S-SV EMS BLS Optional Skills Utilization Patient Care Report (605-A)

Provider:	**Incident #:**	**Date:**	
Name:	☐ Male ☐ Female	**Age:**	**DOB:**
Address:	**City:**	**Phone#:**	
Chief Complaint:		**Weight:**	
Pertinent History:			
Medications:			
Allergies:			

Time	GCS			BP	Pulse	Resp. Rate	SpO2	Pain Scale	By
	E	V	M						

Airway Device: ☐ **King** ☐ **i-gel**	**# Of Attempts:**	**Successful:** ☐ **Yes** ☐ **No**
Time:	**Size:** ☐ **3** ☐ **4** ☐ **5**	**By:**
Bi-lat. Lung Sounds: ☐ **Yes** ☐ **No**	**Epigastric Sounds:** ☐ **Yes** ☐ **No**	**$ETCO_2$ Color Chng:** ☐ **Yes** ☐ **No**
☐ **Mark 1/DuoDote**	☐ **Epinephrine Auto Injector**	☐ **Intranasal (IN) Naloxone**

Time:	**Dose:**	**Site:**	**By:**
Time:	**Dose:**	**Site:**	**By:**

Crew Names: