NORTHWEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM

EST 1972

CE Credit Questions begin after case # 16 in handout

March 2016

QI: CONFIDENTIAL under Medical Studies Act

Northwest Community EMS System
Continuing Education
March 2016
Respiratory Distress & Failure

Objectives

1. Given patient information via an ePCR, evaluate components of assessment in a patient with respiratory signs/symptoms including: history (chief complaint and history of present illness), past medical history (using SAMPLE), and physical examination.

2. Differentiate causes of respiratory distress/failure/arrest based on history and physical examination including asthma/COPD, heart failure, pneumonia, ACS, pulmonary embolus.

3. Develop an overall and specific plan of care for patients with respiratory distress/failure/arrest based on the etiology.

4. Prioritize care for a patient in respiratory distress/failure/arrest.

5. Explain the action, indications, contraindications, and side effects of oxygen, CPAP, positive-pressure ventilation, aspirin, albuterol, ipratropium, epinephrine, midazolam, nitroglycerine,

6. Discuss why patients may feel short of breath prior to the development of crackles in heart failure.

7. Decide how to treat patients presenting in respiratory distress/failure with a past medical history of both CVD and COPD including the use of capnography assessment.

8. Evaluate the appropriate use of 12-lead ECG in patients with respiratory symptoms.

9. Apply the following SOP's to patient situations: drug-assisted ETI, asthma/COPD, ACS, heart failure, and shock.

10. Discuss the causes and effects of myocardial ischemia on the cardio-pulmonary systems.

11. Differentiate oxygenation and ventilation assessment and treatment.

12. Demonstrate use of the pulse oximetry plethysmograph ("pleth") to evaluate signal reliability.

Comprehensive Report

Incident Date: [redacted] Call #: [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 69 Years
Gender: Female
Weight: 54.431 KG / 120.00 LB
Phone: 9999999999

D.O.B: [redacted]
SSN:
Race: White
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: Safety
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 00:41
Disp. Notified: 00:41
Unit Disp.: 00:41
Enroute: 00:43
At Scene: 00:46
At Patient: 00:47
Depart: 01:05
Arrive Dest: 01:12
In Service: 01:52
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0 **To Scene:**
Dest. Miles: 5.3 **To Dest:** 5.3
End Miles: 5.3 **To End:** 0.0
Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies#: Not Applicable

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Driver Only
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Primary Caregiver
[redacted]		

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Distress
Chief Complaint: Difficulty breathing X 4 Hours
Onset Date/Time: [redacted]at 21:41
Alcohol/Drug Use: No Apparent Alcohol/Drug Use
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem
Other Associated Symptoms
Not Applicable

18

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
00:49	190/80	76	RR	24	Normal	85	On Room Air	26	15	0				12	Right Arm	Sitting
01:03	168/78	68	RR	20	Normal	90	Low FIO2 (24-40 pct)	29	15	0				12	Right Arm	Semi-Fowlers

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
00:49	4	5	6	15
01:03	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
IV Contrast		

Patient Medications	Generic Name	Dosage
Trazadone		
Prevastatin		
Lopressor	Metoprolol	
Lanoxin, Digitek	Digoxin	
Eliquis		

Medical Surgery History

Chronic Respiratory - Bronchitis, Cardiac - Dysrhythmia/Arrhythmia , *Atrial Fibrillation*

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Patient	No		

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
00:53	[redacted]	Airway CPAP Treatment	Mouth		2	Unchanged	No	Pt. would not tolerate CPAP or NRM on her face

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
00:50	[redacted]	Oxygen by Nasal Cannula	Inhalation	6 LPM	Improved		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
00:52	12-Lead ECG	12 Lead ECG	Sinus rhythm...Borderline ST depression, anterolateral leads	Artifact	
01:09	ECG-Monitor	II	sinus rhythm	Artifact	

Assessment Exam

Time of Assessment:	[redacted]49:00-06:00	[redacted]01:10:00-06:00
Abdomen-left-lower:	Normal (Soft, Non-Tender)	
Abdomen-left-upper:	Normal (Soft, Non-Tender)	
Abdomen-right-lower:	Normal (Soft, Non-Tender)	
Abdomen-right-upper:	Normal (Soft, Non-Tender)	
Back-cervical:	Normal (No Pain or Deformities)	
Back-lumbar:	Normal (No Pain or Deformities)	
Back-thoracic:	Normal (No Pain or Deformities)	
Chest:	Symmetrical Chest Rise, Clear & Equal Breath Sounds	Symmetrical Chest Rise, Clear & Equal Breath Sounds
Ext-left-low:	C.M.S. Normal	
Ext-left-up:	C.M.S. Normal	C.M.S. Normal
Ext-right-low:	C.M.S. Normal	
Ext-right-up:	C.M.S. Normal	C.M.S. Normal
Eyes-left:	Reactive	Reactive
Eyes-right:	Reactive	Reactive

GU:		
Head:	Normal	Normal
Heart:		
Mental:	Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events	Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events
Neck:	Normal	Normal
Neuro:	Normal Gait / Movement	Normal Gait / Movement
Skin:	Normal	Normal

Narrative

Summary of Events

Dispatched to an A&Ox3 69 y/o female with difficulty breathing. Upon arrival, pt. was sitting on couch where she explained that starting last night (at approx. 0942 hrs) she developed some SOB which gradually worsened to 10/10 difficulty. Pt. denied any chest pain, N/V, lightheadedness, weakness, and syncope. Pt. also denied any recent illness, fever, and cough. Pt. given O2 via NC which helped with SOB, but pt. was still feelings distressed. Initial capnography showed 27 EtCO2 with sharkfin waveform. CPAP attempted multiple times, as well as NRM, but pt. would not tolerate any type of mask, and adamantly refused. 12-lead interpreted as "Sinus rhythm...Borderline ST depression, anterolateral leads." ALS care, EKG, and vitals a stated, and lungs clear bilaterally. [redacted] contacted, no further orders. Pt. transported without incident, care transferred to Ed RN, D8.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable

Area of Vehicle Impacted: Not Applicable

Seat Row Location of Patient:

Position of Patient: Not Applicable

Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

You MUST answer this question regardless if Capnography was used; How did the waveform appear?	Obstruction/Shark Fin

Comprehensive Report

Incident Date: [redacted] Call #: [redacted] Patient Care #: [redacted]

Patient Information

Name: [redacted]

Address: [redacted]

Age: 82 Years
Gender: Female
Weight: 90.718 KG / 200.00 LB
Phone:

D.O.B: [redacted]
SSN:
Race: Other Race
Ethnicity: Hispanic or Latino

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 03:06
Disp. Notified:
Unit Disp.: 03:06
Enroute: 03:08
At Scene: 03:13
At Patient: 03:13
Depart: 03:34
Arrive Dest: 03:39
In Service: 04:30
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: [redacted] **To Scene:**
Dest. Miles: [redacted] **To Dest:** 2.7
End Miles: [redacted] **To End:** 0.3
Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies: [redacted] Police

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Driver Only
[redacted]	EMT-Basic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	EMT-Basic	Fire Company
[redacted]	EMT-Basic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Distress
Chief Complaint: Trouble breathing X
Onset Date/Time: [redacted] t 00:00
Alcohol/Drug Use:
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Other Associated Symptoms

28

Not Applicable

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
03:14	160/90	135	RR	28	Labored	78	On Room Air		15					12	Left Arm	Sitting
03:17				28	Labored	90	High FIO2 (80-100 pct)									Sitting
03:30	172/98	130	RR	24	Labored	95	High FIO2 (80-100 pct)		15					12	Left Arm	Full-Fowlers

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
03:14	4	5	6	15
03:17				
03:30	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
NKDA (No Known Drug Allergies)	NKDA (No Known Drug Allergies)	

Environmental/Food Allergies	Description
None	

Patient Medications	Generic Name	Dosage
Unable to Obtain Patient Medications	Unable to Obtain Patient Medications	

Medical Surgery History

Other , *Right bundle branch block*

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Family			

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
03:22	[redacted]	Venous Access - Extremity	Antecubital-Right	18g	2	Unchanged	Yes	
03:23	[redacted]	Airway CPAP Treatment			1	Improved	Yes	5 peep

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
03:15	[redacted]	Oxygen by Mask	Inhalation	15 LPM	Improved		
03:22	[redacted]	Normal Saline (0.9%)	Intravenous	10 TKO (KVO)	Unchanged	No	
03:32	[redacted]	Nitroglycerin	Sublingual	0.4 MG	Unchanged		
03:37	[redacted]	Nitroglycerin	Sublingual	0.4 MG	Unchanged		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
03:19	ECG-Monitor	II	Sinus Tachycardia	No Ectopy Noted	

Assessment Exam

Time of Assessment: [redacted] 03:14:00-06:00

Abdomen-left-lower:

Abdomen-left-upper:

Abdomen-right-lower:

Abdomen-right-upper:

Back-cervical:

Back-lumbar:

Back-thoracic:

Chest: Rales / Crackles

Ext-left-low: C.M.S. Normal

Ext-left-up: C.M.S. Normal

Ext-right-low: C.M.S. Normal

Ext-right-up: C.M.S. Normal

Eyes-left:

Eyes-right:

GU:

Head:

Heart:

Mental: Normal Mental Status for Patient

Neck:

Neuro: Speech Normal

Skin: Clammy

Narrative

Summary of Events

Dispatched for the trouble breathing. Upon arrival crew found 81 y/o female sitting on the couch. Pt appeared in distress and had labored breathing. Crew had difficult time communicating with the pt due to language barrier. Family stated the pt had some SOB the day before and it increased to the point they contacted EMS. Crew also had a difficult time obtaining pt's medical history from the family but they stated she had no previous breathing problems. Family questioned pt and she denied having CP or any pain in general. Crew continued treatment per heart failure SOP. Crew withheld Aspirin due to the of pt not being able to chew and swallow them at that point. [redacted] contacted with no orders given. Pt monitored en route and crew noted improvement in pt's O2 sat which was 95%. Pt's WOB also slightly improved. Pt taken to room 9 and left in care of RN and staff

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable

Area of Vehicle Impacted: Not Applicable

Seat Row Location of Patient:

Position of Patient: Not Applicable

Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

Is Patient a resident?	yes
If Capnography was used, how did the waveform appear?	Square Constant

Comprehensive Report 34

[redacted]

Incident Date: [redacted] Call #: [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 88 Years
Gender: Male
Weight: 99.790 KG / 220.00 LB
Phone:

D.O.B: [redacted]
SSN:
Race:
Ethnicity:

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location [redacted]
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: No Lights or Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 03:50
Disp. Notified: 03:50
Unit Disp.: 03:50
Enroute: 03:52
At Scene: 03:56
At Patient: 03:57
Depart: 04:15
Arrive Dest: 04:17
In Service: 05:15
In Quarters:
Cancelled:

Incident # [redacted]
Start Miles:
Scene Miles: 0.0
To Scene:
Dest. Miles: 0.2
To Dest: 0.2
End Miles: 0.2
To End: 0.0

Call Sign: [redacted]
Veh. # [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies#: Not Applicable

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Driver Only
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: No Lights or Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Distress
Chief Complaint: Respiratory Distress X
Onset Date/Time: [redacted]t 03:00
Alcohol/Drug Use:
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem

Other Associated Symptoms

Not Applicable

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Sci	PTA	B.G.	RTS	Limb	Patient Position
04:01	96/54	106	RR	30	Normal	82	High FIO2 (80-100 pct)		14	0				11	Right Arm	Semi-Fowlers
04:04	92/56	102	RR	28	Normal	91	High FIO2 (80-100 pct)		14					12	Right Arm	Semi-Fowlers
04:15	92/54	106	RR	26	Normal	92	High FIO2 (80-100 pct)		14					12	Right Arm	Semi-Fowlers

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
04:01	3	5	6	14
04:04	3	5	6	14
04:15	3	5	6	14

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
NKDA (No Known Drug Allergies)	NKDA (No Known Drug Allergies)	

Patient Medications	Generic Name	Dosage
Aspirin	Aspirin	
bisacodyl		
miralax		
Prilosec	Omeprazole	
thiamine		

Medical Surgery History

Cancer, Hypertension, Cardiac - Dysrhythmia/Arrhythmia

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Health Care Personnel			

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
04:02	[redacted]	Airway Positive Pressure Ventilation			1	Improved	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
04:06	ECG-Monitor		Sinus Tachycardia		

