

Illinois Department of Natural Resources  
Office of Mines and Minerals  
Coal Mine EMS System  
Patient Information Report

Date: \_\_\_\_\_ EMT NAME/#: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last
First
Middle

Address: \_\_\_\_\_  
Street
City
State
Zip

Company & Mine: \_\_\_\_\_

Time: Arrived: \_\_\_\_\_ am pm Nature of Call \_\_\_\_\_ Cardiac \_\_\_\_\_ Medical \_\_\_\_\_ Trauma \_\_\_\_\_ Burn \_\_\_\_\_ Behavioral \_\_\_\_\_ other \_\_\_\_\_

Patient: Complaint: \_\_\_\_\_ Medical History: \_\_\_\_\_

Allergies: \_\_\_\_\_ First Impression: \_\_\_\_\_

Medications: \_\_\_\_\_ Condition at Scene: Good Fair Critical

LEVEL OF CONSCIOUS	MENTAL STATUS	SKIN COLOR	PUPILS	BLEEDING	VITAL SIGNS			
<input type="checkbox"/> Conscious/Alert	<input type="checkbox"/> Oriented	<input type="checkbox"/> Normal/Dry	<input type="checkbox"/> Equal/Reactive	<input type="checkbox"/> None	Time	B/P	PLSE	RSP
<input type="checkbox"/> Responds/Voice	<input type="checkbox"/> Disoriented	<input type="checkbox"/> Ashen/Moist	<input type="checkbox"/> Non-Reactive	<input type="checkbox"/> Controllable				
<input type="checkbox"/> Responds/Pain only	<input type="checkbox"/> Combative	<input type="checkbox"/> Cyanotic	<input type="checkbox"/> (R) Larger	<input type="checkbox"/> Hard to Control				
<input type="checkbox"/> Unresponsive		<input type="checkbox"/> Reddish	<input type="checkbox"/> (L) Larger	<input type="checkbox"/> Uncontrollable				

TREATMENT AT SCENE

Oxygen	Airway Adjunct	Provided Ventilations	CPR	DEFIBRILLATION
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Times 1
<input type="checkbox"/> Traction	<input type="checkbox"/> Hemorrhage Control	<input type="checkbox"/> Bandaging	<input type="checkbox"/> Splinting	<input type="checkbox"/> Times 2
<input type="checkbox"/> Spine Board	<input type="checkbox"/> Extrication	<input type="checkbox"/> Psych. First Aid	<input type="checkbox"/> MAST	<input type="checkbox"/> Times 3
<input type="checkbox"/> Cervical Collar	<input type="checkbox"/> Assisted Ventilations	<input type="checkbox"/> Suction	<input type="checkbox"/> Other _____	

Response to Treatment: \_\_\_\_\_ Improved \_\_\_\_\_ No Change \_\_\_\_\_ Deteriorated

TREATMENT: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**RELEASE FROM LIABILITY STATEMENT**

I hereby refuse the emergency medical services offered by \_\_\_\_\_, EMT. I understand that my refusal may jeopardize my health, and hereby release the above named party/s from any and all claims of liability in connection with my refusal.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of EMT

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of EMT

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**RELEASED TO TRANSPORT SERVICE OR OTHER EMT**

Time EMT/s left scene: \_\_\_\_\_ am/pm Released to: \_\_\_\_\_

Time released to transport service \_\_\_\_\_ am/pm \_\_\_\_\_

Signature of receiving service or EMT