# NWCG Medical Evaluation and Treatment Form

| Case # | Location | Time (24HR) | Date | Incident Name | Provider Name |
|---|---|---|---|---|---|
| | | | | | |

| Type of Call | Type of Care | Level of Care | Crew Name | Position |
|---|---|---|---|---|
| ☐ Trauma<br>☐ Medical | ☐ Emergency Care<br>☐ Clinical Guidelines | ☐ ALS ☐ First Aid<br>☐ BLS ☐ Occupational | Resource# | |

| Patient Name | DOB | Age | Sex | Weight | Home Unit |
|---|---|---|---|---|---|
| | | | | | |

| Home Address | Work Address |
|---|---|
| | |

| City | State | Zip | City | State | Zip |
|---|---|---|---|---|---|
| | | | | | |

| Home Phone | Office Phone |
|---|---|
| | |

**Chief Complaint**

**History of Present Illness**

| Signs/ symptoms | Onset |
|---|---|
| Allergies | Provokes/ Palliates |
| Medications | Quality |
| Past medical history | Radiates |
| Last oral intake | Severity |
| Events | Time |

Immunizations:

## Assessment

General Appearance

Loss of consciousness

☐ YES ☐ NO Duration

GCS

| Eye Opening | Verbal | Motor |
|---|---|---|
| 4 Spontaneous<br>3 To Speech<br>2 To Pain<br>1 Not at All | 5 Oriented<br>4 Confused<br>3 Inappropriate Sounds<br>2 Inappropriate Words<br>1 None | 6 Obeys Commands<br>5 Localized Pain<br>4 Withdraws to Pain<br>3 Flexion to Pain<br>2 Extension to Pain<br>1 None |

Mental Status

A V P U

Pupils

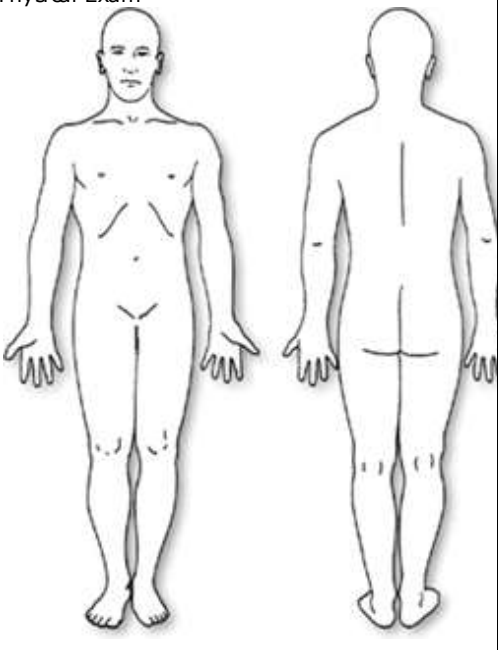
☑ Equal
☐ Nonequal
☐ Reactive
☐ non-reactive

Blood Glucose

Temperature

☐ Fahrenheit
☐ Celsius

Physical Exam



Skin

☐ Normal
☐ Dry
☐ Moist
☐ Flushed
☐ Cyanotic
☐ Pale
☐ Jaundiced

Pulse

☐ Regular
☐ Irregular
☐ Absent

Rate

Respiratory

☐ Normal
☐ Labored
☐ Fatigued
☐ Absent

Rate

Lung Sounds

| Left | Right | |
|---|---|---|
| ☐ | ☐ | Clear |
| ☐ | ☐ | Wheeze |
| ☐ | ☐ | Wet |
| ☐ | ☐ | Diminished |
| ☐ | ☐ | Absent |

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## Vital Signs/Activity Log

| Time | Position | HR | RR | Blood Pressure | | SP02 | Skin | Temp | AVPU | Action/Comments |
|---|---|---|---|---|---|---|---|---|---|---|
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## Narrative

## Disposition

- ☐ Treated, Not Transported
- ☐ Treated, Transported to Medical Unit
- ☐ Treated, Transported by incident vehicle
- ☐ Treated, Transported by Ground Ambulance
- ☐ Treated, Transported by Air Ambulance
- ☐ Treated, Transported Other
- ☐ No Treatment needed
- ☐ Refused Treatment

## Destination

- ☐ Medical Unit
- ☐ Clinic
- ☐ EMS Service
- ☐ Hospital
- ☐ Specialty Resource Center
- ☐ Other

Specify:

## Patient Instructions

## Patient Refusal

I acknowledge that I have been informed that my medical condition requires immediate treatment and/or transport to a physician and that with refusing further emergency medical treatment there is a risk of serious injury, illness or death. Understanding these associated risks, I hereby release the attending medical personnel, their home agency and their advising physician from all responsibility and any ill effects which may result from this action.

| Patient Signature | Date | Witness Signature | Date |
|---|---|---|---|
| | | | |

## Signatures

| Provider Signature | Receiving Signature |
|---|---|
| | |
| **Provider Name** | **Receiving Name** |
| | |