OCMCA FIELD NOTES

DATE: _____ RUN #: _____ AGENCY UNIT #: _____

PATIENT: _____ D.O.B.: _____

ADDRESS: _____

PHONE: _____ PATIENT PRIORITY: _____

PRIMARY COMPLAINT: _____

Vital Signs:	Time #1	Time #2	Time #3	MEDICATIONS
LOC				
B/P				
PULSE				
SKIN PERF.				
RESP				
PUPILS				
SUGAR				ALLERGIES
SPO2				
TEMP				
GLASGOW				
PAIN SCALE				
MEDICAL Hx:				
Patient Weight:		Patient Height:		

TREATMENTS:		
TIME	INTERVENTIONS	SUCCESSFUL Y/N
		Y / N
		Y / N
		Y / N
		Y / N
		Y / N
		Y / N
		Y / N
		Y / N

NARRATIVE:

TECHNICIAN: _____