Name	Employer	Date Submitted

Northwest Community EMS System - Continuing Education – March 2015
Trauma QI Case Reviews - CE Credit Questions

To receive credit for this CE module (Materials needed – CE handout, SOP's):

1) Interpret the ECG strips on handout page 2

ECG	***Interpretation***
1	
2	
3	
4	
5	
6	

2) Interpret the 12L ECG on handout page 3

What, if any, leads have ST elevation (STE)?

What is the significance of STE?

What, if any, leads have pathological Q waves?

What is the significance of Q waves?

Interpretation

3) Review PPT slides (avail on NWCEMSS website) and answer the following questions.

a. How can EtCO2 be useful when assessing & treating trauma pts?

b. Should trauma pts be kept warm or cool?

i. Why?

ii. List 3 ways to accomplish the above temperature control.

c. How does hypoxia impact pts with TBI (traumatic brain injury)?

d. How does hypotension impact pts with TBI?

e. How does combined hypoxia & hypotension affect TBI pts?

f. List 5 pts where hyperoxia is contraindicated.

i. –
ii. –
iii. –
iv. –
v. –

g. How should oxygen be delivered to pts with an O2 sat less than 92%?_____

h. At what rate should you assist vent in pt with or without an adv airway?_____

4) Use the following information (also handout pg 47), to HELP analyze and evaluate the calls (ePCR's on pages 4-45). Complete the grid on the next page (also handout pg 48), identifying 3 things done well and 3 areas with opportunity for improvement for each call.

Primary Assessment	• Airway – patent? • Breathing – adequate? • O2 sat >94%? EtCO2? • Circulation – pulse?	• Skin, color, temp, moisture? • S/S shock? Bleeding? • Disability – GCS? SMR? • bG if GCS <15/AMS?
(ITC) Initial Treatment	• Airway - adjunct needed? • Breathing - O2/PPV needed? • Bleeding controlled?	• Hypoxia treated? • Shock treated? (SBP targets: 80 penetr, 90 blunt, >110 TBI)
Scene Time & Transport	• Scene time <10 min? • Explained if >10 min?	• Appropriate destination?
Secondary & Repeat Assessment	• VS WNL? Repeated? Pain? • Head (HEENT, face, eyes/pupils, nose, mouth, ears, scalp) • Neck (spine, trachea, jugular veins) • Chest (inspect, palpate, auscultate) • Abdomen/pelvis (inspect, palpate)	• Upper/Lower Extr (inspect, palp, PMS) • Back (inspect & palpate)
SOP Specific Tx	• Appropriate?	• Missing/Not done?
Documentation	• MOI described? • Assessment?	• Tx?
What aspect of assessment/treatment was done best?		
What aspect of assessment/treatment had the greatest opportunity for improvement?		
How could documentation have been improved? Was info in narrative that has an incomplete/blank predefined field?		
Is there a SOP that needs clarification? Improvement?		

#	*Done Well*	*Opportunity for Improvement*
A		
B		
C		
D		
E		
F		
G		
H		
I		
J		
K		
L		
M		
N		

Continuing Education

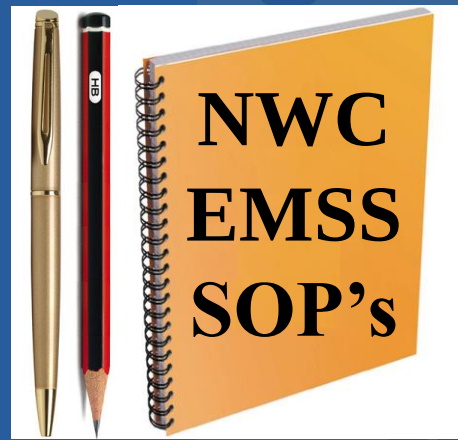
March 2015

Trauma QI Case Reviews

Diana Neubecker RN BSN EMT-PM
EMS System In-Field Coordinator

Materials Needed

- Pen/pencil
- SOP's



Objectives

Upon completion the participant will:

- *Correctly interpret the ECG rhythm when given a 6-second rhythm strip.*
- *Recognize signs of acute myocardial ischemia and injury, old and new infarction when given a 12L ECG.*
- *Analyze and evaluate EMS assessment, treatment and documentation for trauma patients with head, chest, abdominal/pelvic, spine and MSK/extremity injuries when given an ePCR.*

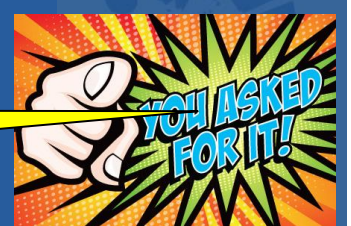
Objectives

Analyze and evaluate EMS assessment, treatment and

DOCUMENTATION

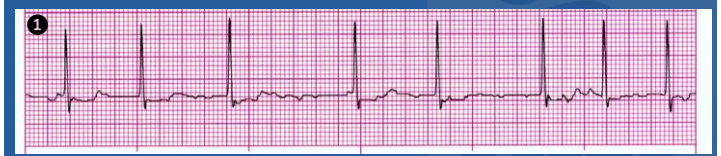
for trauma patients with head, chest, abdominal/pelvic, spine and MSK/extremity injuries when given an ePCR.

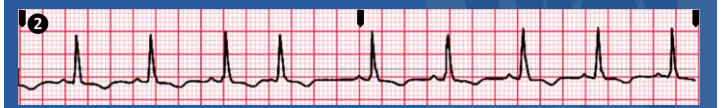
Actually PBPI asked for it…

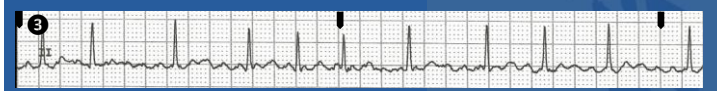


Northwest Community EMS System – Continuing Education
March 2015 – Trauma QI Case Reviews

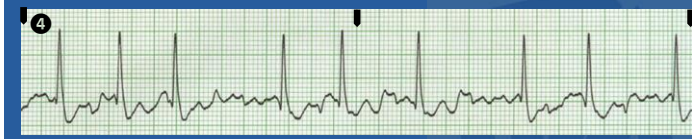
ECG Interpretation

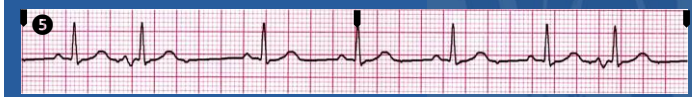


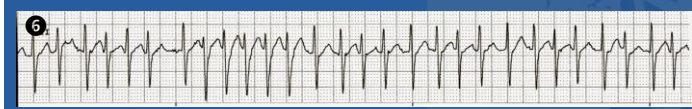




ECG Interpretation



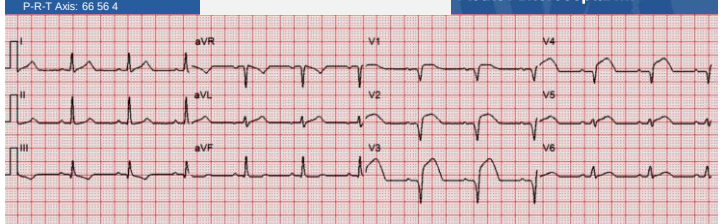




12-L Interpretation

Vent Rate: 72
P Duration: 82 ms
PR Interval: 158 ms
QRS Duration: 92 ms
QT/QTc: 376/411 ms
P-R-T Axis: 66 56 4

What, if any, leads have ST elevation (STE)?	V1-V5 = STE STE = acute injury
What is the significance of STE?	
What, if any, leads have pathologic Q waves?	V1-V4 = Q waves Q waves = infarction
What is the significance of Q waves?	
INTERPRETATION:	Acute Anteroseptal MI

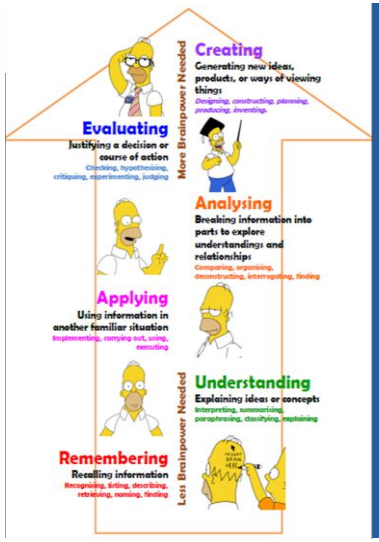


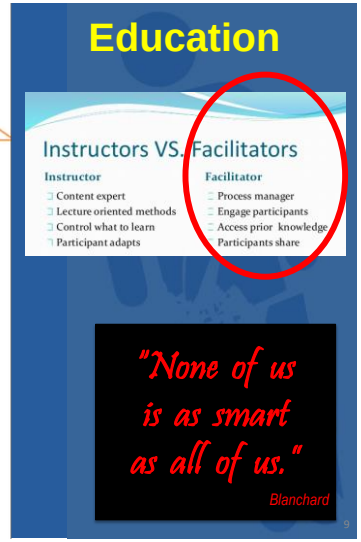
THANK YOU Palatine FD for this 12L ECG

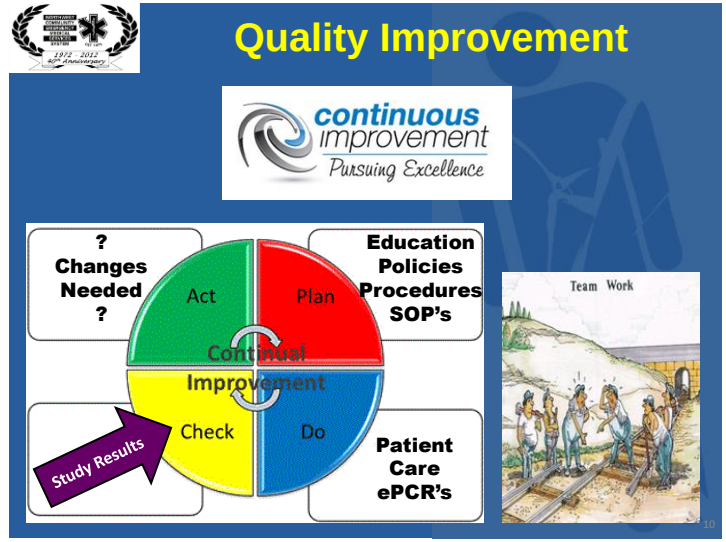
Educational Methodology

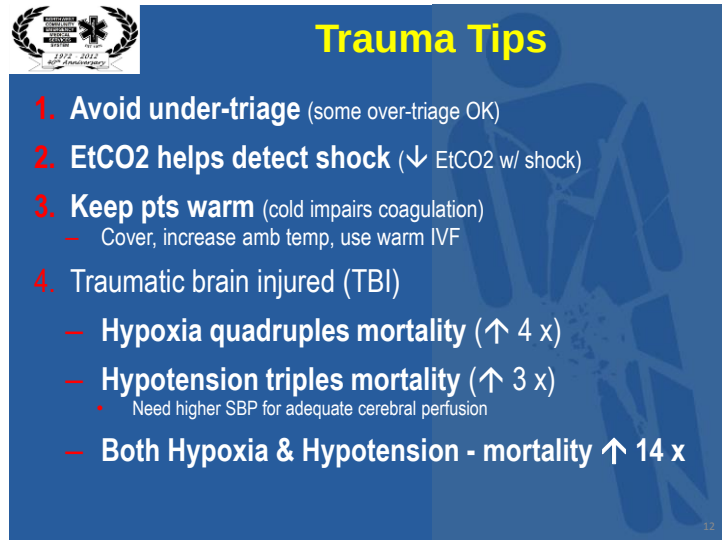
Tie together Education & Quality Improvement

Northwest Community EMS System – Continuing Education
March 2015 – Trauma QI Case Reviews









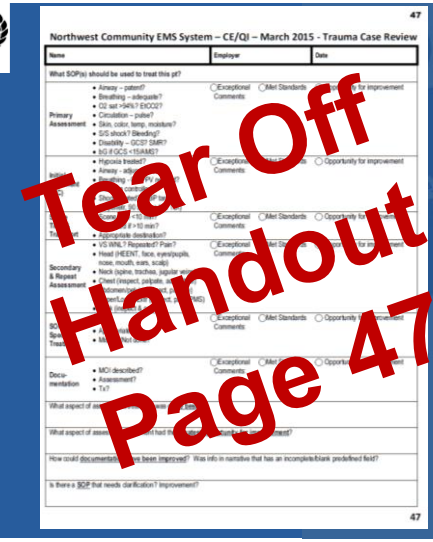
Trauma Tips
Oxygenation & Ventilation

IMC SOP pg 3

- Hyperoxia contraindicated: Give O2 only if hypoxia, titrate without causing hyperoxia (94%)
  1. Uncomplicated Acute MI
  2. Post-cardiac arrest
  3. Acute exacerbations COPD
  4. Stroke
  5. Newborn resuscitation

ITC SOP pg 37

- **SpO2 92-94% = O2 1-6 L/NC**
- **SpO2 < 92% or per protocol = O2 12-15 L (NRB/BVM)**
- Assist ventilation rates - adults
  - Before advanced airway = **10**-12 breaths/minute (asthma: 6-8 BPM)
  - After advanced airway = 8-**10** breaths/minute
  - Do NOT hyperventilate

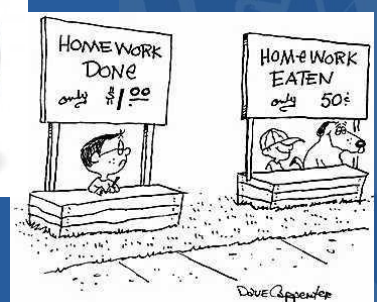


Tear Off Handout Page 47

Everyone Participates

Trauma QI Case Reviews

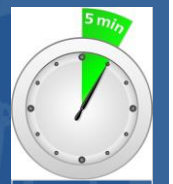
10 minutes to review your assigned case



Trauma QI Case Reviews

For each of the following list **1-2** things.

1. Assessment/treatment done best?
   What are we doing well?
2. Assessment/treatment had the most
   opportunity for improvement?
3. How could **documentation been improved?**
4. **SOP that needs clarification / modification?**



~5 minutes to review & discuss case

NORTHWEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM

EST 1972

1972 - 2012
40th Anniversary

Continuing Education

March 2015

Trauma QI Case Reviews

Objectives – Upon completion the participant will:

1) Correctly interpret the ECG rhythm when given a 6-second rhythm strip.
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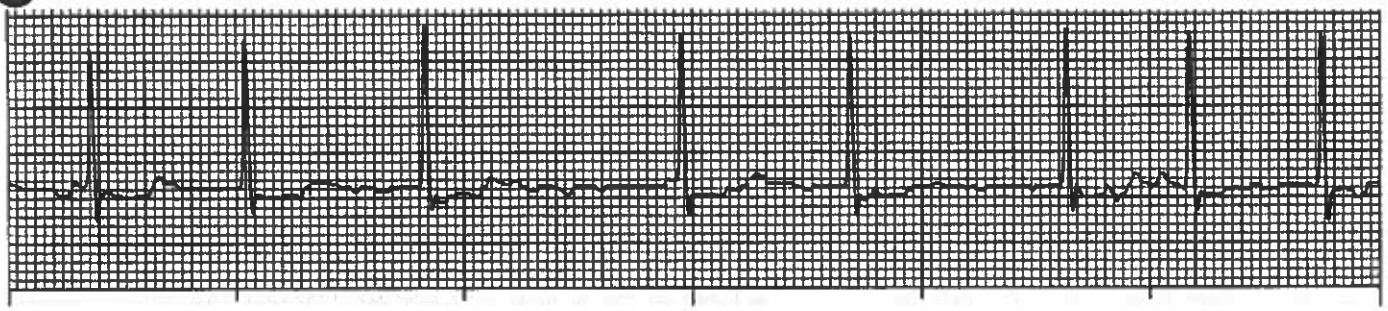
Questions/Comments on this CE are welcome and should be directed to:
Diana Neubecker RN BSN EMT-PM, EMS System In-Field Coordinator
dneubecker@nch.org or 847.618.4488

Northwest Community EMS System – CE – March 2015

1



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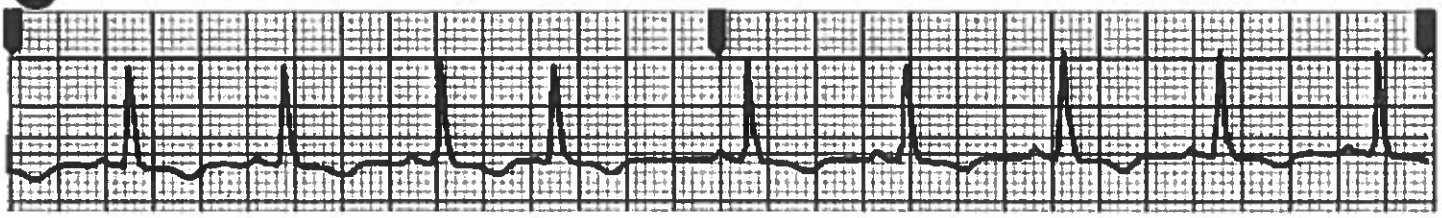

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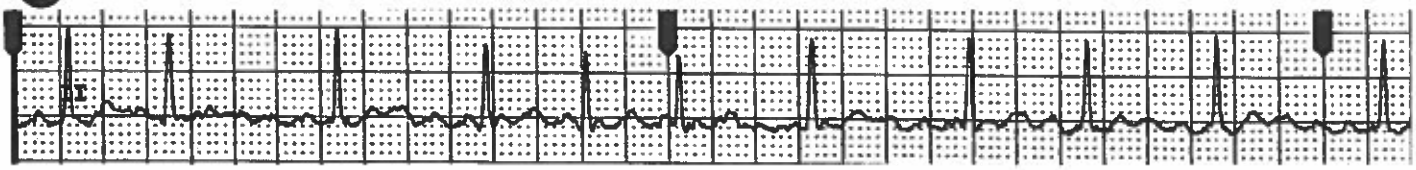

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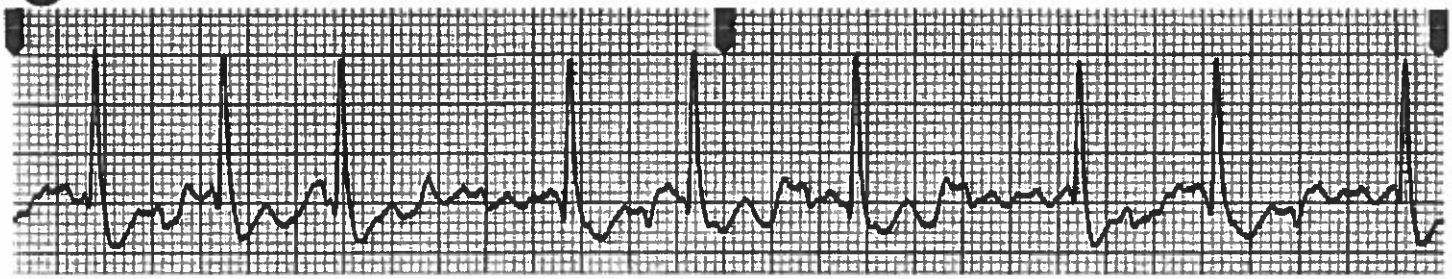

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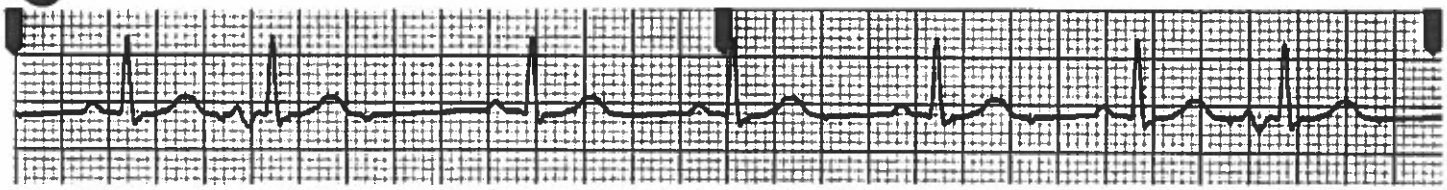

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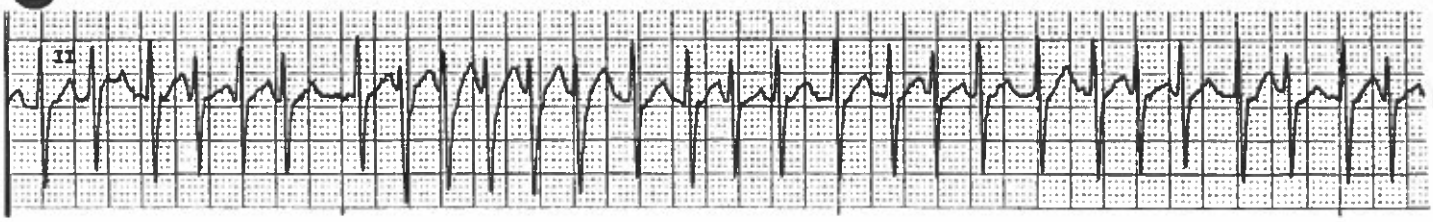

What, if any, leads have ST elevation (STE)?

What is the significance of STE?

What, if any, leads have pathologic Q waves?

What is the significance of Q waves?

INTERPRETATION:

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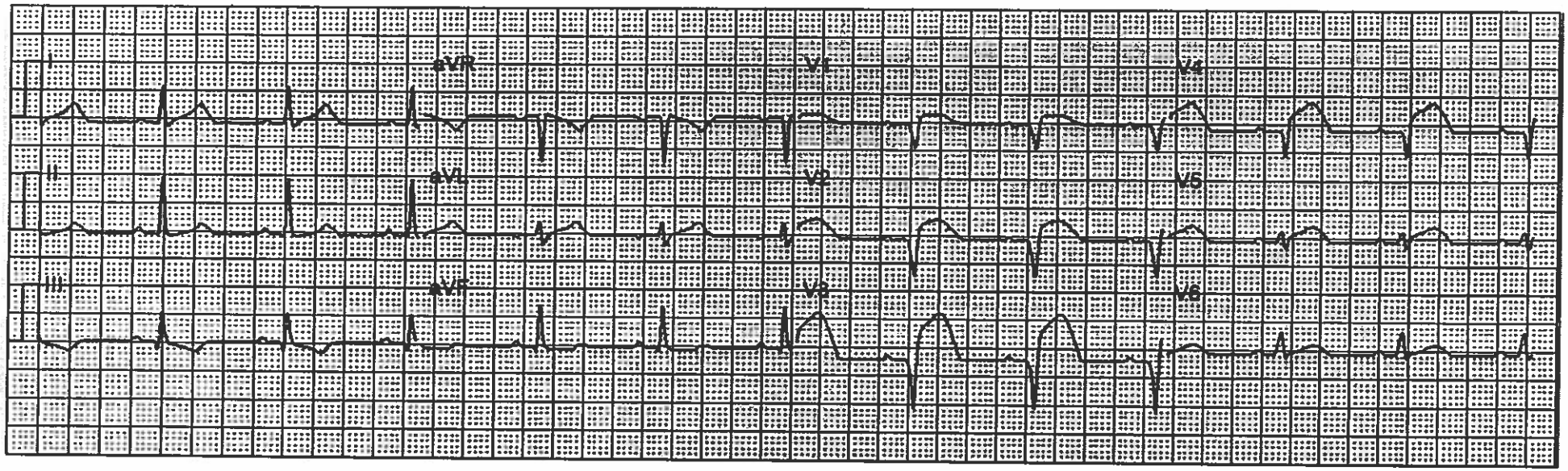


THANK YOU Palatine FD
for this 12L ECG

3

4

Comprehensive Report

[redacted]

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

Patient Information

Name: [redacted]

Age: 28 Years
Gender: Male
Weight: 79.379 KG / 175.00 LB
Phone:

D.O.B: [redacted] (mm/dd/yyyy)
SSN:
Race: White
Ethnicity: Not Hispanic or Latino

Address: [redacted]

Call Type and Location

Call Type: Traffic / Transportation Accident
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Street or Highway
Address: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: Lutheran General Hospital, Park Ridge, IL 60068
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: 19:01
Disp. Notified: 19:01
Unit Disp.: 19:02
Enroute: 19:03
At Scene: 19:07
At Patient: 19:08
Depart: 19:21
Arrive Dest: 19:35
In Service: 20:10
In Quarters:
Cancelled:

Incident [redacted]
Start Miles:
Scene Miles: [redacted] To Scene:
Dest. Miles: [redacted] To Dest: [redacted]
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	Secondary Caregiver
[redacted]	Paramedic	Third Caregiver
[redacted]	Paramedic	Driver Only

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: Lutheran General Hospital
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: Traumatic Injury
Chief Complaint: unresponsive X 5 Minutes
Onset Date/Time: [redacted] at 19:00
Alcohol/Drug Use:
Injury Intent: Accidental / Unintentional
Cause of Injury: Motor Vehicle Traffic Accident
Dispatch Reason: Traffic / Transportation Accident

Primary Symptom:
Unresponsive / Unconscious

Other Associated Symptoms:
Not Applicable

A1

Bleeding

Breathing Problem

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	ECO2	GCS	Pain	Stroke Scl	FTA	B.Gls	RTS	Limb	Patient Position
19:10					Labored				4							
19:12	108/P	99	RR	30	Assisted	80	On Room Air		4					8	Right Arm	Supine
19:17	119/71	101	RR	12		88	High FIO2 (80-100 pct)		4					9	Right Arm	Supine
19:23	128/75	126	RR	12	Assisted	92	High FIO2 (80-100 pct)		4					9	Right Arm	Supine
19:30	97/70	112	RI	10	Assisted	93	High FIO2 (80-100 pct)		4					9	Left Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
19:10	1	2	1	4
19:12	1	2	1	4
19:17	1	2	1	4
19:23	1	2	1	4
19:30	1	2	1	4

Past Medical History

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

Patient Medication	Generic Name	Dosage
Unable to Obtain Allergies	Unable to Obtain Allergies	

Medical/Surgery History:

Unable to Obtain PMH

History Primarily Obtained From:	Pregnancy	Advanced Directive	Practitioner Name
Not Applicable			

Procedures and Treatments

Time	Crew	Name	Location	Size/Equipment	Attempts	Complications	Success	Comments
19:08	[redacted]	Airway Nasopharyngeal			1	Unchanged	Yes	
19:12		Spinal Immobilization - Full Supine			1	Unchanged	Yes	
19:14		Airway Oropharyngeal	Mouth	90mm	1		No	clenched jaw
19:17		Venous Access - Extremity	Antecubital-Right	16	1	Unchanged	Yes	
19:26		Airway Orotracheal Intubation		6.5	1	Unchanged	No	
19:29		Airway King LT-D	Lower Extremity-Right	red	1	Unchanged	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
19:13	[redacted]	Oxygen by Bag-Valve Device	Inhalation	15 LPM	Improved		
19:21		Lidocaine	Intravenous	120 MG	Unchanged		
19:22		Midazolam (Versed)	Intravenous	5 MG	Improved		
19:23		Etomidate	Intravenous	40 MG	Improved		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
19:14	ECG-Monitor		Sinus Tachycardia	No Ectopy Noted	

Assessment Exam

Time of Assessment: [redacted]/2013 00:01:00

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:

Back-lumbar:

Back-thoracic:

Chest: Symmetrical Chest Rise, Clear & Equal Breath Sounds
Ext-left-low:
Ext-left-up:
Ext-right-low:
Ext-right-up:
Eyes-left:
Eyes-right: Not Available, 4-mm, Sluggish
GU:
Head:
Heart:
Mental: Unresponsive
Neck:
Neuro: Not Done
Skin: Pale

Narrative

Summary of Events

[redacted] and [redacted] dispatched for the motorcycle vs automobile with reports of a motorcyclist down with unknown breathing and unknown pulse. UOA, pt. presented lying left lateral recumbant in the street about 50 ft beyond his motorcycle in the direction of travel (east bound), unresponsive, blood coming out of his mouth/nose and with labored breathing. Pt.'s protected jacket was cut along the backside, and then pt. was log rolled onto a scoop stretcher. Helmet was removed to gain better access to his compromised airway. Pt. moved to the back of the ambulance. Pt. bagged with BVM with little increase to SpO2 saturations. Unable to ventilate/oxygenate adequately after inserting and OPA/NPA and with BVM so decision was made to perform DAI en route. One fail attempt with ET Tube and second attempt completed with King away. Lutaran General contacted with no further directives. UOA to Lutherine, Pt. care transeffered to ED nurse without incident.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

Helmet Worn

Vehicular Information

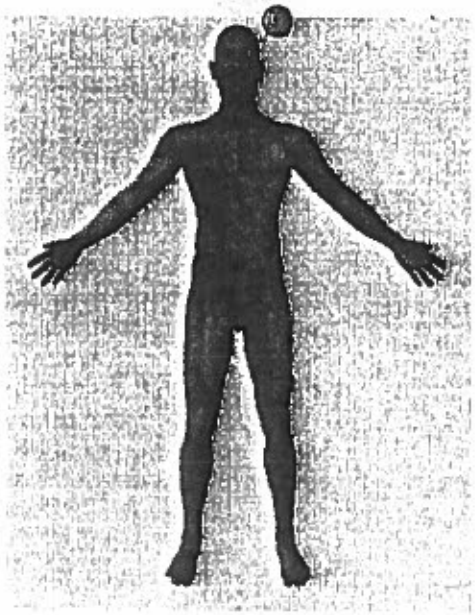
Vehicular Injury Indicators: Not Applicable
Area of Vehicle Impacted: Not Applicable
Seat Row Location of Patient:
Airbag Deployment: Not Applicable
Position of Patient: Not Applicable

Injury Details

Injury #	Injury Site	Injury Detail
1	Face	Not Available/hematoma over left eye

Physical Assessment

Front



Left

A3

7

Comprehensive Report

[redacted]

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

Patient Information

Name: [redacted]

Address: unknown

Age: 35 Years
Gender: Male
Weight: 108.862 KG / 240.00 LB
Phone:

D.O.B: (mm/dd/yyyy)
SSN:
Race:
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Traffic / Transportation Accident
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Street or Highway
Address: [redacted]
Zone: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: Lutheran General Hospital, Park Ridge, IL 60068
Dest. Determ.: Specialty Resource Center
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: 02:28
Disp. Notified: 02:28
Unit Disp.: 02:30
Enroute: 02:30
At Scene: 02:36
At Patient: 02:37
Depart: 02:54
Arrive Dest: 03:11
In Service: 04:57
In Quarters:
Cancelled:

Incident [redacted]
Start Miles:
Scene Miles: 0.0
To Scene:
Dest. Miles: [redacted]
To Dest: [redacted]
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	Secondary Caregiver
[redacted]	Paramedic	Primary Caregiver
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Secondary Caregiver
[redacted]	Paramedic	Driver Only

Call Information

Destination Name: Lutheran General Hospital
Destination Type: Hospital
Destination Determination: Specialty Resource Center
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: Traumatic Injury
Chief Complaint: Altered mental status X 3 Minutes
Onset Date/Time: [redacted] at 02:25
Alcohol/Drug Use: No Apparent Alcohol/Drug Use
Injury Intent: Accidental / Unintentional
Cause of Injury: Motor Vehicle Traffic Accident
Dispatch Reason: Traffic / Transportation Accident

Primary Symptom:

Altered Mental Status

Other Associated Symptoms:

Pain

B1

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
02:54		140	RR	20	Normal	92	On Room Air		13							Supine
03:04		146	RR	20	Normal	92	On Room Air	45	13							Supine
03:09	80/P	142	RR	20	Normal	92	On Room Air		13					11	Left Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
02:54	4	4	5	13
03:04	4	4	5	13
03:09	4	4	5	13

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 History

Unable to Obtain PMH

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Not Applicable	N/A		

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
02:50	[redacted]	Spinal Immobilization - Rigid Collar	Neck		1	Unchanged	Yes	
02:50	[redacted]	Spinal Immobilization - Long Back Board			1	Unchanged	Yes	
02:58	[redacted]	Wound Care	Lower Extremity-Left		1	Unchanged	Yes	
03:03	[redacted]	Venous Access - Extremity	Antecubital-Left	18g	1	Unchanged	No	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Artifact	Cause For Change
03:02	ECG-Monitor	II	Sinus Tach	Artifact	Initial Rhythm

Assessment Exam

Time of Assessment: [redacted] T02:50:00-05:00

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:
Back-lumbar:
Back-thoracic:
Chest: Symmetrical Chest Rise
Ext-left-low: Not Available, C.M.S. Normal, Pain/Tenderness
Ext-left-up: C.M.S. Normal
Ext-right-low: Not Available
Ext-right-up: C.M.S. Normal
Eyes-left: 4-mm
Eyes-right: 4-mm
GU:
Head: Swelling/Edema
Heart:
Mental: Combative, Confused
Neck:
Neuro: Normal Gait / Movement
Skin: Normal

Narrative

B2

Summary of Events

Responded to the reported emergency for a vehicle vs. tree. A vehicle left north bound[redacted] down a ravine, and into a tree. Crews found one patient in a 4 door SUV that had struck a tree. The car had intrusion into the patient compartment with dash and steering wheel deformity. The tree the vehicle hit went into the patient compartment pushing the steering wheel and dashboard into the driver seat. The pt. was not seat belted and was found on his right side with both legs trapped under the steering wheel/dash deformity. Pt. was awake and breathing but was unable to answer questions correctly on arrival. Pt. was confused and crew could not get pt. information. Pt. continued to complain of pain to his left leg. Pt. needed to be extricated from the vehicle, with extrication complete at 0248. Pt. had c-spine precautions taken as soon as possible. Full assessment reveal swelling to the right ankle, laceration on the right knee, abrasion to the right hip, a large laceration into the fatty tissue on the left calf, a steering wheel mark on his abdoman, swelling to both eyes and cheeks, lacerations to the lips, and swelling to the jaw. Pt. was fighting with EMS crew and a BP was not able to be obtained on the first 2 attempts. Pt. continued to be agitated and fighting with EMS crew through the call. ALS care and vitals as stated. LGH was contacted and informed of the level 1 trauma. LGH had no further orders. Pt. care was continued en route and pt. care was transferred to ER Rn bed 1.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

No Safety Equipment/Devices Used

Vehicular Information

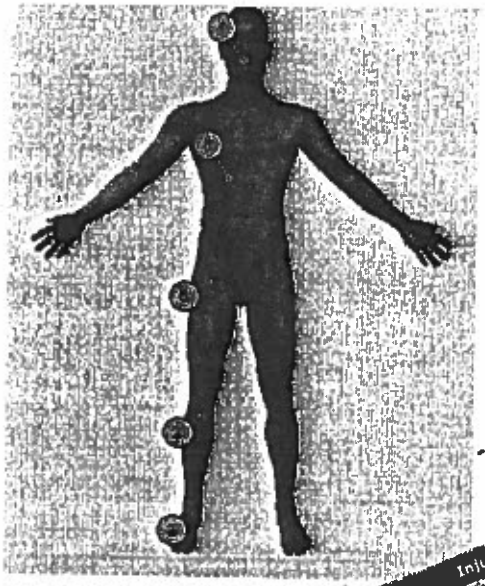
Vehicular Injury Indicators: Dash Deformity, Space Intrusion > 1 Foot, Steering Wheel Deformity

Area of Vehicle Impacted: Center Front, Left Front

Seat Row Location of Patient: 1

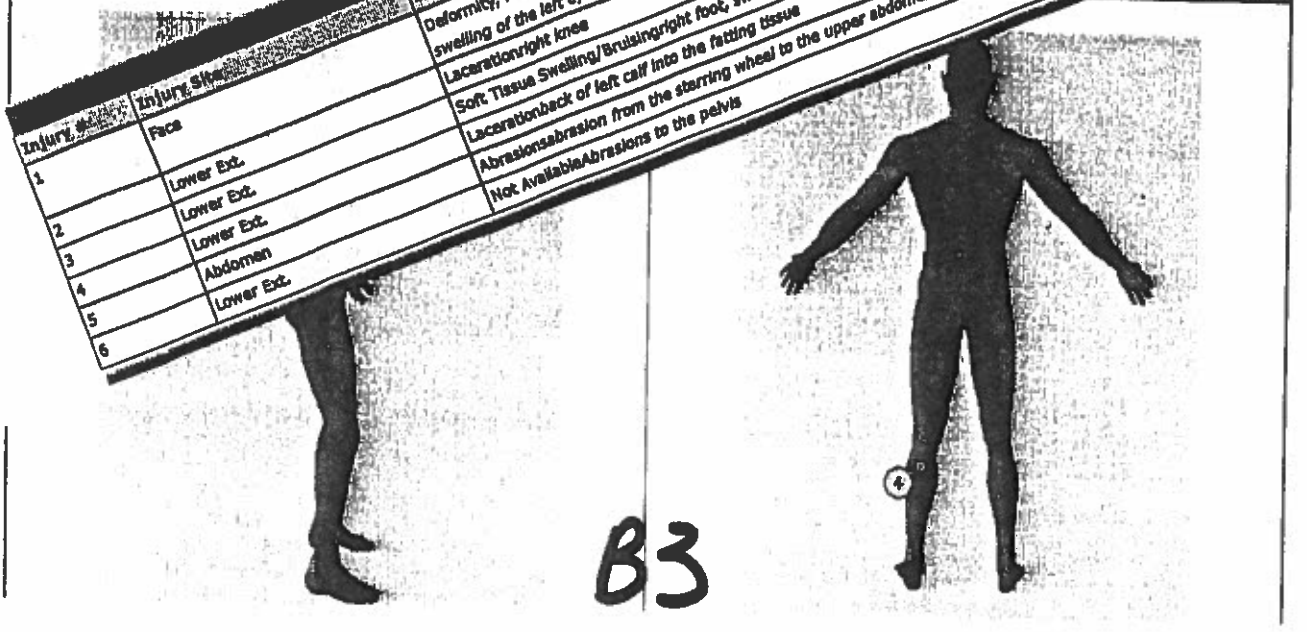
Position of Patient: Driver

Airbag Deployment: Airbag Deployed Front, Airbag Deployed Side



Injury Details

Injury #	Injury Site	Injury Details
1	Face	Deformity, Pain/tenderness, Soft Tissue Swelling/Bruising, Abrasions, Bleeding Controlled abrasions to the face, swelling of the left eye, lips, and jaw, bleeding from the lips
2	Lower Ext.	Lacerationright knee
3	Lower Ext.	Soft Tissue Swelling/Bruisingright foot, swelling to the right foot
4	Abdomen	Lacerationback of left calf into the fatting tissue
5	Lower Ext.	Abrasionsabrasion from the sterring wheel to the upper abdomen.
6		Not Available/Abrasions to the pelvis



B3

10

Comprehensive Report

[redacted]

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

Patient Information

Name: [redacted]

Address: [redacted]

Age: 42 Years
Gender: Male
Weight: 99.790 KG / 220.00 LB
Phone:

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

Call Type and Location

Call Type: Fall Victim
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: Lutheran General Hospital, Park Ridge, IL 60068
Dest. Determ.: Specialty Resource Center
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: 13:42
Disp. Notified:
Unit Disp.: 13:42
Enroute: 13:43
At Scene: 13:44
At Patient: 13:44
Depart: 14:02
Arrive Dest: 14:16
In Service: 14:37
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: [redacted] To Scene:
Dest. Miles: [redacted] To Dest: [redacted]
End Miles: To End:
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]	Paramedic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: Lutheran General Hospital
Destination Type: Hospital
Destination Determination: Specialty Resource Center
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: Traumatic Injury
Chief Complaint: HEAD INJURY FROM FALL X
Onset Date/Time: [redacted]t 13:42
Alcohol/Drug Use: Smell of Alcoholic Beverage on Breath/About PersonPatient Admits to Alcohol UseAlcohol and/or Drug Paraphernalia at Scene
Injury Intent: Accidental / Unintentional
Cause of Injury: Fall
Dispatch Reason: Fall Victim

Primary Symptom:

C1

Unresponsive / Unconscious

Other Associated Symptoms
Bleeding
Breathing Problem

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual	ETCO2	GCS	Pain	Stroke Scl	FTA	Sic.	RTS	Limb	Patient Position
13:45	150/90	60	RR	18	Normal	98	On Room Air		15	0				12	Right Arm	Supine
13:49	128/60	50	RR	8	Agonal	90	On Room Air		3					6	Right Arm	Supine
13:50	150/80	52	RR	12	Assisted	98	High FIO2 (80-100 pct)		3					8	Right Arm	Supine
13:55	128/84	49	RR	12	Assisted	96	High FIO2 (80-100 pct)		3					8	Right Arm	Supine
14:01	130/80	50	RR	12	Assisted	96	High FIO2 (80-100 pct)		3					8	Right Arm	Supine
14:08	120/78	55	RR	12	Assisted	94	High FIO2 (80-100 pct)		3					8	Right Arm	Supine
14:12	124/84	50	RR	12	Assisted	94	High FIO2 (80-100 pct)		3					8	Right Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
13:45	4	5	6	15
13:49	1	1	1	3
13:50	1	1	1	3
13:55	1	1	1	3
14:01	1	1	1	3
14:08	1	1	1	3
14:12	1	1	1	3

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
Unable to Obtain PMH

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Family			

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
13:44	[redacted]	Assessment-Adult			1		Yes	
13:46	[redacted]	Spinal Immobilization - Full Supine			1		Yes	
13:46	[redacted]	Airway ETCO2 by Capnography			1		Yes	
13:49	[redacted]	Airway Oropharyngeal			1		Yes	
13:51	[redacted]	Airway Orotracheal Intubation			2		No	
13:53	[redacted]	Airway King LT-D			1		Yes	
14:02	[redacted]	Venous Access - Extremity	Hand-Left	18g	1	Unchanged	Yes	
14:03	[redacted]	Venous Access - Extremity	Hand-Right	18g	1	Unchanged	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
14:02	[redacted]	Normal Saline (0.9%)	Intravenous	10 TKO (KVO)	Unchanged	No	
14:03	[redacted]	Normal Saline (0.9%)	Intravenous	10 TKO (KVO)	Unchanged	No	

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
13:45	ECG-Monitor		Sinus Bradycardia		

Assessment Exam

C2

Time of Assessment:	[redacted]	[redacted]
Abdomen-left-lower:		
Abdomen-left-upper:		
Abdomen-right-lower:		
Abdomen-right-upper:		
Back-cervical:		
Back-lumbar:		
Back-thoracic:		
Chest:	Clear & Equal Breath Sounds	
Ext-left-low:		
Ext-left-up:		
Ext-right-low:		
Ext-right-up:		
Eyes-left:		
Eyes-right:	Reactive	
GU:		
Head:		
Heart:		
Mental:	Normal Mental Status for Patient, Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events	Unresponsive
Neck:		
Neuro:	Speech Normal	
Skin:	Normal	Normal

Narrative

Summary of Events:

IN SUMMARY CREW CALLED TO LOCATION FOR THE PT WHO FELL. UOA WITH [redacted] AND ENG [redacted] ON SCENE CREW FOUND 42 Y/O MALE PT ALERT ON THE GROUND. PT FAMILY STATED PT WAS TRYING TO GET INTO HIS APARTMENT BY CLIMBING UP SOME SCAFFOLDING. PT FELL APROX 15-20 FEET ONTO HIS HEAD. PT LANDED ON CONCRETE. PT WAS ALERT AND SMELLED OF ETOH. PT ADMITTED TO ETOH. PT DENIES LOC. PT DENIES HEAD, NECK OR BACK PAIN. NO OBVIOUS DEFORMITIES FOUND ON EXAM. CREW FOUND SOME BLEEDING OUT OF HIS LEFT EAR, AND HIS LEFT EYE WAS SWOLLEN SHUT. PT DENIED ANY PAIN. VITAL SIGNS OBTAINED AND MONITORED EN ROUTE. PT WAS FULLY IMMOBILIZED. PT MOVED TO COT / AMB WHERE ALS PROCEDURES WERE PROVIDED. ONCE IN BACK PT BEGAN SNORING RESPIRATIONS AND BECAME UNRESPONSIVE. CREW ASSISTED VENTILATIONS WITH BVM. 2 18 GA IVS ESTABLISHED X 1 IN LEFT AND RIGHT HAND TKO RATE EN ROUTE. EKG SHOWED SINUS BRADY. ET TUBE ATTEMPTED X2 UNSUCCESSFULLY. PT GIVEN KING TUBE. ETCO2 WAS SQUARE AND CONSTANT. DUE TO PT MOI, CREW TRANSPORTED TO LEVEL ONE HOSPITAL. LUTHERAN GENERAL CALLED VIA CELL PHONE AND NO ORDERS WERE GIVEN. PT STATUS REMAINED UNCHANGED THROUGHOUT TRANSPORT. CREW ARRIVED AT LUTHERAN GENERAL, PT MOVED TO BED #3. PT CARE AND REPORT TRANSFERRED TO RN OF BED #3 ALL WITHOUT INCIDENT.

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

Injury #:	Injury Site:	Injury Detail:
1	Lower Ext.	Bleeding Controlled, Abrasions*left knee*
2	Face	Soft Tissue Swelling/Bruising*LEFT EYE*
3	Head	Bleeding Controlled*LEFT EAR*

Billing Information

Comprehensive Report

[redacted] 13

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

Patient Information

Name: [redacted]

Address: [redacted]

Age: 47 Years
Gender: Male
Weight: 99.790 KG / 220.00 LB
Phone:

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

Call Type and Location

Call Type: Traffic / Transportation Accident
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: Lutheran General Hospital, Park Ridge, IL 60068
Dest. Determ.: Specialty Resource Center
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: Extrication > 20 Min, Vehicle Crash
Transport Delay: None
TurnAround Delay: None
Patient Barriers: Unconscious

Response Times and Mileage

1st Resp. Arr.:
PSAP: 07:54
Disp. Notified:
Unit Disp.: 07:55
Enroute: 07:56
At Scene: 08:05
At Patient: 08:06
Depart: 08:25
Arrive Dest: 08:44
In Service: 11:00
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0
To Scene:
Dest. Miles: [redacted]
To Dest: [redacted]
End Miles: [redacted]
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]	Paramedic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: Lutheran General Hospital
Destination Type: Hospital
Destination Determination: Specialty Resource Center
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: Traumatic Injury
Chief Complaint: Unconcious/Unresponsive X 5 Minutes
Onset Date/Time: [redacted] at 07:50
Alcohol/Drug Use: No Apparent Alcohol/Drug Use
Injury Intent: Accidental / Unintentional
Cause of Injury: Motor Vehicle Traffic Accident
Dispatch Reason: Traffic / Transportation Accident

Primary Symptom:

Unresponsive / Unconscious

Other Associated Symptoms:

Bleeding

D1

Breathing Problem

Drainage/Discharge

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scale	DTA	BGL	RTS	Limb	Patient Position
08:09		80	RR	22	Normal				3							Sitting
08:15		84	RR	24	Normal				3							Sitting
08:20		96	RR	28	Normal				3							Sitting
08:28	128/70	76	RR	24	Normal	64			3					8	Right Arm	Supine
08:32	118/54	64	RR	22	Normal	89	High FIO2 (80-100 pct)		3					8	Right Arm	
08:39	120/56	60		26	Normal	89	High FIO2 (80-100 pct)		3					8		Supine
08:43	122/46	100	RR	22	Normal	87	High FIO2 (80-100 pct)		3					8	Right Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
08:09	1	1	1	3
08:15	1	1	1	3
08:20	1	1	1	3
08:28	1	1	1	3
08:32	1	1	1	3
08:39	1	1	1	3
08:43	1	1	1	3

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 Surgical History

Unable to Obtain PMH

Procedure	Tooth #	Surface	Practitioner Name
None			

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comment
08:08	[redacted]	Assessment-Adult			1		Yes	
08:10	[redacted]	Spinal Assessment - No Deficits Noted			1	Unchanged	Yes	
08:10	[redacted]	Wound Care			1	Unchanged	Yes	Apply dressings to actively bleeding skull
08:11	[redacted]	Spinal Immobilization - Rigid Collar			1	Unchanged	Yes	
08:12	[redacted]	Airway Suctioning			1	Improved	Yes	
08:13	[redacted]	Airway Oropharyngeal		100	1	Improved	Yes	
08:14	[redacted]	Wound Care			1	Unchanged	Yes	Apply new trauma dressings to actively bleeding skull
08:20	[redacted]	Wound Care	Head		1		Yes	reapply dressings to actively bleeding skull
08:23	[redacted]	Spinal Immobilization - Long Back Board			1	Unchanged	Yes	
08:25	[redacted]	Cardiac Monitor with chest leads			1		Yes	
08:27	[redacted]	Venous Access - Extremity	Antecubital-Left	14	1		Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
08:27	[redacted]	Normal Saline (0.9%)	Intravenous	10 mL/hr	Unchanged		
08:29	[redacted]	Oxygen by Non-Rebreather Mask	Inhalation	15 LPM	Improved		

ECG Monitor

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

08:26	ECG-Monitor	II	Sinus rhythm			
08:33	ECG-Monitor	II	Sinus rhythm			

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Assessment Exam

Time of Assessment	[redacted] 08:24:00	[redacted] 08:25:00	[redacted] 08:30:00	[redacted] 08:41:00	[redacted] 08:45:00
Abdomen-left-lower:		Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)		
Abdomen-left-upper:		Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)		
Abdomen-right-lower:		Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)		
Abdomen-right-upper:		Normal (Soft, Non-Tender)	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	Symmetrical Chest Rise	Symmetrical Chest Rise	Symmetrical Chest Rise, Clear & Equal Breath Sounds
Ext-left-low:		Not Available	Not Available		
Ext-left-up:		Not Available	Not Available		
Ext-right-low:		Not Available	Not Available		
Ext-right-up:		Not Available	Not Available		
Eyes-left:			Not Available		
Eyes-right:		5-mm	5-mm		
GU:					
Head:		Symmetrical Face	Drainage, Symmetrical Face		
Heart:					
Mental:	Unresponsive	Unresponsive	Unresponsive	Unresponsive	Unresponsive
Neck:		No JVD noted, Trachea Midline	No JVD noted, Trachea Midline		
Neuro:			Not Applicable		
Skin:			Clammy, Cold		

Narrative

Summary of Events

[redacted] dispatched for the accident with injuries. While en route [redacted] upgraded incident when reports of possible extrication. [redacted] on scene before [redacted] units and gave radio size up of two Pts, one requiring immediate extrication and one that had self extricated. Upon arrival crew encountered a two Vehicle accident. One Pt was being attended to by [redacted] crew member. Crew made way to vehicle where [redacted] crews had begun extrication process. Ambulance crew made access into Passenger and made Pt contact. Pt was found seat belted in Driver seat unresponsive. Pt was breathing with equal chest rise, and had a strong radial pulse. Crew noted bleeding from Pts ears nose and mouth, and noticed that the pt had sustained massive facial trauma to his left forehead and eye, crew was unable to find any discernable ocular tissue in Pts left eye area. Crew noted exposed brain tissue and found multiple bone pieces on Pts chest and lap. Crew placed oral airway and began suctioning mouth to maintain Pts airway. Crew also applied multiple trauma dressing to Pts left head in attempts to control bleeding. Pts vehicle had sustained severe damage to the driver side left front and left side front by driver door. [redacted] and [redacted] crews worked diligently to remove the vehicle dash, A post, and steering column from around the Pt to allow removal. Pt was extricated onto Backboard and rushed into Ambulance for transport. Once inside ambulance Crew provided care as documented above. Pt remained unresponsive throughout transport. Pt was maintaining an adequate respiratory rate and depth, and also had clear breath sounds during transport. LGH contacted with initial report. Crew re contacted once inital set of vitals were attained. LGH gave no further orders. Pt care transferred to LGH ER Bed 1

Prior Aid

Prior Aid	Performed By	Outcome
None,		

Safety Equipment Used

Lap Belt

Shoulder Belt

Protective Safety Belt

Vehicular Information

Vehicular Injury Indicators: Dash Deformity, Side Post Deformity, Space Intrusion > 1 Foot, Windshield Spider/Star

Area of Vehicle Impacted: Center Front, Left Front

Seat Row Location of Patient: 1

Position of Patient: Driver

Airbag Deployment: Airbag Deployed Front

Injury Details

Injury #	Injury Site	Injury Detail
1	Head	Bleeding Uncontrolled, Deformity, Avulsion*Open skull Fx on leftforehead*
2	Face	Avulsion, Bleeding Uncontrolled, Deformity*crushed left globe, uncontrolled bleeding, bleeding from ears, nose, and mouth.*

D3

Comprehensive Report

[redacted]

14

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

Patient Information

Name: [redacted]

Address: [redacted]

Age: 55 Years
Gender: Male
Weight: 83.915 KG / 185.00 LB
Phone: 0000000000

D.O.B: [redacted] (mm/dd/yyyy)
SSN:
Race: White
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Fall Victim
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: Lutheran General Hospital, Park Ridge, IL 60068
Dest. Determ.: Specialty Resource Center
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: 22:04
Disp. Notified: 22:04
Unit Disp.: 22:05
Enroute: 22:06
At Scene: 22:10
At Patient: 22:11
Depart: 22:32
Arrive Dest: 23:00
In Service: 00:30
In Quarters:
Cancelled:

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

First Responder Agencies#: Schaumburg Fire, Schaumburg Police

Unit Personnel

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

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: Lutheran General Hospital
Destination Type: Hospital
Destination Determination: Specialty Resource Center
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: Traumatic Injury
Chief Complaint: No complaint, pt unresponsive X
Onset Date/Time: [redacted]at 22:00
Alcohol/Drug Use: No Apparent Alcohol/Drug Use
Injury Intent: Not Known
Cause of Injury: Fall
Dispatch Reason: Fall Victim

Primary Symptom:

Altered Mental Status

E1

Other Associated Symptoms
Not Applicable

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp	Effort	SpO2	SpO2 Qual	EtCO2	GCS	Pain	Stroke Scr	FTA	ECG	RTS	Limb	Patient Position
22:11		70	RR	12	Normal	95	On Room Air		3				123			Supine
22:21	173/90	76	RR	15	Normal	95	On Room Air	17	3					8	Right Arm	Supine
22:26	163/96	70	RR	10	Normal	94	On Room Air	18	3					8	Right Arm	Supine
22:34	170/96	78	RR	17	Normal	97	On Room Air	36	3					8	Right Arm	Supine
22:46	166/92	52	RR	17	Normal	91	On Room Air	31	3					8	Right Arm	Supine
22:51	152/88	67	RR	16	Normal	91	Low FIO2 (24-40 pct)	33	3					8	Right Arm	Supine
22:56	167/98	127	RR	12	Normal	94	Low FIO2 (24-40 pct)	22	3					8	Right Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
22:11	1	1	1	3
22:21	1	1	1	3
22:26	1	1	1	3
22:34	1	1	1	3
22:46	1	1	1	3
22:51	1	1	1	3
22:56	1	1	1	3

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 Problem History
Unable to Obtain PMH

Hospitalization/Surgeries/Trauma	Frequency	Advanced Directives	Practitioner Name
None	N/A		

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
22:11	[redacted]	Assessment-Adult			1	Unchanged	Yes	
22:14	[redacted]	Spinal Immobilization - Full Supine			1	Unchanged	Yes	
22:22	[redacted]	Airway Nasopharyngeal		28 (7)	1	Improved	Yes	
22:23	[redacted]	Airway Oropharyngeal			1	Improved	Yes	
22:28	[redacted]	Venous Access - Extremity	Hand-Right	18g	1	Unchanged	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
22:28	[redacted]	Normal Saline (0.9%)	Intravenous	10 mL	Unchanged	No	
22:47	[redacted]	Oxygen by Nasal Cannula	Inhalation	4 LPM	Improved		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
22:21	ECG-Monitor	II	Sinus Rhythm	No Ectopy Noted	Initial Rhythm

Assessment Exam

Time of Assessment: [redacted] 22:11:00-08:00

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)

18

Chest: Symmetrical Chest Rise, Clear & Equal Breath Sounds
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: Fixed/Non-Reactive
Eyes-right: Fixed/Non-Reactive
GU:
Head: Swelling/Edema, Symmetrical Face
Heart:
Mental: Unresponsive
Neck: Normal
Neuro:
Skin: Normal

Narrative

Summary of Events

[redacted] dispatched for a 55 year old male 'fall victim'. EMS was initially instructed to stage for PD, and did so. While staging, EMS was advised to proceed to the scene with an update indicating the pt had stopped breathing and bystanders were performing CPR. On arrival the pt presented supine in the living room at the bottom of the stairs, not awake, breathing spontaneously, with a pulse, unresponsive to all stimuli. Upon assessment there were no obvious injuries or deformities noted. A bystander on the scene claimed she was with the pt drinking beers earlier in the evening. This same bystander claimed she witnessed the pt fall backwards from the top of the staircase, hitting his head on the landing below. A pt history was not able to be obtained from the bystanders as they were not answering questions, yelling at each other, and crying loudly. PD arrived on the scene and controlled the bystanders. Cervical collar applied in while pt was in his original position. Pt was moved onto a rigid back board and secured. Pt's head was immobilized with straps to the rigid board. Pt moved to the stretcher, secured, and moved to the ambulance. Per Trauma Triage SOP, pt report was called in to LGH while en route. EMS notified OLMC that the pt was a trauma alert. While en route, pt became incontinent. Also while en route it was noted that the pt's head started becoming swollen and soft over the top and back of the skull. Pt maintained a patent airway, breathing spontaneously during transport. Pt care transferred to LGH trauma team.

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

Billing Information

Payment Method:
Work Related?

Medicare Questionnaire

Medically Necessary:
Transported To/For:
Moved by Stretcher:
Round Trip Reason:
Visible Hemorrhaging:
Stretcher Reason:
Unconscious/Shock:
Physical Restraints:
Bed Confined Before:
Hospital Admit:
Bed Confined After:
Weight: 83.915 KG / 185.00 LB
Type of Transport:
MSP Reason:

Service-Defined Questions

Is patient a [redacted]esident?	Yes
Was a 12 Lead ECG left with the ED staff?	Not Applicable
If Capnography was used, how did the waveform appear?	Square Constant

E3

Comprehensive Report

[redacted]

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

Patient Information

Name: [redacted]

Address: [redacted]

Age: 60 Years
Gender: Female
Weight: 81.647 KG / 180.00 LB

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

Call Type and Location

Call Type: Fall Victim
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: Lutheran General Hospital, Park Ridge, IL 60068
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.: 16:24
PSAP: 16:17
Disp. Notified:
Unit Disp.: 16:19
Enroute: 16:19
At Scene: 16:29
At Patient: 16:31
Depart: 16:47
Arrive Dest: 17:06
In Service: 18:50
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: [redacted] To Scene:
Dest. Miles: [redacted] To Dest: [redacted]
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	Secondary Caregiver
[redacted]	Paramedic	Fire Company
[redacted]	EMT-Basic	Driver Only
[redacted]	Paramedic	Third Caregiver

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: Lutheran General Hospital
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: Stroke/CVA
Chief Complaint: unconcious X 15 Minutes
Onset Date/Time: [redacted] at 16:15
Alcohol/Drug Use:
Injury Intent: Accidental / Unintentional
Cause of Injury: Fall
Dispatch Reason: Fall Victim

Primary Symptom:
Unresponsive / Unconscious

F1

Other Associated Symptoms
Altered Mental Status
Nausea / Vomiting

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	etCO2	GCS	Pain	Stroke Scr	PTA	BGL	RTS	Limb	Patient Position
16:27	170/97	98	RR	12	Normal	97	On Room Air		3				97	8		Supine
16:34	166/95	94	RR	12	Normal	97	On Room Air		7					10		Supine
16:40	168/94	90	RR	12	Normal	97	On Room Air		7					10		Supine
16:45	170/90	92	RR	12	Normal	97	On Room Air		7					10		Supine
16:50	164/86	88	RR	12	Normal	98	On Room Air		7					10		Supine
16:55	164/86	88	RR	12	Normal	98	On Room Air		12					11		Supine
17:00	170/84	90	RR	12	Normal	98	On Room Air		3					8		Supine
17:05	168/80	92	RR	12	Normal	98	On Room Air		3					8		Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
16:27	1	1	1	3
16:34	1	1	5	7
16:40	1	1	5	7
16:45	1	1	5	7
16:50	1	1	5	7
16:55	3	4	5	12
17:00	1	1	1	3
17:05	1	1	1	3

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
Coumadin	Warfarin	Coumadin

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

Medical/Surgery History
Cardiac - Myocardial Infarction

History Primarily Obtained From	Problem	Advanced Directives	Directives Notes
Family			

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Reduced	Success	Comments
16:32	[redacted]	Spinal Immobilization - Rigid Collar			1		No	
16:35		Spinal Immobilization - Long Back Board			1		Yes	
16:41		Venous Access - Extremity	Wrist-Left	20	1		No	
16:45		Airway Suctioning			1		Yes	
16:46		Airway Nasopharyngeal			1		Yes	
16:55		Vascular Access - Intraosseous Adult	Tibia IO-Left	Blue	1		Yes	
16:59		Vascular Access - Intraosseous Adult	Tibia IO-Right	Yellow	1		Yes	
16:59		Airway Suctioning			1		Yes	
17:00		Airway Suctioning			1		Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
16:56	[redacted]	Normal Saline (0.9%)	Intraosseous	10 mL/hr			
17:00		Midazolam (Versed)	Intraosseous	5 MG			
17:00		Normal Saline (0.9%)	Intraosseous	10 mL/hr			
17:03		Etomidate	Intraosseous	40 MG			

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
16:30	ECG-Monitor		Normal Sinus Rhythm		

Assessment Exam

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Time of Assessment:	[redacted]T16:32:00-06:00	[redacted]T16:40:00-06:00	[redacted]T16:48:00-06:00	[redacted]T16:55:00-06:00	[redacted]T17:00:00-06:00
Abdomen-left-lower:					
Abdomen-left-upper:					
Abdomen-right-lower:					
Abdomen-right-upper:					
Back-cervical:					
Back-lumbar:					
Back-thoracic:					
Chest:	Symmetrical Chest Rise, Clear & Equal Breath Sounds	Symmetrical Chest Rise, Clear & Equal Breath Sounds	Symmetrical Chest Rise		
Ext-left-low:					
Ext-left-up:					
Ext-right-low:					
Ext-right-up:					
Eyes-left:			4-mm, Sluggish		
Eyes-right:			4-mm, Sluggish		
GU:					
Head:					
Heart:					
Mental:	Unresponsive	Responsive to Painful Stimuli	Responsive to Painful Stimuli	Responsive to Painful Stimuli	Unresponsive
Neck:					
Neuro:	Seizures				
Skin:	Normal	Normal	Normal	Normal	

Narrative

Summary of Events:

Dispatched to home for female who fell. [redacted] began care prior to [redacted] arrival. UOA of [redacted] pt was supine on living room floor. Pts family stated pt was complaining of headache and dizziness before she went outside to smoke. Pts family said pt went out to the balcony to smoke and son in law heard pt fall. Family found pt sitting on her bottom against the railing. Family member attempted to help her into the house and he said pt was in and out of consciousness. Family member laid pt on floor. As pt was calling 911 family member stated pt's eyes rolled back into her head and she looked like she was having a seizure. Pt was moved out of apartment via backboard to stretcher. Pt remained unresponsive on scene and actively vomited once. [redacted] was contacted and asked for direction for transport destination and instructed [redacted] to transport to LGH. During transport to hospital pt began to regain consciousness and removed the nasal airway. LGH contacted with pt update and instructed PM to perform DAI due to pt vomiting and unable to manage airway. IO needle became loose when pt regained consciousness and came out of the leg. Second IO attempt was successful. PM unable to intubate due to pt's jaw being clenched after midazolam and etomidate were given. OPA was unable to be inserted due to clenched jaw. Pt care transferred to LGH room 2. All times approximate.

Prior Aid

Prior Aid	Performed By	Outcome
None,	EMS Provider	

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

Billing Information

Payment Method:

Work Related?

Medicare Questionnaire

Medically Necessary:

Moved by Stretcher:

Visible Hemorrhaging:

Unconscious/Shock:

Bed Confined Before:

Transported To/For:

Round Trip Reason:

Stretcher Reason:

Physical Restraints:

Hospital Admit:

F3

Comprehensive Report

[redacted]

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

Patient Information

Name: [redacted]

Address: [redacted]

Age: 64 Years
Gender: Female
Weight: 113.398 KG / 250.00 LB
Phone:

D.O.B: [redacted] (mm/dd/yyyy)
SSN:
Race: White
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Fall Victim
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: Lutheran General Hospital, Park Ridge, IL 60068
Dest. Determ.: On-line Medical Direction
Diverted From: Alexian Brothers Medical Center
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: 15:02
Disp. Notified:
Unit Disp.: 15:03
Enroute: 15:04
At Scene: 15:07
At Patient: 15:09
Depart: 15:27
Arrive Dest: 15:47
In Service: 17:37
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: [redacted] To Scene:
Dest. Miles: [redacted] To Dest: [redacted]
End Miles: [redacted] To End: 0.0
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	Secondary Caregiver
[redacted]	Paramedic	Third Caregiver
[redacted]	Paramedic	Driver Only
[redacted]	EMT-Basic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: Lutheran General Hospital
Destination Type: Hospital
Destination Determination: On-line Medical Direction
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: Unconscious (Unknown Etiology)
Chief Complaint: Fall X 5 Minutes
Onset Date/Time: [redacted] at 14:57
Alcohol/Drug Use: No Apparent Alcohol/Drug Use
Injury Intent: Accidental / Unintentional
Cause of Injury: Fall
Dispatch Reason: Fall Victim

Primary Symptom

Altered Mental Status

Other Associated Symptoms

G1

15:13	ECG-Monitor	II	Sinus Bradycardia		
15:15	12-Lead ECG		Abnormal ECG unconfirmed, Sinus rhythm with PACs, rSr (V1) probable normal variant, Left ventricular hypertrophy, Lateral ST abnormality may be due to hypertrophy and/or ischemia		

Assessment Exam

Time Of Assessment	[redacted]	[redacted]	[redacted]	[redacted]
Abdomen-left-lower:				
Abdomen-left-upper:				
Abdomen-right-lower:				
Abdomen-right-upper:				
Back-cervical:				
Back-lumbar:				
Back-thoracic:				
Chest:			Clear & Equal Breath Sounds	
Ext-left-low:				
Ext-left-up:				
Ext-right-low:				
Ext-right-up:				
Eyes-left:				
Eyes-right:				
GU:				
Head:				
Heart:				
Mental:	Responsive to Painful Stimuli	Confused, Responsive to Verbal Stimuli		Oriented-Person, Oriented-Place
Neck:				
Neuro:				
Skin:	Normal	Normal		

Narrative

Narrative Entered By: [redacted]

[redacted] and [redacted] dispatched for a fall. Upon our arrival pt was found supine laying in a doorway to living room. Pt was unconscious and had vomit coming from her mouth. Pt's airway was compromised due to vomit and EMS noted snoring respirations. Pt was only responsive to painful stimulus. Pt's husband was on scene and stated that he had come home from the Walgreen's to find pt sitting on the floor upright. Pt told her husband that she had fallen, pt at that time told him she didn't hit her head but was feeling dizzy prior to the fall. Husband stated he left to get pt a pillow and upon returning to her pt was supine and had vomited. EMS noted pt to be incontinent. EMS suctioned pt's mouth to protect airway, as soon as rigid tip was placed in pt's mouth pt clenched down on tip. After approx 30 seconds pt released. ALS care provided as stated above. While treating pt, pt began to become responsive to verbal stimulus. Pt placed on scoop stretcher due to fall, EMS used towel rolls to secure pt's head. Delayed scene time due to location of pt. Pt was laying in between 2 doorways and only access to living room was through door pt was laying in. EMS initial impression due to incontinence was to transport to ABMC from possible seizure. ABMC was contacted with report, ABMC stated due to possible head injury they diverted to Level One TC. EMS stated we would divert to Lutheran General and ABMC would be contacting them with report. During transport pt began vomiting x2. Suction used to protect airway. Pt also became more responsive during transport. Pt kept trying to cough up phlegm, EMS assisted by suctioning. Pt stated to EMS she had no complaints but did not remember falling. Pt care transferred to ED nurses and doctors in room 3.

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

Billing Information

Payment Method:

Work Related?

Medicare Questionnaire

Medically Necessary:

Transported To/For

Nausea / Vomiting

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp	Effort	SpO2	SpO2 Qual	etCO2	GCS	Pain	Stroke Sc	FTA	B.G.	RTS	Limb	Patient Position
15:11	184/90	50	RR	20	Normal	79	On Room Air		9					11	Left Arm	Supine
15:12													198			
15:13						79	Low FIO2 (24-40 pct)	51								Supine
15:14						88	Low FIO2 (24-40 pct)	46								
15:16						95	High FIO2 (80-100 pct)	50								Supine
15:27	206/100	80	RI	16		97	High FIO2 (80-100 pct)	48	12					11	Left Leg	Supine
15:33	214/116	92	RR	21		97	High FIO2 (80-100 pct)	52	13					12	Left Arm	Supine
15:38	218/188	96	RR	17		97	High FIO2 (80-100 pct)	47	14					12	Left Leg	Supine
15:42		102	RI	10		94	High FIO2 (80-100 pct)	41	15							Supine
15:47	188/100	106	RR	14		94	High FIO2 (80-100 pct)		15					12	Left Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
15:11	2	2	5	9
15:12				
15:13				
15:14				
15:16				
15:27	3	4	5	12
15:33	4	4	5	13
15:38	4	5	5	14
15:42	4	5	6	15
15:47	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
family denies medications		

Medical / Surgical History:
Unable to Obtain PMH

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
15:10	[redacted]	Airway Suctioning	Mouth		1		Yes	Pt clinched down on rigid tip
15:20		Spinal Immobilization - Long Back Board			1		Yes	
15:30		Airway Suctioning	Mouth		1		Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
15:12	[redacted]	Oxygen by Nasal Cannula	Inhalation	4 LPM			
15:14		Oxygen by Nasal Cannula	Inhalation	6 LPM			
15:15		Oxygen by Non-Rebreather Mask	Inhalation	15 LPM			

ECG Monitor

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

25

Comprehensive Report

[redacted]

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

Patient Information

Name:[redacted]

Address[redacted]

Age: 18 Years
Gender: Male
Weight: 68.039 KG / 150.00 LB
Phone:

D.O.B[redacted]/dd/yyyy)
SSN:
Race:
Ethnicity:

Call Type and Location	Call Disposition	Response Times and Mileage
Call Type: Auto vs. Pedestrian Resp. Mode: Lights and Siren Urgency: Response: 911 Response Location: Street or Highway Address:[redacted] Zone:[redacted]	Disposition: BLS Treat / Transport Resp. Mode: Lights and Siren Destination: Lutheran General Hospital, Park Ridge, IL 60068 Dest. Determ.: Specialty Resource Center Diverted From: Dispatch Delay: None Response Delay: None Scene Delay: None Transport Delay: None TurnAround Delay: None Patient Barriers: None	1st Resp. Arr.: PSAP: 06:40 Disp. Notified: 06:40 Unit Disp.: 06:41 Enroute: 06:42 At Scene: 06:44 At Patient: 06:45 Depart: 06:55 Arrive Dest: 07:11 In Service: 08:42 In Quarters: Cancelled: Incident #[redacted] Start Miles: Scene Miles: 0.0 To Scene: Dest. Miles:[redacted] To Dest:[redacted] End Miles:[redacted] To End: 0.0 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	Primary Caregiver
[redacted]		
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company

Personal Protective Equipment Used: Eye Protection, Gloves

Call Information

Destination Name: Lutheran General Hospital
Destination Type: Hospital
Destination Determination: Specialty Resource Center
Vehicle Type: Ambulance

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

Factors Affecting Response:

None

Patient Condition

Provider Impression: Traumatic Injury
Chief Complaint: Pain X 5 Minutes
Onset Date/Time:[redacted] at 06:35
Alcohol/Drug Use:
Injury Intent: Accidental / Unintentional
Cause of Injury: Motor Vehicle vs Pedestrian Accident
Dispatch Reason: Auto vs. Pedestrian

Primary Symptom:

Pain

H1

Other Associated Symptoms
Bleeding
Wound

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qlfr	EtCO2	GCS	Pain	Stroke Scr	PTA	BGL	ATS	Limb	Patient Position
06:52	138/80	72	RR	24	Normal	100	On Room Air		13	8				12	Left Arm	Supine
07:07	136/74	64	RR	22	Normal	100	On Room Air		13	5				12	Left Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
06:52	3	4	6	13
07:07	3	4	6	13

Past Medical History

Medication Allergies	Generic Name	Description
NKDA (No Known Drug Allergies)	NKDA (No Known Drug Allergies)	

Patient Medications	Generic Name	Dosage
Patient Denies Medications	Patient Denies Medications	

Medical Problem History
Patient Denies PMH

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Patient			

Procedures and Treatments

Time	Crew	Name	Location	Site or Equipment	Attempts	Response	Success	Comments
06:48	AM	Spinal Immobilization - Rigid Collar			1		Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	BTA	Comments

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Edema	Cause for Change
06:55	ECG-Monitor	II	Normal Sinus Rhythm		

Assessment Exam

Time of Assessment: [redacted]

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
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: Not Available
GU:
Head: Swelling/Edema, Pain/Tenderness, Rash
Heart: Normal Sounds
Mental: Confused, Oriented-Person, Oriented-Place, Oriented-Time
Neck: Pain/Tenderness
Neuro: Speech Normal
Skin: Normal

Narrative

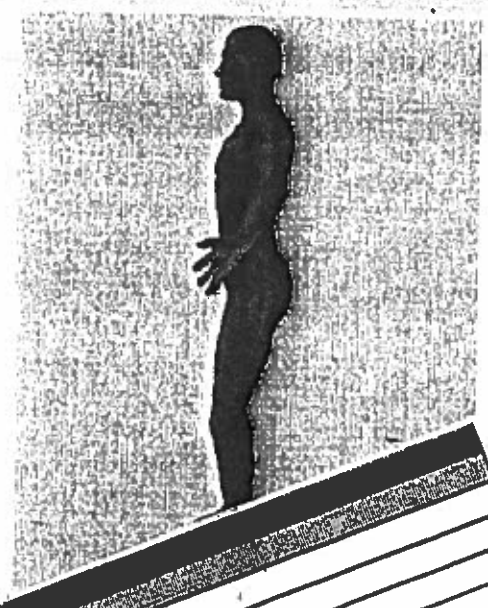
Summary of Events:

Dispatched for a traffic accident, car vs. pedestrian. Arrived to find pt. A&Ox1, attempting to crawl off the roadway, with PD and passersby present. PD and bystanders stated that pt. was jogging with friends, was struck by a car, and dragged underneath "10-15 feet." The vehicle came to a stop with the pt. pinned under it, at which point the driver drove in reverse off of the pt. Pt. was in obvious distress, confused, attempting to stand, and not following commands. C-collar was applied, pt. was moved to the cot and taken to the ambulance. Upon assessment, EMS noted multiple injuries: abrasions to the right shoulder, right ankle and foot, left hand, and medial aspect of left knee. Significant facial trauma noted: swollen lips, broken teeth, right eye swollen and unable to open, and an abrasion/avulsion to the right temple, approximately 4 cm. in diameter, to the right temple that appeared to be down to bone. Facial trauma had been bleeding, but had stopped prior to EMS intervention. All other trauma had bled to a minor degree, and all had stopped without intervention. Pt. was moaning, c/o a stiff neck and "teeth falling out." Pt. opened eyes to verbal command, followed commands appropriately (though required frequent reminders), and had intact SMVs to all extremities. When asked if he was in pain, pt. stated "my neck is sore." When asked if he wanted pain medication, pt. stated "I don't know." As facial trauma prevented IN administration, and as IV acquisition appeared difficult, pain medication was withheld. NCH contacted en route, granted orders to transport to LGH. NCH contacted LGH and notified them of EMS transport to their location. Pt. care monitored, remained unchanged throughout transport. Pt. continued to repeat phrases and complaints, requiring repeated instruction to not move his head or touch facial wounds. Pt. was able to hold conversation about school, friends, family appropriately, could recall running that morning, knew where he was running and how far he was going, but could not recall the accident. Care transferred to LGH, room 1.

