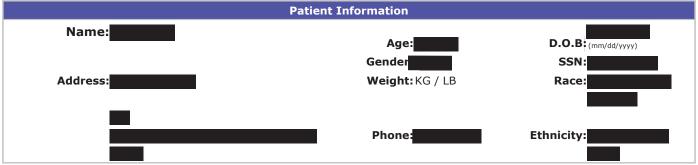
### **Prehospital Care Report**

**Westland Fire Department** 

37201 MARQUETTE WESTLAND, MI 48185

Incident Date: 12/08/2018 Call #: 18-11744 Patient Care #: 1



Provider Impression						
Primary Impression	Secondary Impression					
Other OB/Gyn	Not Applicable					

#### **Narrative**

### **Summary of Events**

Dispatched for possible uterine perforation following medical procedure. ATF female pt laying supine on exam table. Staff at facility st they were performing an elective abortion. Staff st during procedure that a possible uterine perforation occurred due to an excessive amount of fluid being discharged. Staff st abortion was completed fully. Pt st she as minor pain of 5 out of 10. Staff administered 100 mcg of Fentanyl and 1.5 mg of Midazolam prior to procedure. Pt st she has had three previous abortions with no complications. Pt has no other complaints. Pt transported and care transferred to ER.

	Prior Aid	
Prior Aid	Performed By	Outcome
,	N/A,	

Past Medical History										
MEDICATION ALLERGIES	Generic Name	Description								
Prinivil	Lisinopril	ACE Inhibitor Lysine analog of an enalapril metabolite								
Patient Medications	Generic Name	Dosage								
None	None									

### **Medical Surgery History**

History Primarily	Pregnancy	Advanced Directives	Practitioner Name
Obtained From	riegilalicy	Auvanceu Directives	Practitioner Name

### **Assessment Exam**

### **Patient Condition**

Chief Complaint: Possible Uterine Perforation X Minutes

Secondary **Complaint:** Alcohol/Drug Use:

Inc. Date: 12/08/2018 Westland Fire Department Page: 1 Incident #: 18-11744 Date Printed: 02/27/2019 14:42

Injury Onset	Injury Cause	Injury Mechanism	Injury Intent	Ht. of Fall
14:13			Not Recorded	
12/08/2018			Not Recorded	

Primary Symptom	Other Associated Symptoms
Other	Not Recorded

	Patient Vitals															
Time	В/Р	Pulse	Rhythm	Resp.	Effort	SpO2	SpO2 Qual.	EtCO2	GCS	Pain	Stroke Scl	PTA	B.G.	RTS	Limb	Patient Position
14:04	126/	72		18	Normal	100	Rm. Air		15	5				12	Left	Semi-Fowlers
	72														Arm	
14:14	130/	67		18	Normal	100	Rm. Air		15	3				12	Left	Semi-Fowlers
	74														Arm	

	200 1.10.111.15.														
Time	EC	G Type	ECG Lead	ECG Inte	erpretation		ECG Ectopy							Cause F	or Change
	Procedures and Treatments														
Time	Crew	Name				Location		Size of Equ	ipment	Attempts	Respo	nse	Success	Comment	5
14:12		Venous	Access-E	xtremity	′	Antecul	oital-Left	18g		1	Uncha	nged	Yes		
						Intu	bation Co	nfirmatio	on						
Time	astric	ounds Lung L/R	Chest L/R Wave	TCO2	Color	ify Tube	EDD ws Back EDD	EDD	isting	Score	e Depth	epth	be size	erify (-Ray	D/RN Ferify cement

Medication Administered								
Time	Crew	Medication	Route	Dosage	Response	PTA	Comments	
14:12		Normal Saline	Intravenous	Lock/Flush	Unchanged	No		

## **Injury Details**

### **Trauma Team Details**

Trauma Team Not Applicable **Activated:** 

Patient Transport/Positioning								
Patient Moved To Ambulance	Patient's Position In Transport	Patient Moved From Ambulance						
Stretcher	Semi-Fowlers	Stretcher						

Call Type and Location	Call Disposition	Response Times and Mileage							
Call Type: Other	Disposition: Treated,	1st Resp.							
Resp. Lights and Sirens	Transported by	Arr.:							
Mode:	EMS	<b>PSAP:</b> 13:53 <b>Incident #:</b> 18-11744							
Urgency: Immediate	Resp. Mode: No Lights or	Disp. 13:53 Call Sign: Rescue 1							
Response: 911 Response	Sirens	Notified:							
Location: Health Care	<b>Destination:</b> GARDEN CITY	<b>Unit Disp.:</b> 13:54 <b>Veh. #:</b> Rescue-1 2018 Ford							
Facility (clinic,	HOSPITAL,	F450							
hospital, nursing	6245 INKSTER	Enroute: 13:56 Start Miles: 0.0							
home)	RD, Garden	<b>At Scene:</b> 14:00 <b>Scene</b> 0.0 <b>To</b> 0.0							
Address: 35000 Ford Rd	City, MI 48135	Miles: Scene:							
WESTLAND,	<b>Dest.</b> Closest Facility	At Patient: 14:01							
WAYNE, MI 48185	Determ.:	<b>Depart:</b> 14:15							