Assessment Exam

Time of Assessment: [redacted]4:00:00-06:00

Abdomen-left-lower:

Abdomen-left-upper:

Abdomen-right-lower:

Abdomen-right-upper:

Back-cervical:

Back-lumbar:

Back-thoracic:

Chest: Rales / Crackles

Ext-left-low:

Ext-left-up:

Ext-right-low:

Ext-right-up:

Eyes-left: Reactive

Eyes-right: Reactive

GU:

Head:

Heart:

Mental: Responsive to Verbal Stimuli

Neck:
Neuro: Speech Normal
Skin: Normal

3C

Narrative

Summary of Events

[redacted] and [redacted] were called to the scene for an 88 y/o male with shortness of breath. Upon arrival crew found pt lying in bed, conscious, and responsive to verbal stimuli. Pt was in obvious respiratory distress and crews noted audible crackles. Nursing staff had placed a nrb at 15lpm on pt prior to crews arrival. Pt was quickly assessed and v/s were obtained. Crew found Pts spo2 at 82% on the nrb. Pt was unable to speak more than a word or two due to his shortness of breath. Crews noted labored breathing and bilateral crackles and placed pt on c-pap with notable improvement in pts distress. ASA was not given due to pts responsiveness. Crew did not note any distal edema. Pt was secured and placed at a 90 degree angle on stretcher and moved to ambulance. Pt was placed on cardiac monitor and found in sinus tach. Nitro was not given due to pts low b/p. [redacted] was contacted and radio report was given with no further orders. Pt continued to tolerate and improve with c-pap. Pts crackles began to diminish and labored breathing continued to improve. Pt was continually monitored and reassessed en-route with continual improvements in pts distress and spo2. ALS care was continued without incident. Pt care was transferred to ED RN.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable
Area of Vehicle Impacted: Not Applicable
Seat Row Location of Patient:
Position of Patient: Not Applicable
Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

Has the Ambulance Billing Authorization and Privacy Acknowledgment Form been completed with the requisite signature(s)?	Yes
Hospital Log Number (ENTER HOSP CONTACTED FOR OLMC ON "From Scene" TAB)	
If Capnography was used, how did the waveform appear?	

Comprehensive Report [redacted]

Incident Date: [redacted] Call #: [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 83 Years
Gender: Male
Weight: 90.718 KG / 200.00 LB

D.O.B: [redacted] (mm/dd/yyyy)
SSN:
Race: White

Phone: [redacted]
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 07:01
Disp. Notified: 07:01
Unit Disp.: 07:02
Enroute: 07:03
At Scene: 07:07
At Patient: 07:11
Depart: 07:22
Arrive Dest: 07:34
In Service: 09:00
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0
To Scene:
Dest. Miles: 5.9
To Dest: 5.9
End Miles: 5.9
To End: 0.0

Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies: [redacted]

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Driver Only
[redacted]	Paramedic	Fire Company
[redacted]	EMT-Basic	Fire Company
[redacted]	First Responder	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Distress
Chief Complaint: Difficulty Breathing X 1 Hours
Onset Date/Time: [redacted] 06:00
Alcohol/Drug Use: No Apparent Alcohol/Drug Use
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem

Other Associated Symptoms
Not Applicable
Pain / Discomfort in Chest

4B

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl.	PTA	B.G.	RTS	Limb	Patient Position
07:12	180/122	122	RR	24	Normal	86	On Room Air		15	0				12	Left Arm	Sitting
07:18	184/125	123	RR	19	Normal	91	High FIO2 (80-100 pct)	30	15	0				12	Left Arm	Semi-Fowlers
07:23	180/121	123	RR	21	Normal	91	High FIO2 (80-100 pct)	18	15	0				12	Left Arm	Semi-Fowlers
07:28	174/98	120	RR	18	Normal	91	High FIO2 (80-100 pct)	15	15	0				12	Left Arm	Semi-Fowlers
07:34	166/136	120	RR	23	Normal	92	High FIO2 (80-100 pct)	17	15	0				12	Left Arm	

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
07:12	4	5	6	15
07:18	4	5	6	15
07:23	4	5	6	15
07:28	4	5	6	15
07:34	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
NKDA (No Known Drug Allergies)	NKDA (No Known Drug Allergies)	

Patient Medications	Generic Name	Dosage
Zocor	Simvastatin	
Demeron		
Prilosec	Omeprazole	
lyrica		
Parcopa		
Seligiline		

Medical Surgery History
Stroke/CVA, Cardiac, Other , *Parkinsons*

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Family	N/A		

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
07:12	[redacted]	Airway CPAP Treatment	Mouth		1	Improved	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
07:12	[redacted]	Oxygen by Mask	Inhalation	15 LPM	Improved		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
07:23	ECG-Monitor		Sinus Tachycardia		
07:23	12-Lead ECG		Abnormal ECG **Unconfirmed** Sinus Tachycardia, Possible anteroseptal Infarct-age undetermined, Inferior/lateral ST-T abnormality may be due to myocarial ischemia		

Assessment Exam

Time of Assessment [redacted]7:11:00-06:00

Abdomen-left-lower:

Abdomen-left-upper:

Abdomen-right-lower:

Abdomen-right-upper:

Back-cervical:

Back-lumbar:
Back-thoracic:
Chest: Expiratory Wheezing, Inspiratory Wheezing
Ext-left-low:
Ext-left-up:
Ext-right-low:
Ext-right-up:
Eyes-left: Reactive
Eyes-right: Reactive
GU:
Head:
Heart:
Mental: Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events
Neck:
Neuro:
Skin: Normal, Dry / Dehydrated

4c

Narrative

Summary of Events

Called to the scene for a 83 y/o male who had difficulty breathing. Upon arrival at the pt paramedics found him sitting on his family room chair with audible inspiratory and expiratory wheezing. Pt had accessory muscle use. Pt had a hx of a heart attack in 1998, stroke in 1999, and Parkinson's. Pt stated he had chest discomfort from the difficulty breathing. Chest discomfort subsided after use of CPAP. Pt was conscious and A&OX4. Pt denied having CHF or COPD. Pt improved rapidly with use of CPAP. All audible wheezing subsided. Pt had crackles on the right side. Pt denied having any pain after CPAP started. ALS procedures were employed by paramedics, see activities above. Pt was transported in a position of comfort. Extra manpower was taken from [redacted] to assist during transport. Hospital was contacted and information was relayed; no further orders were given. Pt was moved to room 8 and care was transferred to Nurse [redacted] at 0741.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable
Area of Vehicle Impacted: Not Applicable
Seat Row Location of Patient:
Position of Patient: Not Applicable
Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

Is patient a [redacted] resident?	Yes
Was a 12 Lead ECG left with the ED staff?	Yes
If Capnography was used, how did the waveform appear?	Square Increasing

Comprehensive Report

Incident Date: [redacted] Call #: [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]
Address: [redacted]
Age: 83 Years
Gender: Female
Weight: 52.163 KG / 115.00 LB
Phone: [redacted]
D.O.B: [redacted] (mm/dd/yyyy)
SSN:
Race: White
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 08:00
Disp. Notified: 08:00
Unit Disp.: 08:01
Enroute: 08:02
At Scene: 08:07
At Patient: 08:08
Depart: 08:30
Arrive Dest: 08:41
In Service: 09:20
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0 **To Scene:**
Dest. Miles: 5.5 **To Dest:** 5.5
End Miles: 5.5 **To End:** 0.0

Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies#: Not Applicable

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Driver Only
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Distress
Chief Complaint: " I can't breathe" X 2 Hours
Onset Date/Time: [redacted] at 06:00
Alcohol/Drug Use:
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem

Other Associated Symptoms

SB

Weakness
Dizziness

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
08:09	180/68	40	II	24	Labored	74	On Room Air		15	0				12	Right Arm	Right Lateral Recumbent
08:18	198/100	70	II	20	Labored	92	High FIO2 (80-100 pct)		15					12	Right Arm	Semi-Fowlers
08:28	207/106	73	II	12	Assisted	100	High FIO2 (80-100 pct)	19	15					12	Left Arm	Full-Fowlers
08:33	206/116	92	II	12	Assisted	100	High FIO2 (80-100 pct)	15	15					12	Left Arm	Full-Fowlers
08:35	167/86	74	II	12	Assisted	100	High FIO2 (80-100 pct)	17	15					12	Left Arm	Full-Fowlers

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
08:09	4	5	6	15
08:18	4	5	6	15
08:28	4	5	6	15
08:33	4	5	6	15
08:35	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
NKDA (No Known Drug Allergies)	NKDA (No Known Drug Allergies)	

Patient Medications	Generic Name	Dosage
Ambien	Zolpidem	
Apresoline	Hydralazine (PO)	
Aspirin	Aspirin	
Colace		
Coreg	Carvedilol	
Ferrate		
Isordil	Isosorbide	
Lamotrigine		
Norvasc	Amlodipine	
Ocuvite		
Plavix	Clopidogrel	
Xanax	Alprazolam	
Zoloft	Sertraline HCL	

Medical Surgery History

Hypertension, Cardiac , *Bypass surgery 2000*

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Family			

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
08:13	[redacted]	Venous Access - Extremity	Hand-Right	20g	1	Unchanged	Yes	
08:15	[redacted]	Airway CPAP Treatment			1	Improved	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
08:11	[redacted]	Oxygen by Nasal Cannula	Inhalation	4 LPM	Unchanged		
08:13	[redacted]	Normal Saline (0.9%)	Intravenous	10 TKO (KVO)	Unchanged	No	
08:15	[redacted]	Oxygen by Non-Rebreather Mask	Inhalation	15 LPM	Improved	No	
08:25	[redacted]	Albuterol Sulfate	Inhalation via Nebulizer	2.5 MG	Improved	No	
08:25	[redacted]	Ipratropium Bromide (Atrovent)	Inhalation via Nebulizer	0.5 MG	Improved		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change

08:14	ECG-Monitor	II	Sinus Rhythm	PVC - Premature Ventricular Contractions	
08:16	12-Lead ECG	12 Lead ECG	Abnormal ECG Unconfirmed; Sinus Rhythm; Left Bundle branch block	Left Bundle Branch Block	

60

Assessment Exam

Time of Assessment: [redacted]8:10:00-06:00

Abdomen-left-lower: Normal (Soft, Non-Tender)
Abdomen-left-upper: Normal (Soft, Non-Tender)
Abdomen-right-lower: Normal (Soft, Non-Tender)
Abdomen-right-upper: Normal (Soft, Non-Tender)
Back-cervical: Normal (No Pain or Deformities)
Back-lumbar: Normal (No Pain or Deformities)
Back-thoracic: Normal (No Pain or Deformities)
Chest: Expiratory Wheezing, Inspiratory Wheezing
Ext-left-low: C.M.S. Normal
Ext-left-up: C.M.S. Normal
Ext-right-low: C.M.S. Normal
Ext-right-up: C.M.S. Normal
Eyes-left: Reactive
Eyes-right: Reactive
GU: Normal
Head: Normal
Heart:
Mental: Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events
Neck: Normal
Neuro: Normal Gait / Movement
Skin: Normal

Narrative

Summary of Events

In summary, crew dispatched to above location for 83 yo F with difficulty breathing. Upon arrival, crew found pt. AOx4, right lateral recumbent on bed, in obvious respiratory distress. Pt. stated "I can't breathe." Pt. stated that difficulty started approximately two hours prior to EMS arrival. VS and ECG obtained as above. LS wheezes bilaterally in upper lobes, fluid in lower. Fever noted. Pt. also c/o weakness and dizziness, but denied NVD, visual and auditory changes, H/A, recent traumas, LOC, and CP. Pt. husband was on scene and reported that pt. had an MI 3 weeks prior. Secondary assessment revealed no obvious injury or deformity. IV established and CPAP initiated. Pt. moved via cot to MICU and duo neb started in MICU. Contacted [redacted] for orders and transport. No orders given. Continued transport without incident. En route, pt. reported feeling better, but also reported no change in work of breathing. Upon arrival, transferred to [redacted] ED MD in room 8 at 08:43. Report given. Assisted by [redacted]. All times and pt. weight approximate.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable
Area of Vehicle Impacted: Not Applicable
Seat Row Location of Patient:
Position of Patient: Not Applicable
Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

