**Dispatch:**
AGENCY NAME: ____________________ LICENSE #: ____________
INCIDENT #: ____________ RESPONSE #: ____________ UNIT #: ____________
DATE: ____________ RESPONDING FROM: ____________

# Kentucky Board of Emergency Medical Services Ambulance Run Report

**INCIDENT INFORMATION:** COUNTY: ____________
ADDRESS: ____________
CITY: ____________ STATE: ______ ZIP: ______
REASON FOR DISPATCH: ____________
LOCATION PATIENT FOUND: ____________

**MODE OF RESPONSE TO SCENE:** ☐ LIGHTS ☐ SIREN ☐ NONE

| (Circle Driver or Att.) CREW MEMBERS (☐ Additional crew listed in Narrative.) | CERT. NUMBER |
|---|---|
| DRIVER / ATT. 1: | |
| DRIVER / ATT. 2: | |
| DRIVER / ATT. 3: | |

**TYPE OF RESPONSE:**
- ☐ SCH. TRANSFER
- ☐ UNSCH. TRANSFER
- ☐ STAND-BY
- ☐ INTERCEPT / ASSIST
- ☐ SCENE ☐ N/A
- ☐ EMS DNR PRESENT

**TYPE OF SCENE / PICK-UP LOCATION:**
- ☐ HOSPITAL ____________
- ☐ HOME
- ☐ FARM
- ☐ MINE / QUARRY
- ☐ INDUSTRIAL
- ☐ SPORT / RECREATION
- ☐ STREET / HIGHWAY
- ☐ PUBLIC BUILDING
- ☐ RESIDENTIAL INST.
- ☐ EDUCATIONAL INST.
- ☐ OTHER HEALTH CARE FACILITY
- ☐ OTHER ____________
- ☐ UNKNOWN / UNSPEC.

## RESPONSE:

**CIRCUMSTANCES AFFECTING RESP.:**
- ☐ ADVERSE WEATHER
- ☐ CROWD CONTROL
- ☐ EXTRICATION >20 MIN.
- ☐ HAZ-MAT
- ☐ INFECTIOUS EXPOSURE
- ☐ LANGUAGE BARRIER
- ☐ ROAD CONDITIONS
- ☐ UNSAFE SCENE
- ☐ VEHICLE COLLISION
- ☐ VEHICLE PROBLEMS
- ☐ OTHER ____________
- ☐ NONE

| TIME (MILITARY) | | | | |
|---|---|---|---|---|
| CALL RECEIVED | | | | |
| DISPATCH / NOTIF. | | | | |
| EN ROUTE | | | | |
| ON SCENE | | | | |
| AT PATIENT | | | | |
| PATIENT MOVED | | | | |
| DEPARTED SCENE | | | | |
| ARRIVAL AT DEST. | | | | |
| RETURN TO SERVICE | | | | |

**AID BEFORE ARRIVAL BY:**
- ☐ NA ☐ UNKNOWN
- ☐ BY-STANDER / FAMILY
- ☐ BLS FIRST RESPONSE
- ☐ ALS FIRST RESPONSE
- ☐ OTHER ____________

**OTHER RESPONDERS:** ☐ NONE
- ☐ EMS AGENCY (BLS)
- ☐ EMS AGENCY (ALS)
- ☐ AIR AMBULANCE (ALS)
- ☐ FIRE DEPARTMENT
- ☐ RESCUE SQUAD
- ☐ MEDICAL RESP.
- ☐ HAZ-MAT TEAM
- ☐ CORONER
- ☐ LAW ENF. AGENCY
- ☐ OTHER ____________

**PATIENT DEMOGRAPHIC INFORMATION:**

PATIENT NAME ____________ SEX ☐ MALE ☐ FEMALE
ADDRESS ____________
CITY ____________ STATE ______ ZIP ______
PHONE ____________ DOB ______ AGE ______
RACE ☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN ☐ ALASKAN NATIVE ☐ ASIAN / P.I. ☐ OTHER ☐ UNKNOWN
ETHNIC ORIGIN ☐ HISPANIC ☐ NON-HISPANIC ☐ UNKNOWN

RESTRAINTS USED? ☐ YES ☐ NO (REASON ____________ )

PATENT INSURANCE TYPE CODE: ______

**MEDICAL HISTORY:**
- ☐ NONE / UNK
- ☐ ASTHMA
- ☐ BEHAVIORAL DIS.
- ☐ CANCER
- ☐ CARDIAC DIS.
- ☐ DIABETES
- ☐ EMPHYS. / COPD
- ☐ HYPERTENSION
- ☐ RENAL DISORDER
- ☐ SEIZURES
- ☐ STROKE / CVA
- ☐ SUBST. ABUSE
- ☐ TOBACCO USE
- ☐ TRACHEOSTOMY
- ☐ TUBERCULOSIS
- ☐ OTHER (SPEC.) ____________

