


West Virginia Public Service Training
EMT Student Patient Assessment Documentation Form

	Student Name:	WVOEMS #	Shift Date:
	Preceptor Name:	WVOEMS #	Location:
Course Instructor Name:		Started Shift:	Ended Shift:

Chief Complaint:

DISPATCH	RACE	SCENE SURVEY	
<input type="checkbox"/> Non Emergency	<input type="checkbox"/> African American	<input type="checkbox"/> Scene Safe	<input type="checkbox"/> Drowning
<input type="checkbox"/> Emergency	<input type="checkbox"/> American Indian	<input type="checkbox"/> Hazardous Materials	<input type="checkbox"/> Explosion
GENDER	<input type="checkbox"/> Asian	<input type="checkbox"/> Violence	<input type="checkbox"/> Other:
<input type="checkbox"/> Male	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Traffic	
<input type="checkbox"/> Female	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Weather	
AGE:	<input type="checkbox"/> Other	<input type="checkbox"/> Electrical	

MECHANISM OF INJURY	NATURE OF ILLNESS	ASSISTANCE REQUIRED	PATIENT CONDITION
<input type="checkbox"/> MVA	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Additional EMS	<input type="checkbox"/> Stable
<input type="checkbox"/> Pedestrian Struck	<input type="checkbox"/> GI	<input type="checkbox"/> Rescue / FD	<input type="checkbox"/> Unstable
<input type="checkbox"/> Fall	<input type="checkbox"/> GU	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Potentially Unstable
<input type="checkbox"/> Blunt Trauma	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Mutual Aid	<input type="checkbox"/> Critical
<input type="checkbox"/> Penetrating Trauma	<input type="checkbox"/> Stroke / CVA	<input type="checkbox"/> Aeromedical	<input type="checkbox"/> Full Arrest
<input type="checkbox"/> Burn	<input type="checkbox"/> Poison / OD	<input type="checkbox"/> Extrication	<input type="checkbox"/> DOS
<input type="checkbox"/> Other:	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Other:	

PRIMARY PATIENT ASSESSMENT

LOC	AIRWAY	BREATHING	CIRCULATION	SKIN CONDITION
<input type="checkbox"/> Alert	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	Color:
<input type="checkbox"/> Oriented X3	<input type="checkbox"/> Adjunct (OPA)	<input type="checkbox"/> Labored	<input type="checkbox"/> Irregular	Temperature:
<input type="checkbox"/> Verbal	<input type="checkbox"/> Combitube	<input type="checkbox"/> Irregular	<input type="checkbox"/> Bounding / Weak	Condition:
<input type="checkbox"/> Pain	<input type="checkbox"/> King Airway	<input type="checkbox"/> Deep / Shallow	<input type="checkbox"/> Rapid / Shallow	Cap Refill UE: _____ Sec.
<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Intubation	<input type="checkbox"/> Rapid / Slow	<input type="checkbox"/> Absent Carotid/Radial	Cap Refill LE: _____ Sec.
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

FOCUSED HISTORY AND PHYSICAL EXAM

HEAD	NECK	CHEST	ABDOMIN
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS	<input type="checkbox"/> DCAP-BLS
<input type="checkbox"/> Fluid Nose/Ears/Mouth	<input type="checkbox"/> Tracheal Deviation	<input type="checkbox"/> BS R Diminished / Absent	<input type="checkbox"/> Tender RU / LU / RL / LL
<input type="checkbox"/> R Pupil Dil / Const	<input type="checkbox"/> JVD	<input type="checkbox"/> BS L Diminished / Absent	<input type="checkbox"/> Rigid
<input type="checkbox"/> L Pupil Dil / Const		<input type="checkbox"/> Crackles / Rales / Wheezes	
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

PELVIS	LOWER EXTREMITIES	UPPER EXTREMITIES	BACK
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> DCAP-BTLS	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS Right	<input type="checkbox"/> DCAP-BTLS
<input type="checkbox"/> Crepitus	<input type="checkbox"/> DCAP-BTLS Left	<input type="checkbox"/> DCAP-BTLS Left	
<input type="checkbox"/> Unstable	<input type="checkbox"/> PMS Deficit	<input type="checkbox"/> PMS Deficit	
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

CRITICAL INTERVENTIONS

<input type="checkbox"/> Maintain Airway	<input type="checkbox"/> Suctioning	<input type="checkbox"/> APGAR
<input type="checkbox"/> Spinal Immobilization	<input type="checkbox"/> Breathing Treatment	<input type="checkbox"/> Glasco Coma Scale
<input type="checkbox"/> Ventilation	<input type="checkbox"/> Pulse Ox	<input type="checkbox"/> Oxygen LPM _____ / Delivery Device _____
<input type="checkbox"/> Control Bleeding	<input type="checkbox"/> Glucometer Reading	
<input type="checkbox"/> CPR / Defibrillation	<input type="checkbox"/> Temperature	
<input type="checkbox"/> Other:		

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