MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT: NHCCHASNINST 6320.93	ISSUANCE DATE: 20110309
LOCAL FORM TITLE: EMERGENCY RESPONSE DRILL/EVENT REPORT	

_____ (Patient's Name) _____ (Date of Birth) _____ (Date/Time)

Responsiveness: A&O x _____ Verbal or Painful Stimuli: _____

Pain Scale: _____ (if yes) where? _____ (use Nursing Note if needed)

Current Medications Used: _____

_____

Time	BP	HR	RR	Temp	Pulse O2

Past Medical History:_____

_____

_____

_____

History:_____

_____

_____

_____

Allergies (including Latex):_____

_____

VITAL SIGNS (every five minutes until stable or transported)

AIRWAY/BREATHING
Oxygen used: Y or N Amount Given: _____ Rate: _____ Route: _____

Additional Measures Taken:_____

_____

CIRCULATION

EKG Use: Y or N Defibrillation: Y or N

This information is protected by the Privacy Act of 1974 (PL-93-579) and
the Health Insurance Portability and Accountability Act (PL 104-191)

PRACTITIONER'S/NURSE'S NAME	PRACTITIONER'S/NURSE'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

PERSONNEL RESPONDER(S):

1. _____ 3. _____

2. _____ 4. _____

DEFIBRILLATION

Time	Joules	Rhythm Before Shock	Rhythm After Shock
_____	_____	_____	_____
_____	_____	_____	_____

If the defibrillator had to be used, amount of time needed to re-stabilize the patient: _____

_____

Comments:_____

_____

_____

MEDICATIONS:

Time	Type	Dose	Route	Given by	Provider Initials
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Comments and/or Patient Reaction: _____

_____

_____

INTRAVENOUS THERAPY

Type of Solution	IV Site	Drip Rate
_____	_____	_____
_____	_____	_____

(If medications are given intravenously, document in Medication Section)

Comments and/or Patient Reaction: _____

_____

EMS Contacted:

Time Called: _____ Contacted by: _____

ETA: _____ Actual Time of Arrival: _____

Transported to: _____ Transported by: _____

Comments: _____

_____

_____

This information is protected by the Privacy Act of 1974 (PL-93-579) and
the Health Insurance Portability and Accountability Act (PL 104-191)

PRACTITIONER'S/NURSE'S NAME	PRACTITIONER'S/NURSE'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	