DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 7119 (Rev. 02/01)

AMBULANCE REPORT

Completion of this form meets the requirements of administrative rule HFS 110.04(3)(b).
Some client information in this document is confidential under Wis. Stat. 146.82(1).

STATE OF WISCONSIN
Adm. Code HFS 110.04(3)(b)

RESPONSE

Date Incident Reported (Mo/Day/Yr)	Service Name and ID No.	Responding Unit	Station	Patient Care Record / Alarm No.

Incident Address / Location	Incident Municipality	Incident County

Destination Address / Facility Name	Destination Municipality	Destination County

Mileage: (Loaded) End ____ Begin ____ Total ____

Lights And Siren To Scene: ☐ N/A
☐ Non-Emergent, No Lights or Siren
☐ Emergent, Lights and Siren
☐ Initial Emergent, Downgrade To No Lights and Siren
☐ Initial Non-emergent, Upgrade To Lights and Siren

Crash Report No.

(Use Military Times)

Pt. Det. ____ Call Rec. ____ En Route ____ At Scene ____ At Pt. ____ Lv. Scene ____ At Dest. ____ In Service ____

Crew Member Name / License No.

1. ____ 2. ____ 3. ____ 4. ____

Location Type
☐ Airport ☐ Clinic / Medical ☐ Educational Inst. ☐ Farm ☐ Highway / Street ☐ Home / Residence ☐ Hospital ☐ Industrial ☐ Mine / Quarry ☐ Nursing Home ☐ Public Building ☐ Public Outdoors ☐ Recreational / Sport ☐ Residential Inst. ☐ Restaurant / Bar ☐ Waterway ☐ Unspecified ☐ Other ____ ☐ N/A

Response Type
☐ Mutual Aid ☐ Intercept ☐ Response To Scene ☐ Scheduled Interfacility Transfer ☐ Standby ☐ Unscheduled Interfacility Transfer ☐ Unknown ☐ N/A

DEMOGRAPHICS

Patient Last Name / First / M.I.	Mailing Address	City	State	Zip Code	Phone ( )

Emergency Contact Name	Address	City	State	Zip Code	Phone ( )

Personal Physician ☐ N/A	Date of Birth	Age	Weight ☐ lbs ☐ kg	Gender ☐ Male ☐ Female

Social Security No. (Optional) ____

Race ☐ White ☐ Hispanic ☐ Asian/Pacific Islander ☐ Black ☐ American Indian/Alaska Native ☐ Other ____ ☐ Unknown

Work Related Injury ☐ Yes ☐ No

Employer	Address	City	State	Zip Code	Phone ( )

Insurance 1	Group No.	Insured No.

Insurance 2 If MVA, Agency	Address	Phone	Group No.	Insured No.

Medicare	HMO	Medicaid

HISTORY

Signs / Symptoms
☐ Abdominal Pain ☐ Back Pain ☐ Bleeding ☐ Bloody Stool ☐ Breathing Difficulty ☐ Cardiac Arrest ☐ Chest Pain ☐ Choking ☐ Diarrhea ☐ Dizziness ☐ Ear Pain ☐ Eye Pain ☐ Fever/Hyperthermia ☐ Headache ☐ Hypertension ☐ Hypothermia ☐ Nausea ☐ Numbness ☐ Paralysis ☐ Palpitations ☐ Pregnancy / Childbirth ☐ Respiratory Arrest ☐ Seizures / Convulsions ☐ Syncope ☐ Trauma ☐ Unresp. / Unconscious ☐ Vaginal Bleeding ☐ Vomiting ☐ Weakness ☐ Unknown ☐ Other ____ ☐ None

Allergies ☐ None	Patient's Current Medications ☐ None			Last Oral Intake
	Dose	Dose	Dose	
	Dose	Dose	Dose	☐ N/A

Pre-Existing Medical Condition – **Medical**
☐ Asthma ☐ Bleeding Disorders ☐ Cancer ____ ☐ Chronic Renal Failure ☐ Chronic Resp. Failure ☐ CVA / TIA ☐ Diabetes ☐ Gastrointestinal ☐ Headaches ☐ Hepatitis ☐ Hypotension ☐ Seizures / Convulsions ☐ Tuberculosis

Cardiac
☐ Angina ☐ Arrhythmia ☐ Congenital ☐ Congestive Heart Failure ☐ Hypertension ☐ Myocardial Infarction ☐ Cardiac Surgery

Other
☐ Developmental Delay / MR ☐ Psychiatric ☐ Substance Abuse ☐ Tracheostomy ☐ Other ____ ☐ None

ASSESSMENT

Vitals ☐ Vital Continued with Advanced Skills ☐ N/A

Time	BP	Pulse Rate	Pulse Qual.	Resp. / SPO2	Resp. Effort	Level of Consciousness
			☐ Reg ☐ Irr		1 Normal 2 Labored 3 Shallow 4 Absent 5 Assisted	A - Alert ____ V - Verbal P - Pain U - Unresp
			☐ Reg ☐ Irr			
			☐ Reg ☐ Irr			
			☐ Reg ☐ Irr			
			☐ Reg ☐ Irr			

Mental Status/Behavior
☐ Normal ☐ Acute Confusion ☐ Usually Confused ☐ Incoherent ☐ Intermittent Consciousness ☐ Combative ☐ N/A

Eyes ☐ N/A
☐ PERRL
R Reactive L
R Nonreactive L
R Constricted L
R Dilated L
R Blind L
R Cataracts L
R Glaucoma L

Breath Sounds ☐ N/A
R Clear L
R Wet L
R Decreased L
R Wheeze L
R Absent L
☐ Stridor

Skin Temp ☐ Normal ☐ Cool/Cold ☐ Warm/Hot
Moisture ☐ Normal ☐ Dry ☐ Moist ☐ Diaph
Color ☐ Normal ☐ Cyanotic ☐ Pale-Ashen ☐ Cherry ☐ Flushed ☐ Jaundice
Capillary Refill ☐ Normal ☐ Delayed ☐ N/A

Pain Provoke: ____
Quality ☐ Sharp ☐ Dull ☐ Cramp ____ ☐ Crushing ☐ Constant
Radiate ☐ No ☐ Yes
Severity ☐ (1-10) ____
Time (Onset) ☐ 0-15Min ☐ 15-60 Min ☐ 1-12 Hr ☐ 12-24 Hr ☐ Other: ____
☐ N/A

CPR

CPR Provider: ☐ Bystander ☐ First Responder Unit ☐ EMS Unit ☐ Unkn Defib Provider: ☐ PAD ☐ First Responder Unit: ____ ☐ EMS Unit: ____

CPR Start Time ____ Discontinue ____ Witnessed Arrest ☐ Yes ☐ No Time ____ ☐ N/A