**CARDIAC ARREST:**

Witnessed By:
- ☐ NA ☐ UNK.
- ☐ BLS ☐ ALS
- ☐ BY-STANDER

CPR Provided By:
- ☐ NA ☐ UNK.
- ☐ BLS ☐ ALS
- ☐ BY-STANDER

| EVENT | TIME | | | |
|---|---|---|---|---|
| ARREST | | | | |
| CPR INIT. | | | | |
| FIRST DEFIB. | | | | |
| SEC DEFIB. | | | | |
| THIRD DEFIB. | | | | |
| RESUSCITAT. | | | | |
| TERMINATED | | | | |

**PATIENT HISTORY:** PATIENTS PHYSICIAN ____________
CHIEF COMPLAINT ____________
ONSET DATE/TIME ______ / ______ WORK RELATED? ☐ YES ☐ NO
ALLERGIES ____________
MEDICATIONS ____________

**PHYSICAL:** **AIRWAY:** ☐ PATENT ☐ OBSTRUCTED
**BREATHING EFFORT:** ☐ NORM. ☐ INCR. ☐ DECR. ☐ ABSENT

**SKIN COLOR:** ☐ NORM. ☐ PALE ☐ CYAN. ☐ FLUSH
**SKIN COND.:** ☐ NORM. ☐ COOL ☐ DRY ☐ MOIST

**NEUROL.:** ☐ ALERT ☐ VOICE ☐ PAIN ☐ UNRESPONSIVE

**PUPILS:**
L ☐ NORM. ☐ DILAT. ☐ CONST. ☐ REACT ☐ NON-REACT
R ☐ NORM. ☐ DILAT. ☐ CONST. ☐ REACT ☐ NON-REACT

**NECK:** ☐ JVD ☐ PAIN **CAROTID PULSE:** L ☐ PRESENT ☐ DECRS. ☐ ABSENT R ☐ PRESENT ☐ DECRS. ☐ ABSENT

**SUSPECTED USE/ABUSE:** ☐ ALCOH ☐ DRUGS ☐ BOTH ☐ NONE ☐ UNKNOWN

**BREATH SOUNDS:**
L ☐ NORMAL ☐ DECRS. ☐ ABSENT ☐ RALES ☐ RHONCHI ☐ WHEEZES
R ☐ NORMAL ☐ DECRS. ☐ ABSENT ☐ RALES ☐ RHONCHI ☐ WHEEZES

**CHEST WALL:** ☐ ABNORMAL SYMMETRY ☐ CREPITUS ☐ FLAIL CHEST ☐ UNKNOWN

**ABDOMEN:** ☐ DISTEND. ☐ TENDER **SOUNDS:** ☐ INCRS. ☐ DECRS. ☐ ABSENT

**EXTREM.:**
R-UP: ☐ +ROM ☐ -ROM ☐ PULSE ☐ SENS. CAP. REFILL ☐ ≤2S ☐ >2S
L-UP: ☐ +ROM ☐ -ROM ☐ PULSE ☐ SENS. CAP. REFILL ☐ ≤2S ☐ >2S
R-LO: ☐ +ROM ☐ -ROM ☐ PULSE ☐ SENS. CAP. REFILL ☐ ≤2S ☐ >2S
L-LO: ☐ +ROM ☐ -ROM ☐ PULSE ☐ SENS. CAP. REFILL ☐ ≤2S ☐ >2S

**BLS PROCEDURE CODES:**
- 01 – ASST. VENTILATION
- 02 – BLEEDING CONTROL
- 03 – BANDAGE / DRESSING
- 04 – BURN CARE
- 05 – C-COLLAR APPLIED
- 06 – CPR
- 07 – COLD / HOT APPLIED
- 08 – EXTRICATION
- 09 – LONG BD / KED
- 10 – SHORT BD / SCOOP
- 11 – SPLINT, ARM
- 12 – SPLINT, LEG
- 13 – SPLINT, TRACTION
- 14 – POSITION / ELEV.
- 15 – MAST / PASG
- 16 – IV MAINTENANCE
- 17 – OB CARE / DELIV.
- 18 – SUCTION
- 19 – OXYGEN, MASK
- 20 – OXYGEN, CANNULA
- 21 – AIRWAY, ORAL
- 22 – AIRWAY, NASAL
- 23 – DEFIB., AUTOMATIC
- 24 – OTHER BLS PROC.