Is patient a [redacted]esident?	Yes
Was a 12 Lead ECG left with the ED staff?	Yes
If Capnography was used, how did the waveform appear?	Obstruction/Shark Fin

Comprehensive Report

6A [redacted]

Incident Date: [redacted] Call # [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 87 Years
Gender: Female
Weight: 61.235 KG / 135.00 LB

D.O.B: [redacted]yyyy)
SSN:
Race: White

Phone: [redacted]
Ethnicity: Not Known

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 08:02
Disp. Notified: 08:02
Unit Disp.: 08:03
Enroute: 08:03
At Scene: 08:05
At Patient: 08:07
Depart: 08:23
Arrive Dest: 08:24
In Service: 09:15
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0
To Scene:
Dest. Miles: 0.3
To Dest: 0.3
End Miles: 0.3
To End: 0.0

Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies#: Not Applicable

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Secondary Caregiver
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Driver Only

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Distress
Chief Complaint: SOB X 35 Minutes
Onset Date/Time: [redacted]t 07:30
Alcohol/Drug Use: No Apparent Alcohol/Drug Use
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem

Other Associated Symptoms
Not Applicable

6B

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
08:10	152/119	115	RR	30	Labored	78	Low FIO2 (24-40 pct)		15					11	Right Arm	Sitting
08:15	174/102	114	RR	28	Labored	81	High FIO2 (80-100 pct)		15					12	Right Arm	Sitting
08:20	165/110	125	RR	28	Labored	83	On Room Air		15					12	Right Arm	Sitting

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
08:10	4	5	6	15
08:15	4	5	6	15
08:20	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
Aspirin	Aspirin	
diltiazem		
dronedarone		
penicillins		
sulfa		

Environmental/Food Allergies	Description
Food Allergy	Chocolate

Patient Medications	Generic Name	Dosage
Tambocor	Flecainide	
Visicare		
Advair		
Allegra	Fexofenadine HCL	
Atrovent	Ipratropium bromide	
Cosa		
Cozaar	Losartin	
eliquis		
evista		
Lipitor	Atorvastatin	
Lopressor	Metoprolol	
Oxygen	Oxygen	4.000 Liters
Prednisone	Glucocorticoids	
Proventil, Ventolin	Albuterol	
Singulair	Montelukast Sodium	

Medical Surgery History

Chronic Respiratory - Bronchitis, Osteoperosis, Hypertension, Cardiac, Asthma, Cardiac - Dysrhythmia/Arrhythmia , *Muscular deconditioning, Pansinusitis, Pneumonia, Atelectasis of the left lung, Pancreatitis, Pulmonary atelectisis, Hiatal Hernia, Hyperoxemia, Allergic rhinitis, A-fib, Chronic Sinusitis, SVT, O2 dependance*

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Repeat Patient Record	No		

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
08:11	[redacted]	Airway CPAP Treatment	Mouth		1	Unchanged	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
08:09	[redacted]	Oxygen by Non-Rebreather Mask	Inhalation	15 LPM	Unchanged		
08:12	[redacted]	Oxygen by Nebulizer	Inhalation	6 LPM	Unchanged		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
08:08	ECG-Monitor		Sinus tach		

Comprehensive Report

Incident Date: [redacted] Call #: [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 64 Years
Gender: Female
Weight: 117.934 KG / 260.00 LB
Phone:

D.O.B.: [redacted]
SSN:
Race: White
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: Other
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 08:51
Disp. Notified:
Unit Disp.: 08:51
Enroute: 08:52
At Scene: 08:57
At Patient: 08:58
Depart: 09:20
Arrive Dest: 09:30
In Service: 10:30
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: [redacted] **To Scene:**
Dest. Miles: [redacted] **To Dest:** 5.3
End Miles: [redacted] **To End:** 0.0
Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies#: Not Applicable

Unit Personnel

Crew Member#	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Driver Only
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Asthma
Chief Complaint: SOB X 10 Minutes
Onset Date/Time: [redacted] at 18:00
Alcohol/Drug Use: No Apparent Alcohol/Drug Use
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem

Other Associated Symptoms

Assessment Exam

Time of Assessment:	[redacted]08:07:00-06:00	[redacted]08:07:00-06:00
Abdomen-left-lower:	Normal (Soft, Non-Tender)	
Abdomen-left-upper:	Normal (Soft, Non-Tender)	
Abdomen-right-lower:	Normal (Soft, Non-Tender)	
Abdomen-right-upper:	Normal (Soft, Non-Tender)	
Back-cervical:	Normal (No Pain or Deformities)	
Back-lumbar:	Normal (No Pain or Deformities)	
Back-thoracic:	Normal (No Pain or Deformities)	
Chest:		Not Available
Ext-left-low:	C.M.S. Normal	
Ext-left-up:	C.M.S. Normal	
Ext-right-low:	C.M.S. Normal	
Ext-right-up:	C.M.S. Normal	
Eyes-left:	Reactive	
Eyes-right:	Reactive	
GU:	Normal	
Head:	Normal	
Heart:		Not Available
Mental:	Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events	
Neck:	Normal	
Neuro:	Normal Gait / Movement	
Skin:		Not Available

Narrative

Summary of Events

In summary, A[redacted], and S[redacted] were dispatched for a female with trouble breathing. On scene the pt was found sitting in a tripod position with increased work of breathing. Pt was unable to speak but could nod her head yes and no. Pt had significant SOB. A history was unable to be obtained, due to lack of documentation in the room. ALS care was initiated. Pt is on a nasal cannula normally. Pt was given a non-breather @ 15 Lpm. Pt's condition did not improve. Pt was then given a neb with CPAP, pt's SPO2 increased slightly. Epi was not given due to tachycardia, unknown medical conditions, unknown allergies, and hypertension. [redacted] was contacted, and they had no further orders. Pt was transported without incident, and care was transferred to the ED RN.

Prior Aid

Prior Aid	Performed By:	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators:	Not Applicable		
Area of Vehicle Impacted:	Not Applicable		
Seat Row Location of Patient:		**Position of Patient:**	Not Applicable
Airbag Deployment:	Not Applicable		

Injury Details

Service-Defined Questions

Is this patient a [redacted]esident?	Yes - Resident
What field was signed on the Medicare Billing Form?	Section III - EMS/Receiving Hospital
Was this a mutual aid call t[redacted]	No - Not Mutual Aid t[redacted]
If Capnography was used, how did the waveform appear?	Obstruction/Shark Fin

Breathing Problem
Cough
Aphasia
Vomiting Alone

78

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
08:59	148/76	138	RR	42	Shallow	62	On Room Air	21	15	0				11	Right Arm	Sitting
09:02		136	RR	42	Shallow	72	Low FIO2 (24-40 pct)		15							Sitting
09:04		132	RR	38	Shallow	84	High FIO2 (80-100 pct)	24	15							Sitting
09:08	150/86	126	RR	36	Shallow	90	High FIO2 (80-100 pct)	25	15					11	Right Arm	Sitting
09:12		140	RR	42	Shallow	91	High FIO2 (80-100 pct)	27	15						Right Arm	Full-Fowlers
09:17	142/78	124	RR	34	Shallow	96	High FIO2 (80-100 pct)	28	15					11	Right Arm	Full-Fowlers
09:24	148/88	136	RR	38	Shallow	95	High FIO2 (80-100 pct)	28	15					11	Right Arm	Full-Fowlers
09:30		128	RR	32	Shallow	96	High FIO2 (80-100 pct)	27	15						Right Arm	Full-Fowlers

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
08:59	4	5	6	15
09:02	4	5	6	15
09:04	4	5	6	15
09:08	4	5	6	15
09:12	4	5	6	15
09:17	4	5	6	15
09:24	4	5	6	15
09:30	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
Unable to Obtain Allergies	Unable to Obtain Allergies	

Patient Medications	Generic Name	Dosage
Zocor	Simvastatin	
Lopressor	Metoprolol	
Cozaar	Losartin	
Bayer Aspirin	Aspirin	
clotrimazole		

Medical Surgery History

Hypertension, Asthma, Chronic Respiratory (COPD)

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Patient	No		

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
09:11	[redacted]	Venous Access - Extremity	Hand-Right	20g	1	Unchanged	No	
09:14	[redacted]	Airway CPAP Treatment	Mouth	1	1	Improved	Yes	5-7 PEEP
09:15	[redacted]	Venous Access - Extremity	Antecubital-Left	20g	1	Unchanged	No	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
09:00	[redacted]	Oxygen by Nasal Cannula	Inhalation	6 LPM	Improved		
09:03	[redacted]	Oxygen by Non-Rebreather Mask	Inhalation	15 LPM	Improved		
09:05	[redacted]	Albuterol Sulfate	Inhalation via Nebulizer	2.5 MG	Unchanged		
09:05	[redacted]	Ipratropium Bromide (Atrovent)	Inhalation via Nebulizer	0.5 MG	Unchanged		

09:06	Epinephrine 1:1000	Intramuscular	0.3 MG	Unchanged			

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
09:00	ECG-Monitor	II	Sinus Tachycardia	No Ectopy Noted	Initial Rhythm

Assessment Exam

Time of Assessment:	[redacted]08:58:00-06:00	[redacted]09:20:00-06:00	[redacted]09:27:00-06:00
Abdomen-left-lower:			
Abdomen-left-upper:			
Abdomen-right-lower:			
Abdomen-right-upper:			
Back-cervical:			
Back-lumbar:			
Back-thoracic:			
Chest:	Symmetrical Chest Rise, Accessory Muscles, Clear & Equal Breath Sounds, Sounds Present Bilaterally, Sounds Present Right Side, Sounds Present Left Side, Sounds Present At Bases, Sounds Present At Apexes	Symmetrical Chest Rise, Accessory Muscles, Clear & Equal Breath Sounds, Sounds Present Bilaterally, Sounds Present Right Side, Sounds Present Left Side, Sounds Present At Bases, Sounds Present At Apexes	Symmetrical Chest Rise, Clear & Equal Breath Sounds, Sounds Present Bilaterally, Sounds Present Right Side, Sounds Present Left Side, Sounds Present At Bases, Sounds Present At Apexes
Ext-left-low:	C.M.S. Normal		
Ext-left-up:	C.M.S. Normal		
Ext-right-low:	C.M.S. Normal		
Ext-right-up:	C.M.S. Normal		
Eyes-left:	Reactive		Reactive
Eyes-right:	Reactive		Reactive
GU:			
Head:	Normal	Normal	Normal
Heart:			
Mental:	Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events	Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events	Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events
Neck:	Normal	Normal	
Neuro:	Normal Gait / Movement, Aphasic	Normal Gait / Movement, Aphasic	Normal Gait / Movement
Skin:	Cold, Cyanotic, Dry / Dehydrated	Cold, Cyanotic, Dry / Dehydrated	Cyanotic, Warm, Dry / Dehydrated

Narrative

Summary of Events

Crew was dispatched for a pt with breathing problems. Upon arrival pt was found sitting on couch upright, A/O x 4 of 4 with a GCS of 15. Pt care was initiated and pt was assessed. Pt was home by herself with her neighbor calling EMS. Pt explained in symptoms to crew requiring one breath for one word. Pt stated "I have bad breathing for 10 minuets. Had cough 2 days with yellow spit. Short of breath yesterday night." Pt had cyanosis throughout person with cool dry skin. Pt vomited on crew arrival but only sputum was present with a yellow tinge. Severe distress asthma SOP followed. Pt had sever breathing problem. Pt denied any pain, weakness, dizziness, altered vision/hearing, or recent trauma. Pt was ventilating adequately with good clear breath sounds but was not oxygenating due to low O2 saturation. Pt had larger BMI and could not assist crew transferring to stair chair. Crew was delayed on scene moving pt. Pt secured to stair chair and moved to cot. Pt transferred to cot and secured. Cot secured in ambulance. Pt given epi 1:1,000 and closely monitored. Pt was put on CPAP and showed immediate signs of improvement. Pt cyanosis continually moved distally and normal color returned to pt core. SPO2 stabilized and maintained. OLMC was contacted with no orders given. ALS care was continued en route. Upon arrival pt condition had improved through skin, SPO2, respiratory effort, and overall condition. Pt was moved to room 8 where care was transferred to MD.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable

Area of Vehicle Impacted: Not Applicable

Seat Row Location of Patient:

Position of Patient: Not Applicable

Airbag Deployment: Not Applicable

Injury Details	
Service-Defined Questions	
Residency?	Resident
If Capnography was used, how did the waveform appear?	Obstruction/Shark Fin
Mutual Aid?	No

