INCIDENT INFO

Date	Inc. #	Jur. Sta.	Location Code	MCI?	PD & Unit #	
07/10/2018	4046	003		☐ Y ■ N		■ Regular Run ☐ No Pt ☐ Cx at Scene ☐ PuB Asst ☐ IFT ☐ DOA ☐ FireLine ☐ Pg 2

BH 18 003 00538
Orig. Seq. #

Inc Loc	Street Number	Street Name	Apt #	City Code	Incident Zip Code
Inc	99	N LA CIENEGA	303	BH	90210

Prov	A/B/H	Unit	Disp	Arrival	At Pt	Left	At Fac	Fac Equip	Avail
BH	A	R5842	18 36	18 40	18 41	18 51	18 54	19 34	19 40

Team Member ID

#1	P6223	#2	P11403
#3	P10354	#4	E044478
#5	E046966	#6	P8597
#7		#8	

TRANS

Med.Ctrl.	Protocol	Protocol	VIA	TRANS TO	RATIONALE
CNA			■ ALS ☐ BLS ☐ Heli ☐ No Transport	■ MAR ☐ PeriNat ☐ EDAP ☐ STEMI ☐ TC/PTC ☐ PMC ☐ PrimAry Stroke Ctr. ☐ SART ☐ OTHER ☐ Comp. StroKe Ctr.	■ No SC Req'd ☐ Criteria/Required ☐ Guidelines ☐ Judgment ☐ EXtremis ☐ No SC Access ☐ ED Sat ☐ Request by

Pre-Notification? ☐Y ☐N
AMA? ☐Y ☐N
Code 3? ☐Y ☐N
Rec. Fac. [redacted]

PT INFO

Name/Last [redacted] First M.I. DOB [redacted] Phone

Street Number Street Name Apt# City State Zip [redacted] Mileage 0

Insurance	Hospital ID	PMD Name	Partial SS #
			0964

COMMENTS

[redacted] female found lying supine AOx3 C/c vaginal bleeding following elective abortion procedure. Pmd states procedure ended 1200 and pt "oozing" blood since PMD gave 2 liters IV fluids and called for trans to cSmc for further monitoring. Pt denies any pain at this time and has no additional complaint.

Hx [redacted]

Allergies [redacted] ASA Allergy? ☐ Y ☐ N

Meds [redacted] SEDs in past 48hrs ☐ Y ☐ N

PATIENT ASSESSMENT

Pt 1 of 1 # Pts
Transported 1
Age [redacted] ■ Y ☐ M ☐ W ☐ D ☐ H ☐ Est.
Gender ☐ M ■ F
Weight [redacted] ■ Lbs ☐ Kg
Peds Color Code ☐ Too Tall
Distress Level ☐ None ■ MilD ☐ Mod ☐ Severe

Pt Complaint OB VA
Prov Impress VABL
Mechanism

GCS/mLAPSS/LAMS

Time	18 43	
Eyes	4	
Verbal	5	
Motor	6	
GCS Total	15	

Normal for Pt/Age ☐ Y ☐ N
mLAPSS ☐ Met ☐ Not Met
Last known well: ☐ Unk
Date: Time:
LAMS
Facial Droop: ____ Arm Drift: ____
Grip Strength: ____ Total Score: ____

COMPLAINTS

MEDICAL

☐ Abd/Pelvic Pain ☐ Agitated Delirium ☐ Allergic Reaction ☐ Altered LOC ☐ Apneic Episode ☐ BEHavioral ☐ Bleeding Other Site ☐ Brief Resolved Unexpl. Event ☐ Cardiac Arrest ☐ Chest Pain ☐ CHoking/Airway Obstr. ☐ Cough/Congestion ☐ DOA ☐ DYsrhythmia ☐ FEver ☐ Foreign Body ☐ GI Bleed ☐ Head Pain ☐ HYpoglycemia ☐ Local Neuro Signs ☐ Med Device Complaint ☐ Nausea/Vomiting ☐ Near Drowning ☐ Neck/Back Pain ☐ No Medical Complaint ☐ NOsebleed ☐ PalpitationS ■ OBstetrics ☐ LAbor ☐ NeWborn ☐ OverDose ☐ POisoning ☐ Other Pain ☐ Respiratory Arrest ☐ SEizure ☐ Shortness of Breath ☐ SYncope ■ VAginal Bleed ☐ WEak/DIzzy ☐ Inpatient Medical ☐ OTher

TRAUMA

☐ No Apparent Injury ☐ BUrns/Elec. Shock ☐ SBP <90, <70 (<1yr) ☐ RR <10/>29, <20 (<1yr) ☐ Susp. Pelvic FX ☐ Spinal Cord Injury ☐ Inpatient Trauma

B	P		B	P	
☐	☐	Traumatic Arrest	☐	☐	Abdomen
☐	☐	Head ☐ GCS≤14			Diffuse Abd. Tend.
☐	☐	Face/Mouth	☐	☐	Genitals/ButtocKs
☐	☐	Neck	☐	☐	Extremities
☐	☐	Back		☐	EXtr.↑knee/elbow
☐	☐	Chest			FRactures ≥ 2 long
	☐	Flail Chest		☐	Amp.↑wrist/ankle
☐	☐	Tension Pneumo.	☐	☐	Neur/Vasc/Mangl'd
☐	☐	Minor Lacerations			

MECHANISM

Protective Devices: ☐ SeatBelt ☐ AirBag ☐ HeLmet ☐ CarSeat/Booster

☐ Enclosed Vehicle ☐ EJected ☐ EXtricated @____ ☐ Pass. Space. Intr. ☐ >12" ☐ >18" ☐ Survived Fatal Accident ☐ Impact > 20 mph Unenclosed ☐ Ped/Bike Runover/Thrown/>20mph ☐ Ped/Bike < 20mph ☐ FAll ☐ 15ft/>10ft. ☐ ASsault ☐ STabbing ☐ GSW ☐ Motorcycle/Moped ☐ SPorts/Recreation ☐ Self-Inflict'd/Acc. ☐ Self-Inflict'd/Int. ☐ AntiCoagulants ☐ Special Consid. ☐ Telemetry Data ☐ Hazmat Exposure ☐ ANimal Bite ☐ CRush ☐ Electrical Shock ☐ Thermal Burn ☐ Work-Related ☐ UNknown ☐ OTher:

IMPRESSION

☐ Cardiac Arrest Non-Trauma ☐ DOA-Obvious Death-DEAD ☐ SHOcK ☐ HypOTeNsion ☐ SEPSis ☐ HYPOglycemia ☐ HYPeRglycemia ☐ HYperTensioN ☐ CP- Susp. Cardiac ☐ CP-STEMI ☐ CP- Non Cardiac ☐ Cardiac DYSRhythmia ☐ PALPitations ☐ OverDose/POison/Ingestion ☐ Alcohol Intoxication-ETOH

☐ SEizure-ACtive ☐ SEizure-POstictal ☐ ALOC (Not HYPO or SE) ☐ STRoKe/CVA/TIA ☐ DIZZiness/Vertigo ☐ Head Pain-Non Traumatic ☐ SYNCope/Near Syncope ☐ General WEAKness ☐ Epistaxis-NOseBLeed ☐ ALlergic Reaction(X) ☐ ANaPHylaxis ☐ DYstonic Reaction(X) ☐ NO Medical Complaint

☐ ShOrt of Breath-Bronchospasm ☐ Resp. Distress/Pulm Edema/CHFF ☐ Resp. Arrest-Resp. Failure ☐ Resp. Distress-OTher ☐ BRUE (ALTE) ☐ Airway Obstruction-CHOKing ☐ COld/FLu Symptoms ☐ SMOKe Inhalation ☐ INHaLational Injury ☐ CarbOn MOnoxide ☐ Med. Device Malfunction-FAIL ☐ EXtremity Pain-Non Traumatic ☐ Body Pain-Non Traumatic

☐ ABdOminal Pain ☐ NAusea/VoMiting ☐ UPper GI Bleeding ☐ LOwer GI Bleeding ☐ GenitoUrinary DisOrder ☐ DiarRHeA ■ VAginal BLeeding ☐ PREGnancy Complication ☐ Pregnancy/LABoR ☐ ChildBiRTH (Mother) ☐ Newborn-BABY ☐ FEVeR ☐ STiNGs/Venomous Bites

☐ Behavioral/PSYCh Crisis ☐ AGitated DElirium ☐ TRauMAtic Injury ☐ Traumatic Arrest-Blunt CABT ☐ Traumatic Arrest-Penetr CAPT ☐ BURN ☐ Hazmat Skin Exposure-DCON ☐ ELeCTrocution ☐ EYE Problem-Unspecified ☐ ENT/Dental Problem-Unspecified ☐ HEAT- Hyperthermia Environ. ☐ Hypothermia/COLD Injury

PHYSICAL

PUPILS
■ PERL ☐ PInpoint ☐ Sluggish ☐ Fixed & Dil. ☐ Cataracts ☐ Unequal ☐ Pt's Norm

RESP
■ Normal ■ Clear ☐ Wheezes ☐ Rales ☐ RHonchi ☐ SnoringG ☐ Unequal ☐ JVD ☐ Stridor ☐ Labored ☐ Apnea ☐ AMU
Tidal Volume ■ N ☐ + ☐ -

SKIN
■ Normal ☐ Diaphoretic ☐ Cyanotic ☐ Hot ☐ Flushed ☐ CoLd ☐ Pale
Cap Refill: ☐ NoRmal ☐ DElayed

12 LEAD

12 Lead Time:			2nd 12 Lead Time:		
Software Interpretation:			Software Interpretation:		
☐ NL	☐ ABnl	☐ STEMI	☐ NL	☐ ABnl	☐ STEMI
EMS Interpretation:			EMS Interpretation:		
☐ NL	☐ ABnl	☐ STEMI	☐ NL	☐ ABnl	☐ STEMI
ArtiFact	☐ Y	☐ N	ArtiFact	☐ Y	☐ N
Wavy Baseline	☐ Y	☐ N	Wavy Baseline	☐ Y	☐ N
Paced Rhythm	☐ Y	☐ N	Paced Rhythm	☐ Y	☐ N
Transmitted?	☐ Y	☐ N	Transmitted?	☐ Y	☐ N

THERAPIES

	TM#
☐ Back Blows/Thrust	
☐ BVM ☐ CO2	
☐ Breath Sounds	
☐ Chest Rise	
☐ Existing Trach	
☐ OP/NP Airway	
☐ Cooling Measures	
☐ DRessings	
☐ Ice Pack	
☐ TourniQuet	
☐ Hemostatic Dressing	
☐ OX ____ lpm ☐ NC ☐ Mask	
☐ REstraints	
☐ Distal CSM Intact	
☐ Spinal Motion Restriction	
☐ C-Collar ☐ BackboarD	
☐ CMS Intact - Before	
☐ CMS Intact - After	
☐ SPlint ☐ Traction Splint	
☐ SUction	
☐ BLd Gluc #1 ____ #2 ____	
☐ CPAP ____ cm H2O Time: ____	
☐ FB Removal	
☐ IV ____ g ____ site	
☐ I.O. ____ g ____ length	
☐ Needle THoracostomy	
☐ Vagal Maneuver	
☐ TC Pacing ____ mA ____ bpm Time: ____	
☐ OTher ____	

ARREST

Witness ☐ Citizen ☐ EMS ☐ None
☐ Citizen CPR ☐ Citizen AED
EMS CPR @ ____ (time)
Arrest to CPR ____ (min)
AED ☐ Analyze ☐ Defibrillation
☐ ALS Resuscitation (use pg 2)

Reason(s) for Withholding/Terminating Resuscitation:
☐ DNR/AHCD/POLST ☐ T.O.R
Time of 814 Death: ____
☐ RIgor ☐ LIvidity ☐ Blunt Trauma
☐ OTher ____
☐ FAmily ____ (signature)

SPECIAL CIRCUMSTANCES
DNR/AHCD/POLST? ☐ Y ☐ N Poison Control Contacted? ☐ Y ☐ N
Suspected: ☐ ETOH? ☐ Drugs? ☐ Abuse/Neglect
≥20wks IUP? ☐ Y ☐ N ____ wks
Barriers to Pt. Care: ☐ Speech ☐ Hearing ☐ Language
☐ Physical ☐ Other ____ Translator: ____

