Addendum 1: Recorder Sheet

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age/Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Kilograms Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illness Symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temperature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_rectal/forehead/ear/armpit

EMS time called:\_\_\_\_\_\_\_\_\_\_\_\_\_ Flight (phone #) ALS (911) BLS (phone #)

Hospital contacted:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ time:\_\_\_\_\_\_\_\_\_\_\_Physician name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Closest Hospital ED (phone #) Children’s Hospital ED (phone #)

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| --- | --- | --- | --- | --- | --- | --- |
| Time | Heart rate | Pulse ox | Respiratory  rate | Blood  Pressure | Pulses (Yes,no) | Exam notes |
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| --- | --- | --- | --- | --- | --- |
| Time | Medication | Dose  mg, ml | IV, IO,  IM, PO | Oxygen L/min NC, FM, BVM, ET | Other, AED, Chest Compressions |
|  | Epinephrine 1:1,000 |  | IM |  |  |
|  | Epinephrine 1:10,000 |  | IV/IO |  |  |
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Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_