Comprehensive Report

Incident Date: [redacted] Call #: [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 53 Years
Gender: Female
Weight: 95.254 KG / 210.00 LB
Phone: [redacted]

D.O.B: [redacted]
SSN:
Race: White
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 11:54
Disp. Notified: 11:54
Unit Disp.: 11:54
Enroute: 11:56
At Scene: 12:00
At Patient: 12:02
Depart: 12:24
Arrive Dest: 12:31
In Service: 13:30
In Quarters: 13:35
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 4.3
To Scene:
Dest. Miles: 4.3
To Dest: 0.0
End Miles: 4.3
To End: 0.0
Call Sign: [redacted]
Veh. # [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies: [redacted]

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Driver Only
[redacted]		
[redacted]	Paramedic	Fire Company
[redacted]	First Responder	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Distress
Chief Complaint: Respiratory Distress X 45 Minutes
Onset Date/Time: [redacted] at 11:09
Alcohol/Drug Use: No Apparent Alcohol/Drug Use
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem

Other Associated Symptoms

Not Applicable

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
12:04	140/78	76	RR	45	Fatigued	78	On Room Air	27	15	0			130	11	Right Arm	Left Lateral Recumbent
12:16	215/110	108	RR	39	Normal	96	High FiO2 (80-100 pct)	40	15	0				11	Right Arm	Semi-Fowlers
12:26	180/98	108	RR	32	Shallow	97	High FiO2 (80-100 pct)	37	15					11	Right Arm	Semi-Fowlers

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
12:04	4	5	6	15
12:16	4	5	6	15
12:26	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
Unable to Obtain Allergies	Unable to Obtain Allergies	

Patient Medications	Generic Name	Dosage
Unable to Obtain Patient Medications	Unable to Obtain Patient Medications	

Medical Surgery History

Diabetes, Cardiac - Stent

History Primarily Obtained From	Pregnancy	Advanced Directives:	Practitioner Name
Family	No		

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
12:08	[redacted]	Airway CPAP Treatment			1	Improved	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
12:05	[redacted]	Oxygen by Non-Rebreather Mask	Inhalation	15 LPM	Unchanged		
12:08	[redacted]	Albuterol Sulfate	Inhalation via Nebulizer	2.5 MG	Unchanged		
12:08	[redacted]	Ipratropium Bromide (Atrovent)	Inhalation via Nebulizer	0.5 MG	Unchanged		
12:18	[redacted]	Aspirin (ASA)	Oral	324 MG	Unchanged		
12:24	[redacted]	Midazolam (Versed)	Intranasal	2 MG	Improved		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
12:07	ECG-Monitor	II	Sinus rhythm	S-T Segment Elevation	
12:17	12-Lead ECG	12 Lead ECG	Abnormal ECG **Unconfirmed** ***MEETS ST ELEVATION MI CRITERIA** *Sinus tachycardia *Right axis deviation *Possible lateral infarct-age undertermined *Possible septal infarct-age undertermined *Inferior ST Elevation CONSIDER INFARCT *Anteroseptal ST depression is probably reciprocal to inferior infarct		
12:22	12-Lead ECG	12 Lead ECG	Abnormal ECG **Unconfirmed** ***MEETS ST ELEVATION CRITERIA*** *Sinus tachycardia *Right axis deviation *IV conduction conducted *Lateral infarct-age undertermined *Possible septal infarct-age undertermined *Inferior ST elevation CONSIDER ACUTE INFARCT		

Assessment Exam

Time of Assessment: [redacted] 12:04:00-06:00

Abdomen-left-lower:

Abdomen-left-upper:

Abdomen-right-lower:

Abdomen-right-upper:

Back-cervical:

Back-lumbar:

Back-thoracic:

Chest: Rales / Crackles, Expiratory Wheezing

Ext-left-low:
Ext-left-up:
Ext-right-low:
Ext-right-up:
Eyes-left: Reactive
Eyes-right: Reactive
GU:
Head:
Heart:
Mental: Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events
Neck:
Neuro: Normal Gait / Movement, Speech Normal
Skin: Clammy, Capillary Nail Bed Refill < 2 Seconds

8C

Narrative

Summary of Events

Amb[redacted] received a call for a 53 yr old female Pt. with low blood pressure and diabetic. UOA Pt. was lying on her left side in bed in obvious respiratory distress. Pt. was alert and oriented x4, warm, pink, and clammy. Pts. husband stated Pts. respiratory distress started 45 minutes prior to contacting EMS. Pt. was stating "I can't breathe, I can't breathe." Vitals were assessed. Pts. lung sounds had crackles and wheezes in all fields. Pt. was placed on capnography and a NRB. Capnography showed a shark wave pattern and shallow rapid respirations. Pt. denied any chest pain. Pt. did have a cardiac Hx, with stents approximately 14-17 years ago. Pt. was placed on the CPAP with a duo nebulizer given. Pts. O2 saturation improved from 78% to 97% with the CPAP. Attempted a 12L ECG in the Pts. bedroom, however, the Pt. was too anxious to comply. Pt. was assisted to the cot and into the ambulance. A 12L ECG was done in the back of the ambulance revealing a possible STEMI. Pt. denied any chest pain, but did state it was painful to breathe. Pt. was given 324 mg of ASA PO. Pt. was still very anxious and agitated so Pt. was given 2mg of versed IN after it was determined that it would be very difficult to get an IV on the Pt. The versed calmed the Pt. down and respirations improved. Continued to monitor Pt. condition en route to the hospital with no further changes noted. Pt. care was turned over to the ED Dr. in room 7 with a verbal report given.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable
Area of Vehicle Impacted: Not Applicable
Seat Row Location of Patient:
Position of Patient: Not Applicable
Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

Is patient a [redacted]esident?	Yes
Was a 12 Lead ECG left with the ED staff?	Yes
If Capnography was used, how did the waveform appear?	Obstruction/Shark Fin

Comprehensive Report

Incident Date: [redacted] Call #: [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 77 Years
Gender: Female
Weight: 55.338 KG / 122.00 LB
Phone:

D.O.B: [redacted]
SSN:
Race:
Ethnicity:

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: [redacted]
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: No Lights or Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 13:54
Disp. Notified: 13:54
Unit Disp.: 13:55
Enroute: 13:56
At Scene: 13:58
At Patient: 13:59
Depart: 14:16
Arrive Dest: 14:18
In Service: 15:20
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0
To Scene:
Dest. Miles: 0.2
To Dest: 0.2
End Miles: 0.2
To End: 0.0

Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies#: Not Applicable

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Driver Only
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: No Lights or Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Distress
Chief Complaint: Difficulty Breathing X
Onset Date/Time: [redacted] at 12:00
Alcohol/Drug Use:
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem

Other Associated Symptoms

Not Applicable

GB

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Sc	PTA	B.G.	RTS	Limb	Patient Position
14:00	124/70	98	RR	18	Normal	89	Low FIO2 (24-40 pct)	30	15	0				12	Left Arm	Semi-Fowlers
14:12	114/80	102	RR	18	Normal	96	High FIO2 (80-100 pct)	30	15	0				12	Right Arm	Semi-Fowlers
14:18	116/84	96	RR	18	Normal	97	High FIO2 (80-100 pct)	30	15	0				12	Right Arm	Semi-Fowlers

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
14:00	4	5	6	15
14:12	4	5	6	15
14:18	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
NKDA (No Known Drug Allergies)	NKDA (No Known Drug Allergies)	

Patient Medications	Generic Name	Dosage
Cozaar	Losartin	
Prednisone	Glucocorticoids	
heparin		
Cipro	Ciprofloxacin	
Xanax	Alprazolam	
Celebrex	Celecoxib	
Synthroid	Levothyroxine Sodium	

Medical Surgery History

Hypertension, Other, Psychological/Behavioral - Depression, Psychological/Behavioral - Anxiety Disorder (Panic Attacks) , *Pulmonary Fibrosis*

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Health Care Personnel			

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
14:02	[redacted]	Airway CPAP Treatment			1	Improved	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
14:10	ECG-Monitor		Sinus Tachycardia		

Assessment Exam

	Time of Assessment: [redacted]14:00:00-06:00	[redacted]15:00-06:00
Abdomen-left-lower:		
Abdomen-left-upper:		
Abdomen-right-lower:		
Abdomen-right-upper:		
Back-cervical:		
Back-lumbar:		
Back-thoracic:		
Chest:	Symmetrical Chest Rise, Rales / Crackles	Symmetrical Chest Rise, Rales / Crackles
Ext-left-low:		
Ext-left-up:		
Ext-right-low:		
Ext-right-up:		
Eyes-left:	Reactive	
Eyes-right:	Reactive	
GU:		
Head:		

Heart:

Mental: Responsive to Verbal Stimuli

Neck:

Neuro:

Skin: Normal, Pale

Narrative

Summary of Events

[redacted] and [redacted] were called to a nursing home facility for a 77 y/o female with difficulty breathing. Upon arrival crew found pt with nursing staff conscious and alert. Pt was on a NC at 5lpm with noticeable accessory muscle use. Staff stated " pt had new onset of lethargy and low spo2 that they attributed to a new prescription to xanex." Staff also drew blood and found a high carbon dioxide level. Pt was assessed and v/s were obtained. Crew noted bi-lateral crackles, lethargy and accessory muscle use. C-pap and ETCO2 was placed on pt and pt was moved to and secured on stretcher. Pts Spo2 improved to 96% on C-pap. Crew was unable to obtain an orientation due to lethargy. Per family and staff pt has been on bi-pap for a prolonged period of time and is always on NC. Pt was moved to ambulance. Pt was placed on cardiac monitor and found in NSR. [redacted] was contacted and radio report was given with no further orders. Pt was continually monitored and reassessed en-route with minimal changes. Pt became noticeably more alert and Spo2 improved to 97% on C-pap. Crew continued to note bi-lateral crackles but accessory muscle use was improving. ALS care was continued without incident. Pt care was transferred to ED RN.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable

Area of Vehicle Impacted: Not Applicable

Seat Row Location of Patient:

Airbag Deployment: Not Applicable

Position of Patient: Not Applicable

Injury Details

Service-Defined Questions

Has the Ambulance Billing Authorization and Privacy Acknowledgment Form been completed with the requisite signature(s)?	Yes
Hospital Log Number (ENTER HOSP CONTACTED FOR OLMC ON "From Scene" TAB)	
If Capnography was used, how did the waveform appear?	

Comprehensive Report

IDA [redacted]

Incident Date: [redacted] Call #[redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 83 Years
Gender: Male
Weight: 165.000 KG / 363.76 LB
Phone:
D.O.B: [redacted]
SSN:
Race: White
Ethnicity:

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: [redacted]
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.: 15:54
PSAP: 15:49
Disp. Notified: 15:49
Unit Disp.: 15:49
Enroute: 15:51
At Scene: 15:57
At Patient: 16:00
Depart: 16:13
Arrive Dest: 16:16
In Service: 16:50
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0
To Scene:
Dest. Miles: 0.4
To Dest: 0.4
End Miles: 0.4
To End: 0.0

Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies#: Not Applicable

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Secondary Caregiver
[redacted]		
[redacted]	Paramedic	Driver Only
[redacted]	Paramedic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance
Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Arrest
Chief Complaint: Respiratory Distress X
Onset Date/Time: [redacted]t 11:00
Alcohol/Drug Use:
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem
Other Associated Symptoms
Not Applicable

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
15:57	72/42	98	RR	40	Agonal	84	High FIO2 (80-100 pct)	20	6					7	Right Arm	Semi-Fowlers
16:10	84/50	72	RR	12	Assisted	90	High FIO2 (80-100 pct)	48							Right Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
15:57	1	2	3	6
16:10				

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
Unable to Obtain Allergies	Unable to Obtain Allergies	

Patient Medications	Generic Name	Dosage
Unable to Obtain Patient Medications	Unable to Obtain Patient Medications	

Medical Surgery History

Diabetes, Hypertension, Chronic Respiratory (COPD), Cardiac - Dysrhythmia/Arrhythmia , *Hypothyroid, dementia,*