Care Provided by PD:
☐ TourniQuet
☐ NarCan
☐ Hemostatic Dressing
☐ OTher

Total IV Fluids Received: ____ mls

VITALS

Time	TM#	BP	Pulse	RR	O2 Sat	Pain	CO2	Time	TM#	Rhythm	Meds/Defib	Dose	Route	Result
18:44	2	144 / 84	98	16	100	0		18:45	2	SR				
19:33	2	154 / 84	100	16	100	0								
		/												
		/												

Morphine Given: ____ mg Wasted: ____ mg
Midazolam Given: ____ mg Wasted: ____ mg
Fentanyl Given: ____ mcg Wasted: ____ mcg
Narcotic Wasted: RN Witness Name (print) ____ Signature ____

Reassessment after Therapies and/or Condition on Transfer:

Care Transferred To: ■ Facility ☐ ALS ☐ BLS ☐ Heli	Transfer VS	Time	TM#	BP	Pulse	RR	O2 Sat	CO2	Rhythm	CPAP Pressure	GCS
		18 56	2	144/ 84	98	16	100				E 4 V 5 M 6

Signature TM completing form Sig #1 K Vertrees Sig #2 B Weist Reviewed By

Date: 07/10/2018 Provider Code: _____ Unit: _____ Seq. #: BH1800300538

Patient Name: _____ [redacted] _____ Sec. Seq. #: _____ (if applicable)

Incident #: 4046

VITAL SIGNS	Time	TM#	BP	Pulse	RR	O2 Sat	Pain	CO2
			/					
			/					
			/					
			/					
			/					
			/					
			/					
			/					

MEDS/DEFIB	Time	TM#	Rhythm	Meds/Defib	Dose	Route	Result

Additional Comments:

REASON FOR ADVANCED AIRWAY

☐ **R**espiratory **A**rrest ☐ **C**ardiopulmonary **A**rrest ☐ **HY**poventilation ☐ **PR**ofoundly Altered ☐ **OT**her: _____

THE FOLLOWING SECTION MUST BE COMPLETED ON ALL PATIENTS REQUIRING ADVANCED AIRWAY INTERVENTIONS

ENDOTRACHEAL **T**UBE/KING AIRWAY Attempts:

ET/KING PM#_____ ET/KING PM#_____ ET/KING PM#_____ ET/KING PM#_____ SUCCESS: ☐ **Y** ☐ **N** Time Inserted: _____

ETT/King Size: _____

☐ **F**lex **G**uide ☐ **EL**M

Tube Placement: Mark at teeth: _____

Complications During Tube Placement: ☐ **N**one ☐ **E**mesis/Secretions/Blood ☐ **C**lenching ☐ **A**natomy ☐ Gag **R**eflex ☐ **G**astric Distention ☐ **O**ther: _____

Initial Advanced Airway Tube Placement Confirmation:

☐ **B**ilateral **B**reath Sounds ☐ **B**ilateral **C**hest Rise ☐ **A**bsent **G**astric Sounds ☐ EtCO2 Detector Colorimetric: ☐ **Y** ☐ **T** ☐ **P**

☐ EID **N**o **R**esistance ☐ Capnography #: _____ ☐ Waveform Capnography (attach printout)

ONGOING VERIFICATION OF CORRECT ADVANCED AIRWAY PLACEMENT

Time: _____

☐ Reassessed after patient movement

☐ Verified **C**orrect pla**C**ement ☐ **S**uspected **D**islodgement

Spontaneous Respirations: ☐ **Y** ☐ **N**

Time: _____

☐ Reassessed after patient movement

☐ Verified **C**orrect pla**C**ement ☐ **S**uspected **D**islodgement

Spontaneous Respirations: ☐ **Y** ☐ **N**

ALS AIRWAY UNABLE (REASON)

☐ Positive **G**ag Reflex ☐ **A**natomy

☐ **B**lood/Secretions

☐ Unable to Visualize **C**ords

☐ Unable to Visualize **E**piglottis

☐ Equipment Failure

☐ **L**ogistical/Environmental Issues

☐ **D**escribe Issues: _____

CARDIAC ARREST/RESUSCITATION

☐ **R**estoration of **P**ulse: _____ (Time)

☐ **R**esuscitation **D**/C by Base @ _____ (Time)

Pronounced by: _____ M.D.

