pennsylvania
DEPARTMENT OF HEALTH

QRS Patient Report

Date:	Time:	EMS Agency Name

Patient Name:	Phone #:	Date of Birth	Age	☐Male ☐Female

Chief Complaint	Provider Impression:

History/Exam

Symptoms/History (SAMPLE)

For Altered Mental Status, Chest pain, or Stroke

Onset of Symptoms /Last Seen Normal

Date	Time

Past Medical History

☐ Diabetes ☐ HTN ☐ Heart Problems ☐ Cancer ☐ Seizures ☐ Asthma/COPD ☐ TIA/Stroke ☐ Other:

Allergies: ☐ NKDA

Pertinent Physical Exam Findings:

Medications:

Patient's medications or medication list delivered with report ☐Yes ☐No

VITAL SIGNS

Time	Pulse	Blood Pressure		Resp	Pupils	Glucose	SpO2	MENTAL STATUS (AVPU) (Check Best Response)			
								☐ Alert	☐ Voice	☐ Pain	☐ Unresponsive
								☐ Alert	☐ Voice	☐ Pain	☐ Unresponsive
								☐ Alert	☐ Voice	☐ Pain	☐ Unresponsive

ECG (if applicable)

Rhythm: 12 Lead Interpretation: ECG delivered with report? Y / N

EMS Treatments & Notes

Time	Treatment

IV	Y / N	Size/Location:		Total IV Fluid Volume Given: mL	Oxygen LPM

Provider Transferring Care	Certification Number	Care Transferred To:	
Name (Print)		Receiving Agency Name	Time of Transfer:

Additional QRS Crew Members	Additional QRS Crew Members

Revised 3/1/2012