DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 7119 (Rev. 02/01)

AMBULANCE REPORT

Completion of this form meets the requirements of administrative rule HFS 110.04(3)(b).
Some client information in this document is confidential under Wis. Stat. 146.82(1).

STATE OF WISCONSIN
Adm. Code HFS 110.04(3)(b)

RESPONSE

Date Incident Reported (Mo/Day/Yr)	Service Name and ID No.	Responding Unit	Station	Patient Care Record / Alarm No.

Incident Address / Location	Incident Municipality	Incident County

Destination Address / Facility Name	Destination Municipality	Destination County

Mileage:(Loaded) End ____ Begin ____ Total ____

Lights And Siren To Scene: ☐ N/A
☐ Non-Emergent, No Lights or Siren
☐ Emergent, Lights and Siren
☐ Initial Emergent, Downgrade To No Lights and Siren
☐ Initial Non-emergent, Upgrade To Lights and Siren

Crash Report No.

(Use Military Times)

Pt. Det. ____ Call Rec. ____ En Route ____ At Scene ____ At Pt. ____ Lv. Scene ____ At Dest. ____ In Service ____

Crew Member Name / License No.

1. ____ 2. ____ 3. ____ 4. ____

Location Type
☐ Airport ☐ Clinic / Medical ☐ Educational Inst. ☐ Farm ☐ Highway / Street ☐ Home / Residence ☐ Hospital ☐ Industrial ☐ Mine / Quarry ☐ Nursing Home ☐ Public Building ☐ Public Outdoors ☐ Recreational / Sport ☐ Residential Inst. ☐ Restaurant / Bar ☐ Waterway ☐ Unspecified ☐ Other _____ ☐ N/A

Response Type ☐ N/A
☐ Mutual Aid ☐ Intercept ☐ Response To Scene ☐ Scheduled Interfacility Transfer ☐ Standby ☐ Unscheduled Interfacility Transfer ☐ Unknown

DEMOGRAPHICS

Patient Last Name / First / M.I.	Mailing Address	City	State	Zip Code	Phone ( )

Emergency Contact Name	Address	City	State	Zip Code	Phone ( )

Personal Physician ☐ N/A	Date of Birth	Age	Weight ☐ lbs ☐ kg	Gender ☐ Male ☐ Female

Social Security No. (Optional) ____

Race ☐ White ☐ Hispanic ☐ Asian/Pacific Islander ☐ Black ☐ American Indian/Alaska Native ☐ Other _____ ☐ Unknown

Work Related Injury ☐ Yes ☐ No

Employer	Address	City	State	Zip Code	Phone ( )

Insurance 1	Group No.	Insured No.

Insurance 2 If MVA, Agency	Address	Phone	Group No.	Insured No.

Medicare	HMO	Medicaid

HISTORY

Signs / Symptoms
☐ Abdominal Pain ☐ Back Pain ☐ Bleeding ☐ Bloody Stool ☐ Breathing Difficulty ☐ Cardiac Arrest ☐ Chest Pain ☐ Choking ☐ Diarrhea ☐ Dizziness ☐ Ear Pain ☐ Eye Pain ☐ Fever/Hyperthermia ☐ Headache ☐ Hypertension ☐ Hypothermia ☐ Nausea ☐ Numbness ☐ Paralysis ☐ Palpitations ☐ Pregnancy / Childbirth ☐ Respiratory Arrest ☐ Seizures / Convulsions ☐ Syncope ☐ Trauma ☐ Unresp. / Unconscious ☐ Vaginal Bleeding ☐ Vomiting ☐ Weakness ☐ Unknown ☐ Other _____ ☐ None

Allergies ☐ None	Patient's Current Medications ☐ None			Last Oral Intake
	Dose	Dose	Dose	
	Dose	Dose	Dose	☐ N/A

Pre-Existing Medical Condition -- **Medical**
☐ Asthma ☐ Bleeding Disorders ☐ Cancer _____ ☐ Chronic Renal Failure ☐ Chronic Resp. Failure ☐ CVA / TIA ☐ Diabetes ☐ Gastrointestinal ☐ Headaches ☐ Hepatitis ☐ Hypotension ☐ Seizures / Convulsions ☐ Tuberculosis

Cardiac
☐ Angina ☐ Arrhythmia ☐ Congenital ☐ Congestive Heart Failure ☐ Hypertension ☐ Myocardial Infarction ☐ Cardiac Surgery

Other
☐ Developmental Delay / MR ☐ Psychiatric ☐ Substance Abuse ☐ Tracheostomy ☐ Other _____ ☐ None

ASSESSMENT

Vitals ☐ Vital Continued with Advanced Skills ☐ N/A

Time	BP	Pulse Rate	Pulse Qual.	Resp. / SPO2	Resp. Effort	Level of Consciousness
			☐ Reg ☐ Irr		1 Normal 2 Labored 3 Shallow 4 Absent 5 Assisted	A - Alert_____ V - Verbal P - Pain U - Unresp
			☐ Reg ☐ Irr			
			☐ Reg ☐ Irr			
			☐ Reg ☐ Irr			
			☐ Reg ☐ Irr			

