INCIDENT INFO

Date	Inc. #	Jur. Sta.	Location Code	MCI?	PD & Unit #	
08/06/2019	4892	003		☐ Y ■ N		■ Regular Run ☐ No PT ☐ Cx at Scene ☐ PuB Asst ☐ IFT ☐ DOA ☐ FireLine ☐ Mutual Aid ☐ Pg 2

BH 19 308 00957
Orig. Seq. # _____

Inc Loc: 99 | Street Number: LA CIENEGA | Street Name: 303 | Apt #: BH | City Code: 90211 | Incident Zip Code

Prov	A/B/H	Unit	Disp	Arrival	At Pt	Left	At Fac	Fac Equip	Avail
BH	A	R3844	12:28	12:32	12:36	12:46	12:48	13:05	13:10

Team Member ID

#1 P10997	#2 P11640
#3 P9526	#4 E043720
#5 E044478	#6 E112016
#7	#8

TRANS

Protocol	Protocol	Notification?		VIA	TRANS TO	RATIONALE
1217		AMA?	☐ Y ■ N	■ ALS	■ MAR ☐ PeriNat ☐ EDAP ☐ STEMI	■ No SC Req`d ☐ Criteria/Required ☐ Guidelines
Med. Ctrl: MTP	Rec. Fac: CSM	Code 3?	☐ Y ■ N	☐ BLS	☐ TC/PTC ☐ PMC ☐ PrimAry Stroke Ctr.	☐ Judgment ☐ EXtremis ☐ No SC Access
		Release at Scene?	☐ Y ☐ N	☐ Heli	☐ SART ☐ Other ☐ Comp. StroKe Ctr.	☐ ED Sat ☐ Request by _____
		Treat & Refer?	☐ Y ☐ N	☐ No Transp		

PT INFO

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

Street Number | Street Name | Apt# | City | State | Zip: [redacted] | Mileage: 1.15

Insurance | Hospital ID | PMD Name | Partial SS #: [redacted]

COMMENTS

Pt found lying in surgery bed with CC of vaginal bleed x approximately 500cc post DNE procedure, finished at 11:30. Pt was 18 wks pregnant with twins. Pt received 850 NS during procedure. No pain. Pt feels drowsy from procedure. G4P1.

Hx NONE

Allergies NONE — ASA Allergy? ☐ Y ☐ N

Meds NONE — SEDs in past 48hrs ☐ Y ☐ N

Suspected:
ETOH? ☐ Y ☐ N
Drug Use? ☐ Y ☐ N

If yes:
☐ AMPhetamines ☐ HEROin ☐ COCaine ☐ Cannabis (THC) ☐ Other OPioid ☐ OTHer

Route:
☐ INJected ☐ INGested ☐ INHaled ☐ OTHer

COMPLAINTS

MEDICAL

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

TRAUMA

☐ No Apparent Injury	☐ Traumatic Arrest	☐ Abdomen	☐ Protective Devices: ☐ SeatBelt ☐ AirBag ☐ HeLmet ☐ CarSeat/Booster	
☐ BUrns/Elec. Shock	☐ Head ☐ GCS≤14	☐ Diffuse Abd. Tend.	☐ Enclosed Vehicle	☐ ASsault ☐ Telemetry Data
☐ Critical Burn	☐ Face/Mouth	☐ Genitals	☐ EJected ☐ EXtricated @____	☐ STabbing ☐ GSW ☐ Hazmat Exposure
☐ SBP <90, <80 (<1yr)	☐ Neck	☐ ButtocKs	☐ Pass. Space. Intr. ☐ >12" ☐ >18"	☐ Motorcycle/Moped ☐ ANimal Bite
☐ RR <10/>29, <20 (<1yr)	☐ Back	☐ Extremities	☐ Survived Fatal Accident	☐ SPorts/Recreation ☐ CRush
☐ Susp. Pelvic FX	☐ Chest	☐ EXt. ↑ knee/elbow	☐ Impact > 20 mph Unenclosed	☐ Self-Inflict'd/Acc. ☐ Electrical Shock
☐ Spinal Cord Injury	☐ FlailChest	☐ FRactures ≥ 2 long	☐ Ped/Bike Runover/Thrown/>20mph	☐ Self-Inflict'd/Int. ☐ Thermal Burn
☐ Inpatient Trauma	☐ TensionPneumo	☐ Amp ↑ wrIst/ankle	☐ Ped/Bike < 20mph	☐ AntiCoagulants ☐ Work-Related
☐ Uncontrolled Bleeding	☐ MinorLacerations	☐ Neur/Vasc/Mangl'd	☐ FAll ☐ 15ft/>10ft. ☐ TAser ☐ Special Consid.	☐ UNknown ☐ OTher:_____

IMPRESSION

☐ Abdominal Pain/Problems (ABOP)	☐ Childbirth (Mother) (BRTH)	☐ Hyperthermia (HEAT)	☐ Resp. Distress/Pulm Edema/CHF (CHFF)
☐ Agitated Delirium (AGDE)	☐ Cold/Flu Symptoms (COFL)	☐ Hypoglycemia (HYPO)	☐ Seizure-Active (SEAC)
☐ Airway Obstruction/Choking (CHOK)	☐ Diarrhea (DRHA)	☐ Hypotension (HOTN)	☐ Seizure-Postictal (SEPI)
☐ Alcohol Intoxication (ETOH)	☐ Dizziness/Vertigo (DIZZ)	☐ Hypothermia/Cold Injury (COLD)	☐ Sepsis (SEPS)
☐ Allergic Reaction (ALRX)	☐ DOA-Obvious Death (DEAD)	☐ Inhalation Injury (INHL)	☐ Shock (SHOK)
☐ ALOC-Not Hypoglycemia or SE (ALOC)	☐ Dystonic Reaction (DYRX)	☐ Lower GI Bleeding (LOGI)	☐ Smoke Inhalation (SMOK)
☐ Anaphylaxis (ANPH)	☐ Electrocution (ELCT)	☐ Medical Device Malfunction-Fail (FAIL)	☐ Stings/Venomous Bites (STNG)
☐ Behavioral/Psychiatric Crisis (PSYC)	☐ ENT/Dental Emergencies (ENTP)	☐ Nausea/Vomiting (NAVM)	☐ Stroke/CVA/TIA (STRK)
☐ Body Pain-Non Traumatic (BPNT)	☐ Epistaxis (NOBL)	☐ Newborn (BABY)	☐ Submersion/Drowning (DRWN)
☐ BRUE (BRUE)	☐ Extremity Pain/Swelling-Non-Traumatic (DIZZ)	☐ No Medical Complaint (NOMC)	☐ Syncope/Near Syncope (SYNC)
☐ BURN (BURN)	☐ Eye Problem-Unspecified (EYEP)	☐ Overdose/Poisoning/Ingestion (ODPO)	☐ Traumatic Arrest-Blunt (CABT)
☐ Carbon Monoxide (COMO)	☐ Fever (FEVR)	☐ Palpitations (PALP)	☐ Traumatic Arrest-Penetrating (CAPT)
☐ Cardiac Arrest-Non-Traumatic (CANT)	☐ Genitourinary Disorder-Unspecified (GUDO)	☐ Pregnancy Complications (PREG)	☐ Traumatic Injury (TRMA)
☐ Cardiac Dysrhythmia (DYSR)	☐ HazMat Exposure (DCON)	☐ Pregnancy/Labor (LABR)	☐ Upper GI Bleeding (UPGI)
☐ Chest Pain-Not Cardiac (CPNC)	☐ Headache-Non-Traumatic (HPNT)	☐ Respiratory Arrest/Failure (RARF)	■ Vaginal Bleeding (VABL)
☐ Chest Pain-STEMI (CPMI)	☐ Hyperglycemia (HYPR)	☐ Respiratory Distress/Bronchospasm (SOBB)	☐ Weakness-General (WEAK)
☐ Chest Pain-Suspected Cardiac (CPSC)	☐ Hypertension (HYTN)	☐ Respiratory Distress/Other (RDOT)	

PHYSICAL

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

RESP: ■ Normal ☐ Wheezes ☐ RHonchi ☐ Unequal ☐ Stridor ☐ Apnea ☐ Clear ☐ Rales ☐ SnoringG ☐ JVD ☐ Labored ☐ AMU

Tidal Volume ■ N ☐ + ☐ -

SKIN: ■ Normal ☐ Cyanotic ☐ Flushed ☐ Pale ☐ Diaphoretic ☐ Hot ☐ CoLd

Cap Refill: ■ NoRmal ☐ DElayed

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

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

ARREST

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

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 Abuse/Neglect? ☐ Y ☐ N Contacted MCS (LVAD)? ☐ Y ☐ N
≥20wks IUP? ☐ Y ☐ N _____ wks
Barriers to Pt. Care: ☐ Speech ☐ Hearing ☐ Language ☐ Physical ☐ Other _____ Translator: _____

VITALS

Time	TM#	BP	Pulse	RR	O2 Sat	Pain	CO2
12:39	2	108 / 73	85	18	100	0	
		/					
		/					
		/					

Time	TM#	Rhythm	Meds/Defib	Dose	Dose Units	Route	Result

PATIENT ASSESSMENT

Pt 1 of 1 # Pts
Transported 1
Age 39 ■ Y ☐ M ☐ W ☐ D ☐ H ☐ Est.
Gender ☐ M ■ F ☐ N
Weight 120 ■ Lbs ☐ Kg
Peds Color Code _____ ☐ Too Tall
Distress Level ☐ None ■ MilD ☐ Mod ☐ Severe
Pt Complaint VA
Prov Impress VABL
Mechanism

GCS / STROKE

Time	12 39	
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: _____

THERAPIES

TM#

☐ Assisted with HomeMeds _____
☐ Back Blows/Thrust _____
☐ BVM ☐ CO2 _____ _____
☐ Breath Sounds _____
☐ Chest Rise _____
☐ Existing Trach _____
☐ OP/NP Airway _____
☐ Cooling Measures _____
☐ DRessings _____
☐ Ice Pack _____
☐ TourniQuet _____
☐ Hemostatic Dressing _____
☐ 0X _____ 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 _____
☐ IO _____ g _____ length _____
Site ☐ HUmerus ☐ TibiA
☐ Needle THoracostc _____
Site ☐ 2nd ICS ☐ 4th ICS
☐ Vagal Maneuver _____
☐ TC Pacing _____ mA _____ bpm _____
Time: _____
☐ OTher _____ _____

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

Total IV/IO Fluids Rec'd: _____ mls

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
		12:54	2	119/ 80	77	16	99				E 4 V 5 M 6

Signature TM completing form Sig #1 | Sig #2 | Reviewed By

Date: 08/06/2019 Provider Code: _____ Unit: _____ Seq. #: BH1930800957

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

Incident #: 4892

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

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

Additional Comments:
97.6

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 TUBE/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 **F**ailure
☐ **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 ☐ **E**tCO2 ☐ **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 MTP
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:** 08/06/2019

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: _____CSM_____ 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