S-SV EMS BLS Optional Skills Utilization Patient Care Report (605-A)

Provider:	Incident #:	Incident Date:
Incident Address:	Incident City:	

Patient Information

Name:	☐ Male ☐ Female	Weight:
Chief Complaint:	Age:	DOB:

Medical History:	Medications	Allergies

Time	GCS	BP	Pulse	Resp. Rate	SpO2	Pain Scale	By

Airway Device: ☐ King ☐ i-gel	# Of Attempts:	Successful: ☐ Yes ☐ No
Time:	Size: ☐ 3 ☐ 4 ☐ 5	By:
Bi-lat. Lung Sounds: ☐ Yes ☐ No	Epigastric Sounds: ☐ Yes ☐ No	$ETCO_2$ Color Chng: ☐ Yes ☐ No
☐ Mark 1/DuoDote	☐ Epinephrine Auto Injector	☐ Intranasal (IN) Naloxone

Time:	Dose:	Site:	By:
Time:	Dose:	Site:	By:

Patient Care Narrative

Crew Names: