Patient Care Report (Complete)

Putnam County Ambulance Service
700 County Sevices Dr.
Cookeville , TN
Phone: Fax:

Page No: 1/9
Report Date: 02/04/2015

Trip Number: 14-10666 **D.O.S.** 02/27/14 13:41:29 **Shift:** A **Call Sign:** 708 **Station:** STATION 1
Name: ROBERT TATANISH **Unit:** E708 **Call Type:**

Patient

Name: ROBERT TATANISH **Age:** 64 Years **Race:** White
Address: 5450 BUNKER HILL RD **Birth Date:** 04/09/1949
City: Cookeville **SSN#:** xxx-xx-0285
State: TN **Zip:** 38506 **Phone:** (931)284-7791 **Gender:** Male

Incident

Service Requested:	911 Response (Scene)	Dispatch Chief Complaint:	Cardiac Arrest
Primary Role:	Transport	Response Mode:	Lights and Sirens
Dispatch Priority:	Emergency	EMD Performed?	[Not Applicable]
		EMD Card Number:	

Call Times / Mileage

Times

Incident:		Arrived Patient:	2/27/2014 13:54:24	Back At Zone:	
Received:	2/27/2014 13:41:29	Transferred:			
Dispatch Notified:	2/27/2014 13:41:29	Left Scene:	2/27/2014 14:12:20		
Unit Notified:	2/27/2014 13:41:59	Arrived Dest:	2/27/2014 14:25:14		
Unit Enroute:	2/27/2014 13:42:47	Back In Service:	2/27/2014 14:25:44		
Arrived Scene:	2/27/2014 13:49:04	Cancelled:			

Odometer Reading

Beginning:	Scene: 4181	To Scene: .00	Total: .00
Destination: 4189.1	End:	Loaded Miles: 8.10	

Crew

Name	Cert Number	Role
Collin Young	40217	Driver
Kevin Jolly	15500	Primary Patient Caregiver
Ernest Copeland	11308	Secondary Patient Caregiver
Jonathan Medley	37879	Third Patient Caregiver

Delays

Response:
Transport:
Dispatch:
Turnaround:
Scene:

Scene

Other Services at the Scene:
Number of Patients at the Scene: 1
Estimated Time of First Responder: [Not Applicable]
Mass Casualty Incident? [Not Applicable]
Other Agencies:

Incident/Pickup Location

Location Type: Home/Residence
Department:
Incident Location: PATIENTS RESIDENCE
Grid/Zone:
Address: 5450 BUNKER HILL RD
City: Cookeville
State: TN Zip: 38506

Patient

Name: ROBERT TATANISH **Age:** 64 **Race:** White
Address: 5450 BUNKER HILL RD **Birth Date:** 04/09/1949
City: Cookeville **SSN#:** xxx-xx-0285
State: TN **Zip:** 38506 **Phone:** (931)284-7791 **Gender:** Male

Patient History / Notes

Description:

Drug Allergies / Notes

Drug Name:

Current Medications

Drug Code	Drug Name	Dose	Units	Route

Patient Insurance

	Medicare # / Policy #	Group ID	Medicaid # / Insured Name	Relationship
Insurance Company				
Primary				
Cigna	UO912130501		ROBERT TATANISH	Self

Situation

Complaints:

Skin Turgor:	< 2 seconds	Ears:	No Abnormalities Noted
Dependent Lividity:	N/A	Neck:	No Abnormalities Noted
Rigor Mortis:	N/A	Neck Veins:	Normal
Head Rash:	Clear	Trachea:	Midline
Torso Rash:	Clear	Devices:	
Abdomen Rash:	Clear	Nose Drainage:	
Left Arm Rash:	Clear	Mouth Drainage:	Clear
Right Arm Rash:	Clear	Right Ear Drainage:	
Left Leg Rash:	Clear	Left Ear Drainage:	
Right Leg Rash:	Clear	Pain Provoked By:	
Groin Rash:	Clear	Pain Quality:	
		Pain Region:	
		Pain Radiation:	
		Pain Severity:	
		Pain Time:	