Mental Status/Behavior ☐ N/A
☐ Normal ☐ Acute Confusion ☐ Usually Confused ☐ Incoherent ☐ Intermittent Consciousness ☐ Combative

Eyes ☐ N/A
☐ PERRL
R Reactive L
R Nonreactive L
R Constricted L
R Dilated L
R Blind L
R Cataracts L
R Glaucoma L

Breath Sounds ☐ N/A
R Clear L
R Wet L
R Decreased L
R Wheeze L
R Absent L
☐ Stridor

Skin Temp ☐ Normal ☐ Cool/Cold ☐ Warm/Hot
Moisture ☐ Normal ☐ Dry ☐ Moist ☐ Diaph
Color ☐ Normal ☐ Cyanotic ☐ Pale-Ashen ☐ Cherry ☐ Flushed ☐ Jaundice
Capillary Refill ☐ Normal ☐ Delayed ☐ N/A

Pain Provoke: _____
Quality ☐ Sharp ☐ Dull ☐ Cramp ☐ Crushing ☐ Constant
Radiate ☐ No ☐ Yes _____
Severity ☐ (1-10) _____
Time (Onset) ☐ 0-15Min ☐ 15-60 Min ☐ 1-12 Hr ☐ 12-24 Hr ☐ Other: _____ ☐ N/A

CPR

CPR Provider: ☐ Bystander ☐ First Responder Unit ☐ EMS Unit ☐ Unkn
Defib Provider: ☐ PAD ☐ First Responder Unit: _____ ☐ EMS Unit: _____
CPR Start Time _____ Discontinue _____ Witnessed Arrest ☐ Yes ☐ No Time _____ ☐ N/A

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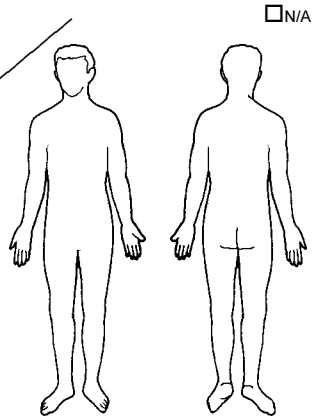
Service Name and ID No.	Patient Last Name / First / M.I.	Patient Care Record / Alarm No.

PHYSICAL EXAMINATION

Physical Examination ☐N/A

Injury / Pain Location	Pain (No Trauma)	Blunt	Dis / FX	Gunshot	Laceration / Abrasion	Puncture / Stab	Soft Tissue Swelling	Burn
Head / Face								
Neck								
Chest / Axilla								
Abdomen								
Back / Flank								
Pelvis / Hip								
L Arm U L J								
R Arm U L J								
L Leg U L J								
R Leg U L J								



Glasgow Coma Scale

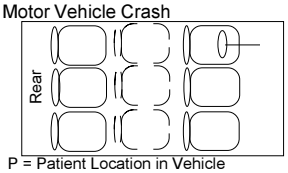
		Scene	Enroute
A.	Eye Opening		
	Spontaneous	4	4
	To voice	3	3
	To pain	2	2
	None	1	1
B.	Verbal Response		
	Oriented	5	5
	Confused	4	4
	Inappropriate words	3	3
	Incomprehensible Words	2	2
	None	1	1
C.	Motor Response		
	Obeys commands	6	6
	Purposeful movement	5	5
	Withdraws to pain	4	4
	Flexion to pain	3	3
	Extension to pain	2	2
	None	1	1

Time _____

A. + B. + C. = _____ _____ ☐N/A

TRAUMATIC INJURY

Motor Vehicle Crash ☐N/A



P = Patient Location in Vehicle
X = Location of Damage to Vehicle

Type ☐N/A
☐ Car ☐ Motorcycle
☐ Truck ☐ ATV
☐ Van ☐ Snowmobile
☐ Semi ☐ Watercraft
☐ Bus ☐ Aircraft

Exterior Damage ☐N/A
☐ None
☐ Minor
☐ Moderate
☐ Major
☐ Rollover

Interior Damage ☐N/A
☐ None
☐ Spidered Window
☐ St. Wh. Bent
☐ Compart. Intrusion
☐ Patient Ejected

Restraints ☐N/A

	Obs	Rprt
Airbag	☐	☐
Lap Belt	☐	☐
Shoulder Belt	☐	☐
Child Seat	☐	☐

Safety Equipment ☐N/A
☐ None ☐ Float. Dev.
☐ Helmet ☐ Unknown
☐ Eye Prot.
☐ Prot. Clothing