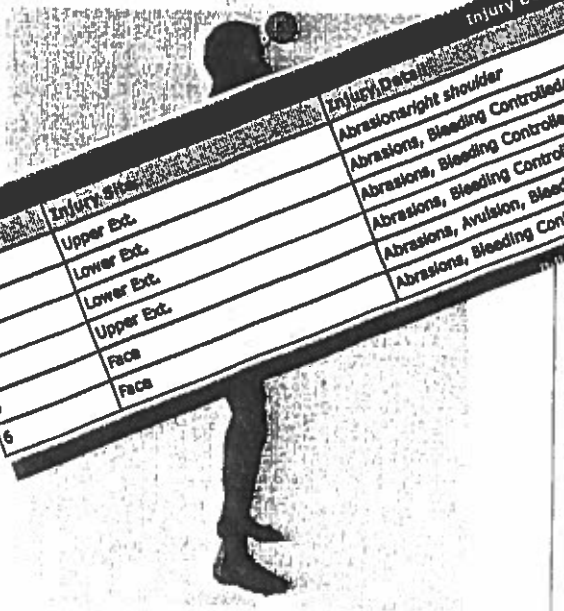
Physical Assessment

Front

Left



Right



Injury Details

Injury #	Injury Site	Injury Details
1	Upper Ext.	Abrasion, right shoulder
2	Lower Ext.	Abrasions, Bleeding Controlled, right foot
3	Lower Ext.	Abrasions, Bleeding Controlled, left knee
4	Upper Ext.	Abrasions, Bleeding Controlled, back of left hand
5	Face	Abrasions, Avulsion, Bleeding Controlled, Pain/tenderness, face
6	Face	Abrasions, Bleeding Controlled, Pain/tenderness, Soft Tissue Swelling/Bruising, Broken, loose teeth

H3

Comprehensive Report

[redacted]

D

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

Patient Information

Name: [redacted]

Age: 20 Years
Gender: Male
Weight: 77.111 KG / 170.00 LB
Phone:

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

Address: [redacted]

Call Type and Location	Call Disposition	Response Times and Mileage
Call Type: Auto vs. Pedestrian Resp. Mode: Lights and Siren Urgency: Response: 911 Response Location: Home/Residence Address: [redacted]	Disposition: ALS Treat / Transport Resp. Mode: Lights and Siren Destination: Lutheran General Hospital, Park Ridge, IL 60068 Dest. Determ.: Specialty Resource Center Diverted From: Dispatch Delay: None Response Delay: None Scene Delay: None Transport Delay: None TurnAround Delay: None Patient Barriers: Unconscious	1st Resp. Arr.: PSAP: 07:45 Disp. Notified: Unit Disp.: 07:45 Enroute: 07:47 At Scene: 07:50 At Patient: 07:50 Depart: 07:57 Arrive Dest: 08:13 In Service: 10:12 In Quarters: Cancelled: Incident #: [redacted] Start Miles: Scene Miles: 0.0 To Scene: Dest. Miles: [redacted] To Dest: [redacted] 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	Secondary Caregiver
[redacted]	Paramedic	Third Caregiver
[redacted]	Paramedic	Driver Only
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company

Personal Protective Equipment Used: Eye Protection, Gloves

Call Information

Destination Name: Lutheran General Hospital
Destination Type: Hospital
Destination Determination: Specialty Resource Center
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: Traumatic Injury
Chief Complaint: unconcious X 5 Minutes
Onset Date/Time: [redacted]t 07:40
Alcohol/Drug Use:
Injury Intent: Accidental / Unintentional
Cause of Injury: Motor Vehicle vs Pedestrian Accident
Dispatch Reason: Auto vs. Pedestrian

Primary Symptom:

Unresponsive / Unconscious

I1

Other Associated Symptoms:
Not Applicable
Bleeding
Pain

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Sc	PTA	B.G.	RTS	Limb	Patient Position
07:56	150/100	96	RR	28	Normal	100	On Room Air	44	6				190	10	Left Arm	Supine
08:02	130/90	94	RR	26	Normal	99	On Room Air	43	6					10	Left Arm	Supine
08:09	120/80	100	RR	20	Normal	98	On Room Air	44	6					10	Left Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
07:56	1	2	3	6
08:02	1	2	3	6
08:09	1	2	3	6

Past Medical History

Medication Allergies	Generic Name	Description
unknown		

Patient Medications	Generic Name	Dosage
unknown		

Medical Surgery History
Unable to Obtain PMH

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Not Applicable			

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
07:52	[redacted]	Spinal Immobilization - Rigid Collar			1	Unchanged	Yes	
07:53	[redacted]	Spinal Immobilization - Long Back Board			1		Yes	
07:53	[redacted]	Spinal Immobilization - Long Back Board			1		Yes	
07:53	[redacted]	Spinal Immobilization - Long Back Board			1		Yes	
07:56	[redacted]	Venous Access - Extremity	Antecubital-Right		18	Unchanged	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
07:57	ECG-Monitor	II	Normal Sinus Rhythm	No Ectopy Noted	

Assessment Exam

Time of Assessment: [redacted]T07:51:00-06:00

Abdomen-left-lower:
Abdomen-left-upper:
Abdomen-right-lower:
Abdomen-right-upper:
Back-cervical:
Back-lumbar:
Back-thoracic:
Chest: Symmetrical Chest Rise, Clear & Equal Breath Sounds
Ext-left-low:
Ext-left-up:
Ext-right-low:
Ext-right-up:
Eyes-left: Reactive
Eyes-right: Reactive
GU:
Head:
Heart:

I2

Mental: Responsive to Painful Stimuli
Neck:
Neuro: Decorticate Posturing
Skin: Capillary Nail Bed Refill < 2 Seconds

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Narrative

Summary of Events

Crew dispatched to the above location for a vehicle vs pedestrian. Upon arrival crew found an unresponsive male with his c-spine being held by a bystander. Bystander stated he was an off duty paramedic, and that the pt was attempting to run across the street and was struck by a vehicle. Speed limit in that area was approx 45 mph. Pt was unresponsive upon the bystander making pt contact. Pt was moaning and crew noted bleeding coming from his right ear, and bruising and abrasions on the right side rib cage area. A hemotoma was noted on pt's forehead as well. Pt had decorticate posturing and was only responsive to pain. Pt's pupils were equal and reactive but dilated and moved up and to the right. C-Collar placed on pt and pt moved to a backboard then to [redacted]. NWCH contacted and advised crew was transporting to LGH. Vitals obtained and pt was placed on cardiac monitor. IV established. Remainder of transport was w/o incident and pt care was transferred to ED Dr room 1 upon arrival at NWCH.

Prior Aid

Prior Aid	Performed By	Outcome
None,	N/A,	

Safety Equipment Used

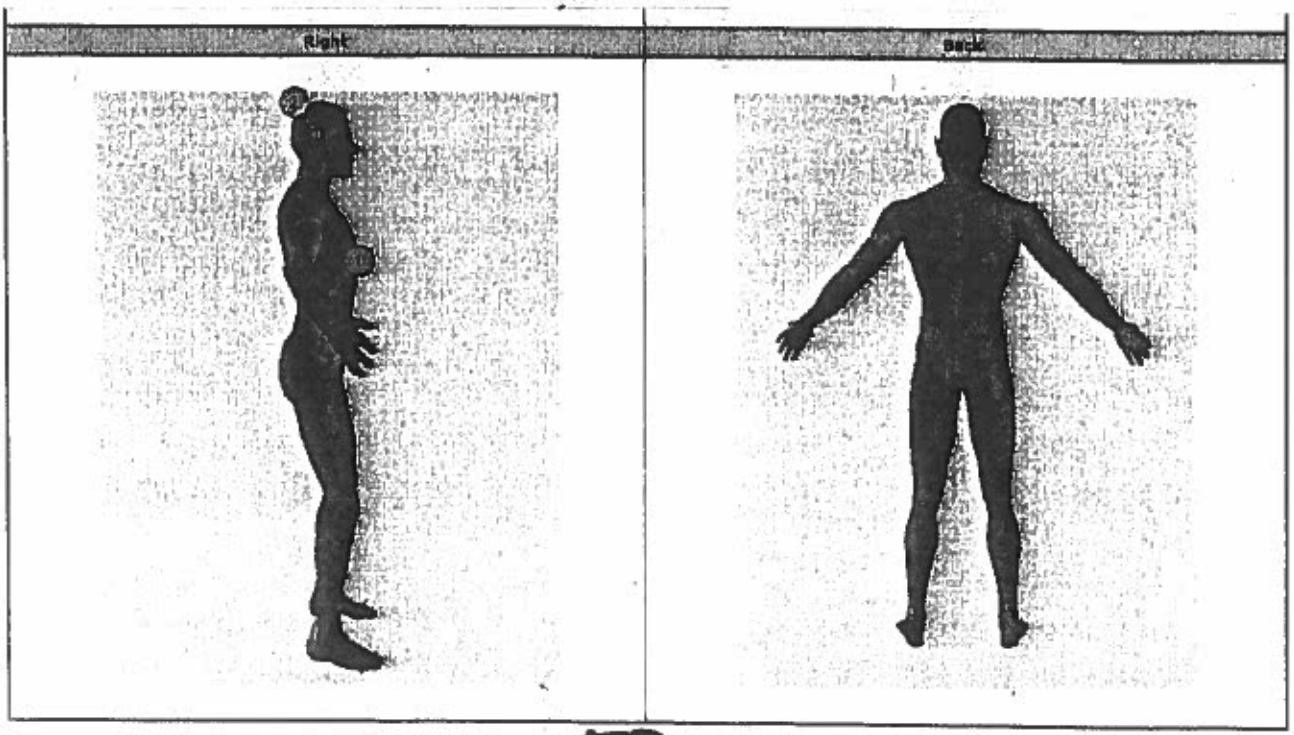
Not Applicable

Vehicular Information

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

Injury Details

Injury #	Injury Site	Injury Detail
1	Thorax	Abrasions, Soft Tissue Swelling/Bruisingchest
2	Head	Bleeding Controlled, Laceration, Soft Tissue Swelling/Bruising*laceration behind right ear, bleeding from right ear controlled, hemotoma on forehead right side.*



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Comprehensive Report

[redacted]

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

Patient Information

Name: [redacted]

Address: [redacted]

Age: 56 Years
Gender: Female
Weight: 86.183 KG / 190.00 LB
Phone:

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

Call Type and Location

Call Type: Fall Victim
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: Lutheran General Hospital, Park Ridge, IL 60068
Dest. Determ.: On-line Medical Direction
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: Safety
TurnAround Delay: None
Patient Barriers: None

Response Times and Mileage

1st Resp. Arr.:
PSAP: 18:52
Disp. Notified: 18:52
Unit Disp.: 18:52
Enroute: 18:54
At Scene: 18:56
At Patient: 18:56
Depart: 19:18
Arrive Dest: 19:35
In Service: 20:45
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0 To Scene:
Dest. Miles: 0.0 To Dest: 0.0
End Miles: 0.0 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	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	Paramedic	Fire Company
[redacted]	EMT-Basic	Fire Company
[redacted]	Paramedic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: Lutheran General Hospital
Destination Type: Hospital
Destination Determination: On-line Medical Direction
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: Traumatic Injury
Chief Complaint: Altered Mental Status X
Onset Date/Time: [redacted] at 21:00
Alcohol/Drug Use:
Injury Intent: Not Known
Cause of Injury: Fall
Dispatch Reason: Fall Victim

Primary Symptom:

Other Associated Symptoms:
Not Applicable

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Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual	EtCO2	GCS	Pain	Stroke Scr	RTA	B.Gl.	RTS	Limb	Patient Position
19:03		90	RR	20	Normal	95	On Room Air		9		CISS Incon.		164			Supine
19:13		100	RR	20	Normal	96	On Room Air		9							Supine
19:23		96	RR	22	Normal	95	On Room Air		9							Supine
19:33		110	RR	20	Normal	96	On Room Air		9							Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
19:03	3	2	4	9
19:13	3	2	4	9
19:23	3	2	4	9
19:33	3	2	4	9

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
Penicillin	Penicillin	
Cipro	Ciprofloxacin	Gr+, Gr-, mycoplasma 60% bioavailable orally. Cmax=2.7 (2.0) Fluoroquinolone. Decreases Phenytoin levels.

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

Medical / Current History

Other , *MS, Scoliosis, Stenosis, Fybro Myalgia*

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Family			

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
19:00	[redacted]	Wound Care	Head		1		Yes	
19:02		Spinal Immobilization - Rigid Collar			1		Yes	
19:07		Spinal Immobilization - Long Back Board			1		Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	RTA	Comments

ECG Monitor

Time	ECG Type	ECG Lead	ECG Rhythm Interpretation	ECG Ectopy	Cause For Change
19:17	ECG-Monitor	II	Sinus tachycardia		

Assessment Exam

Time of Assessment: [redacted] 02 Dec 2016

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
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: Swelling/Edema
Heart: Normal Sounds
Mental: Combative, Responsive to Verbal Stimuli, Incoherent

Neck: Normal
Neuro: Normal Gait / Movement
Skin: Normal

Narrative

Summary of Events:

Dispatched for a person who fell. On scene Pt was found lying on bathroom floor combative and making incomprehensible sounds. Pt's eyes opening responsive to verbal. Pt's withdrew to pain. Pt's mental status was not reliable. Pt was lying on floor, with her pants and underpants around her ankle, with shower curtain and rod wrapped around her right arm. Pt had a visible laceration to top of her head just above her forehead. Lac was approx 2 inches. Bleeding had stopped. Unknown how Pt became injured and on floor of bathroom. Pt's brother on scene. Brother stated that Pt is normally alert, oriented and conversational. Brother stated that Pt's current mental status is not her norm. Pt was last contacted by family last night at approx 9pm. Brother stated that Pt was not injured last night when contacted. Unknown what time Pt became injured and fell in bathroom. Brother unable to provide Pt medications. Pt immobilized with c-collar and scoop stretcher. Scene time delayed due to combative Pt and immobilization needs. ALS care administered. NCH contacted. NCH advised [redacted] to transport to LGH per SOP. Pt transported to LGH ED. All times are 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

Billing Information

Payment Method:
Work Related?

