Foothills RETAC Preliminary Patient Care Report CR#________________

Patient Name:	Date/Time of Transport	Date/Time of Injury/Event	Type of Patient: (circle) Medical Trauma

Chief Complaint/Overall Impression:

Transport	
Transporting Agency	Unit #______________
Origin	❒ Scene ❒Med/Center______________________________ ❒ Other____________________
Receiving Facility	❒ Basic Pt Contact Info:
Patient Information	
Patient Information	❒ Male ❒ Female ❒ Age ________yrs *or* _________mos. (peds) *or* ________days
Injury/Illness Circumstances	
Location of Injury/Event	County of Injury: Exact Location:
Mechanism of Injury or Medical event Hx	
Protective Devices/Equipment	❒ Seat belt ❒ Airbag Deployment ❒ Child's car seat/booster seat ❒ Lap Belt ❒ Helmet ❒ Other ____________________________

Pertinent Medical History

Clinically Pertinent PMH:

Meds:

Allergies:

Vital Signs	
Initial VS Time:	BP ____________ P __________ R __________ SpO2___________ Glucose ___________ GCS: Eye 1-4 _______ Motor 1-6 _________ Verbal 1-5 _________ Total ____________
Repeat VS Time:	BP ____________ P __________ R __________ SpO2___________ Glucose ___________ GCS: Eye 1-4 _______ Motor 1-6 _________ Verbal 1-5 _________ Total ____________
Treatments /Interventions	
IV:	_____ gauge Placement___________ Attempts__________ CCs Infused ___________
Airway:	❒ O2_________lpm per ______________ ❒ Advanced Airway Type______________ ❒ Intubation Attempts _______________ ETCO2_______________
Meds given Route/dose/time	
Immobilization Other Splint	❒ C-Collar All neuro/ CMS checks normal pre-spinal immobilization ❒ Yes ❒ No ❒ Backboard All neuro/ CMS checks normal post-spinal immobilization ❒ Yes ❒ No Type_____________________________ ❒ CMS Intact Pre-immobilization ❒ CMS Intact Post
Monitor	Initial Rhythm ______________________ ATTACH ECG Electrical Treatment _____________________ # of shocks __________ Joules ___________at max Response: ______________________

_________________________ _________________________ _________________________

Paramedic/EMT Signature Facility Signature Date/Time Care Transferred

Original Copy to Facility **NCR Copy to Agency**