

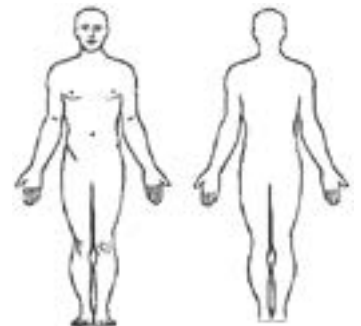


Name:		Gender:	
Age:	Birthdate:	Weight:	<input type="checkbox"/> kg <input type="checkbox"/> lbs
Emergency Contact:		Phone:	
Location:	Time Arrived on Scene:	Date:	

Subjective	Scene:		
	Symptoms:	Allergies:	Medications:
	Pertinent History:	Last In / Out:	Events:

Objective	Physical Exam:

Vitals	Time	AVPU	Pulse	Resp. (Rate & Quality)	Skin	Other (Temp, BP, SpO2)



ASSESSMENT AND TREATMENT PLAN

A = Assessment (Problem List)

A' = Anticipated Problems

P = Treatment Plan

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ADDITIONAL NOTES

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Patient care transfer information (if applicable). Note agency, location, & time:

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Care Provider:

Certification level:

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