Medicare Questionnaire

Medically Necessary:
Transported To/From:
Moved by Stretcher:
Round Trip Reason:
Visible Hemorrhaging:
Stretcher Reason:
Unconscious/Shock:
Physical Restraints:
Bed Confined Before:
Hospital Admit:
Bed Confined After:
Weight: 86.183 KG / 190.00 LB
Type of Transport:
MSP Reason:

Service-Defined Questions

Has the Ambulance Billing Authorization and Privacy Acknowledgment Form been completed with the requisite signature(s)?	Yes
Which Hospital was contacted for On-line Medical Control?	Lutheran General
Hospital Log Number	
If Capnography was used, how did the waveform appear?	

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Comprehensive Report

[redacted]

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

Patient Information

Name: [redacted]

Address: [redacted]

Age: 34 Years
Gender: Female
Weight: 54.431 KG / 120.00 LB
Phone:

D.O.B: [redacted]/dd/yyyy)
SSN:
Race:
Ethnicity: Not Hispanic or Latino

Call Type and Location

Call Type: Fall Victim
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: Lutheran General Hospital, Park Ridge, IL 60068
Dest. Determ.: Other (note in comments)
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: 08:51
Disp. Notified: 08:51
Unit Disp.: 08:51
Enroute: 08:52
At Scene: 08:53
At Patient: 08:56
Depart: 09:10
Arrive Dest: 09:31
In Service: 10:30
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0
To Scene:
Dest. Miles: [redacted]
To Dest: [redacted]
End Miles: [redacted]
To End: [redacted]
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	Secondary Caregiver
[redacted]	Paramedic	Fire Company

Personal Protective Equipment Used: Eye Protection, Gloves

Call Information

Destination Name: Lutheran General Hospital
Destination Type: Hospital
Destination Determination: Other (note in comments)
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: Unconscious (Unknown Etiology)
Chief Complaint: Unconscious X 20 Minutes
Onset Date/Time: [redacted] at 08:30
Alcohol/Drug Use: Not Known
Injury Intent: Accidental / Unintentional
Cause of Injury: Fall
Dispatch Reason: Fall Victim

Primary Symptom:

Unresponsive / Unconscious

Other Associated Symptoms:

K1

Nausea / Vomiting

Unresponsive / Unconscious

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	etCO2	GCS	Pain	Stroke Scr.	FTA	B.Gl.	RTS	Limb	Patient Position
08:59	150/90	60	RR	16	Normal	92	On Room Air	30	3		Cincinnati Stroke Scale Abnormal		140	8	Left Arm	Supine
09:16	140/P	60	RR	16	Assisted	92	High FiO2 (80-100 pct)		3					8	Right Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Scor.
08:59	1	1	1	3
09:16	1	1	1	3

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
Sulfa Drug Allergy	Sulfa Drug Allergy	In full SULFONAMIDE DRUG, sulfa also spelled SULPHA, any member of a group of synthetic antibacteria

Patient Medications	Generic Name	Dosage
Prednisone	Glucocorticoids	

Medical Surgical History

Other , *Rheumatoid arthritus*

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

Procedures and Treatments

Time	Crew	Name	Location	Size or Equipment	Attempts	Response	Success	Comments
09:00	[redacted]	Spinal Immobilization - Rigid Collar	Neck		1	Unchanged	Yes	
09:01	[redacted]	Spinal Immobilization - Long Back Board			1	Unchanged	Yes	
09:05	[redacted]	Airway Nasopharyngeal	Nose	22	1	Unchanged	Yes	
09:07	[redacted]	Venous Access - Extremity	Antecubital-Left	18G	1	Unchanged	Yes	
09:10	[redacted]	Airway Oropharyngeal	Mouth		1	Unchanged	Yes	
09:13	[redacted]	Airway Suctioning	Mouth		1	Unchanged	Yes	
09:16	[redacted]	Airway Positive Pressure Ventilation	Mouth		1	Unchanged	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
09:06	[redacted]	Oxygen by Non-Rebreather Mask	Inhalation	15 LPM	Unchanged		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
09:03	ECG-Monitor	II	Normal Sinus Rhythm	No Ectopy Noted	Initial Rhythm

Assessment Exam

Time of Assessment: [redacted]

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

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

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

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

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

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

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

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

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

Eyes-left: Fixed/Non-Reactive

Eyes-right: Fixed/Non-Reactive

K2

GU:
Head: Normal, Symmetrical Face
Heart: Normal Sounds
Mental: Unresponsive
Neck: Normal
Neuro: Not Applicable
Skin: Pale

Narrative

Summary of Events

A[redacted] called to the scene for a 34 y/o female that fell in the shower. Upon our arrival pt's husband on scene stated pt fell in the shower approx. 20 minutes ago. Pt's husband stated he moved the pt from the shower, dressed her and put her in bed. Pt was unconscious laying supine in bed with snoring respirations. Pt's husband on scene described seizure like activities after the patient fell. Crew assessed pt as stated in report. Upon head to toe assessment crew found no trauma injuries. Crew assessed pupils - pinpoint non reactive. Crew applied c-collar and back board with spider straps and reassessed pt. Crew obtained vitals and SAMPLE history from husband. Husband stated pt was not sick prior to today. Pt's husband denied any abnormal activities leading up to fall. Husband denied pt. drug use. Crew applied patient on cardiac monitor, inserted nasal airway and applied capnography. Crew moved pt as ambulance and reassessed. Crew contacted NWCH with request for by-pass to LGH. Request was granted with no orders given. Crew stated an IV 18g in pt's left AC with NS running TKO. Crew continued to reassess pupils and vitals with no changes. Pt vomited one time during transport to the hospital. Crew log rolled pt and suctioned her airway. Crew contacted LGH with pt update no further orders given. Upon our arrival at LGH Doctor met crew in ambulance bay to receive hand off report. Pt was transferred to ER Room 3. Pt care was transferred.

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

Billing Information

Payment Method:
Work Related?

Medicare Questionnaire

Medically Necessary:
Moved by Stretcher:
Visible Hemorrhaging:
Unconscious/Shock:
Bed Confined Before:
Bed Confined After:
Type of Transport:
Transported To/From:
Round Trip Reason:
Stretcher Reason:
Physical Restraints:
Hospital Admit:
Weight: 54.431 KG / 120.00 LB
MSP Reason:

Service-Defined Questions

Which Hospital was contacted for On-line Medical Control?	Northwest Community
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?	Square Constant

K3

37

Comprehensive Report

[redacted]

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

Patient Information

Name: Unknown, [redacted]

Address: unknown

Age: 30 Years
Gender: Male
Weight: 81.647 KG / 180.00 LB
Phone:

D.O.B: (mm/dd/yyyy)
SSN:
Race: Other Race
Ethnicity: Hispanic or Latino

Call Type and Location

Call Type: Traffic / Transportation Accident
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Street or Highway
Address: [redacted]

Call Disposition

Disposition: ALS Treat / Transport
Resp. Mode: Lights and Siren
Destination: Lutheran General Hospital, Park Ridge, IL 60068
Dest. Determ.: Specialty Resource Center
Diverted From:
Dispatch Delay: None
Response Delay: None
Scene Delay: None
Transport Delay: None
TurnAround Delay: None

Response Times and Mileage

1st Resp. Arr.: 01:46
PSAP: 01:39
Disp. Notified:
Unit Disp.: 01:40
Enroute: 01:42
At Scene: 01:46
At Patient: 01:46
Depart: 01:52
Arrive Dest: 02:09
In Service: 03:15
In Quarters:
Cancelled:

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

First Responder Agencies: [redacted] Fire Department, [redacted] Police Dept.

Unit Personnel

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

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: Lutheran General Hospital
Destination Type: Hospital
Destination Determination: Specialty Resource Center
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: Traumatic Injury
Chief Complaint: difficulty breathing X 5 Minutes
Onset Date/Time: [redacted] 01:30
Alcohol/Drug Use: Smell of Alcoholic Beverage on Breath/About Person
Injury Intent: Accidental / Unintentional
Cause of Injury: Pedestrian Traffic Accident
Dispatch Reason: Traffic / Transportation Accident

Primary Symptom:
Altered Mental Status

4

Other Associated Symptoms
Bleeding
Pain
Swelling

Patient Vitals

Time	BP	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	FTA	B.G.	RTS	Limb	Patient Position
01:47				6	Agonal				7							Right Lateral Recumbent
01:50	96/53	108	RR	14	Shallow	96	On Room Air		9					11	Right Arm	Supine
01:55	100/60	104	RR	30	Shallow	94	On Room Air		12					10	Right Arm	Supine
02:00	98/P	112	RR	35	Shallow	85	On Room Air	38	12					10	Left Arm	Supine
02:05	100/P	92	RR	35	Shallow	93	High FiO2 (80-100 pct)	41	12					10	Left Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
01:47	1	1	5	7
01:50	2	2	5	9
01:55	1	5	6	12
02:00	1	5	6	12
02:05	1	5	6	12

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	

Unable to Obtain PMH

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
None	N/A		

Procedures and Treatments

Time	Num	Name	Location	Size/Equipment	Attempts	Response	Success	Comments
01:47	[redacted]	Spinal Assessment - No Deficits Noted			1	Unchanged	Yes	
01:48	[redacted]	Spinal Immobilization - Full Supine			1	Improved	Yes	
01:48	[redacted]	Spinal Immobilization - Full Supine			1	Improved	Yes	
01:50	[redacted]	Cardiac Monitor with Pads/Paddles			1	Unchanged	Yes	
02:00	[redacted]	Venous Access - Extremity	Antecubital-Right	16	1	Unchanged	Yes	

Medication Administered

Time	Num	Medication	Route	Dosage	Response	PTA	Comments
02:00	[redacted]	Normal Saline (0.9%)	Intravenous	500 mL	Improved		
02:02	[redacted]	Oxygen by Non-Rebreather Mask	Inhalation	15 LPM	Improved		

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change
01:51	ECG-Monitor	Pads	Sinus Tachycardia	No Ectopy Noted	

Assessment Exam

Time of Assessment: [redacted] 01:46:00-05:00	[redacted] Witnessed
Abdomen-left-lower: Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)
Abdomen-left-upper: Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)
Abdomen-right-lower: Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)
Abdomen-right-upper: Normal (Soft, Non-Tender)	Normal (Soft, Non-Tender)
Back-cervical: Normal (No Pain or Deformities)	Normal (No Pain or Deformities)
Back-lumbar: Normal (No Pain or Deformities)	Normal (No Pain or Deformities)
Back-thoracic: Normal (No Pain or Deformities)	Normal (No Pain or Deformities)
Chest: Decreased Breath Sounds-Left, Decreased Breath Sounds-Right	Decreased Breath Sounds-Left, Decreased Breath Sounds-Right, Sounds Present At Apexes
Ext-left-low: C.M.S. Normal	C.M.S. Normal

Ext-left-up: C.M.S. Normal	C.M.S. Normal
Ext-right-low: Edema, Pain/Tenderness	Edema, Pain/Tenderness
Ext-right-up: C.M.S. Normal	C.M.S. Normal
Eyes-left: 4-mm, Reactive	Reactive
Eyes-right: 4-mm, Reactive	Reactive
GU:	
Head: Swelling/Edema	Pain/Tenderness
Heart: Normal Sounds	Normal Sounds
Mental: Unresponsive	Oriented-Person, Oriented-Place
Neck: Normal	
Neuro:	Normal Gait / Movement
Skin: Pale	Normal

Narrative

Summary of Events

Called for MVA - pedestrian vs. truck. Initial caller stated male patient was struck by a pick-up truck and appeared deceased. First police on scene updated info. stating patient was breathing but unconscious. Upon EMS arrival, we found a male patient, appx. 30 years old, lying on side of road with speed limits of 40-45mph, unconscious. Obvious deformity bilaterally to lower extremities. Patient initially presented with agonal respirations, unresponsive, pale in color. Once patient was repositioned and fully immobilized there was improvement in his color, respirations and mental status. Throughout call patient maintained a patent airway. En route to hospital patient became more responsive and started answering questions appropriately. His main complaint was difficulty breathing. Lung sounds were absent in the lower fields but clear in upper fields bilaterally. Sp02 remained in 90's with supplemental oxygen, BP remained above 90 throughout call. NWCH was contacted, advised we would be transporting to Lutheran General for level I trauma care. NWCH would contact LGH and transfer the call information. Patient remained alert and appropriately talking to EMS while en route to hospital. Care transferred and full report given to LGH trauma team.

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

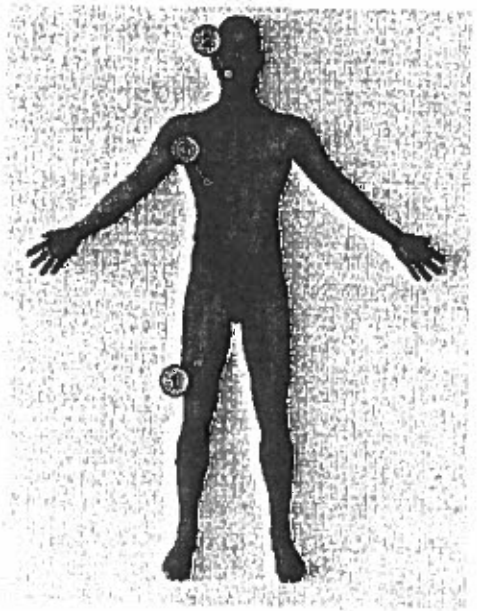
Airbag Deployment: Not Applicable

Injury Details

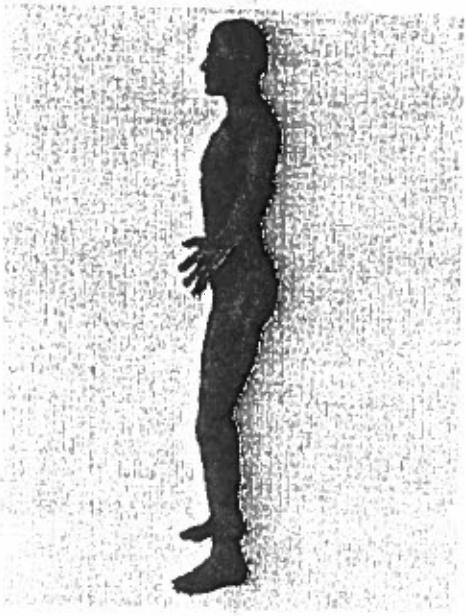
Injury #	Injury site	Injury Detail
1	Lower Ext.	Deformity, Dislocation/Fracture*right thigh*
2	Face	Abrasions, Pain/tenderness, Soft Tissue Swelling/Bruising, Bleeding Controlled*face*
3	Thorax	Pain/tenderness, Crepitus*chest*

Physical Assessment

Front



Left



LB

Comprehensive Report

[redacted]

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

Patient Information

Name: [redacted]

Address: [redacted]

Age: 26 Years
Gender: Male
Weight: 95.254 KG / 210.00 LB
Phone:

D.O.B: [redacted] (mm/dd/yyyy)
SSN:
Race: White
Ethnicity: Not Hispanic or Latino

Call Type and Location	Call Disposition	Response Times and Mileage
Call Type: Assault Stab / GSW Resp. Mode: Lights and Siren Urgency: Response: 911 Response Location: Other Location Address: [redacted] Zone: [redacted]	Disposition: ALS Treat / Transport Resp. Mode: Lights and Siren Destination: Lutheran General Hospital, Park Ridge, IL 60068 Dest. Determ.: Specialty Resource Center Diverted From: Northwest Community Hospital Dispatch Delay: None Response Delay: None Scene Delay: Distance Transport Delay: Distance, Traffic TurnAround Delay: None Patient Barriers: None	1st Resp. Arr.: PSAP: 17:56 Disp. Notified: 17:56 Unit Disp.: 17:58 Enroute: 17:59 At Scene: 18:01 At Patient: 18:08 Depart: 18:18 Arrive Dest: 18:42 In Service: 20:33 In Quarters: Cancelled: Incident #: [redacted] Start Miles: Scene Miles: 0.0 To Scene: Dest. Miles: [redacted] To Dest: [redacted] End Miles: [redacted] To End: 0.0 Call Sign: [redacted] Veh. #: [redacted] Veh. Type: Ambulance Primary Role: ALS Ground Transport

First Responder Agencies#: [redacted] Police, [redacted] Sheriff's Police

Unit Personnel

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

Personal Protective Equipment Used: Eye Protection, Gloves

Call Information

Destination Name: Lutheran General Hospital
Destination Type: Hospital
Destination Determination: Specialty Resource Center
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: Behavioral/Psychiatric Disorder
Chief Complaint: Stab wound. X 5 Hours
Onset Date/Time: [redacted] at 13:00
Alcohol/Drug Use: Smell of Alcoholic Beverage on Breath/About PersonPatient Admits to Alcohol UsePatient Admits to Drug Use
Injury Intent: Intentional, Self
Cause of Injury: Cut/Pierce
Dispatch Reason: Assault Stab / GSW

Primary Symptom:

MI

Bleeding
Other Associated Symptoms
Behavioral / Psychiatric Problem
Wound

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Sc.	PTA	BG	RTS	Limb	Patient Position
18:12		130	RR	24	Normal	98	On Room Air		15				325		Left Arm	Supine
18:20		126	RR	24	Normal	98	On Room Air		15						Right Arm	Semi-Fowlers
18:25	94/P	120	RR	24	Normal	99	On Room Air		15					12	Right Arm	Supine
18:30	104/P	110	RR	20	Normal	98	On Room Air		15					12	Right Arm	Supine
18:38	104/P	120	RR	22	Normal	99	On Room Air		15					12	Right Arm	Supine

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
18:12	4	5	6	15
18:20	4	5	6	15
18:25	4	5	6	15
18:30	4	5	6	15
18:38	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
Unknown Anxiety medication		
Unknown depression medication.		

Medical/Surgical History

Psychological/Behavioral - Depression, Psychological/Behavioral - Anxiety Disorder (Panic Attacks) , *unknown*

Patient Refused Chest Decompression	Pregnancy	Advanced Directives	Patient Name
Patient	N/A		

Procedures and Treatments

Time	Crew	Item	Location	Size or Equipment	Attempts	Result	Success	Comments
18:14	[redacted]	Venous Access - Extremity	Antecubital-Right	18g	1	Unchanged	Yes	
18:18	[redacted]	Venous Access - Extremity	Antecubital-Left	18g	1	Unchanged	Yes	
18:22	[redacted]	Wound Care	Chest-Left		1	Unchanged	Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	PTA	Comments
18:14	[redacted]	Normal Saline (0.9%)	Intravenous	200 mL	Unchanged	No	
18:18	[redacted]	Normal Saline (0.9%)	Intravenous	200 mL	Unchanged	No	
18:23	[redacted]	Normal Saline (0.9%)	Intravenous	200 mL			
18:26	[redacted]	Normal Saline (0.9%)	Intravenous	TKO (KVO)		No	

ECG Monitor

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

Assessment Exam

Time of Assessment: [redacted]T18:08:00-05:00

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:

Back-lumbar:

Back-thoracic:

Chest: Clear & Equal Breath Sounds, Sounds Present Bilaterally

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: 3-mm
Eyes-right: 3-mm, Reactive
GU:
Head:
Heart:
Mental: Oriented-Person, Oriented-Place, Oriented-Time
Neck:
Neuro:
Skin: Pale

Narrative

Summary of Event:

Called to the [redacted] forest preserve for the 26 y/o who attempted suicide by stabbing himself in the chest. Upon arrival bystanders waved crews down path and led police to pt. The pt was lying on the ground with his clothing soaked in blood. The pt was lying on an off-path walking trail. Pedestrians walking the trail came upon pt and he told them he was attempting suicide. Upon assessment the pt had clotted blood across his chest. The pt admitted to trying to end his life by stabbing himself in the chest with a kitchen knife approximately 5 hours prior. The pt also admitted to attempting to cut his wrists resulting in superficial lacerations. Pt claims to have thrown knife into woods. The pt claims he attempted suicide by consuming 1/2 bottle of rum, taking 120 Aleve, and then stabbing himself in the chest and cutting his wrists. The pt was brought to the ambulance by placing him on the cot and wheeling him through the trail. Upon reaching the ambulance, pts vitals were assessed. Pt did not have a palpable radial pulse nor a palpable BP. The pt did have a carotid pulse. The pts wounds were assessed. The stab wound was approximately 1 1/2" puncture wound to L. pectoral region. The pt claims the knife did not go through his ribs. The pt denied any difficulty breathing. Initially pts skin parameters were pale and pt was cool to the touch. Two IVs were established and fluids were administered. NWCH was contacted with radio report of pt being transported to LGH. En route to LGH a palpable pulse and BP were established. Also pts skin parameters improved. Pt care was transferred to Trauma team at LGH.

ALL TIMES AND WEIGHTS ARE APPROXIMATE.

Prior Aid

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

Safety Equipment Used

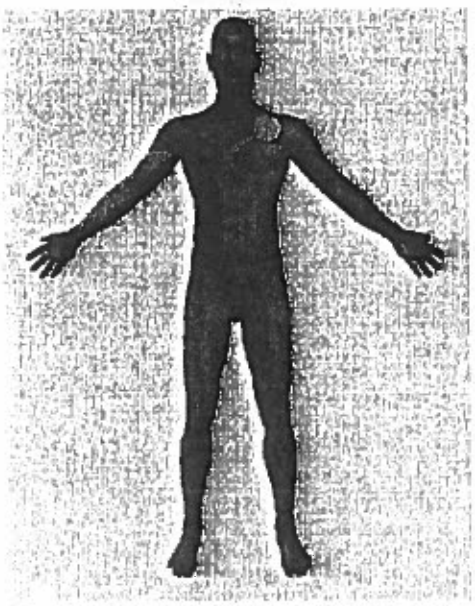
Not Applicable

Injury Details

Injury #	Injury Site	Injury Detail
1	Thorax	Bleeding Controlled*Stab wound to L pectoral region.*

Physical Assessment

Front



Left

M3

43

Comprehensive Report

[redacted]

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

Patient Information

Name: [redacted]

Address: [redacted]

Age: 9 Years
Gender: Female
Weight: 31.751 KG / 70.00 LB
Phone:

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

Call Type and Location

Call Type: Traffic / Transportation Accident
Resp. Mode: Lights and Siren
Urgency:
Response: 911 Response
Location: Street or Highway
Address: [redacted]

Call Disposition

Disposition: BLS Treat / Transport
Resp. Mode: Lights and Siren
Destination: Lutheran General Hospital, Park Ridge, IL 60068
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: 14:54
Disp. Notified:
Unit Disp.: 14:53
Enroute: 14:57
At Scene: 15:05
At Patient: 15:05
Depart: 15:18
Arrive Dest: 15:29
In Service: 16:27
In Quarters:
Cancelled:

Incident #: [redacted]
Start Miles:
Scene Miles: 0.0
To Scene:
Dest. Miles: [redacted]
To Dest: [redacted]
End Miles: [redacted]
To End: [redacted]
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]	EMT-Basic	Fire Company

Personal Protective Equipment Used: Gloves

Call Information

Destination Name: Lutheran General Hospital
Destination Type: Hospital
Destination Determination: Closest Facility
Vehicle Type: Ambulance
Response Request: 911 Response (Scene)
Response Disposition: BLS Treat / Transport
Lights Sirens To Scene: Lights and Siren
Lights Sirens From Scene: Lights and Siren

Factors Affecting Response:
None

Patient Condition

Provider Impression: Traumatic Injury
Chief Complaint: HEAD PAIN X
Onset Date/Time: [redacted] at 14:54
Alcohol/Drug Use:
Injury Intent: Accidental / Unintentional
Cause of Injury: Motor Vehicle Traffic Accident
Dispatch Reason: Traffic / Transportation Accident

Primary Symptom:
Pain

Other Associated Symptoms:

NI

Not Applicable

Patient Vitals

Time	B/P	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	RTA	B.Gl.	RTS	Limb	Patient Position
15:10	168/98	122	RR	26	Normal	98	On Room Air		15					12		
15:26	162/90	116	RR	24	Normal	98	On Room Air		15					12		

Glasgow Coma Score

Date/Time	Glasgow Eye Opening	Glasgow Verbal	Glasgow Motor	Glasgow Coma Score
15:10	4	5	6	15
15:26	4	5	6	15

Past Medical History

MEDICATION ALLERGIES	Generic Name	Description
NKDA		

Patient Medications	Generic Name	Dosage
PT DENIES		

Medical Surgery History:

Parent/Guardian Denies PMH

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name
Family			

Procedures and Treatments

Time	Crew Name	Location	Size of Equipment	Attempts	Response	Success	Comments
15:07	Spinal Immobilization - Full Supine			1		Yes	
15:13	Assessment-Pediatric			1		Yes	

Medication Administered

Time	Crew	Medication	Route	Dosage	Response	RTA	Comments

ECG Monitor

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

Assessment Exam

Time of Assessment: [redacted] 15:10:00:000

Abdomen-left-lower:
Abdomen-left-upper:
Abdomen-right-lower:
Abdomen-right-upper:
Back-cervical:
Back-lumbar:
Back-thoracic:
Chest: Clear & Equal Breath Sounds
Ext-left-low:
Ext-left-up:
Ext-right-low:
Ext-right-up:
Eyes-left: 4-mm, Reactive
Eyes-right: 4-mm
GU:
Head:
Heart:
Mental: Oriented-Person, Oriented-Place, Oriented-Time, Oriented-Events
Neck:
Neuro: Speech Normal
Skin: Normal, Capillary Nail Bed Refill < 2 Seconds

Narrative

Summary of Events:

Called to the scene of a single car MVA on the expressway. Upon arrival found 9 y/o female lying supine on the ground a/o x 3. Pt was unrestrained rear seat passenger that was ejected through the side window of vehicle that rolled over back onto its wheels. Heavy damage to front, left side, and roof of vehicle. No airbags deployed.

NZ

About one foot of intrusion into the passenger compartment on the left side of vehicle. Pts mother states pt was awake and answering all her questions on scene. Pt c/o back pain and pain to the back of her head. Pt also has pain to her left wrist. No deformity. SMV intact. Pt also has abrasions on her right cheek, nose, chin, and both knees. Pt has a hematoma on her forehead as well. Secondary assessment was unremarkable. Abdomen was soft and tender. Luthern General contacted and no further orders given. Pt transported to er in stable condition.

45

Prior Aid

Prior Aid	Performed By	Comments
None.	N/A	

Safety Equipment Used

Not Applicable

No Safety Equipment/Devices Used

Vehicular Information

Vehicular Injury Indicators: Ejection, Rollover/Roof Deformity, Space Intrusion > 1 Foot

Area of Vehicle Impacted: Left Front, Left Side, Rollover

Seat Row Location of Patient: 2

Position of Patient: Not Known

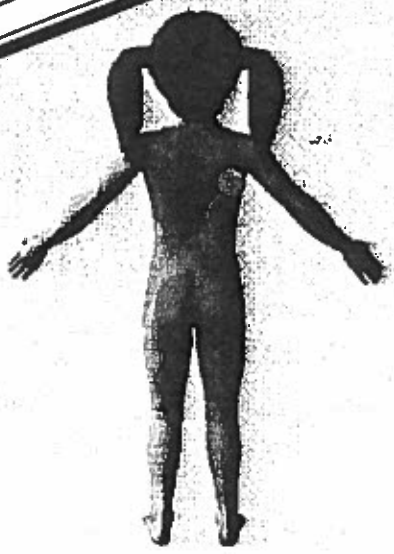
Airbag Deployment: Not Applicable

Physical Assessment

Front

Left

Right



Injury Details

Injury #	Injury System	Injury Description
1	Face	Abrasions/face
2	Face	Bleeding Controlled, Abrasions/face
3	Lower Ext.	Abrasions/right knee
4	Lower Ext.	Abrasions/left knee
5	Upper Ext.	Pain/tenderness/left forearm
6	Spine	Pain without swelling/bruisingspine

N3

Northwest Community EMS System – CE/QI – March 2015 - Trauma Case Review

Name	Employer	Date

What SOP(s) should be used to treat this pt?

Primary Assessment	• Airway – patent? • Breathing – adequate? • O2 sat >94%? EtCO2? • Circulation – pulse? • Skin, color, temp, moisture? • S/S shock? Bleeding? • Disability – GCS? SMR? • bG if GCS <15/AMS?	◯Exceptional Comments:	◯Met Standards	◯ Opportunity for improvement
Initial Treatment (ITC)	• Hypoxia treated? • Airway - adjunct needed? • Breathing - O2/PPV needed? • Bleeding controlled? • Shock treated? (SBP targets: • 80 penetr, 90 blunt, >110 TBI)	◯Exceptional Comments:	◯Met Standards	◯ Opportunity for improvement
Scene Time & Transport	• Scene time <10 min? • Explained if >10 min? • Appropriate destination?	◯Exceptional Comments:	◯Met Standards	◯ Opportunity for improvement
Secondary & Repeat Assessment	• VS WNL? Repeated? Pain? • Head (HEENT, face, eyes/pupils, nose, mouth, ears, scalp) • Neck (spine, trachea, jugular veins) • Chest (inspect, palpate, auscultate) • Abdomen/pelvis (inspect, palpate) • Upper/Lower Extr (inspect, palp, PMS) • Back (inspect & palpate)	◯Exceptional Comments:	◯Met Standards	◯ Opportunity for improvement
SOP Specific Treatment	• Appropriate? • Missing/Not done?	◯Exceptional Comments:	◯Met Standards	◯ Opportunity for improvement
Docu-mentation	• MOI described? • Assessment? • Tx?	◯Exceptional Comments:	◯Met Standards	◯ Opportunity for improvement

What aspect of assessment/treatment was **done best**?

What aspect of assessment/treatment had the **greatest opportunity for improvement**?

How could **documentation have been improved**? Was info in narrative that has an incomplete/blank predefined field?

Is there a **SOP** that needs clarification? Improvement?

#	Done Well	Opportunity for Improvement
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		