Left Eye		**Right Eye**	
Reactivity:	Non-Reactive	Reactivity:	Non-Reactive
Description:	Round	Description:	Round
Pupil Size	5	Pupil Size:	5
DCAP-BTLS:	No Abnormalities Noted	DCAP-BTLS:	No Abnormalities Noted
Drainage:		Drainage:	

Chest			
Chest Left:	No Abnormalities Noted	Heart Sounds:	Not Assessed
Chest Right:	No Abnormalities Noted	Devices:	
L-U Anterior Breath Sounds	Minimal to No Breath Sounds	R-U Anterior Breath Sounds	Minimal to No Breath Sounds
L-M Anterior Breath Sounds	Minimal to No Breath Sounds	R-M Anterior Breath Sounds	Minimal to No Breath Sounds
L-L Anterior Breath Sounds	Minimal to No Breath Sounds	R-L Anterior Breath Sounds	Minimal to No Breath Sounds
L-U Posterior Breath Sounds	Minimal to No Breath Sounds	R-U Posterior Breath Sounds	Minimal to No Breath Sounds
L-M Posterior Breath Sounds	Minimal to No Breath Sounds	R-M Posterior Breath Sounds	Not Assessed
L-L Posterior Breath Sounds	Minimal to No Breath Sounds	R-L Posterior Breath Sounds	Minimal to No Breath Sounds
Pain Provoked By:		Pain Radiation:	
Pain Quality:		Pain Severity:	
Pain Region:		Pain Time:	

Abdomen			
Left Upper:	No Abnormalities Noted	Right Upper:	No Abnormalities Noted
Left Lower:	No Abnormalities Noted	Right Lower:	No Abnormalities Noted
Bowel Sounds:	Not Assessed	Complaints:	

Abdomen		Pelvis	
Cervical:	No Abnormalities Noted	DCAP-BTLS	No Abnormalities Noted
Thoracic:	No Abnormalities Noted	Device	
Lumbar:	No Abnormalities Noted		

Left Arm		Right Arm	
DCAP-BTLS:	No Abnormalities Noted	DCAP-BTLS:	No Abnormalities Noted
Motor / Sens:	Not Assessed	Motor / Sens	Not Assessed
Radial:	Absent	Radial:	Absent
Brachial:	Absent	Brachial:	Absent

Left Leg		Right Leg	
DCAP-BTLS:	No Abnormalities Noted	DCAP-BTLS:	No Abnormalities Noted
Motor /Sens:	Not Assessed	Motor / Sens:	Not Assessed
Pedal:	Absent	Pedal:	Absent
Posterior:	Absent	Posterior:	Absent

Vitals

Time	PTA	EKG	BP/S	BP/D	Pulse	Resp Rate	SaO2	CO2	Gluc.	Temp	Pain	GCS
02/27/14 13:54:24	0	Ventricular Fibrillation										3
02/27/14 14:16:00	0	Ventricular Tachycardia	75	50	133	12	92		144			

Est. Body Weight in KG: 0 Broselow / Luten Color: [Not Applicable]

Treatment

Time	Treatment Given	Details	Medic	Assistant
02/27/14 13:49:00	CPR MANUAL		15500	
02/27/14 13:49:00	CPR MANUAL		15500	
02/27/14 13:49:00	CARDIAC MONITOR		15500	
02/27/14 13:51:00	DEFIBRILLATION-MANUAL	Arrest To Defib:> 15 min---Defib Energy:290(Joules)---Defib Post Rhytm:Ventricular Fibrillation---Defib Pre Rhythm:Ventricular Fibrillation	15500	
02/27/14 13:54:24	AIRWAY-SUCTIONING		15500	
02/27/14 13:54:24	CPR AUTOPULSE		15500	
02/27/14 13:55:00	IO-ADULT	Iv Site:Other---Fluid:NS---Guage:16---Rate:Bolus---Tube Size:10	37879	

02/27/14 13:57:00	NORMAL SALINE	Route:Intraosseous---Dose: ---Dose Units:ML/HR--- Response:Improved---Complication:None	37879
02/27/14 13:57:00	EPINEPHRINE 1:10,000	Route:Intraosseous---Dose:1---Dose Units:MG--- Response:Unchanged---Complication:None	37879
02/27/14 13:57:00	OXYGEN	Route:Inhalation---Dose:15---Dose Units:L/MIN--- Response:Improved---Complication:None	15500
02/27/14 13:57:00	DEFIBRILLATION-MANUAL	Arrest To Defib:> 15 min---Defib Energy:285(Joules)- ---Defib Post Rhytm:Ventricular Fibrillation---Defib Pre Rhythm:PEA	15500
02/27/14 13:58:00	BLOOD GLUCOSE ANALYSIS		37879
02/27/14 13:59:00	DEFIBRILLATION-MANUAL	Arrest To Defib:> 15 min---Defib Energy:285(Joules)- ---Defib Post Rhytm:Ventricular Fibrillation---Defib Pre Rhythm:Normal Sinus Rhythm	11308
02/27/14 14:00:00	AIRWAY-INTUBATION CONFIRM CO2	Tube Size:7.5(mm)---Secured At:23(cm)---Secured With:Other---Breath Sounds Left:Normal--- Right:Normal---C02:25	15500
02/27/14 14:01:00	CAPNOGRAPHY		15500
02/27/14 14:02:00	VASOPRESSIN (ADH)	Route:Intravenous---Dose:40---Dose Units:IU--- Response:Improved---Complication:None	37879
02/27/14 14:12:00	AMIODARONE (CORDARONE)	Route:Intraosseous---Dose:150---Dose Units:MG--- Response:Improved---Complication:None	37879
02/27/14 14:13:00	DEFIBRILLATION-MANUAL	Arrest To Defib:> 15 min---Defib Energy:287(Joules)- ---Defib Post Rhytm:Ventricular Tachycardia---Defib Pre Rhythm:Ventricular Tachycardia	11308
02/27/14 14:18:00	12 LEAD		11308
02/27/14 14:24:00	DEFIBRILLATION-MANUAL	Arrest To Defib:> 15 min---Defib Energy:261(Joules)- ---Defib Post Rhytm:Ventricular Tachycardia---Defib Pre Rhythm:Normal Sinus Rhythm	11308

Outcome / Disposition

Destination

Destination Type:	Hospital	Referring Physician:	
Reason:	Closest Facility (none below)	Department:	ED
Destination Name:	COOKEVILLE REGIONAL MEDICAL CENTER	Facility ID:	0095
Address:	1 MEDICAL CENTER BLVD		
City:	Cookeville		
State: TN	Zip: 38501		

Patients Condition Upon Arrival At Destination: Improved

Disposition

Patient Disposition:	Treated, Transported by EMS	Received By:	KEN
Transport Mode from Scene:	Lights and Sirens	ED Disposition:	Admitted to Hospital ICU
Transported to Ambulance:	Stretcher	Hospital Disposition:	[Not Applicable]
Position During Transport:	Supine		
Transported from Ambulance:	Stretcher		

Given To

Patients Valuables:

Hospital Room #: 222

Protective Equipment Used:

Suspected Contact With Body Fluids:

Type:

Narrative

RESPONDED: IMMEDIATE

THE PATIENT WAS MOVED TO THE COT BY: MULTI PERSON CARRY WITH SMITH COT AND AUTO PULSE

CHIEF/SECONDARY COMPLAINT: CARDIAC ARREST,

ADDITIONAL SIGNS, SYMPTOMS, COMPLAINTS:

PRESENT HISTORY: CARDIAC ARREST

PAST MEDICAL HISTORY: NONE

TREATMENTS: OXYGEN, EPINEPHRINE 1:10,000, NORMAL SALINE, VASOPRESSIN (ADH), AMIODARONE (CORDARONE). CARDIAC MONITOR, CPR MANUAL, CPR MANUAL, DEFIBRILLATION-MANUAL, AIRWAY-SUCTIONING, CPR AUTO PULSE, IO-ADULT, BLOOD GLUCOSE ANALYSIS, AIRWAY-INTUBATION CONFIRM CO2, CAPNOGRAPHY, 12 LEAD, DEFIBRILLATION-MANUAL.

PRIMARY CAREGIVER:
EMT-PARAMEDIC, 37879, JONATHAN MEDLEY SERVED AS THIRD PATIENT CAREGIVER
EMT-INTERMEDIATE, 40217, COLLIN YOUNG SERVED AS DRIVER
CRITICAL CARE PARAMEDIC, 11308, ERNEST COPELAND SERVED AS SECONDARY PATIENT CAREGIVER
CRITICAL CARE PARAMEDIC, 15500, KEVIN JOLLY SERVED AS PRIMARY PATIENT CAREGIVER

NARRATIVE:
MEDIC 708 RESPONDED IMMEDIATE, LIGHTS AND SIRENS TO 5450 BUNKER HILL RD, COOKEVILLE. REPORTED: CARDIAC ARREST

C.
COMPLAINTS: CARDIAC ARREST,

H.

PAST MEDICAL HISTORY: NONE
MEDICATIONS: UNKNOWN
ALLERGIES: UNKNOWN
PRESENT HISTORY: FIGHTING GRASS FIRE AND DEVELOPED CHEST PAIN THEN IMMEDIATELY WENT TO CARDIAC ARREST

A. UOA PT SUPINE ON GROUND WITH FIREFIGHTERS DOING CPR. PT HAS WHITE FROTH / SPUTUM COMING FROM MOUTH. PT IS ATTEMPTING AGONAL RESPIRATIONS. PT HAS NO CAROTID PULSE. SKIN IS PALE AND CYANOTIC .

TIME: 02/27/2014 13:54:24 B/P: /, PULSE: , RESPIRATIONS: , SPO2: , BLOOD GLUCOSE: , TEMPERATURE: ORAL, GCS SCORE 3, PAIN SCALE 0 , EKG RHYTHM VENTRICULAR FIBRILLATION. TIME: 02/27/2014 14:16:00 B/P: 75/50, PULSE: 133, RESPIRATIONS: 12, SPO2: 92, BLOOD GLUCOSE: 144, TEMPERATURE: ORAL, GCS SCORE , PAIN SCALE , EKG RHYTHM VENTRICULAR TACHYCARDIA

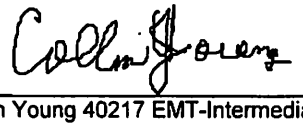
R. CARDIAC MONITOR TO PT ALONG WITH AUTO PULSE. ECG VIA PADS V FIB. PT IMMEDIATELY SHOCKED AT 200 J AND CPR RESTARTED WITH THE RHYTHM OF V FIB. PT PLACED ON AUTO PULSE AND MOVED TO COT AND IN UNIT. CONTINUE WITH CPR VIA AUTO PULSE, HUMERAL IO LEFT SIDE MEDLEY WITH NORMAL SALINE BOLUS AND EPI 1:10. 1 MG. BVM. INTUBATION ATTEMPT EMT-PS P WHITE UNSUCCESSFUL . BVM AND CONT WITH CPR. INTUBATION JOLLY CCEMT-P SUCCESSFUL . VISUAL THROUGH CORDS, FOG IN TUBE, EDD INFLATION, POSITIVE BILATERAL LUNG SOUNDS, NEGATIVE EPIGASTRIC SOUNDS, CHEST RISE AND FALL, CO2 MONITOR WITH POSITIVE READING. ETT SECURED AT 23 AT THE LIPS. CONT WITH CPR. PT ECG RHYTHM V FIB TO V TACH . ADMIN 40 UNITS OF VASOPRESSIN. SHOCKED PT MULTIPLE TIME WITH CPR IN BETWEEN. AMIODARONE 150 MG IN 100 ML NORMAL SALINE ADMINISTERED OVER 10 PERIOD FOR V TACH WITH A PULSE. PT HAS ROSC. NOT SURE OF EXACT TIME. HYPOTHERMIA PROTOCOL STARTED WITH COOLING WITH NORMAL SALINE AND COOL PACKS TO BODY. 12 LEAD DONE WITH ST ELEVATION V-4 , V-5, V-6. CONT WITH VENTILATION VIA ETT WITH SATS INCREASING AND CO2 READING WITHIN NORMAL RANGE. B/G WAS CHECKED 144. V/S WERE OBTAINED AT @ 14:16 75/50 PULSE 133 WITH CAROTID PULSE. ED WAS ADVISED AND WAS STANDING BY AND READY

