

Trauma Tag ID _____ Agency _____ Run# _____ Phone _____

Patient Name _____ Age _____ Gender _____ Incident Date _____

MOI / Chief Complaint _____ Incident Time _____

- LOC
- Alert
 - Verbal
 - Painful
 - Unresponsive

GCS										
	Eye Opening	Spontaneous To Speech To Pain None	4 3 2 1	Best Verbal Response	Oriented Disoriented Monosyllabic Incomprehensible None	5 4 3 2 1	Best Motor Response	Obeys Commands Localizes Pain Withdraws from Pain Abnormal Flexion to pain Extension to Pain None	6 5 4 3 2 1	

VITALS	TIME	Blood Pressure	Pulse Rate	Respirations	Pulse Ox	EKG	Oxygen Flow Rate _____	ETT Size _____	Depth _____
							Device: Cannula Mask BVM	Complications _____	
							Comments:		

PMHx _____
 Meds _____
 Allergies _____

Meds / Fluids Given	Dose / Rate/ Tot. Fluids	Time Given

TREATMENTS (brief)

Crew Member _____ Received By _____ Handoff Time _____

PCR Short Form This form is to be used by EMS services to provide patient care information to the receiving facility upon delivery of the patient when a complete patient care report cannot be completed. Please print legibly. Complete this form and leave with the RN receiving the patient.
THIS FORM DOES NOT REPLACE THE OFFICIAL AMBULANCE RUN REPORT OR PATIENT CARE REPORT

This space reserved for other signatures/affidavits used by EMS provider