Delaware BLS
Patient Care Notes

Date:	BLS Unit:	Incident #:
Pt. Priority: ❑ 1 ❑ 2 ❑ 3 ❑ 4	Gender: ❑ M ❑ F	

Patient Name: _____

Patient Address: _____

City: _____ State: _____

Phone: _____ SSN: _____

Date of Birth: _____ Age: _____ Weight: _____Kg.

Incident Location:	DMOST / DNR: ❑ YES ❑NO

Chief Complaint: _____

Time of Onset: _____ ❑ Minutes ❑Hours ❑Days ❑Weeks

Allergies: ❑ **NKDA** ❑ Latex ❑ Sulfa ❑ PCN _____ _____ _____ _____ _____ _____ _____

Medications: _____ _____ _____ _____ _____ _____ _____ _____

History: ❑Diabetes ❑Cardiac ❑ HTN ❑Cholesterol ❑ Asthma ❑COPD ❑ Seizures

Vitals 1	Vitals 2	Vitals 3
Time:	Time:	Time:
Pulse:	Pulse:	Pulse:
Resp.:	Resp.:	Resp.:
SpO2: ❑O2	SpO2: ❑O2	SpO2: ❑O2
B/P: /	B/P: /	B/P: /
Glucose:	Glucose:	Glucose:
Temp.:	Temp.:	Temp.:
AVPU:	AVPU:	AVPU:

Respirations	Skin	Pulse	Pupils
Left Right	❑ Warm	❑ Regular	❑ PEERL
❑ Clear ❑	❑ Dry	❑ Irregular	❑ Unequal
❑ Stridor ❑	❑ Cool	❑ JVD	❑ Fixed/Dilated
❑ Rhonchi ❑	❑ Hot	❑ Edema	❑ Constricted
❑ Wheezes ❑	❑ Clammy	Cap. Refill	Left Right
❑ Decreased ❑	❑ Diaphoretic	_____ Seconds	___ MM ___
❑ Absent ❑	❑ Cyanotic		

AFTER ENTERING INFO INTO DEMRS, DESTROY THIS NOTES PAGE

GCS		Cincinnati Stroke Scale		VAN Large Vessel	
Eyes (4):	_____	Facial Droop:	❑ YES ❑ NO	Visual Distubance:	❑
Motor (6):	_____	Arm Drift:	❑ YES ❑ NO	Aphasia (verbalizing):	❑
Verbal (5):	_____	Speech:	❑ YES ❑ NO	Neglect (Feel/Move):	❑
Total (15):	_____	CSS POSITIVE	❑	VAN POSITIVE:	❑

CPR START TIME:	AED Shocks (#): ❑1 ❑ 2 ❑ 3 ❑4 ❑ 5❑ O: ___
Bystandard CPR: ❑ YES ❑ NO	CPR STOP TIME:

Oxygen		Airway		Medications (total in MG or total does)			
LPM:		OPA	❑	Epi Pen Adult		Glucose	
BVM	❑	NPA	❑	Epi Pen JR		Benadryl	
NRB	❑	Suction	❑	Draw Up EPI		Tylenol	
NC	❑	CPAP	❑	Albuterol Neb		Zofran ODT	
Neb	❑	Size _____		Atrovent Neb		Pt. Nitro.	
Other:				MDI		Aspirin	
❑ Abuse Suspected				Alcohol Prep		Narcan	

ALS Unit:		Hospital Transpored:		Transfer Of Care Time:	
Consulting MD #:		Patient Disposition:	❑ Waiting Room ❑ To Room: _____ ❑ Hallway ❑ Triage ❑ Other		

Armband, Medical Record Number OR Place Sticker Here

Mileage Start:	Mileage End:	Mileage Total:

Treatment / Notes:

EMT Name / ID #: _____

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8/28/24 BC