NORMAL SALINE, EPINEPHRINE 1:10,000, OXYGEN, VASOPRESSIN (ADH), AMIODARONE (CORDARONE). CPR MANUAL, CPR MANUAL, CARDIAC MONITOR, DEFIBRILLATION-MANUAL, CPR AUTO PULSE, AIRWAY-SUCTIONING, IO-ADULT, BLOOD GLUCOSE ANALYSIS, AIRWAY-INTUBATION CONFIRM CO2, CAPNOGRAPHY, 12 LEAD, DEFIBRILLATION-MANUAL.

T.
TRANSPORTED LIGHTS AND SIRENS TO COOKEVILLE REGIONAL MEDICAL CENTER. CARE WAS GIVEN TO STAFF 222 , VERBAL AND WRITTEN REPORTS WERE LEFT.
Completed By: KJolly

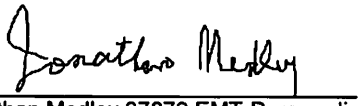
Signatures

CREW



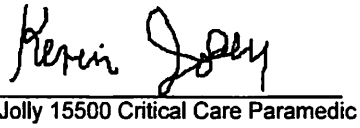
Collin Young 40217 EMT-Intermediate — Driver — 2/28/2014

CREW



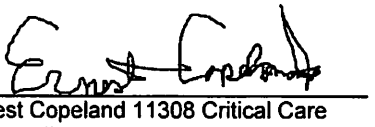
Jonathan Medley 37879 EMT-Paramedic — Third Care Giver — 2/28/2014

CREW



Kevin Jolly 15500 Critical Care Paramedic — Primary Care Giver — 2/28/2014

CREW



Ernest Copeland 11308 Critical Care Paramedic — Secondary Care Giver — 2/28/2014

PHYSICIAN FACESHEET - PATIENT DEMOGRAPHICS - Cookeville Regiona 02/28/14 1159

NAME	: TATANISH,ROBERT	ADM DATE/TIME	: 02/27/14 1500
ADDRESS #1	: 5450 BUNKER HILL RD	UNIT #	: 000493635
ADDRESS #2	:	ACCOUNT #	: 1405800488
CITY	: COOKEVILLE	PHONE (H)	: (931)284-7791
CO/ST/ZIP	: PUTNAM TN 38506	PHONE (W)	:
FIN CLASS	: I COMMERCIAL INSU	PHONE (C)	:
Language	: ENGLISH	RACE	: 0 CAUCASIAN
BIRTHDATE	: 04/09/49 64Y	SEX	: M MALE
SS #	: 167-42-0285	MARITAL STAT	: M MARRIED
.		ACCIDENT	:
ADMIT DX	: S/P CARDIAC ARREST,AMI		:
WORKING DX	: S/P CARDIAC ARREST,AMI	PRI CARE MD	:
ADMIT MD	: LITTLE,THOMAS	CONSULT MD #1	: KONA,HIMA B
ATTEND MD	: LITTLE,THOMAS	CONSULT MD #2	:
REFER MD	:	CONSULT MD #3	:
ER MD	:	SHARED MD	:
GUARANTOR	: TATANISH,ROBERT	RELATIVE	: TATANISH,JUDY
ADDRESS #1	: 5450 BUNKER HILL RD	REL ADDRESS 1	: 5450 BUNKER HILL RD
ADDRESS #2	:	REL ADDRESS 2	:
CITY	: COOKEVILLE	REL CITY	: COOKEVILLE
CO/ST/ZIP	: PUTNAM TN 38506	REL CO/ST/ZIP	: PUTNAM TN 38506
PHONE (W)	:	REL PHONE (H)	: (931)284-7791
PHONE (C)	:	REL PHONE (W)	:
REL TO PT	: SELF	REL TO PT	: SPOUSE
EMPLOYER	:		
ADDRESS #1	:	CITY	:
ADDRESS #2	:	CO/ST/ZIP	:

