### Boston University Emergency Medical Services Patient Care Report Form

<table>
<thead>
<tr>
<th>Date</th>
<th>Student</th>
<th>Employee</th>
<th>Visitor</th>
<th>ID# or SS#</th>
<th>Building</th>
<th>Location</th>
</tr>
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<tbody>
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</tbody>
</table>

**Name**
- First
- Last
- Phone

**Address**
- Street
- Apt./Box#
- City
- State
- Zip

**Age**

**DOB**

**Sex**

**Activity**
- Family Rec
- Intramural
- Recreation
- Club
- Summer Camp
- Non-Credit Class
- PE Class
- Other

**Past Medical History**

**Chief Complaint/Mechanism of Injury**

**Times**
- Time of Injury
- Time of Event
- Transport Called
- If Yes: Time called
- Patient Departed

**Disposition**
- If Yes: Time called
- Patient Departed

**Transport Called**
- Yes
- No

**Vitals**

<table>
<thead>
<tr>
<th>Vitals</th>
<th>Set 1</th>
<th>Set 2</th>
<th>Set 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse/min</td>
<td>NWB</td>
<td>R I</td>
<td>NWB</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Respirations/min</td>
<td>NSD</td>
<td>R I</td>
<td>NSD</td>
</tr>
<tr>
<td>Capillary Refill</td>
<td>&lt;2 sec</td>
<td>&gt;2 sec</td>
<td>&lt;2 sec</td>
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</table>

**Skin Color**

- Temperature
- Moisture

**Airway**

- Patent
- Partially obstructed
- Fully obstructed

**Pulse/Resp. Codes:**
- N-Normal
- W-Weak
- B-Bounding
- S-Shallow
- D-Deep
- R-Regular
- I-Irregular

**Equipment Used**

**Trachea**
- Midline
- Deviated
- Tugging
- JVD
- L/R O

**C-Spine**
- Normal
- Deformed
- Rigid
- Distended
- Tense
- Palpable Mass
- Guarding

**Abdomen**
- Quadrant
- Reduced/Absent:

**Extremities**
- Deformity
- Ecchymosis
- Swelling
- Crepitus

**Initial Assessment**

- Focused Assessment/Patient Interview

- Physical Examination

- Treatment/Ongoing Assessment

I hereby refuse treatment / transport to a hospital and acknowledge that the above mentioned treatment/transportation was offered and advised by the Emergency Medical Service Provider, Boston University Police, and/or Student Health Services. I hereby release any such persons, The Department of Physical Education, Recreation, and Dance, and Boston University from liability for respecting and following my expressed wishes. Patient Signature

- Witness Signature

- Patient Name (print)

- Witness Name (print)

- EMS Provider Name (print)

- EMT Certification #

- EMS Provider Signature

- Date