Cuyahoga Falls Fire Department
Patient Care Record

Name: **Incident #:** 201800007520 **Date:** 11/03/2018 Patient 1 of 1

Patient Information				Clinical Impression		
Last		Address		Primary Impression		
First		Address 2		Secondary Impression		
Middle		City		Protocol Used		
Gender	Female	State		Anatomic Position		
DOB	12/11/1984	Zip		Chief Complaint		
Age	33 Yrs, 10 Months, 23 Days	Country		Duration	Units	
Weight		Tel		Secondary Complaint		
Pedi Color		Physician		Duration	Units	
SSN		Ethnicity	Not Hispanic or Latino	Patient's Level of Distress		
Race	White			Signs & Symptoms		
Advance Directive		None		Injury		
Resident Status				Medical/Trauma		
				Barriers of Care		
				Alcohol/Drugs		
				Pregnancy		
				Initial Patient Acuity		
				Final Patient Acuity		
				Patient Activity		

Medication/Allergies/History

Medications	
Allergies	
History	

Vital Signs

Time	AVPU	Side	POS	BP	Pulse	RR	SPO2	ETCO2	CO	BG	Temp	Pain	GCS(E+V+M)/Qualifier	RTS	PTS
12:17															

Flow Chart

Time	Treatment	Description	Provider
12:18			ZAWACKI, CHARMAINE

Initial Assessment

Category	Comments	Abnormalities
Mental Status		Mental Status
Skin		Skin
HEENT		Head/Face
		Eyes
		Neck/Airway
Chest		Chest
		Heart Sounds
		Lung Sounds
Abdomen		General
		Left Upper
		Right Upper
		Left Lower
		Right Lower
Back		Cervical
		Thoracic
		Lumbar/Sacral
Pelvis/GU/GI		Pelvis/GU/GI

11/03/2018 12:50:28
PCRID: 9f83cba4-6c84-4f12-8f12-a98d00a62638
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Data Version: 00000-000000010A23B99D

Initial Assessment

Category	Comments	Abnormalities	
Extremities		Left Arm	
		Right Arm	
		Left Leg	
		Right Leg	
		Pulse	
		Capillary Refill	
Neurological		Neurological	

Assessment Time: 11/03/2018 12:15:00

Narrative

Sq3 responded to an ems call to north east Ohio woman's clinic. For a 33 yr old female patient t

Squad arrival. Patient was alert and oriented, [illegible] vital signs obtained, receiving ed contacted and verbal report was given. No further orders. Patient transported in a position of comfort. Nurse from woman's clinic rode along in Squad with crew. Upon arrival at receiving ed patient was transferred to the care of ED physician staff. Verbal report was given, face sheet provided. Sq3 crew returned to service. Hard copy was faxed. End of report.

Specialty Patient - Obstetrical

Gravida		Membrane Intact		APGAR	1 Min	5 Min
Para		Onset		Activity		
Abortions		Contractions		Pulse		
Last Menstrual Period		Frequency		Grimace		
Due Date		Date/Time of Birth		Appearance		
Prenatal Care		Placenta Delivered		Respiration		
OB Physician				Score		
High Risk Pregnancy						
Complications						

Incident Details		Destination Details		Incident Times	
Location Type	Doctor's Office / Clinic	Disposition	Transported Lights/Siren	PSAP Call	12:04:39
Location		Transport Due To	Patient's Choice	Dispatch Notified	
Address	2127 STATE RD	Transported To	Akron General Medical Center	Call Received	12:04:39
Address 2		Requested By	Patient	Dispatched	12:04:40
Mile Marker		Destination	Hospital	En Route	12:04:55
City	Cuyahoga Falls	Department	Emergency Room	Resp on Scene	
County	Summit	Address	1 Akron General Ave	On Scene	12:07:17
State	OH	Address 2	11	At Patient	12:08:00
Zip	44223	City	Akron	Care Transferred	
Medic Unit	SQ3	County	Summit	Depart Scene	12:17:04
Medic Vehicle	SQ3	State	Ohio	At Destination	12:26:57
Run Type	911 Response	Zip	44307	Pt. Transferred	12:28:00
Priority Scene	Emergent	Zone		Call Closed	12:37:59
Shift	A Shift	Condition at Destination		In District	
Zone	Station 3	Destination Record #		At Landing Area	
Level of Service		Trauma Registry ID			
EMD Complaint	No Other Appropriate Choice	EMD Card Number			

Crew Members

Personnel	Role	Certification Level

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Name: [redacted] **Incident #:** 201800007520 **Date:** 11/03/2018 Patient 1 of 1

Crew Members		
KERNER, BENJAMIN	Lead	
FACEMIRE, KENNETH	Driver	EMT-Paramedic - 0156003
ZAWACKI, CHARMAINE	Other	

Mileage		
Scene	1.0	
Destination	5.8	
Loaded Miles	4.8	geo-verified
Start		
End		
Total Miles		

Delays	
Category	**Delays**
Dispatch Delays	None/No Delay
Response Delays	None/No Delay
Scene Delays	None/No Delay
Transport Delays	None/No Delay
Turn Around Delays	None/No Delay

Additional Agencies

Patient Transport Details			
How was Patient Moved to Ambulance	Stretcher	**How was Patient Moved From Ambulance**	Stretcher
Patient Position During Transport	Semi-Fowlers	**Condition of Patient at Destination**	Improved

Billing Authorization

Authorization	Billing Authorization

Section I - Authorization for Billing

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that Cuyahoga Falls Fire Department (CFFD) provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. *A copy of this form is valid as an original* I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by CFFD 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 CFFD, 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 CFFD 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 CFFD. I authorize CFFD to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to CFFD and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payors 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 CFFD, now, in the past, or in the future. This includes liability to interest, reasonable attorney fees, collection fees and courts costs encountered by CFFD or the debt collection agency.

Signature

Signed On	11/03/2018 12:31:17
Notice of Privacy Practices Provided	Yes
Billing Authorization	Agree
HIPAA Acknowledgement	Agree

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Section II - Authorized Representative Signature

Complete this section only if the patient is physically or mentally unable to sign.
Authorized representatives include only the following:(Check one)

Patient's Legal Guardian
Patient's Medical Power of Attorney
Relative or other person who receives benefits on behalf of the patient
Relative or other person who arranges treatment or handles the patient's affairs
Representative of an agency or institution that provided care, services or assistance to patient

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payer for any services provided to the patient by the transporting ambulance service 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.**

Signature

Signed On	
Notice of Privacy Practices Provided	
Printed Name	
Reason unable to sign	

Section III - EMS Personnel and Facility Signatures

Complete this section if the patient was mentally or physically incapable of signing, and no Authorized Representative (section II) was available or willing to sign on behalf of the patient at the time of service.

EMS Personnel Signature

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.**

Signed On	
Printed Name	
Reason unable to sign	

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..**

Signed On	
Notice of Privacy Practices Provided	
Printed Name	
Title of Representative	

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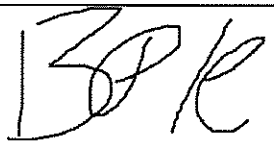
Facility Signatures

Signed On	
Receiving	

Signed On	
Paperwork Received	

Signed On	
Airway Confirmation	

Provider Signatures



Lead Provider	KERNER, BENJAMIN	**Certification Level**	

Provider	FACEMIRE, KENNETH	**Certification Level**	EMT-Paramedic - 0156003

Provider	ZAWACKI, CHARMAINE	**Certification Level**	

Provider		**Certification Level**	

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