EMERGENCY CONTACT	: STEWARD,ANN	EMR REL TO PT	: SISTER
EMR HOME PHONE	: (931)319-4378	EMR WORK PHONE	:

. INSURANCE 1		INSURANCE 2	
COMPANY	: CIGNA		:
GROUP #	: 3205296		:
POL/SS #	: U0912130501		:
INSURED	: TATANISH,ROBERT		:
INSURED DOB	: 04/09/49		:
REL TO INS	: *SELF		:
MAIL TO	: CIGNA		:
ADDRESS #1	:		:
ADDRESS #2	:		:
CITY/ST/ZIP	: CHATTANOOGA TN 37422		:
PHONE	: (800)244-6224 EXT :		: EXT :
CLAIM #	:		:
APPROV/REF	:		:
COMMENT	:		:

. INSURANCE 3		INSURANCE 4	
COMPANY	:		:
GROUP #	:		:
POL/SS #	:		:
INSURED	:		:
INSURED DOB	:		:
REL TO INS	:		:
MAIL TO	:		:
ADDRESS #1	:		:
ADDRESS #2	:		:
CITY/ST/ZIP	:		:
PHONE	: EXT :		: EXT :
CLAIM #	:		:
APPROV/REF	:		:
COMMENT	:		:

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Putnam County Emergency Medical Service
Short Patient Care Report
931-528-1555

Run Number	10666	**Name: Last, F, M:**	Patanish, Robert	**Date:** 2/27/14	
Unit Number	708	**Call Location:**	5450 Bunker Hill Rd	**Age**	64
Approximate Call Received		**Transport to:**	222	**D.O.B**	4-9-49
Approximate Transport		**Arrive to patient / First Contact:**		**Race**	~~□W~~ □B □H □O
Approximate Arrival		**12 Lead acquired:**		**Gender:**	~~□Male~~ □ Female

Past History	
Medication	
Allergies	

Time	M/A	B/P	Pulse Rate	Pulse Desc.	Resp	EKG	Sa 02 %	O2 L	ETCO2	BG Mg/dl	Temp ° F	CO	GCS	Pain * of 10
		/												
		/												

Device	Time	Provider	Size	Attempts	Success?	Bilat B.S.	Absent Gastric Sound	Chest Rise?	Direct Visual	ETCO2	Fogging	Syringe re-inflate	C M
~~ET~~/NT/Surg/Esoph	1400 1410	KY TC	7.5	1	—	—	—	—	—	—	—	—	23

I.V.	Time	Fluid	Size	Site	Attempts	Rate/Flush	ID	Total cc	Successful	Unsuccessful
IV/NS/IO	1357	NS	15	(L) Hum	1		JM			
IV/NS/IO										

Time	Medication	Mix	Dose	Route	Site	Volume	Pump	ID	Order	Assess	Pain * of 10
1357	EPI 1:10		1 mg								
1302	VASO		40								
	Amio		150 mg in 100								

{~~EKG~~} {~~12 lead~~} { Fax 12 lead to: _____ □Successful □Unsuccessful} {□TSI} Splint/bandage: _____
Airway/Breathing: {O2 _____ LPM by □NC □NRB □Simple □ Nebulizer □ BVM □ventilate at _____ bpm □tidal vol _____ cc □OA □NA}

