Hot/Cold Diaphoretic\_\_\_\_\_\_\_ **Extremities:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Comments:** |
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| **Orders**/**Procedures**: |
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| **Physician/Provider Signature** | **DATE/TIME** |
| **Discharged by:** | **TRANSFERRED TO: DATE/TIME****EMS UNIT**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Other**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Discharge Instructions**: **(HOME)**  |
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| **PT VERBALIZED UNDERSTANDING:** YES NO **ACCOMPANIED BY:** SELF OTHER: |
| **PT SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **TRACKING No. \_\_\_\_\_\_\_\_\_\_** |