



PATIENT NAME:	
DOC NUMBER:	DATE OF BIRTH:

### EMERGENCY RESPONSE RECORD

DATE	TIME NOTIFIED	TIME ARRIVED	FACILITY/LOCATION	ALLERGIES
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**Patient Response:**  To verbal     To pain     Unresponsive     Oriented     Confused

**Airway:**  Patent     Compromised    **Lungs:**  Clear     Abnormal: \_\_\_\_\_

<b>VITAL SIGNS</b>	TIME:	TIME	TIME	TIME	TIME	TIME
	Temp					
	BP					
	HR					
	Resp					
	O <sub>2</sub> %					
	CBG					

**Condition/Emergency:**

- |                                         |                                            |                                        |                                      |
|-----------------------------------------|--------------------------------------------|----------------------------------------|--------------------------------------|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Allergic reaction | <input type="checkbox"/> Altercation   | <input type="checkbox"/> Asthma      |
| <input type="checkbox"/> Bleeding       | <input type="checkbox"/> Burn              | <input type="checkbox"/> Cardiac       | <input type="checkbox"/> Dehydrated  |
| <input type="checkbox"/> Diabetic       | <input type="checkbox"/> Fracture          | <input type="checkbox"/> Head injury   | <input type="checkbox"/> Injury      |
| <input type="checkbox"/> Laceration     | <input type="checkbox"/> Overdose          | <input type="checkbox"/> Pain          | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Seizure        | <input type="checkbox"/> Suicide attempt   | <input type="checkbox"/> Mental health | <input type="checkbox"/> Pregnancy   |
| <input type="checkbox"/> Labor          | <input type="checkbox"/> Other: _____      |                                        |                                      |

**Notes:**

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**Treatment:**

- 911** – Time: \_\_\_\_\_     O<sub>2</sub> delivery     Suction     Oral airway     Nasopharyngeal
- C-collar/Backboard     IV – Gauge: \_\_\_\_\_ Attempts: \_\_\_\_\_ Site: \_\_\_\_\_     Poison control
- Other: \_\_\_\_\_    Notes: \_\_\_\_\_

<b>Medications:</b>				
TIME:				
Narcan				
O <sub>2</sub> LPM				
ASA				
Nitro SL				
Duo Neb				
Epi Pen				
Gluco gel				
Glucagon				
D50				
Other				

**CPR:**

CPR started by: \_\_\_\_\_

Time initiated: \_\_\_\_\_

CPR:			
AED:			

CPR stopped per: \_\_\_\_\_ Time: \_\_\_\_\_

Notes: \_\_\_\_\_

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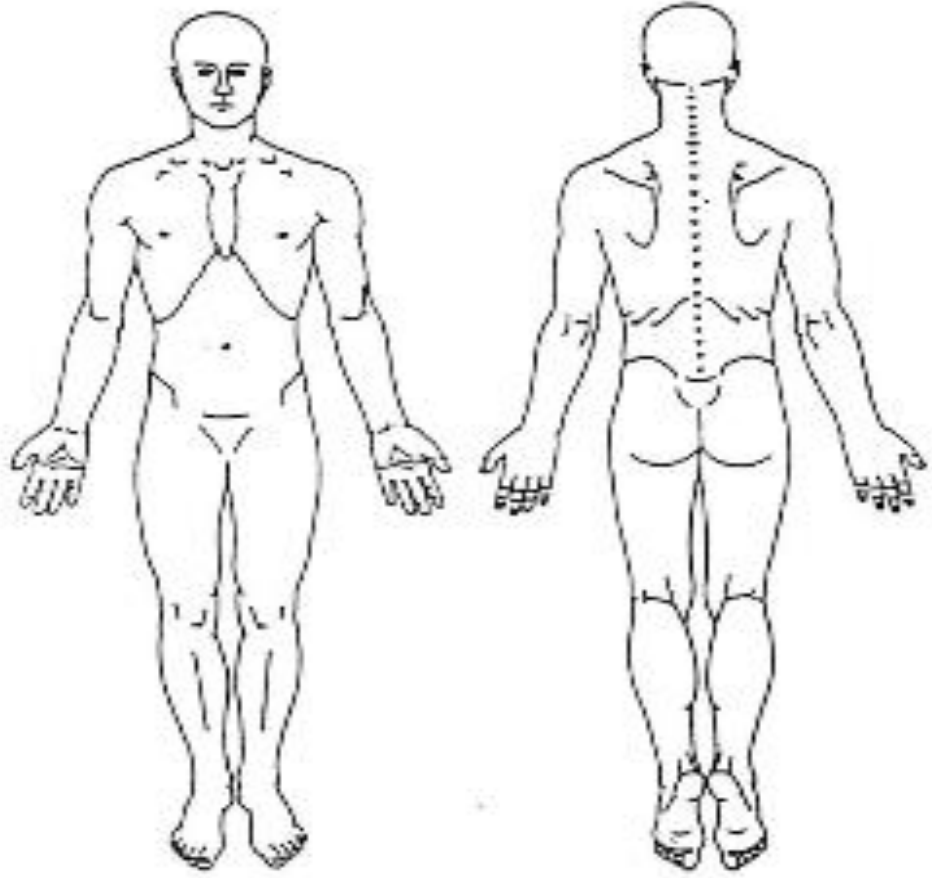


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State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

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Notes/Comments:

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<b>COMPLETED BY</b>		
_____	_____	_____
SIGNATURE AND STAMP	DATE	TIME

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