| TIME | CERT. # | PULSE | RESP. | SBP / DBP | TEMP | EYE | VERB. | MOT | G.C.S. | R.T.S. | PROC. | ATT. | SUC. | AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |
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**PRIMARY IMPRESSION CODE** ☐☐
USE NUMBER FROM BOX BELOW

**SIGNS/SYMPTOMS/IMP.:** (CHECK ALL WHICH APPLY)
- 01 ABDOMINAL PAIN
- 02 AIRWAIY OBSTR.
- 03 ALLERGIC REACT.
- 04 ALTERED L.O.C.
- ☐ BACK PAIN
- 05 BEHAVIOR / PSYCH.
- ☐ BLOODY STOOL
- 06 CARDICAC ARREST
- 07 CARD. RHYT. DIST.
- 08 CHEST PAIN
- 09 DIABETIC EMERG.
- ☐ DIARRHEA
- ☐ DIZZINESS
- ☐ EAR PAIN
- 10 ELECTROCUTION
- ☐ EYE PAIN
- ☐ HEADACHE
- ☐ HYPERTENSION
- 11 HYPERTHER. / FEVER
- 12 HYPOTHERMIA
- 13 HYPOVOL. / SHOCK
- 14 INHALATION INJURY
- ☐ NAUSEA / VOMITING
- 15 OBVIOUS DEATH
- ☐ PALPITATIONS
- ☐ PARALYSIS
- 16 POISON / DRUG
- 17 PREG. / OB DELIVERY
- 18 RESP. ARREST
- 19 RESP. DISTRESS
- 20 SEIZURE
- 21 SEXUAL ASSAULT
- 22 SMOKE INHALATION
- 23 STING / BITE
- 24 STROKE / CVA
- 25 SYNCOPE / FAINTING
- 26 TRAUMA (PAGE 2)
- ☐ UNRESPONSIVE
- 27 VAGINAL HEMMOR.
- ☐ WEAKNESS
- 28 NOT APPLICABLE
- 29 UNKNOWN

**PATIENT DISPOSITION:**
- ☐ NA
- ☐ UNKNOWN
- ☐ TREATED, TRANSPORT
- ☐ TREATED, RELEASED
- ☐ OBVIOUSLY DECEASED
- ☐ TREATED, TRANSF. CARE
- ☐ NO TREATMENT REQ.
- ☐ NO PATIENT FOUND
- ☐ TREATED, TR. BY P.O.V.
- ☐ TREATMENT REFUSED
- ☐ CALL CANCELED

**PATIENT CONDITION AT LAST DEST.:**
- ☐ UNCHANGED ☐ EXPIRED
- ☐ BETTER ☐ UNKNOWN
- ☐ WORSE ☐ NA

**MODE OF TRANSPORT:** ☐ LIGHTS ☐ SIREN ☐ NONE
**DESTINATION** ____________

**DESTINATION DETERMINED BY:** ☐ PATIENT ☐ PROTOCOL ☐ CLOSEST ☐ LAW ENF. ☐ MANAGED CARE ☐ PATENT'S DR. ☐ DR. ON SCENE ☐ MED CTRL. ☐ OTHER ☐ UNKNOWN / NA

REPRESENTATIVE OF FACILITY ASSUMING CARE ____________ E.M.S. CARE PROVIDER ____________

**Use Ball-Point Pen Black or Blue**


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REPORT ID:
AGENCY NAME: ______________________ LICENSE #: ______________

