



**Maryland Institute For  
Emergency Medical Services Systems**

Prehospital Consultation/Interventions  
Radio Report Form

Priority: 1 2 3 4  Pre Code  
 Specialty Referral

ETA: \_\_\_\_\_ Unit # \_\_\_\_\_

Receiving \_\_\_\_\_

ALS  Specialty Care  
 BLS  Helicopter \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm Age: \_\_\_\_\_ Sex:  M  F Wt: \_\_\_\_\_ Kg/Lbs

Chief Complaint/Mechanism of Injury:

MOLST/DNR:  A<sub>1</sub>  A<sub>2</sub>  B

TRAUMA CATEGORY:

Alpha  Bravo  
 Charlie  Delta  N/A

Initial Vitals:

Time \_\_\_\_\_

Temperature \_\_\_\_\_

B/P \_\_\_\_\_ / \_\_\_\_\_

Pulse \_\_\_\_\_

RR \_\_\_\_\_

Pain \_\_\_\_\_

Repeat Vitals:

Time \_\_\_\_\_

Temperature \_\_\_\_\_

BP \_\_\_\_\_ / \_\_\_\_\_

Pulse \_\_\_\_\_

RR \_\_\_\_\_

Pain \_\_\_\_\_

Glucometer: \_\_\_\_\_

ETCO<sub>2</sub> \_\_\_\_\_

O<sub>2</sub> Sat. \_\_\_\_\_ %

12-Lead EKG

Y N N/A

Sent

Received

STEMI Alert

P.M.H./Routine Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Last Known Well Time: \_\_\_\_\_

Pertinent Findings:  GCS \_\_\_\_\_  Cinn. Scale \_\_\_\_\_  LAMS Score \_\_\_\_\_

<b>Respiratory</b> <input type="checkbox"/> Clear <input type="checkbox"/> Rales <input type="checkbox"/> Labored <input type="checkbox"/> Stridor <input type="checkbox"/> Rhonchi <input type="checkbox"/> Wheezes <input type="checkbox"/> Decreased <input type="checkbox"/> L <input type="checkbox"/> R	<b>Pulse</b> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Thready <b>Circulation</b> <input type="checkbox"/> JVD <input type="checkbox"/> Edema Cap. Refill: _____ sec.	<b>Skin</b> <input type="checkbox"/> Warm <input type="checkbox"/> Hot <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Clammy <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Cyanotic	<b>Neurology</b> <b>LOC:</b> <input type="checkbox"/> Alert <input type="checkbox"/> Verbal <input type="checkbox"/> Pain <input type="checkbox"/> Unresp. <b>Pupils:</b> <input type="checkbox"/> PERRL <input type="checkbox"/> Unequal <input type="checkbox"/> Fixed & Dilated	<b>Motor:</b> <input type="checkbox"/> Follows Commands <input type="checkbox"/> Localizes <input type="checkbox"/> Withdraws <input type="checkbox"/> Postures <input type="checkbox"/> Flaccid	<b>Monitor</b> <input type="checkbox"/> Nor Sinus <input type="checkbox"/> Asystole <input type="checkbox"/> SinusTach <input type="checkbox"/> PEA <input type="checkbox"/> Sinus Brad <input type="checkbox"/> PVC's <input type="checkbox"/> A-Fib <input type="checkbox"/> Vent Fib <input type="checkbox"/> A-Flutter <input type="checkbox"/> Vent Tach <input type="checkbox"/> SVT <input type="checkbox"/> Paced <input type="checkbox"/> Block <input type="checkbox"/> Other Degree ① ② ③	<b>Oxygen</b> <input type="checkbox"/> NR Mask <input type="checkbox"/> Nasal Cannula _____ L/min. <input type="checkbox"/> BVM <input type="checkbox"/> ET <input type="checkbox"/> NT <input type="checkbox"/> Other Adv. Airway <input type="checkbox"/> CPAP <input type="checkbox"/> CPR in Progress <input type="checkbox"/> Ventilator <input type="checkbox"/> NGT	<b>Equipment</b> <input type="checkbox"/> Spine Imm <input type="checkbox"/> Splint <input type="checkbox"/> Pelvic Binder <input type="checkbox"/> Defib <input type="checkbox"/> Cardiovert <input type="checkbox"/> Paced	<input type="checkbox"/> IV1 Time Started _____ <input type="checkbox"/> IV2 <input type="checkbox"/> IO <input type="checkbox"/> EJ Rate: _____ Gauge: _____ Site: _____ Amount Infused: _____ <input type="checkbox"/> Bloods Drawn
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Medication	Dose	Route	Medication	Dose	Route	Medication	Dose	Route
Acetaminophen	_____	_____	Diphenhydramine	_____	_____	Morphine Sulfate	_____	_____
Activated Charcoal	_____	_____	Dopamine	_____	_____	Naloxone	_____	_____
Adenosine	_____	_____	Epinephrine	_____	_____	Nitroglycerin Tablet	_____	_____
Albuterol Sulfate	_____	_____	Etomidate	_____	_____	Nitroglycerin Paste	_____	_____
Amiodarone	_____	_____	Fentanyl	_____	_____	Ondansetron	_____	_____
Aspirin	_____	_____	Glucagon	_____	_____	Oral Glucose	_____	_____
Atropine Sulfate	_____	_____	Haloperidol	_____	_____	Oxygen	_____	_____
Calcium Chloride	_____	_____	Ipratropium/Atrovent	_____	_____	Sodium Bicarbonate	_____	_____
Dexamethasone	_____	_____	Ketamine	_____	_____	Succinylcholine	_____	_____
Dextrose	_____	_____	Lidocaine	_____	_____	Vecuronium	_____	_____
Diazepam	_____	_____	Magnesium Sulfate	_____	_____			
Diltiazem	_____	_____	Midazolam	_____	_____			

Interventions:  None \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ RN Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Medical direction given **OR**  Notification only

Present for consult **OR**  Not present for consult/notification