Prehospital Care Report

Westland Fire Department
37201 MARQUETTE
WESTLAND, MI 48185

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

Patient Information

Name: [redacted]
Address: [redacted]
Age: [redacted]
Gender [redacted]
Weight: KG / LB
Phone: [redacted]
D.O.B: [redacted] (mm/dd/yyyy)
SSN: [redacted]
Race: [redacted]
Ethnicity: [redacted]

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

[redacted]

History Primarily Obtained From	Pregnancy	Advanced Directives	Practitioner Name

Assessment Exam

Patient Condition

Chief Complaint: Possible Uterine Perforation X Minutes
Secondary Complaint:
Alcohol/Drug Use:

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

Primary Symptom	Other Associated Symptoms
Other	Not Recorded

Patient Vitals

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

ECG Monitor

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Ectopy	Cause For Change

Procedures and Treatments

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success	Comments
14:12	[redacted]	Venous Access-Extremity	Antecubital-Left	18g	1	Unchanged	Yes	

Intubation Confirmation

Time	Preoxy	Gastric Sounds	Lung L/R	Chest L/R	Wave Form	ETCO2 Numeric	ETCO2 Color	Verify Tube	EDD Draws Back	EDD Inflates	EDD	Misting	POGO Score	Secured	Tube Depth At	Depth	Tube size	Verify X-Ray	MD/RN Verify Placement

Medication Administered

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

Injury Details

Trauma Team Details

Trauma Team Activated: Not Applicable

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 Type: Other
Resp. Mode: Lights and Sirens
Urgency: Immediate
Response: 911 Response
Location: Health Care Facility (clinic, hospital, nursing home)
Address: 35000 Ford Rd WESTLAND, WAYNE, MI 48185

Call Disposition

Disposition: Treated, Transported by EMS
Resp. Mode: No Lights or Sirens
Destination: GARDEN CITY HOSPITAL, 6245 INKSTER RD, Garden City, MI 48135
Dest. Determ.: Closest Facility

Response Times and Mileage

1st Resp. Arr.:
PSAP: 13:53
Disp. Notified: 13:53
Unit Disp.: 13:54
Enroute: 13:56
At Scene: 14:00
At Patient: 14:01
Depart: 14:15

Incident #: 18-11744
Call Sign: Rescue 1
Veh. #: Rescue-1 2018 Ford F450
Start Miles: 0.0
Scene Miles: 0.0
To Scene: 0.0

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

Unit Personnel

Crew Member	Level of Certification	Role
[redacted]	EMT-Paramedic	Primary Patient Caregiver
[redacted]	EMT-Paramedic	Primary Patient Caregiver

Billing Information

Payment Method:	**Work Related?** Not Applicable

Insurance Information

Company Name	Company City	Company State	Insurance Policy #	Relationship To Insured
[redacted]			[redacted]	Self

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

Hospital/Receiving Agent Signature

Hospital/Receiving Agent

I acknowledge that the above patient was transferred to my care.

I Agree I Disagree Not Applicable

Signature [redacted]

Printed Name [redacted] Date 12/08/2018 18:54

Patient Consent Form

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.

I Agree I Disagree Not Applicable

Signature [redacted]

Printed Name [redacted] Date 12/08/2018

Technician

Technician

I acknowledge that I have provided the above assessments/treatments for this patient.

I Agree I Disagree Not Applicable

Ambulance Crew Member Statement

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 were available or willing to sign on the patient's behalf.

I Agree I Disagree **Not Applicable**

Signature

Printed Name [redacted] Date 12/08/2018

Reason Pt. Unable to Sign

Valuables

Valuables:

Belongings Left: At Destination with Patient