**AIRWAY: □No C/O	□Patent □Self-maint □Compromised □OA □NA □OETT □NETT □Trach □Esophageal A/W {□Manual C-Spine control by _____} {Gag reflex □yes □no} {Blink reflex □yes □no} { □blood □secretions □vomit}
**BREATHING: □No C/O	□WNL □Non labored □Labored □Resp distress □Tachypnea □Bradypnea □Hypervent □Apnea □Shallow □Kussmaul □C-S □Stridor □Snoring □Agonal
**CIRCULATION	□WNL □Compromised Carotid R _____ L _____ Radial R _____ L _____ Pedal R _____ L _____ {□ Doppler assessment pulse} {□Symptomatic □Asymptomatic □Low B/P □High B/P} {Pulse □Thready □Bounding} {Cap refill _____sec} {Estimated total blood loss _____ cc Location: _____}
SKIN □No C/O	{□Pink □Pale □Flushed □Ashen □Jaundiced □Cyanotic □Mottled} {□Warm □Hot □Cool} {□Dry □ Moist □Diaphoretic □Clammy} {Skin tugor _____ seconds}
NEURO □No C/O	□Awake □Responds to verbal □Responds to pain □Unresponsive {□Oriented □X-4 □time □person □place □events □disoriented} (Eyes □4 spontaneous □3 to command □2 to pain □1 none) (Speech □5 oriented □4 confused □3 inappropriate □2 garbled □1 none) (Movement □6 obeys command □5 localizes pain □4 withdraws □3 decorticate □2 decerebrate □1 none) Glasgow total: _____

Narrative: □ Responded Immediately to: □ Routine response to: □ Scheduled response to:

64(M) Cardiac Arrest in field at fire scene, VUA CPR in progress. Cont = Auto pulse Loaded INTubated IO EPI Amio. Shocks multiple X's return of pulse, hypothermic protocol (Cooling) NG Tube. SUCTION B/G.

□EMT-IV □EMT-P ~~□CCEMT-P~~ Kevin Jolly LICENSE # 155U Date: 2/27/14
Revised 11/5/13

Please attach copy of EKG to this form and leave at receiving facility. Scan this form into ePCR as attachment

Putnam County Emergency Medical Service

Short Patient Care Report

931-528-1555

HIPAA/ INSURANCE/RECEIVING

I acknowledge receipt of medical services from Putnam County EMS on the date set forth above; or I acknowledge that the above named patient received services from Putnam County EMS on the date set forth. By virtue of providing the service, I agree that Putnam County EMS has the right to accept assignment of benefits and submit a claim to Medicare or other insurance(s) on behalf of myself or the patient. I acknowledge that the notice of privacy practices has been offered. I further state, that I have read and understand the above statements.

Detailed reason why patient can't sign: ☑ Unconscious ☐ Death ☐ Scene flight

_____

_____

☐ Patient ☐ Healthcare POA ☑ Legal Guardian
☐ Receives Gov. Benefits for Patient ☐ Arranges appoints
☐ Provider Representative

Sign: X Judy Fatonall Date: 2/27/14

Print: Judy Fatonall

Received Sign: X Date: 2/27/14

Received Print: Ken

INSURANCE STATEMENT / BILL RESPONSIBILITY

The patient and/or the nearest relative will sign this form if any of the following situations are applicable. Please check the applicable statements.

Hospital to Hospital

☐ Medicare and most private insurances will not pay for ambulance transportation to another hospital if the indicated procedures/treatments are available at this facility. I understand that I will be responsible for all charges incurred in the event that insurance does not reimburse PCEMS.

Doctor's Office

☐ I understand that Medicare and most private insurances will not pay for ambulance transportation to a physician's office. I understand that I will be responsible for all charges incurred in the event that insurance does not reimburse PCEMS.