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Health Care Personnel			

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
16:00	[redacted]	Airway Oropharyngeal			1	Unchanged	Yes	
16:03	[redacted]	Airway Ventilator			1	Improved	Yes	
16:05	[redacted]	Venous Access - Extremity	Antecubital-Right	18	1	Improved	Yes	
16:09	[redacted]	Airway Orotracheal Intubation		7.5	1	Improved	Yes	
16:12	[redacted]	Airway Suctioning		10 french	1	Improved	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
16:05	[redacted]	Normal Saline (0.9%)	Intravenous	500 mL	Unchanged		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
15:59	ECG-Monitor		A-Fib		

Assessment Exam

Time of Assessment [redacted] **5:55:00-06:00**

Abdomen-left-lower:

Abdomen-left-upper:

Abdomen-right-lower:

Abdomen-right-upper:

Back-cervical:

Back-lumbar:

Back-thoracic:

Chest: Rales / Crackles

Ext-left-low:

Ext-left-up:

Ext-right-low:

Ext-right-up:

Eyes-left: Reactive

Eyes-right: Reactive

GU:

Head:

Heart:
Mental: Unresponsive
Neck:
Neuro:
Skin: Warm, Diaphoresis

LOC

Narrative

Summary of Events

A[redacted] and S[redacted] responded to [redacted] for an 83 yo male in respiratory distress. S[redacted] arrived on scene and found the pt unresponsive in his bed, breathing rapidly and shallow. Facility staff placed a NRB at 15 L on the pt. S[redacted] began assessment of the pt and found him to be hot, and diaphoretic, with course lung sounds and hypotensive. Facility staff then provided S[redacted] an old form DNR that stated the pt did not wish to have CPR done. Crew members continued assessment, placed the pt on ecg monitor and established an IV. A[redacted] arrived on scene and pt was moved to stretcher. A[redacted] had staff then contact family to see if DNR would allow for an ET tube to be placed. Staff was able to quickly contact the family and they wanted the pt to have a tube placed if needed. Pt was then moved to the MICU. While moving the pt his respirations became agonal. Crew then stopped movement and placed an OPA and began ventilating the patient. Once inside MICU crew then placed a 7.5 ET tube. Tube was seen passing the cords, tube began misting, EDD was a free pull and crew confirmed with lung sounds in all fields and also had a good capnography reading. Tube was secured at 22 at the teeth. Crew continued reassessing the pt and contacted [redacted] with no questions or orders. Pt was taken to ER room 10 and left in care of RN and DR.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable
Area of Vehicle Impacted: Not Applicable
Seat Row Location of Patient:
Position of Patient: Not Applicable
Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

Is this patient a [redacted]	No - Non Resident
What field was signed on the Medicare Billing Form?	Section III - EMS/Receiving Hospital
Was this a mutual aid call to [redacted]	No - Not Mutual Aid to [redacted]
If Capnography was used, how did the waveform appear?	Obstruction/Shark Fin

Comprehensive Report

[redacted]

Incident Date: [redacted] Call #: [redacted] Patient Care #: 1 / 1

Patient Information

Name [redacted]

Address: [redacted]

Age: 75 Years
Gender: Female
Weight: 63.503 KG / 140.00 LB

D.O.B: [redacted]
SSN:
Race: White

Phone: [redacted]
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: No Lights or Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 16:11
Disp. Notified: 16:11
Unit Disp.: 16:13
Enroute: 16:13
At Scene: 16:15
At Patient: 16:17
Depart: 16:35
Arrive Dest: 16:41
In Service: 17:30
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 3.6
To Scene:
Dest. Miles: 3.6
To Dest: 0.0
End Miles: 3.6
To End: 0.0

Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies#: Not Applicable

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Driver Only
[redacted]		
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: No Lights or Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Non-Asthma COPD (Emphysema/Chronic Bronchitis)
Chief Complaint: "I'm having trouble breathing" X
Onset Date/Time: [redacted] at 16:00
Alcohol/Drug Use:
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem

Other Associated Symptoms
Cough

11B

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
16:17	190/100	90	RR	26	Normal	86	Low FIO2 (24-40 pct)	21	15		Cincinnati Stroke Scale Normal			12	Right Arm	Sitting
16:27	194/102	98	RR	24	Normal	90	High FIO2 (80-100 pct)	28	15		Cincinnati Stroke Scale Normal			12	Right Arm	Sitting
16:38	194/100	99	RR	22	Normal	96	High FIO2 (80-100 pct)	32	15		Cincinnati Stroke Scale Normal			12	Right Arm	Semi-Fowlers

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
16:17	4	5	6	15
16:27	4	5	6	15
16:38	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
NKDA (No Known Drug Allergies)	NKDA (No Known Drug Allergies)	

Patient Medications	Generic Name	Dosage
Lipitor	Atorvastatin	
Nexium	Esomeprazole Magnesium	
Prinivil	Lisinopril	
Advair		
Plavix	Clopidogrel	
Proventil, Ventolin	Albuterol	

Medical Surgery History

Chronic Respiratory - Emphysema, Hypertension, GI/GUI - Gastric Reflux , *Bacterial Lung Infection 2 weeks ago*

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Patient			

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
16:28	[redacted]	Airway CPAP Treatment			1		Yes	Pt's SPO2, capnography and breathing improved with Albuterol Neb treatment throught CPAP mask

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
16:17	[redacted]	Oxygen by Nebulizer	Inhalation	15 LPM	Unchanged		pt's breathing remained unchanged after first Neb treatment
16:18	[redacted]	Albuterol Sulfate	Inhalation via Nebulizer	2.5 MG	Unchanged		pt breathing remained unchanged after first Neb treatment
16:18	[redacted]	Ipratropium Bromide (Atrovent)	Inhalation via Nebulizer	0.5 MG	Unchanged		pt's breathing remained unchanged after first Neb treatment
16:28	[redacted]	Albuterol Sulfate	Inhalation via Nebulizer	2.5 MG	Improved		Pt's SPO2, breathing and capnography improved after second albuterol Neb treatment through CPAP

16:28 [redacted]	Oxygen by Mask	Inhalation	15 LPM	Improved		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change

Assessment Exam

Time of Assessment: [redacted]16:17:00-06:00

Abdomen-left-lower: Normal (Soft, Non-Tender)
Abdomen-left-upper: Normal (Soft, Non-Tender)
Abdomen-right-lower: Normal (Soft, Non-Tender)
Abdomen-right-upper: Normal (Soft, Non-Tender)
Back-cervical: Normal (No Pain or Deformities)
Back-lumbar: Normal (No Pain or Deformities)
Back-thoracic: Normal (No Pain or Deformities)
Chest: Rales / Crackles
Ext-left-low: C.M.S. Normal
Ext-left-up: C.M.S. Normal
Ext-right-low: C.M.S. Normal
Ext-right-up: C.M.S. Normal
Eyes-left: Reactive
Eyes-right: Reactive
GU:
Head: Normal
Heart:
Mental: Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events
Neck: Normal
Neuro: Normal Gait / Movement
Skin: Dry / Dehydrated

Narrative

Summary of Events

Amb[redacted] was called on scene for a 75 y/o female having trouble breathing. Upon arrival, pt was sitting upright in chair of her kitchen. Pt was A&O X 3 c/o difficulty breathing for the past two days and progressively getting worse today. Pt was breathing her own O2 on 2 Lpm via nasal cannula. Pt stated that her normal SPO2 is at 92 when she is on her own O2 supply at 2 Lpm via nasal cannula. Pt stated that her SPO2 was at 86 just prior to EMS arrival. Pt appeared to be in some mild respiratory distress upon EMS arrival but was able to speak in short sentences. Pt stated that she has a hx of emphysema and she was just treated for a bacterial infection in her lungs two weeks ago. Pt denied LOC, headache, N/V/D, dizziness, numbness, tingling, disorientation, chest pain, neck pain, abdominal pain, back pain, any other pain or any other injuries. Primary assessment reveals vitals as noted above with no obvious external injuries to pt. Secondary assessment reveals mild respiratory distress with short rapid breaths. Pt also had crackles bilaterally in the lungs upon listening to breath sounds and was coughing up a clear sputum. Otherwise, secondary assessment was unremarkable. Pt's initial SPO2 showed a reading of 86 with pt's capnography showing a reading of 21 with a shark fin waveform. Pt was given Albuterol 2.5 mg and Ipatropium .5 mg via nebulizer with 15 Lpm O2. The first Nebulizer treatment did not help pt's breathing. Pt was then given another dose of Albuterol 2.5 mg nebulizer treatment through a CPAP mask at 15 Lpm O2. This second treatment improved the pt's breathing and improved pt's SPO2 to a reading of 96 with a capnography reading of 32 shark fin waveform. [redacted]OLMC was contacted while en route to hospital with no further instructions given per OLMC. Pt was transported to [redacted]ED without incident with pt's SPO2 and breathing improving while en route. Pt was transferred to [redacted]D room 7 RN. Pt report was given to RN. Assisted by Engine [redacted]crew. All times are approximate. End of report.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable
Area of Vehicle Impacted: Not Applicable
Seat Row Location of Patient:
Position of Patient: Not Applicable
Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

Is patient a [redacted]sident?	Yes

Was a 12 Lead ECG left with the ED staff?	Not Applicable
If Capnography was used, how did the waveform appear?	Obstruction/Shark Fin

Comprehensive Report

[redacted]

Incident Date: [redacted] Call #: [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 71 Years
Gender: Female
Weight: 40.823 KG / 90.00 LB
Phone:

D.O.B: [redacted]
SSN:
Race:
Ethnicity:

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 16:34
Disp. Notified: 16:34
Unit Disp.: 16:34
Enroute: 16:35
At Scene: 16:37
At Patient: 16:39
Depart: 16:51
Arrive Dest: 17:04
In Service: 18:15
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0
To Scene:
Dest. Miles: 6.8
To Dest: 6.8
End Miles: 6.8
To End: 0.0
Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies#: Not Applicable

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Secondary Caregiver
[redacted]		
[redacted]	Paramedic	Driver Only
[redacted]	Paramedic	Fire Company
[redacted]	EMT-Basic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Distress
Chief Complaint: "I'm having trouble breathing" X 30 Minutes
Onset Date/Time: [redacted] at 16:09
Alcohol/Drug Use: No Apparent Alcohol/Drug Use
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem

Other Associated Symptoms
Not Applicable

12

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
16:42	182/P	120	II	30	Labored	80	Low FiO2 (24-40 pct)	45	15					11	Left Arm	Sitting
16:55	182/102	112	II	30	Labored	85	High FiO2 (80-100 pct)	12	15					11	Left Arm	Full-Fowlers
17:01	148/96	112	II	30	Labored	90	High FiO2 (80-100 pct)	20	15					11	Left Arm	Full-Fowlers

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
16:42	4	5	6	15
16:55	4	5	6	15
17:01	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
Unable to Obtain Allergies	Unable to Obtain Allergies	

Patient Medications	Generic Name	Dosage
Zocor	Simvastatin	
Cardizem/Diacor-XR	Diltiazem	
Accupril	Quinapril	
Spiriva		
Lanoxin, Digitek	Digoxin	

Medical Surgery History
Cardiac - Myocardial Infarction, Chronic Respiratory (COPD)

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Family			

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
16:42	[redacted]	Airway CPAP Treatment			1	Improved	Yes	5 PEEP
16:56	[redacted]	Airway CPAP Treatment			1	Improved	Yes	10 PEEP

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
16:48	ECG-Monitor	II	Atrial fibrillation	No Ectopy Noted	

Assessment Exam

Time of Assessment: [redacted]:40:00-06:00

Abdomen-left-lower:

Abdomen-left-upper:

Abdomen-right-lower:

Abdomen-right-upper:

Back-cervical:

Back-lumbar:

Back-thoracic:

Chest: Accessory Muscles, Decreased Breath Sounds-Left, Decreased Breath Sounds-Right

Ext-left-low:

Ext-left-up:

Ext-right-low:

Ext-right-up:

Eyes-left:

Eyes-right:

GU:

12C

Head:

Heart:

Mental: Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events

Neck:

Neuro: Normal Gait / Movement, Speech Normal

Skin: Pale, Diaphoresis

Narrative

Summary of Events

Called to scene for difficulty breathing. On arrival, found A&Ox4 pt sitting in chair at home in severe respiratory distress. Pt was speaking in 2 word sentences and was used accessory muscles. Pt was in process of self-administered nebulizer treatment, which was not working. Pt was also on unknown amount of home O2 delivery via nasal cannula. CPAP immediately placed on pt at 5cm PEEP with slight improvement. Pt was initially anxious due to CPAP being on, but was able to coach pt to point of tolerance. Capnography and SpO2 numbers fluctuated throughout call, didn't appear to be very accurate. After 2nd set of vitals, PEEP was increased to 10cm with further improvement in breathing quality. Pt stated she felt slightly better than before we were called. Called medical control, no orders given. While en route to ED, breathing appeared less labored. Transported pt without incident to bed #C1, gave report to RN.