Cause of Injury ☐N/A

☐ Aircraft Related
☐ Athletic Event
☐ Bicycle Crash
☐ Bite
☐ Chemical Exposure
☐ Child Battering Suspected
☐ Drowning
☐ Drug Ingestion
☐ Electrocution (Non-Light.)
☐ Excessive Cold
☐ Excessive Heat
☐ Fall
☐ Fire / Flames
☐ Firearm Self-Inflicted
☐ Firearm Accidental
☐ Firearm Assault
☐ Lightning
☐ Machinery Injury
☐ Mechanical Suffocation
☐ Motor Vehicle (Non-Traff.)
☐ Motor Vehicle (Traffic)
☐ Pedestrian Traffic
☐ Physical Assault
☐ Poison, Not Drugs
☐ Radiation Exposure
☐ Sexual Assault
☐ Smoke Inhalation
☐ Stabbing
☐ Stings (Plant / Animal)
☐ Water Transport Incident
☐ Unknown
☐ Other _____

COMMENT

Provider Impression If more than one impression is checked, Circle Primary One

☐ Abd. Pn. / Problems
☐ Airway Obstruction
☐ Allergic Reaction
☐ Altered L.O.C.
☐ Behavioral / Psych
☐ Cardiac Arrest
☐ Cardiac Rhythm. Disturb.
☐ Chest Pn. Discomfort
☐ Congestive Heart Failure
☐ Diabetic Symptoms
☐ Electrocution
☐ GI Bleed
☐ Headache
☐ Hypertension
☐ Hyperthermia / Fever
☐ Hypothermia
☐ Hypovolemia / Shock
☐ Intoxication Suspected / Alcohol Ingestion
☐ Obvious Death
☐ Poison / Drug Ingestion
☐ Pregnancy / Ob Delivery
☐ Respiratory Arrest
☐ Respiratory Distress
☐ Seizure
☐ Sexual Assault / Rape
☐ Toxic Inhalation
☐ Stings / Bites
☐ Stroke / CVA / TIA
☐ Syncope / Fainting
☐ Traumatic Injury
☐ Vaginal Hemorrhage
☐ Unknown
☐ Other _____

Chief Complaint / Mechanism of Injury: Time of Onset:

Comments:

Procedure or Treatment

	EMT	EMT
☐ Assisted Ventilation		
☐ Backboard		
☐ Bleeding Control		
☐ Burn Care		
☐ CPR		
☐ Cervical Immobilization		
☐ DNR Protocol		
☐ Glucose Administration		
☐ Nasopharyngeal Airway		
☐ Obstetric Care / Delivery		
☐ Oropharyngeal Airway		
☐ O2 By Mask _____ liters		
☐ O2 By Cannula _____ liters		
☐ Physical Exam		
☐ Radio / Phone Report		
☐ Splint of Extremity		
☐ Traction Splint		
☐ Vital Signs		
☐ OTHER: _____		
☐ None		

If an advanced skill is performed, complete form DPH 7300

MISCELLANEOUS

Incident Disposition
☐ Treated / Transported by EMS

Destination Type - AND - Destination Determination
☐ Home / Residence
☐ Police / Jail
☐ Medical Office / Clinic
☐ Skilled Nursing Facil.
☐ Hospital Direct Admit
☐ Hospital ED
☐ Morgue
☐ Other
☐ Closest Facility
☐ Diversion
☐ EMT Choice
☐ Law Enforce. Choice
☐ Managed Care
☐ On Line Med. Direction
☐ Patient / Family Choice
☐ Patient / Phys. Choice
☐ Protocol
☐ Specialty Center
☐ Other

☐ Treated / Transferred Care
☐ To Aero-Medical Unit
☐ To ALS Unit
☐ To BLS Unit
☐ To Law Enforcement

☐ Treated / No Transport
☐ Treat. / Trans. by Priv. Veh.
☐ Treat. / Trans. by Other Means
☐ Treated and Released
☐ Patient Refused Care

☐ No Treat. Needed
☐ Dead at Scene
☐ Cancelled
☐ Unknown
☐ No Patient Found

Lights And Siren During Transport: ☐N/A
☐ Non-Emergent, No Lights or Siren
☐ Emergent, Lights and Siren
☐ Initial Emergent, Downgrade To No Lights and Siren
☐ Initial Non-emergent, Upgrade To Lights and Siren

Patient Transported
☐ Prone
☐ Supine
☐ Sitting
☐ Patient Restrained
☐ Head Elevated
☐ Feet Elevated
☐ In _____ Lateral Position
☐ Other _____

Other Services on Scene
☐ Law Enforcement _____
☐ Fire _____
☐ Other _____
☐ None
☐ Physician
☐ First Responder _____
☐ Nurse / Physician Assistant
☐N/A

Arrival Status ☐N/A
☐ Unchanged
☐ Better
☐ Worse
☐ DOA
☐ Unknown

PPE Used ☐N/A
☐ Gloves
☐ Gown
☐ Goggles
☐ Mask
☐ Other _____

Facility Notified By ☐N/A
☐ Radio
☐ Phone
☐ Unable*
☐ No Need*
☐ Direct
☐ EKG Telemetry
* Explain_____

Difficulties Encountered
☐ Dispatch ☐ Other _____
☐ Extrication
☐ Hazardous Material
☐ Language Barrier
☐ Road
☐ Unsafe Scene
☐ Vehicle Problems
☐ Weather ☐N/A

Time Report Received: By:
Report Given To: _____ ☐N/A
EMT Signature