Rhythm when pronounced: _____

Comments: _____

VERIFICATION OF TUBE PLACEMENT

(attach waveform printout **OR** obtain physician signature)

Receiving Facility: _____ Verification Technique: ☐ **V**isualization ☐ **A**uscultation ☐ EtCO2 ☐ **X**-ray

Placement: ☐ **T**racheal ☐ **E**sophageal ☐ **R**ight Main Comments: _____

(Print Name) _____ Signature: _____ M.D.

H-1993-2 (07/20/17)

Sig 1: _____ Sig 2: _____

PATIENT RELEASE

I hereby release BEVERLY HILLS FIRE DEPARTMENT EMS provider and
Por este acto rel vio *proveedor de asistencia y*

Hospital (if base contact made) from any _____ [redacted] _____
hospital de posibilidad de incurrir en demanda

liability of medical claims resulting from my refusal of emergency care and/or transportation to the nearest
medical resultado de mi denegación de tratamiento emergencia o transportacion a la clinica mas proxima. A mas

recommended medical facility. I further understand that I have been directed to contact my personal physician as to my
de esto, comprendo yo que me han dado instrucciones a communicar con mi medico privado de mi estato medical

present condition as soon as possible. I have received an explanation of the potential consequences of my refusal
tan pronto como es posible. Me han explicado la importancia de mi opcion y los resultados posible por mi denegacion.

Risks / Consequences _____
Riesgos / Consequencias

Reason for refusal _____
Mi argumento para denegar

Additional comments _____
Mas comentos

Patient Signature *Firma del Paciente*	Date *Fecha*
Legal Representative *Custodio Legal*	Relationship to Patient *Parentesco al Paciente*
Witness 1 *Presenciador*	Date *Fecha*
Witness 2 *Presenciador*	Date *Fecha*

Yes

- ☐ GCS = 15
- ☐ Advised of risks and consequences
- ☐ Interpreter used Name: _____
- ☐ Patient has plans for follow up

Refused

☐ Treatment ☐ Transport

Yes

- ☐ Advised alternative medical care at once
- ☐ Understands consequences of refusal
- ☐ Instructed to recontact 911 if patient's condition deteriorates or patient reconsiders the need for 911 assistance

Beverly Hills Fire Department – Ambulance Transport Services
Consent Form w/Assignment of Benefits Authorization- -

Patient Name: _____ [redacted] _____ **Date:** 07/10/2018

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that Beverly Hills Fire Department will only provide a copy of its Notice of Privacy Practices to the patient or other party via mail if requested. *A copy of this form is valid as an original*

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.
NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by **Beverly Hills Fire Department** now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by **Beverly Hills Fire Department**, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to **Beverly Hills Fire Department** any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to **Beverly Hills Fire Department**. I authorize **Beverly Hills Fire Department** to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to **Beverly Hills Fire Department** and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by **Beverly Hills Fire Department**, now, in the past, or in the future. I also authorize **Beverly Hills Fire Department** to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

If the patient signs with an "X" or other mark, a witness should sign below.

X_____ _____ X_____ _____
Patient Signature or Mark | Date | Witness Signature | Date

_____
Witness Address

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if the patient is physically or mentally incapable of signing.

Describe the circumstances that make it impractical for the patient to sign: _____

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **Beverly Hills Fire Department** now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **only** the following individuals:

- ☐ Patient's legal guardian
- ☐ Relative or other person who receives social security or other governmental benefits on behalf of the patient
- ☐ Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs
- ☐ Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient

X_____ _____ _____
Representative Signature | Date | Printed Name of Representative

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section **only** if: (1) the patient was physically or mentally incapable of signing, **and**
(2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

Describe the circumstances that make it impractical for the patient to sign: _____

Name and Location of Receiving Facility: _____ Time: _____

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **Beverly Hills Fire Department**.

A. Ambulance Crew Member Statement (*must* be completed by crew member at time of transport)
My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. **My signature is not an acceptance of financial responsibility for the services rendered.**

X_____ _____ _____
Signature of Crewmember | Date | Printed Name and Title of Crewmember

B. Receiving Facility Representative Signature
The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered.**

X_____ _____ _____
Signature of Receiving Facility Representative | Date | Printed Name and Title of Receiving Facility Representative