Prior Aid

Prior Aid	Performed By	Outcome
Airway-Nebulizer Treatment,	Patient	Worse

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable

Area of Vehicle Impacted: Not Applicable

Seat Row Location of Patient:

Position of Patient: Not Applicable

Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

Was transport mileage entered?	Yes
Is the patient a resident o[redacted]	Yes
Is this a mutual or auto aid call?	No
If Capnography was used, how did the waveform appear?	Obstruction/Shark Fin

Comprehensive Report

13A [redacted]

Incident Date: [redacted] Call #: [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 77 Years
Gender: Female
Weight: 145.150 KG / 320.00 LB
Phone [redacted]

D.O.B [redacted]
SSN:
Race: White
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Chest Pain
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 19:05
Disp. Notified:
Unit Disp.: 19:05
Enroute: 19:06
At Scene: 19:09
At Patient: 19:10
Depart: 19:22
Arrive Dest: 19:31
In Service: 20:05
In Quarters:
Cancelled:

Incident # [redacted]
Start Miles:
Scene Miles: [redacted] **To Scene:**
Dest. Miles: [redacted] **To Dest:** 5.9
End Miles: [redacted] **To End:** 0.0
Call Sign [redacted]
Veh. # [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies#: Not Applicable

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Driver Only
[redacted]	EMT-Basic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Distress
Chief Complaint: Chest Pain X 30 Minutes
Onset Date/Time: [redacted] at 18:30
Alcohol/Drug Use:
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Chest Pain

Primary Symptom

Breathing Problem

Other Associated Symptoms

Not Applicable

13B

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
19:10	188/92	86	RR	18	Normal	97	Low FIO2 (24-40 pct)		15	8			186	12	Right Arm	Sitting
19:15	176/98	100	RR	20	Fatigued	90	Medium FIO2 (40-80 pct)		15	8				12	Right Arm	Semi-Fowlers
19:20		124	RR	30	Labored	88	Medium FIO2 (40-80 pct)		15	8						Semi-Fowlers
19:30	182/77	120	RR	28	Labored	78	High FIO2 (80-100 pct)		15	8				12		Full-Fowlers

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
19:10	4	5	6	15
19:15	4	5	6	15
19:20	4	5	6	15
19:30	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
celebrex		
Vioxx	Rofecoxib	COX-2 Inhibitor Hepatic Metabolism
Zithromax	Azithromycin	

Patient Medications	Generic Name	Dosage
clonodine		
Cozaar	Losartin	
duoneb		
glucosamine		
Glucotrol	Glipizide	
humibid		
Lasix	Furosemide	
Lipitor	Atorvastatin	
Norco		
Norvasc	Amlodipine	
Singulair	Montelukast Sodium	
symbicort		
zetia		
Zoloft	Sertraline HCL	

Medical Surgery History

Chronic Respiratory - Emphysema, Diabetes, Hypertension, Cardiac - Congestive Heart Failure, Chronic Respiratory (COPD), GI/GUI - Urinary Tract Infection (UTI)

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Family	No		

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
19:21	[redacted]	Airway CPAP Treatment	Mouth		1	Unchanged	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
19:16	[redacted]	Albuterol Sulfate	Inhalation via Nebulizer	2.5 MG	Unchanged		
19:16	[redacted]	Ipratropium Bromide (Atrovent)	Inhalation via Nebulizer	0.5 MG	Unchanged		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
19:11	ECG-Monitor	II	Normal Sinus Rhythm	No Ectopy Noted	

Assessment Exam

Time of Assessment: [redacted]:10:00-06:00 | [redacted]9:20:00-06:00 | [redacted]9:30:00-06:00

Abdomen-left-lower: Normal (Soft, Non-Tender) | Normal (Soft, Non-Tender) | Normal (Soft, Non-Tender)

Abdomen-left-upper:	Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)
Abdomen-right-lower:	Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)
Abdomen-right-upper:	Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)
Back-cervical:	Normal (No Pain or Deformities)	Normal (No Pain or Deformities)	Normal (No Pain or Deformities)
Back-lumbar:	Normal (No Pain or Deformities)	Normal (No Pain or Deformities)	Normal (No Pain or Deformities)
Back-thoracic:	Normal (No Pain or Deformities)	Normal (No Pain or Deformities)	Normal (No Pain or Deformities)
Chest:	Accessory Muscles, Expiratory Wheezing, Chest Pain/Pressure Non-Radiating	Accessory Muscles, Decreased Breath Sounds-Left, Decreased Breath Sounds-Right	Accessory Muscles, Decreased Breath Sounds-Left, Decreased Breath Sounds-Right
Ext-left-low:	C.M.S. Normal	C.M.S. Normal	C.M.S. Normal
Ext-left-up:	C.M.S. Normal	C.M.S. Normal	C.M.S. Normal
Ext-right-low:	C.M.S. Normal	C.M.S. Normal	C.M.S. Normal
Ext-right-up:	C.M.S. Normal	C.M.S. Normal	C.M.S. Normal
Eyes-left:	Reactive	Reactive	Reactive
Eyes-right:	Reactive	Reactive	Reactive
GU:			
Head:	Normal	Normal	Normal
Heart:			
Mental:	Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events	Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events	Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events
Neck:	Normal	Normal	Normal
Neuro:	Normal Gait / Movement	Normal Gait / Movement	Normal Gait / Movement
Skin:	Normal	Normal	Normal

Narrative

Summary of Events

In summary [redacted] was dispatched to above location for chest pain. U/A found pt AOx3 sitting at the kitchen table. Pt. was c/o chest pain that was substernal non-radiating @ 8/10. Pt. stated that the pain started 30 minutes ago, and her daughter gave her 324mg of baby aspirin. Pt. was also c/o difficulty breathing that was suddenly coming on. Crew obtained pt. vitals and noticed that the pt. became very short of breath, and was asking for her nebulizer. Crew administered a neb and moved pt. to MICU. 12-lead ECG was unable to be obtained due to pt. movement. Pt. became worse over time and couldn't breath with her neb. Crew put pt. on CPAP with inline neb. Crew noted pt was struggling to take deep breaths and crew coached her while on CPAP. Pt. was able to calm down for the transport, but eventually couldn't tolerate the mask, and took it off. Pt. lung sounds were diminished at this time, and sounded very congested. Crew contacted [redacted] with no further orders given. Crew transported ALS to [redacted] and transferred care to ER staff in room Trauma A. All times approx. EOR

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable

Area of Vehicle Impacted: Not Applicable

Seat Row Location of Patient:

Position of Patient: Not Applicable

Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

Resident Status?	Resident
Was mileage entered?	Yes
Hospital Log Number	
If Capnography was used, how did the waveform appear?	

Comprehensive Report

[redacted]

Incident Date: [redacted] Call #: [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 77 Years
Gender: Female
Weight: 54.431 KG / 120.00 LB
Phone: [redacted]

D.O.B: [redacted]
SSN:
Race: White
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Unconscious / Fainting
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.: 19:53
PSAP: 19:44
Disp. Notified: 19:44
Unit Disp.: 19:45
Enroute: 19:45
At Scene: 19:49
At Patient: 19:50
Depart: 20:17
Arrive Dest: 20:31
In Service: 22:33
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0
To Scene:
Dest. Miles: 8.8
To Dest: 8.8
End Miles: 8.8
To End: 0.0
Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies: [redacted]

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Fire Company
[redacted]	EMT-Basic	Fire Company
[redacted]	Paramedic	Secondary Caregiver
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Third Caregiver
[redacted]	Paramedic	Driver Only
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance
Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Arrest
Chief Complaint: Respiratory Arrest X
Onset Date/Time: [redacted]t 19:42
Alcohol/Drug Use: No Apparent Alcohol/Drug Use
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Unconscious / Fainting

Primary Symptom
Unresponsive / Unconscious
Other Associated Symptoms
Breathing Problem

HB

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
19:55	210/P	108	RR	8	Assisted			84	3				262	6	Left Arm	Supine
20:02	180/P	108	RR	8	Assisted			84	3					6	Left Arm	Supine
20:10	160/100	112	RR	8	Assisted	100	High FIO2 (80-100 pct)	68	3					6	Left Arm	Supine
20:15	154/P	112	RR	8	Assisted	100	High FIO2 (80-100 pct)	68	3					6	Left Arm	Supine
20:20	148/P	112	RR	8	Assisted	100	High FIO2 (80-100 pct)	68	3					6	Left Arm	Supine
20:25	146/P	112	RR	8	Assisted	100	High FIO2 (80-100 pct)	64	3					6	Left Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
19:55	1	1	1	3
20:02	1	1	1	3
20:10	1	1	1	3
20:15	1	1	1	3
20:20	1	1	1	3
20:25	1	1	1	3

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
Penicillin	Penicillin	

Patient Medications	Generic Name	Dosage
Albuterol Inhaler		
Celexa	citalopram	
Synthroid	Levothyroxine Sodium	
Zocor	Simvastatin	
Dictiazlam		

Medical Surgery History
Chronic Respiratory (COPD)

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Family	No		

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
19:58	[redacted]	Airway Nasopharyngeal	Nose	26	1	Unchanged	Yes	
20:01	[redacted]	Airway Orotracheal Intubation	Mouth	7	1	Unchanged	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
19:52	[redacted]	Oxygen by Bag-Valve Device	Inhalation	15 LPM	Unchanged		
20:00	[redacted]	Midazolam (Versed)	Intravenous	5 MG	Unchanged		
20:00	[redacted]	Etomidate	Intravenous	30 MG	Unchanged		
20:04	[redacted]	Midazolam (Versed)	Intravenous	2 MG	Unchanged		
20:05	[redacted]	Albuterol Sulfate	Inhalation via Nebulizer	2.5 MG	Unchanged		
20:05	[redacted]	Ipratropium Bromide (Atrovent)	Inhalation via Nebulizer	0.5 MG	Unchanged		
20:05	[redacted]	Oxygen by Nebulizer	Inhalation	6 LPM	Unchanged		
20:09	[redacted]	Midazolam (Versed)	Intravenous	2 MG	Unchanged		
20:13	[redacted]	Midazolam (Versed)	Intravenous	2 MG	Unchanged		
20:15	[redacted]	Albuterol Sulfate	Inhalation via Nebulizer	2.5 MG	Unchanged		
20:20	[redacted]	Midazolam (Versed)	Intranasal	2 MG	Unchanged		

20:24	[redacted]	Midazolam (Versed)	Intranasal	2 MG	Unchanged	
20:25	[redacted]	Albuterol Sulfate	Inhalation via Nebulizer	2.5 MG	Unchanged	
20:28	[redacted]	Midazolam (Versed)	Intranasal	2 MG	Unchanged	

14c

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
20:02	ECG-Monitor	II	Sinus Tachycardia		

Assessment Exam

	Time of Assessment: [redacted]19:55:00-06:00	[redacted]20:10:00-06:00
Abdomen-left-lower:		
Abdomen-left-upper:		
Abdomen-right-lower:		
Abdomen-right-upper:		
Back-cervical:		
Back-lumbar:		
Back-thoracic:		
Chest:	Decreased Breath Sounds-Left, Decreased Breath Sounds-Right	Symmetrical Chest Rise, Decreased Breath Sounds-Left, Decreased Breath Sounds-Right, Assisted / Ventilated Sounds
Ext-left-low:		
Ext-left-up:		
Ext-right-low:		
Ext-right-up:		
Eyes-left:		
Eyes-right:		
GU:		
Head:		
Heart:		
Mental:	Unresponsive	Unresponsive
Neck:		
Neuro:		
Skin:		Normal

Narrative

Summary of Events

[redacted] responded for a 77 year old female, who had passed out. Family on-scene stated that the pt experienced difficulty breathing, took her emergency inhaler and went to the bathroom. Family checked on her and found her unconscious, with lips turning blue. Upon our arrival found pt in the bathroom, unconscious in respiratory arrest, with a strong pulse. Crew moved pt out of the bathroom and placed pt on a backboard. Nasal airway was inserted in right nostril and ventilations assisted via BVM. Pt was placed on the monitor, showing sinus tachycardia. Vitals obtained as above. Lungs were decreased in all fields. Capnography was shark fin at 82 mmHG. IV was attempted and successful in the Right AC. Pt was taking gasping breaths. Crew prepared for intubation and was successful, following DAI protocol. In-line Albuterol/Ipratropium nebulizer started. Pt moved up the stairs to the stretcher and out to the ambulance. Versed and Albuterol were repeated as above. Pt was switched over to the auto-vent with tidal volume set at 200 mL, due to tightness of the lungs. [redacted] was contacted with no questions. No changes in pt condition during transport. Care transferred to ED ER Staff RN D8, report given.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable

Area of Vehicle Impacted: Not Applicable

Seat Row Location of Patient:

Position of Patient: Not Applicable

Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

Was transport mileage entered?	Yes
Is the patient a resident o[redacted]	Yes

Is this a mutual or auto aid call?	No
If Capnography was used, how did the waveform appear?	Obstruction/Shark Fin

14D

Comprehensive Report

Incident Date: [redacted] Call #: [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 65 Years
Gender: Female
Weight: 70.307 KG / 155.00 LB
Phone:

D.O.B: [redacted]
SSN:
Race:
Ethnicity:

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 20:07
Disp. Notified: 20:07
Unit Disp.: 20:08
Enroute: 20:09
At Scene: 20:13
At Patient: 20:14
Depart: 20:21
Arrive Dest: 20:31
In Service: 21:31
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0
To Scene:
Dest. Miles: 9.0
To Dest: 9.0
End Miles: 9.0
To End: 0.0
Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies#: Not Applicable

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Secondary Caregiver
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Driver Only

Personal Protective Equipment Used: Eye Protection, Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Distress
Chief Complaint: I am having trouble breathing X 30 Minutes
Onset Date/Time: [redacted] at 19:44
Alcohol/Drug Use: No Apparent Alcohol/Drug Use
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem

Other Associated Symptoms
Not Applicable

KB

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
20:16	190/120	140	RR	38	Shallow	82	On Room Air	35	15					11	Left Arm	Semi-Fowlers
20:20	190/P	144	RR	40	Shallow	93	High FiO2 (80-100 pct)	50	15					11	Left Arm	Semi-Fowlers
20:28	190/P	144	RR	38	Shallow	99	High FiO2 (80-100 pct)	50	15					11	Left Arm	Semi-Fowlers

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
20:16	4	5	6	15
20:20	4	5	6	15
20:28	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
Penicillin	Penicillin	

Patient Medications	Generic Name	Dosage
Advair		
Flonase	Fluticasone propionate	
Vibramycin	Doxycycline	
Cheratussin		
Pravastatin		
Nabumetone		
Nubain	NALBUPHINE HYDROCHLORIDE	
Avapro	Irbesartan	

Medical Surgery History
Diabetes, Hypertension, Chronic Respiratory (COPD)

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Family	N/K		

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
20:21	[redacted]	Airway CPAP Treatment			1		Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
20:17	[redacted]	Albuterol Sulfate	Inhalation via Nebulizer	2.5 MG	Improved	No	
20:17	[redacted]	Ipratropium Bromide (Atrovent)	Inhalation via Nebulizer	0.5 MG	Improved	No	

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
20:18	ECG-Monitor	II	Sinus Tachycardia	No Ectopy Noted	Initial Rhythm

Assessment Exam

Time of Assessment: [redacted] 20:16:00-06:00

Abdomen-left-lower: Normal (Soft, Non-Tender)

Abdomen-left-upper: Normal (Soft, Non-Tender)

Abdomen-right-lower: Normal (Soft, Non-Tender)

Abdomen-right-upper: Normal (Soft, Non-Tender)

Back-cervical: Normal (No Pain or Deformities)

Back-lumbar: Normal (No Pain or Deformities)

Back-thoracic: Normal (No Pain or Deformities)

Chest: Symmetrical Chest Rise, Accessory Muscles, Decreased Breath Sounds-Left, Decreased Breath Sounds-Right

Ext-left-low: C.M.S. Normal

Ext-left-up: C.M.S. Normal

Ext-right-low: C.M.S. Normal

Ext-right-up: C.M.S. Normal
Eyes-left: Reactive
Eyes-right: Reactive
GU:
Head: Normal
Heart:
Mental: Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events
Neck: Normal
Neuro: Normal Gait / Movement
Skin: Diaphoresis

Narrative

Summary of Events:

In summary, dispatched to the reported emergency of a patient having difficulty breathing. Upon arrival, patient walked to the door and was A&Ox4. Patient was in respiratory distress, breathing at an accelerated rate with shallow breaths. Patient stated she had COPD and had been having difficulty breathing for the past 30 minutes. Patient stated she took her advair twice with no relief. Patient stated she had difficulty like this event the week prior that was relieved by the advair. Patient denied any other symptoms. Patient was immediately moved to the ambulance without incident. Patient transported to [redacted] ALS without incident. [redacted] was contacted en route with no further orders for crew per ER RN. Patient continually monitored en route. Patient acknowledged to crew that her breathing was getting easier with the treatments while en route. Upon arrival at [redacted], patient transported to ER Room D10 without incident. Patient care and report transferred to ER RN. All times approximate.

Prior Aid

Prior Aid	Performed By:	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable
Area of Vehicle Impacted: Not Applicable
Seat Row Location of Patient:
Position of Patient: Not Applicable
Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

Was transport mileage entered?	Yes
Is the patient a resident of [redacted]?	Yes
Is this a mutual or auto aid call?	No
If Capnography was used, how did the waveform appear?	Square Constant

Comprehensive Report

[redacted]

Incident Date: [redacted] Call # [redacted] Patient Care #: 1 / 1

Patient Information

Name: [redacted]

Address: [redacted]

Age: 66 Years
Gender: Female
Weight: 136.078 KG / 300.00 LB
Phone: [redacted]

D.O.B: [redacted]
SSN:
Race: White
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Breathing Problem
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Home/Residence
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: [redacted]
Dest. Determ.: Closest Facility
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 20:27
Disp. Notified: 20:27
Unit Disp.: 20:27
Enroute: 20:28
At Scene: 20:31
At Patient: 20:32
Depart: 20:42
Arrive Dest: 20:45
In Service: 21:35
In Quarters: 21:40
Cancelled:

Incident # [redacted]
Start Miles:
Scene Miles: 0.0 **To Scene:**
Dest. Miles: 2.0 **To Dest:** 2.0
End Miles: 2.0 **To End:** 0.0

Call Sign: [redacted]
Veh. #: [redacted]
Veh. Type: Ambulance
Primary Role: ALS Ground Transport

First Responder Agencies#: Not Applicable

Unit Personnel

Crew Member	Crew Member Level	Crew Member Role
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Driver Only
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]		

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: [redacted]
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance

Response Request: 911 Response (Scene)
Response Disposition: ALS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response

None

Patient Condition

Provider Impression: Respiratory Distress
Chief Complaint: Breathing Problem X 2 Days
Onset Date/Time [redacted] at 09:00
Alcohol/Drug Use: Patient Denies Alcohol/Drug Use
Injury Intent: Not Applicable
Cause of Injury: Not Applicable
Dispatch Reason: Breathing Problem

Primary Symptom

Breathing Problem

Other Associated Symptoms
Weakness

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
20:33	154/102	94	RR	44	Normal	80	On Room Air	40	15	10				11	Right Arm	Semi-Fowlers
20:39	152/196	90	RR	36	Normal	94	On Room Air	40	15	6			371	11	Right Arm	Semi-Fowlers

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
20:33	4	5	6	15
20:39	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
Penicillin	Penicillin	

Patient Medications	Generic Name	Dosage
Unable to Obtain Patient Medications	Unable to Obtain Patient Medications	

Medical Surgery History
Diabetes, Hypertension , *GERD*

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Patient	No		

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
20:32	[redacted]	Airway CPAP Treatment			1	Improved	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
20:33	[redacted]	Oxygen by Non-Rebreather Mask	Inhalation	15 LPM	Unchanged		
20:35	[redacted]	Aspirin (ASA)	Oral	324 MG	Unchanged		
20:36	[redacted]	Nitroglycerin	Sublingual	0.4 MG	Unchanged		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
20:34	12-Lead ECG		Sinus Rhythm		

Narrative

Summary of Events

In summary: Eng [redacted] and Amb [redacted] dispatched for the PT having trouble breathing. Upon arrival PT was walking towards front door where crew helped PT to the cot. PT complained of have trouble breathing for the past two days. PT called 911 tonight because she couldn't take it anymore. PT did not have any chest pain, but pain from not being able to catch her breath. No obvious injuries noted. PT was taken to [redacted] where ALS care was started. [redacted] was contacted with no orders given. PT taken ER, where ER nurse took report.

Assessment tab not working, known problem

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Not Applicable

Vehicular Information

Vehicular Injury Indicators: Not Applicable

Area of Vehicle Impacted: Not Applicable

Seat Row Location of Patient:

Position of Patient: Not Applicable

Airbag Deployment: Not Applicable

Injury Details

Service-Defined Questions

Log Number	

Communication quality	Good
If Capnography was used, how did the waveform appear?	Inconclusive
Is PT. a [redacted] Resident?	Yes
Mutual Aid Call?	NO

CE Credit Questions - Resources to use: NWC EMSS SOP's & paramedic textbook (any of following: *Paramedic Practice Today* [Aehlert]; *Paramedic Care: Principles & Practice* [Bledsoe, Porter & Cherry]; *Emergency Care in the Streets* [Caroline, Elling & Smith]; *Mosby's Paramedic Textbook* [Sanders, McKenna, Lewis & Quick])

Respiratory Distress Assessment

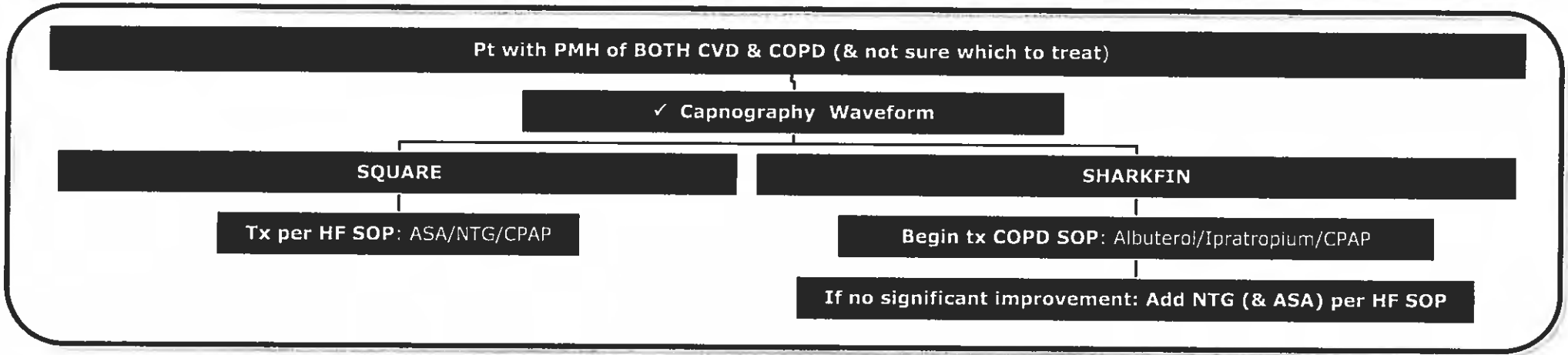
CC & HPI (OPQRST)	PMH (SAMPLE)	PE
o CC o Onset (sudden/gradual/what doing) o Provoke/palliate o Quality o Region/radiation (s/s upper vs. lower: nose, throat, lungs) o Severity of distress o Time	o Signs/symptoms, pert negs (CP, cough, fever, NV, recent illness/injury/exposure) o Allergies o Medications o PMH o Last meal o Events surrounding	o LOC: AVPU & GCS/mentation, position o BP, P & quality o RR, effort & pattern, audible sounds o O2 sat, EtCO2 & capnogram o ECG, 12L o Skin color, temp, moisture o HEENT: pupils, mucous membr, pursed lip, speech, JVD o Chest: lung sounds, acc muscle use, retractions, shape o Extr: clubbing, cyanosis, pedal edema

List conditions that should be considered and assessed for in pts w/ respiratory distress?		
1	3	5 6 7
2	4	

Stop & reverse the progression

Resp DISTRESS → Resp FAILURE → Resp ARREST → CARDIAC Arrest

What are some different treatments that may be used when caring for pts w/ respiratory distress?		
1	4	7 8 9 10
2	5	
3	6	



DIANA:ce-mar-16

Case – Questions (select 12 cases to complete)		List 2 ways (the most important) care may have been improved
1 69F	a. What % of ♀ and pts >65 have CP w/ ACS? b. Is dyspnea considered an "angina equivalent"? c. What are metoprolol, digoxin, pravastatin, eliquis used to treat? d. What is STD a sign of? e. If the anterolateral heart is ischemic, can that affect its ability to pump adequately? f. If so, what can that lead to? g. When the pulmonary vasculature is congested with blood, what s/s may the pt c/o of? h. What is EMS tx for ischemia? i. Must a pt have CP - to be given NTG? j. What are 2 NTG actions? k. Is a hypoxic pt likely to be calm/cooperative? l. If a pt is anxious & not tolerating CPAP, what can be given? m. Can a pt in HF present with a sharkfin capno waveform? n. Is this pt on any asthma/COPD meds?	
2 82F	a. What % of ♀ and pts >65 have CP w/ ACS? b. Is dyspnea considered an "angina equivalent"? c. What are indications for a 12L ECG? d. What is the value of a prehospital 12L ECG? e. Can an AWMI present as a pt in acute HF? f. What is reasonable length of time (to acquire Hx & PE) between pt contact and 1st dose of NTG in a pt w/ HF? 19 min? g. How often should NTG be given to pts in HF? Is there any dose limit to NTG for pts in HF? h. Why should NTG be repeated that often? i. Does a pt need to have an IV prior to administering NTG? j. Did this pt need, or were they given, any IVF or IV meds? k. What is the disadvantage to an unsuccessful AC IV in a pt?	
3 88M	a. What % of ♀ and pts >65 have CP w/ ACS? b. Is dyspnea considered an "angina equivalent"? c. What are indications for a 12L ECG? d. What is the value of a prehospital 12L ECG?	

	e. Should an 88M c/o SOB, with a cardiac PMH get a prehospital 12L ECG? f. In "procedures," is CPAP the same as "positive pressure ventilation"? g. What are VS requirements for CPAP? h. What is the difference between HF and cardiogenic shock? i. Different people have different "normal" BP's; can a pt be in shock with a SBP of 92? j. What other parameters can be used to assess for shock?	
4 83M	a. What does "possible anteroseptal infarct – age undetermined" on a 12L ECG mean? b. What type of MI is most likely to result in HF? c. What is myocardial ischemia? d. What does "inferior/lateral ST-T abnormality may be due to myocardial ischemia" on a 12L ECG mean? e. What does prehospital treatment of ischemia include? f. PM's note "chest discomfort subsided after use of CPAP," why might that have occurred? g. When treating pts w/ CPAP, what should be documented? h. PM's note, "had crackles on R side," what might localized crackles be a sign of? i. What HPI should be assessed when considering pneumonia?	
5 83F	a. Initial VS @ 0809 indicated O2 sat of 74% on RA, at 08:11 the pt was given O2 via NC at 4L, was that appropriate? b. IV established @ 0813 by PM "D"; CPAP was started @ 0815 by PM "D", was that an appropriate sequence of treatment? c. Did this pt need an IV for IVF or meds? d. From 08:28 to 08:35 resp effort is listed as "assisted," what does "assisted" respiratory effort mean? e. Is there any other documentation that the pts respirations were assisted? f. Considering the pts BP (high 207/106), what does that tell you about the myocardial workload? g. It is documented the pt had PVC's, what are PVC's a sign of? h. Looking at pts meds (apresoline, ASA, carvedilol, isorbide, amlodipine, clopidogrel), what condition does she likely have? i. What PMH is listed for the pt? j. Pts 12L ECG indicates LBBB, what is that an indication of? k. When the LV is damaged, what condition may result? l. What is SOP tx for HF? m. Did this pt receive ASA? n. Did this pt receive NTG? o. Does this pt have PMH of COPD or take COPD meds?	

	p. Did this pt meet SOP criteria for administration of albuterol & ipratropium? q. Does wheezing mean the pt has asthma/COPD? r. Can pts in HF present with wheezing?	
6 87F	a. What % of ♀ and pts >65 have CP w/ ACS? b. Is dyspnea considered an "angina equivalent"? c. What are indications for 12L ECG? d. What is the value of a prehospital 12L ECG? e. Can an MI present as a pt in acute HF? f. Did pt receive/meet criteria for a 12L ECG? g. What cardiac meds is this pt on? h. What COPD meds is this pt on? i. What is the initial BP? j. By what method should initial BP be measured? Why? k. What s/s of resp distress was pt experiencing? l. c/o SOB, should lung sounds be assessed? (yes) Why? m. Repeat assessment lists chest, heart, and skin as "not available," what does that mean? n. Was pt experiencing any CP? o. Does a sharkfin capnography waveform automatically mean pt has exacerbation asthma/COPD? p. Can pts in HF present with a sharkfin waveform? q. What was EtCO2 value? r. If CPAP does not initially improve O2 sat, what should be done? s. What PEEP was being delivered to the pt w/ CPAP? t. Narrative states "given a neb with CPAP," what does that mean? u. Are any nebulizer administered medications listed as given? v. What amount of PEEP was the pt being given with CPAP? w. @0820 O2 sat 83% RA; tachypnea (RR 28, labored), tachycardia (125), hypertensive (165/110) – should they be on O2?	
7 64F	a. What condition are simvastatin, metoprolol, losartan and ASA used to treat? b. Did pt take any COPD medications? c. Do most pts with COPD take COPD meds? d. Is a 64 yo pt c/o SOB w/ PMH CVD a candidate for a 12L ECG?	

	e. What % of ♀ and pts >65 have CP w/ ACS? f. Is dyspnea considered an "angina equivalent"? g. What are indications for a 12L ECG? h. What is the value of a prehospital 12L ECG? i. Would acquiring 12L ECG be a good idea - prior to admin epi to elderly hypoxic, tachycardic pt, w/ PMH of CVD? j. 64F, 260lbs, PMH CVD, c/o sudden onset SOB (10 min), tachypnea (RR 42, shallow), tachycardia (138), hypoxic (O2 sat 62%), low EtCO2 (21), skin cold & cyanotic, clear & equal breath sounds bilaterally, what condition should be considered? k. What are risk factors for PE? l. How will a PE affect the EtCO2 level? m. Provider impression lists "asthma," what is the difference between asthma & COPD? n. Does this pt present with a classic asthma hx & PE? o. When going epinephrine IM to a pt weighing 260 lbs, what modification should be made?	
8 53F	a. What does this pt have a PMH of? b. Does pt have PMH of or take meds for asthma/COPD? c. Did pt meet SOP criteria for administration of albuterol/ipratropium? d. Does 12L ECG interpretation help point to possible cause of resp distress? e. What SOP would have been appropriate to use when treating pt? f. Can pts in acute HF present with wheezing and crackles? g. What is SOP tx for HF? h. Did pt receive NTG? i. What is the action of NTG?	
9 77F	a. What % of ♀ and pts >65 have CP w/ ACS? b. Is dyspnea considered an "angina equivalent"? c. What are indications for 12L ECG? d. What is the value of a prehospital 12L ECG? e. Can an MI present as a pt in acute HF? f. Did pt receive/meet criteria for a 12L ECG? g. EtCO2 values are documented, what was the waveform? h. 77 yo pt c/o difficulty breathing, PMH cardiac, bilateral crackles, hypoxia, what medical condition should be considered? i. What is SOP tx for HF?	

	j. Did this pt receive ASA? k. Did this pt receive NTG? l. What amount of PEEP was delivered to the pt via CPAP? m. What are other causes of crackles that should be considered in an elderly pt in a NH? n. What are s/s of pneumonia that should be assessed for?	
10 83M	a. What was this pts GCS? b. Should a pt w/ GCS of 6 get bG checked? c. What was his bG level? d. Is pulse oximetry reliable in hypotensive pts? e. What can be done to assess reliability of pulse ox reading? f. What SOP should have been used to treat this pt? g. Should 500mL IVF be given to pt w/ BP 72/42 in respiratory distress and hypoxic with crackles? h. What treatment should this pt have received? i. Crew noted pt was hot/warm & diaphoretic, what condition should also be considered? j. In sepsis, can hypotension be caused by both vasodilation and myocardial depression? k. Does DNR mean do not treat? l. Should pts with a DNR be treated differently prior to cardiac/resp arrest? m. Does the new POLST forms give more direction regarding a patient's wishes regarding care/tx than old DNR forms?	
11 75F	a. What condition are the meds atorvastatin, lisinopril, and clopidogrel used to treat? b. What % of ♀ and pts >65 have CP w/ ACS? c. Is dyspnea considered an "angina equivalent"? d. What are indications for 12L ECG? e. What is the value of a prehospital 12L ECG? f. Can an MI present as a pt in acute HF? g. Did pt receive/meet criteria for a 12L ECG? h. What are causes for COPD exacerbation? i. Can albuterol be repeated if initial dose of albuterol/ipratropium is given?	
12 71F	a. What condition are the meds simvastatin, diltiazem, quinapril and digoxin used to treat? b. What does pt have a PMH of? c. What % of ♀ and pts >65 have CP w/ ACS?	

	d. Is dyspnea considered an "angina equivalent"? e. What are indications for 12L ECG? f. What is the value of a prehospital 12L ECG? g. Can an MI present as a pt in acute HF? h. Did pt receive/meet criteria for a 12L ECG? i. Was the pt having any CP? j. What was the initial and last O2 sat? k. Was this pts hypoxia corrected? l. An O2 saturation of 90% is equivalent to an approximate PaO2 of what? m. What are normal PaO2 levels? n. What are pale, diaphoretic skin signs of? o. What medications may have been used to treat this pt? p. Did the patient receive any of those medications?	
13 77F	a. What does pt have a PMH of and take medications to treat? b. Was this pt c/o CP? c. Was the pt given any medication for the CP? d. What was pts initial HR & BP, could NTG have been administered? e. What were the pts lungs sounds? f. What was the pts EtCO2 reading & waveform? g. How was pt treated? h. How did pt respond to treatment? i. How was the pts initial and later resp effort? j. How did the pts O2 sat change with treatment? k. How did the pts pulse/heart rate change? l. c/o substernal, non-radiating CP 8/10, began 30m ago, hypoxia, ↓ breath sounds – what should be considered? m. Would NTG have been appropriate to administer? n. Would fentanyl have been appropriate to administer?	
14 77F	a. Was this pt in respiratory distress or failure? b. How is resp failure different from distress? c. Are midazolam & etomidate indicated to intubate a pt w/ GCS = 3?	

	d. What RR was used to treat this pt? e. Was it appropriate? Why? f. Should pt have been ventilated faster to ↓ EtCO2? Why? g. Was an IV established, w/ IVF, on this pt?	
15 65F	a. What % of ♀ and pts >65 have CP w/ ACS? b. Does pt have major CVD risk factors? c. Is dyspnea considered an "angina equivalent"? d. What are indications for 12L ECG? e. What is the value of a prehospital 12L ECG? f. Can an MI present as a pt in acute HF? g. Did pt receive/meet criteria for a 12L ECG? h. Was a pain assessment documented? i. Is a square capno waveform consistent w/ a diagnosis of COPD? j. What are this pts HR (140-144), BP (190/120) & diaphoresis indicative of? k. What resp condition should have been considered in this pt?	
16 66F	a. What % of ♀ and pts >65 have CP w/ ACS? b. Does pt have major CVD risk factors? c. Is dyspnea considered an "angina equivalent"? d. What are indications for 12L ECG? e. What is the value of a prehospital 12L ECG? f. Can an MI present as a pt in acute HF? g. Did pt receive/meet criteria for a 12L ECG? h. What were the pts lungs sounds? i. How often should NTG be given when tx HF? Is there any dose limit to NTG in tx HF? j. What PEEP was being delivered to this pt w/ CPAP? k. Might a pt in resp distress, misinterpret CP due to ACS as "pain from not being able to catch breath"?	