Preliminary Patient Information Sheet

Jurisdictional Incident #: _____ Date: _____ Arrived at Hospital _____ : _____

Priority: ❑1 ❑2 ❑3 ❑4 Level of Consciousness: ❑A ❑V ❑P ❑U

Patient Name: _____ Date of Birth: _____ Gender: ❑ M ❑ F

Patient's Address: _____

City: _____ State: _____ Patient's Phone Number: ( ) _____

Chief Complaint: _____

Past Medical History: (DNR ❑A ❑B) _____

Current Medications: _____

Allergies: _____

Vitals:	Vitals:	Respiratory	Skin	Pupils:	
B/P: ___/___	B/P: ___/___	❑ Clear	❑ Warm	❑ PERRL	Glucometer _____
Pulse: _____	Pulse: _____	❑ Rales	❑ Hot	❑ Unequal	Oxygen _____ Lpm
Respirations: ___	Respirations: ___	❑ Labored	❑ Cool	❑ Fixed and Dilated	Cardiac Rhythm:
SpO_2: _____	SpO_2: _____	❑ Stridor	❑ Dry	❑ L ❑ R	_____
		❑ Rhonchi	❑ Clammy		
		❑ Wheezes	❑ Diaphoretic		
		❑ Decreased ❑ L ❑ R	❑ Cyanotic		

Assessment/Treatment: _____

Provider's Name (Print): _____ Unit #: _____

This is not a complete Patient Care Report