

Tracking number: _____

ILLINOIS MEDICAL EMERGENCY RESPONSE TEAM
PATIENT RECORD

Location: _____

DATE: _____ TIME: _____ DOB: _____ AGE: _____ M / F

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

CHIEF COMPLAINT:	PMH:
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MEDICATION:

ALLERGIES:	LNMP:	WEIGHT:
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VITAL SIGNS FLOW SHEET							
TIME	B/P	PULSE	RESP	SPO2	TEMP	GCS	Glucose

Nurse/Medic
Signature _____

TIME	COMMENTS / TREATMENT / PROCEDURES FLOW SHEET

TIME	MEDICATION DOSE / ROUTE	TIME GIVEN	STAFF SIGNATURE

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:** _____

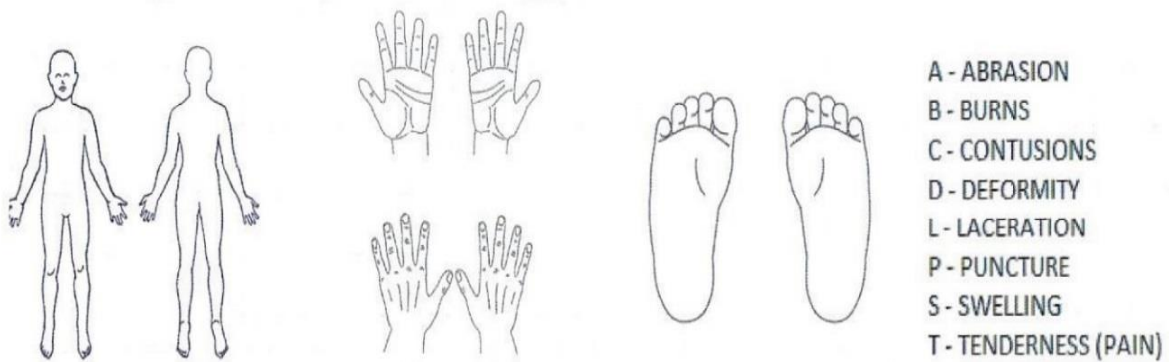
Pulmonary: Clear _____ Wheezing _____ Rales _____ Rhonchi _____ Other _____

CV: Reg. Rhythm _____ Irreg. Rhythm _____ Normal Rate _____ Tachy _____ Brady _____

Abdomen: Soft, NT _____ Tenderness _____ Location _____

Skin: Normal _____ Hot/Cold Diaphoretic _____ **Extremities:** _____

Comments:



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