Southern Tier Regional EMS Council

ONLINE MEDICAL CONTROL REPORT

Date: _____
Time: _____
ETA: _____
Ambulance Service/Provider #
_____
Unit: _____

Medical Control MD: _____

- ☐ Arnot Ogden Medical Center
- ☐ Corning Hospital
- ☐ Ira Davenport Memorial Hospital
- ☐ Schuyler Hospital
- ☐ St. James Mercy
- ☐ St. Joseph's Hospital

Patient Age: _____
Patient sex: M F
Triage level: 1 2 3 4 5

Chief complaint: _____
Associated symptoms: _____
Mechanism of injury: _____
Illness: _____

FILL OUT ONLY WHAT IS APPROPRIATE FOR THIS PATIENT: (Stroke) Last known well date/time_____

TIME	RESP	PULSE	BP	GCS	PUPILS	SKIN	CUPS	COMMENT

☐ Medication list with patient
☐ Pertinent Medication _____
_____

Allergies: list _____

Past Medical History

DM		CVA		Asthma	
Hypertension		COPD		Seizure	
MI		Heart Disease		Pre-hospital DNR	
Dialysis		CA		Other	

IV's Established: _____
Blood Glucose: _____

O2 LMP: _____
100 % NRM
NC
ETT# _____

NTG x1 x2 x3
ASA 324mg yes
Immobilize yes no

Cincinnati Stroke Scale Positive___Negative___

Time	Treatment	Response	Comment

RN/MD signature:_____

Revised 12/8/2014