NWCG Medical Evaluation and Treatment Form

Case #	Location	Time (24HR)	Date	Incident Name	Provider Name

Type of Call	Type of Care	Level of Care	Crew Name	Position
☐ Trauma ☐ Medical	☐ Emergency Care ☐ Clinical Guidelines	☐ ALS ☐ First Aid ☐ BLS ☐ Occupational	Resource#	

Patient Name	DOB	Age	Sex	Weight	Home Unit

Home Address	Work Address

City	State	Zip	City	State	Zip

Home Phone	Office Phone

Chief Complaint

History of Present Illness

Signs/ symptoms	Onset
Allergies	Provokes/ Palliates
Medications	Quality
Past medical history	Radiates
Last oral intake	Severity
Events	Time

Immunizations:

Assessment

General Appearance

Loss of consciousness

☐ YES ☐ NO Duration

GCS

Eye Opening	Verbal	Motor
4 Spontaneous 3 To Speech 2 To Pain 1 Not at All	5 Oriented 4 Confused 3 Inappropriate Sounds 2 Inappropriate Words 1 None	6 Obeys Commands 5 Localized Pain 4 Withdraws to Pain 3 Flexion to Pain 2 Extension to Pain 1 None

Mental Status

A V P U

Pupils

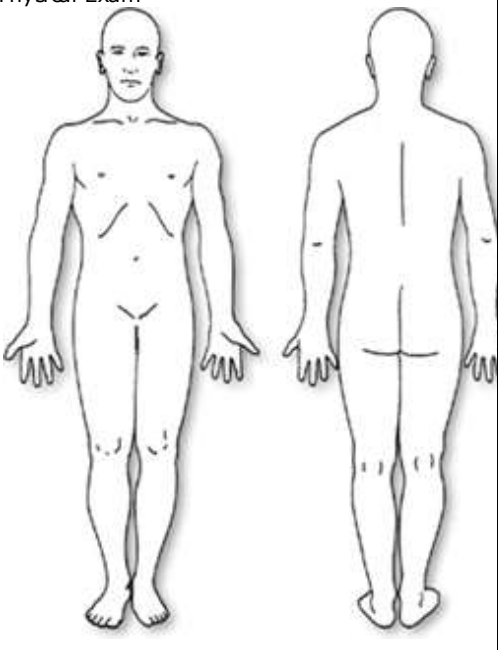
☐ Equal
☐ Nonequal
☐ Reactive
☐ non-reactive

Blood Glucose

Temperature

☐ Fahrenheit
☐ Celsius

Physical Exam



Skin

☐ Normal
☐ Dry
☐ Moist
☐ Flushed
☐ Cyanotic
☐ Pale
☐ Jaundiced

Pulse

☐ Regular
☐ Irregular
☐ Absent

Rate

Respiratory

☐ Normal
☐ Labored
☐ Fatigued
☐ Absent

Rate

Lung Sounds

Left	Right	
☐	☐	Clear
☐	☐	Wheeze
☐	☐	Wet
☐	☐	Diminished
☐	☐	Absent

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Vital Signs/Activity Log

Time	Position	HR	RR	Blood Pressure		SP02	Skin	Temp	AVPU	Action/Comments

Narrative

Disposition

- ☐ Treated, Not Transported
- ☐ Treated, Transported to Medical Unit
- ☐ Treated, Transported by incident vehicle
- ☐ Treated, Transported by Ground Ambulance
- ☐ Treated, Transported by Air Ambulance
- ☐ Treated, Transported Other
- ☐ No Treatment needed
- ☐ Refused Treatment

Destination

- ☐ Medical Unit
- ☐ Clinic
- ☐ EMS Service
- ☐ Hospital
- ☐ Specialty Resource Center
- ☐ Other

Specify:

Patient Instructions

Patient Refusal

I acknowledge that I have been informed that my medical condition requires immediate treatment and/or transport to a physician and that with refusing further emergency medical treatment there is a risk of serious injury, illness or death. Understanding these associated risks, I hereby release the attending medical personnel, their home agency and their advising physician from all responsibility and any ill effects which may result from this action.

Patient Signature	Date	Witness Signature	Date

Signatures

Provider Signature	Receiving Signature
Provider Name	**Receiving Name**