Chelan / South Douglas County PREHOSPITAL **CARDIAC DATA FORM**

DEMOGRAPHICS:			
FIRST NAME:	LAST NAME:	Middle Name:	
DOB:	Agency Run Number:	☐Male ☐ Female	
CALL Information:			
Prehospital Agency Name:	Final Destination Name:	Date of Call:	
Time of Call PCEP/ Request Time: ______:______	Dispatch Time: ______:______	☐Transfer ☐ 911	☐ALS ☐BLS ☐ILS
En route to Scene Time: ______:______	Arrival on-scene Time: ______:______	Arrival at Patient Side: _____:_____	
Enroute to Destination Time: ______:______	Arrival at Destination Time: ______:______	Onset of Symptoms: Date - ___/____/_____ Time- ______:______	
Treatment Information:			
Activated "Cardiac Alert" w/ hospital ☐YES ☐NO	Time of "Cardiac Alert": ______:______	ASA Given: ☐Yes ☐No	
Nitro Given: ☐Yes ☐NO	12-lead ECG: ☐YES ☐NO ☐N/A Time of 1sr 12-lead ______:______	STEMMI Present: ☐YES ☐NO	

Complete this form with each Cardiac Activation.

Send Completed form to:

- Destination Hospital
- Local MPD