INCIDENT #: __________ RESPONSE #: __________ UNIT #: ____________

DATE: ____________ TIME CALL RECEIVED: ______________________

# Kentucky Board of Emergency Medical Services Ambulance Run Report
## Page 2 – ALS/Injury/Narrative

PATIENT NAME ______________________ SEX ☐MALE ☐FEMALE AGE ________ NOTE ______________

| BLS PROCEDURE CODES: | | | | ALS PROCEDURE CODES: | | |
|---|---|---|---|---|---|---|
| | 06 – CPR | 13 – SPLINT, TRACTION | 20 – OXYGEN, CANNULA | | 55 – EGG MONITORING | 62 – PULSE OXIMETRY |
| | 07 – COLD / HOT APPLIED | 14 – POSITION / ELEV. | 21 – AIRWAY, ORAL | | 56 – CARDIAC, PACING | 63 – OTHER ALS PROC. |
| 01 – ASST. VENTILATION | 08 – EXTRICATION | 15 – MAST / PASG | 22 – AIRWAY, NASAL | 50 – CARDIOVERSION | 57 – GLUCOSE, BLOOD | |
| 02 – BLEEDING CONTROL | 09 – LONG BD / KED | 16 – IV MAINTENANCE | 23 – DEFIB., AUTOMATIC | 51 – CAPNOMETRY | 58 – INTUBATION | |
| 03 – BANDAGE / DRESSING | 10 – SHORT BD / SCOOP | 17 – OB CARE / DELIV. | 24 – OTHER BLS PROC. | 52 – CHEST DECOMP. | 59 – INTRAOSSEOUS ACCESS | |
| 04 – BURN CARE | 11 – SPLINT, ARM | 18 – SUCTION | | 53 – CRICOTHYROTOMY | 60 – INTRAVENOUS ACCESS | |
| 05 – C-COLLAR APPLIED | 12 – SPLINT, LEG | 19 – OXYGEN, MASK | | 54 – DIFIB., MANUAL | 61 – GASTRIC TUBE | |

| TIME | CERT. # | PULSE | RESP. | SBP / DBP | TEMP | EYE | VERB. | MOT | G.C.S. | R.T.S. | PROC. | ATT. | SUC. | AMOUNT | OXY. SAT. | CARDIAC RHYTHM | RATE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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| TIME | CERT. # | MEDICATION ADMINISTERED | DOSE | ROUTE | SITE | AUTHORITY |
|---|---|---|---|---|---|---|
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MANUAL DEFIBRAILATION: JOULES 1st ________ 2nd ________ 3rd ________

**CAUSE OF INJURY:**

☐ MOTOR VEH., TRAF.
☐ MOTOR VEH., OTH.
☐ PEDESTRIAN, TRAF.
☐ BICYCLE
☐ BOAT / WATERCRAFT
☐ AIRCRAFT
☐ DRUG POISONING
☐ CHEMICAL POISON
☐ FALL OR JUMP
☐ FIRE / FLAMES
☐ SMOKE INHALATION
☐ EXCESSIVE HEAT
☐ EXCESSIVE COLD
☐ VENOMOUS STING
☐ BITE
☐ LIGHTNING
☐ DROWNING / N.D.
☐ MEC. SUFFOCATION
☐ MACHINERY
☐ ELECTROCUTION
☐ RADIATION EXPOSURE
☐ FIREARM
☐ KNIFE
☐ BLUNT OBJECT
☐ RAPE / SEXUAL ASSAULT
☐ B ATTERING / ASSAULT
☐ OTHER ____________
☐ UNKNOWN
☐ NOT APPLICABLE

**INTENT OF INJURY:** ☐ ACCIDENT ☐ UNKNOWN ☐ INTENT. – SELF ☐ INTENT. – OTHER

**SUPPLEMENTARY INFORMATION**

Fluids Administered (cc) ____________

Fluids Output (cc) ____________

Est. Bloodloss (cc) ____________

Pediatric Training Score ____________

**SAFETY DEVICES USED BY PT.:**

☐ AIR BAG
☐ LAP & SHOULDER BELT
☐ LAP BELT ONLY
☐ SHOULDER BELT ONLY
☐ HELMET
☐ NONE / UNKNOWN
☐ CHILD SAFETY SEAT
☐ EYE PROTECTION
☐ PROTECTIVE CLOTHING
☐ PERS. FLOATATION DEVICE
☐ OTHER (SPECIFY BELOW)

______________________________

**M.V.C.:**

VEHICLE PLATE ______________ STATE ________

DRIVER LICENSE ______________ STATE ________

PATIENT POSITION IN VEHICLE ______________________

TRIAGE CRITERIA ______________________

| INJURIES: | Amput | Blunt | Burn | Crush | Disloc | GSW | Lacer | Pain | Punc | Swell |
|---|---|---|---|---|---|---|---|---|---|---|
| External | | | | | | | | | | |
| Head | | | | | | | | | | |
| Face | | | | | | | | | | |
| Neck | | | | | | | | | | |
| Thorax | | | | | | | | | | |
| Abdomen | | | | | | | | | | |
| Spine | | | | | | | | | | |
| Upper Ext. | | | | | | | | | | |
| Lower Ext. | | | | | | | | | | |
| Unspecified | | | | | | | | | | |

## NARRATIVE:

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REPRESENTATIVE OF FACILITY ASSUMING CARE

E.M.S. CARE PROVIDER

MEDICAL CONTROL FACILITY ID NUMBER:



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