Hello everyone,

We have added the stroke assessment tools to the PAEMS *Preliminary Field Medical Report Form*, more commonly called "*Short Form*." You will find this new information listed under the *Present Illness* section. If you suspect that your patient is having a stroke please check "YES" and then check all the items underneath that apply. After checking all that apply; note the time that the patient was seen without having the symptoms in the blank provided.

Also take note on the short form that there is now a place to note the patient's weight as well as blood sugar. If you suspect possible stroke blood sugar and patient weight need to be noted.

The level of consciousness and possible stroke areas are now in the light gray color and are mandatory to complete for each patient.

Possible Stroke Definitions:

Aphasia – Difficulty finding the right words (also described as word salad), or mute. Not just slurred speech alone.

Dysarthria – difficult or unclear articulation of speech that is otherwise linguistically normal.

Gaze palsy – eyes deviated to one side or unable to cross midline

Neglect – not able to pay attention to one side (right or left)

Thank you for your corporation in implementing this new version of the short form.

-PAEMS Staff

Peoria Area Emergency Medical Services System
304 E. Illinois Ave, Peoria, IL 61603 Phone (309) 655-2113 Fax (309) 655-2090 www.paems.org

Patient Label

OSF
SAINT FRANCIS MEDICAL CENTER
Peoria, IL

Preliminary Field Medical Report Form
H0060-82501-08-1365-1 (Rev. 03/17)
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H0060-1365

Provider Agency: _____ Unit: _____
Log #: _____ Time: _____

Peoria Area EMS System

Light Gray Sections are MANDATORY!

SIGNIFICANT BODY EXPOSURE: ☐ YES ☐ NO

DATE OF CALL	DISPATCH NUMBER

TIMES (NOT VERIFIED)

Alarm	At Scene	At Hospital	Available	Cleared

SERVICES PROVIDED
☐ ALS ☐ ILS ☐ BLS

RECEIVING HOSPITAL

PATIENT INFORMATION
NAME (LAST) (FIRST) (MI)
HOME ADDRESS
CITY / STATE / ZIP AGE GENDER M F

LOCATION OF CALL

PT MOVED / AMBULATING PTA
☐ YES ☐ NO

PATIENT FOUND
☐ LYING ☐ STANDING
☐ SITTING ☐ ENTRAPPED

PAST HISTORY
☐ CARDIAC ☐ HTN ☐ SEIZURE
☐ DIABETIC ☐ ASTHMA ☐ COPD

FAMILY MD

PATIENT COMPLAINT / ONSET

MEDS
☐ None ☐ Unknown

OTHER MEDICAL HX:

PT. WEIGHT_____

PRESENT ILLNESS

LEVEL OF CONSCIOUSNESS
☐ ALERT
☐ VERBAL
☐ PAINFUL
☐ UNRESPONSIVE
☐ LOC
☐ BLOOD SUGAR_____

POSSIBLE STROKE? ☐ YES ☐ NO
MARK ALL THAT APPLY
☐ DROWSY ☐ DIZZY
☐ DOUBLE VISION ☐ DYSARTHRIA
☐ APHASIA ☐ GAZE PALSY
☐ NEGLECT
☐ WEAKNESS (FACE, ARM, LEG)
☐ LOSS OF SENSATION (FACE, ARM, LEG)
☐ LOSS OF VISION (ONE OR BOTH EYES)
RECORD TIME LAST SEEN WITHOUT SYMPTOMS_____
If symptoms <6 hours call stroke alert to receiving hospital.

CARDIAC / RESPIRATORY
☐ CHEST PAIN
☐ RADIATION_____
☐ PAIN SHARP / DULL
☐ PAIN WORSE
☐ INSPIRATION
☐ EXPIRATION
☐ DYSPNEA
☐ OTHER:_____

GI / GU
☐ PAIN: _____
☐ NAUSEA / VOMITING
☐ COFFEE GROUND EMESIS
☐ TARRY STOOLS
☐ DIARRHEA
☐ VAGINAL DISCHARGE / BLEEDING

ALLERGIES
☐ None ☐ Unknown

PHYSICAL EXAM

SKIN COLOR

INITIAL		LAST
☐	NORMAL	☐
☐	PALE	☐
☐	CYANOTIC	☐
☐	FLUSHED	☐
☐	JAUNDICED	☐
☐	MOTTLED	☐
☐	ASHENED	☐

SKIN TEMP

INITIAL		LAST
☐	NORMAL	☐
☐	COOL	☐
☐	COLD	☐
☐	HOT	☐
☐	WARM	☐

SKIN MOISTURE

INITIAL		LAST
☐	NORMAL	☐
☐	MOIST	☐
☐	DRY	☐
☐	WET	☐

NEURO
PUPILS
REACT: ☐ YES ☐ NO
EQUAL: ☐ YES ☐ NO
SIZE: R: _____ L: _____
OTHER: _____

LUNG SOUNDS

LEFT		RIGHT
I L	CLEAR	I L
I L	RHONCHI	I L
I L	RALES	I L
I L	WHEEZES	I L
I L	DIMINISHED	I L
I L	ABSENT	I L

DISTRESS: ☐ MILD ☐ MODERATE ☐ SEVERE

GI / GU
☐ TENDERNESS
☐ GUARDING
☐ RIGIDITY
☐ OTHER:

PELVIS
STABLE ☐ YES ☐ NO
PAIN ☐ YES ☐ NO
INCONTINENT? ☐ YES ☐ NO

EXTREMITIES
MAEW ☐ YES ☐ NO
EDEMA ☐ YES ☐ NO
TRAUMA ☐ YES ☐ NO

GLASGOW COMA SCALE

EYE OPENING
☐ SPONTANEOUS
☐ TO SPEECH
☐ TO PAIN
☐ NONE

VERBAL RESPONSE
☐ ORIENTED
☐ DISORIENTED
☐ INCOHERENT
☐ MOANS
☐ NONE

MOTOR RESPONSE
☐ OBEYS
☐ LOCALIZES
☐ WITHDRAWS
☐ DECORTICATE
☐ DECEREBRATE
☐ NONE

TIME	PULSE	RESP	BP	AVPU	RHYTHM	02 SAT	TREATMENT	DOSE	ROUTE	RESPONSE

Comments - _____

SIGNATURE OF PERSON RECEIVING PATIENT
X_____

☐ CODE SUMMARY ATTACHED ☐ RHYTHM STRIPS ATTACHED ☐ TRAUMA SUPPLEMENT / CONTINUUM ATTACHED

CREW SIGNATURES
PRIMARY PROVIDER: _____ ID: _____
SECONDARY PROVIDER: _____ ID: _____