Inc. Date: 12/08/2018 Westland Fire Department Page: 2 Incident #: 18-11744 Date Printed: 02/27/2019 14:42

Call Type and Location	Call Disposition	Response Times and Mileage						
	Diverted	Arrive 14:27	Dest. Miles: 4.0	To Dest: 4.0				
	From:	Dest:						
	<b>Response</b> None	<b>In</b> 14:38						
	Delay:	Service:						
	Scene Delay: None	In	End Miles: 4.0	<b>To End:</b> 0.0				
	Transport None	Quarters:						
	Delay:	Cancelled:						

Unit Personnel				
Crew Member	Level of Certification	Role		
	EMT-Paramedic	Primary Patient Caregiver		
	EMT-Paramedic	Primary Patient Caregiver		

# **Billing Information** Work Related? Not Applicable

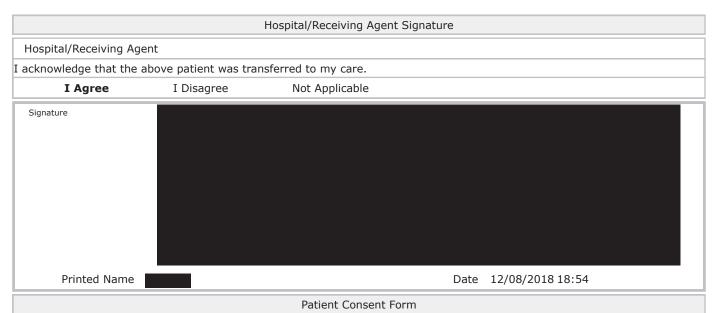
Insurance Information					
Company Name	Company City	Company State	Insurance Policy #	Relationship To Insured	
				Self	

**Payment Method:** 

### **Patient Occupation Information** Occupation Industry

Service-Defined Questions				
Run Priority	2			
CT #	5679			
Primary Response District	Station 1			
Drug Box/ A-Pack				
Mutual Aid Given or Received	N/A			
Department Given or Receiving Mutual Aid	NA			
Additional WLFD units dispatched				
Opioid Overdose	No			

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## HIPAA Consent

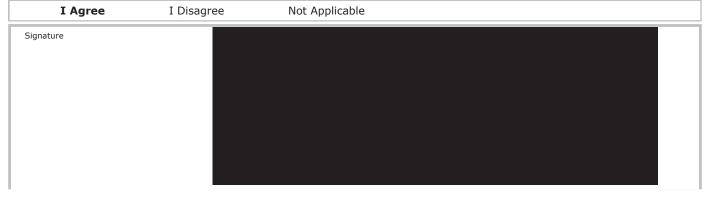
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment or health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I Agree I Disagree Not Applicable
Waiver of Liability

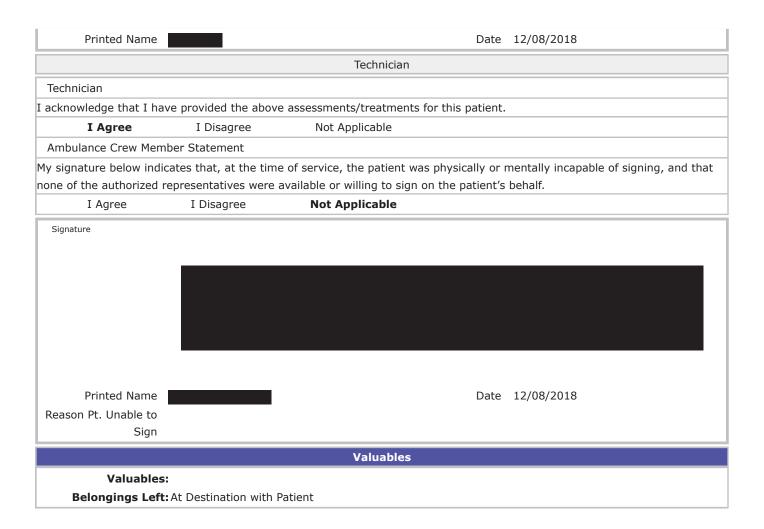
I refuse treatment and/or transportation by the providing ambulance service. I assume responsibility for my own, my child's own, or any family member's medical treatment. I have been advised to seek the attention of a physician. I release the providing ambulance service, its employees, officers and directors from liability resulting from my own, my child's own, or any other family member's refusal of medical treatment or transportation.

I Agree I Disagree **Not Applicable**Authorization for Billing

I authorize the release to the Social Security Administration and Centers for Medicare and Medicaid Services, any HMO/PPO, other private or public insurance, or their agents, fiscal intermediaries or carriers or an independent agency performing billing or collection functions on behalf of the ambulance service, any personal, medical or billing information needed for this or a related claim. I understand I will be responsible for any services that are not paid/covered by my insurance. A copy of this authorization shall be valid as the original and shall remain in effect until revoked in writing by the patient/insured. I request payment of medical insurance benefits either to me or to the ambulance service.







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 Patient Name:
 Westland Fire Department
 Page: 5

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