Transport to other than nearest facility

☐ I understand that Medicare and many private insurance companies will not pay for ambulance transportation to facilities other than the nearest hospital. I understand that I will be responsible for all charges incurred in the event that insurance does not reimburse PCEMS.

Release of Liability

☐ I _____ acting as the patient, responsible party or relative of the patient, do hereby release from all liability, Putnam County Emergency Medical Services and their employees, that might arise from the transport of this patient to another hospital other than the nearest medical facility. It is recommended by Putnam County Emergency Medical Services and their employees that each patient be evaluated at the nearest medical facility and stabilized. Transfer to another medical facility can then be arranged. I understand that the Paramedic may elect to divert to the nearest medical facility if the patient's condition is not stable for transfer in the best judgment of the attending Paramedic or EMT.

Sign: _____ Date: ___/___/___

Print: _____

Refusal of Transport

This is to certify that Putnam County Emergency Medical Service and/or an associated First Responder Agency have offered me treatment and/or transport. I am refusing treatment and/or transport of my own free will. The consequences of refusing medical care and transportation have been explained to me. I understand that my decision not to accept treatment and transport may have adverse effects on my health including my own death. I assume all responsibility and hereby release and agree to hold harmless the Putnam County Emergency Medical Services and any associated First Responding Agency, and their employees from all liability of whatsoever nature. You will not receive a bill if you are not transported. I understand that I retain the right to call for Emergency Medical Services at any time.

I have received a copy of the Notice of Privacy Practices

YOU HAVE A RIGHT TO EMERGENCY MEDICAL CARE AND TRANSPORTATION TO THE NEAREST MEDICAL FACILITY. EMS ENCOURAGES EACH PATIENT TO SEEK MEDICAL CARE.

_____
Printed name of Patient

_____ Date: ___/___/___
Signature of Patient

_____
Witness with agency/relation

PHYSICIAN CERTIFICATION STATEMENT (PCS) FOR NON-EMERGENCY AMBULANCE TRANSPORT

CHECK ALL THAT APPLY:

___Requires Continuous Oxygen Therapy ___Requires IV Maintenance
___Requires Cardiac Monitoring ___Requires Mechanical Ventilation
___Requires Isolation Precautions ___Requires Restraints
___Requires other Advanced Treatment
___Recent Fracture/Joint Replacement with Limited Mobility
___Patient's weight exceeds wheelchair limitations ___Seizure Risk
___Post-Operative Surgery ___Pregnancy Complications
Comments: _____
___Decreased Mental Status ___Unconscious ___Respiratory Problems
___Stroke ___Advanced Renal Failure ___Crippling Arthritis
___Paralysis ___Quadriplegia ___Advanced Cancer ___Fracture
___Chest Pain ___Alzheimers Disease ___Cardiac Disease ___Blind
___Congestive Heart Failure ___Decubitus Ulcers ___Parkinsons Disease
___Cellulitus ___ Contractures or Fetal Position ___Morbid Obesity
___Severe Pain ___Extreme Weakness ___Fall Risk
___Extreme Dementia
___Comment: _____

Hospital to Hospital Transfer:

Is the patient being transported for a treatment, specialist or procedure unavailable at your facility? Yes No If yes, please explain unavailable service:

_____
If no, explain why patient is being transferred

Physician Certification of Medical Necessity

By my signature, I certify that the above information is true and correct based on my evaluation of this patient. In my professional opinion, the patient requires transport by ambulance and should not be transported by other means. I understand that this information will be used by the Center for Medicare, Medicaid and TennCare Services to support the determination of medical necessity for ambulance services.

Signature of Physician _____
Print Name _____ (or) Date: ___/___/___
Signature of RN, PA or approved title
_____ Title _____

Patient Does Not Meet Medical Necessity

The patient, in my medical opinion, **DOES NOT** meet the criteria for ambulance transportation. Signature of Physician, RN, PA or approved title
_____ Date ___/___/___

Please attach copy of EKG to this form and leave at receiving facility. Scan this form into ePCR as attachment