

**APPENDIX 1**  
**DISPATCH CARD OF THE EMERGENCY MEDICAL SERVICE TEAM\***

Identification of the EMS team supervisor	EMS team location on stand-by (address):
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**I. CALL RECEIPT**

Unit receiving call:	Identification code of the medical dispatch officer receiving call:	Dispatch no.:	Date of call receipt (yy-mm-dd):	Time of call receipt (hh:mm):
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**Address or site of the event:**

City:	Street:	House no.:	Appartment no.:	Floor no.:	Staircase:
Description of the event:				Geographical coordinates:	

**Reason of the call:**

Urgency level*:	Anamnesis — description:
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**Patient identification:**

Name and surname:	Patient age:	Age description:	Sex:
	years:      months:      days:	<input type="checkbox"/> child <input type="checkbox"/> adult	<input type="checkbox"/> M <input type="checkbox"/> F

**Caller identification:**

Name and surname:	Calling from:	Notification to:	Comments:
Caller description: <input type="checkbox"/> individual <input type="checkbox"/> fire fighters <input type="checkbox"/> police <input type="checkbox"/> physician <input type="checkbox"/> municipal guard <input type="checkbox"/> other.....	<input type="checkbox"/> street phone <input type="checkbox"/> transceiver <input type="checkbox"/> teleinformatic channel <input type="checkbox"/> telephone (caller's phone no.) .....	<input type="checkbox"/> fire fighters <input type="checkbox"/> police <input type="checkbox"/> sanitary inspectorate <input type="checkbox"/> other.....	

**II. DECISION MADE**

Dispatch decision: <input type="checkbox"/> own EMS team involved <input type="checkbox"/> other supervisor's EMS team involved <input type="checkbox"/> call forwarded to another dispatch officer <input type="checkbox"/> EMS team called off	EMS team identifier:	Team vehicle identifier:	Dispatch mode: <input type="checkbox"/> emergency <input type="checkbox"/> regular	Type of team: <input type="checkbox"/> specialist <input type="checkbox"/> basic	Date and time of EMS team dispatch:
EMS team:      — profession      Head of team** ..... ..... ..... .....	Dispatch forwarded to: ..... time: hh ..... min..... code of medical dispatch officer .....		Dispatch called off by: name and surname of person calling off the EMS team: ..... time: hh ..... min ..... code of medical dispatch officer .....		Dispatch forwarded by: <input type="checkbox"/> radio <input type="checkbox"/> telephone <input type="checkbox"/> informatically  Code of medical officer ordering EMS team dispatch:

**III. DISPATCH CARRIED OUT**

Intervention took place <input type="checkbox"/> on site <input type="checkbox"/> away from the event site <input type="checkbox"/> patient remained on site <input type="checkbox"/> patient taken care of and transported to ..... <input type="checkbox"/> emergency unit <input type="checkbox"/> trauma centre <input type="checkbox"/> other unit <input type="checkbox"/> specialized hospital unit <input type="checkbox"/> patient taken over by medical air rescue team <input type="checkbox"/> patient not present on site <input type="checkbox"/> patient refused medical assistance	<b>PATIENT'S STATEMENT</b> Having received information concerning the health risks and possibility of my death hereby decline to: <input type="checkbox"/> receiving medical assistance, <input type="checkbox"/> being transported to hospital I declare having received extensive information concerning my health status and having obtained answers to all my questions expressed date ..... time ..... signature of patient or legal guardian .....	<b>TIME-POINTS OF DISPATCH</b> Time of EMS team departure: hh ..... min ..... Time of arrival on site: hh ..... min ..... Time of patient admission to emergency department/unit/other: hh ..... min ..... Time of return to event site/dispatch ending: hh ..... min .....
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**IV. DECEASE**

Patient died: before EMS team arrived <input type="checkbox"/> during medical intervention <input type="checkbox"/> during transport	Time of death/intervention abandoned*** [ ] : [ ]	Suspected crime: yes <input type="checkbox"/> no <input type="checkbox"/>	Notification to: police <input type="checkbox"/> sanitary inspectorate <input type="checkbox"/> other .....	Death certificate issued: yes <input type="checkbox"/> no <input type="checkbox"/>
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**V. SUMMARY**

Medical intervention certificate issued to: the patient <input type="checkbox"/> legal guardian <input type="checkbox"/> hospital <input type="checkbox"/> other .....	Disinfection procedure after dispatch end: performed <input type="checkbox"/> not performed <input type="checkbox"/>	Infectious disease certificate issued: yes <input type="checkbox"/> no <input type="checkbox"/>
Medical procedures carried out by the EMS team (ICD9):	Km:	Signature and stamp of the EMS team head:

\*1. Emergency dispatch  
#Explanatory translation

2. Urgent dispatch

3. Other

\*\*Mark the name of the EMS team head

\*\*\*Medical intervention abandoned — for team without physician

cont.→

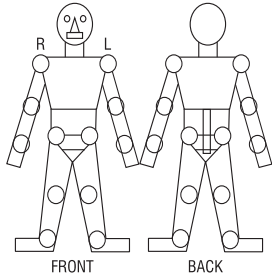
# MEDICAL INTERVENTION CARD\*

Code of the emergency medical service (EMS) team supervisor:	Code of EMS team on dispatch:	Dispatch no.:
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## I. ANAMNESIS

	<b>Event site</b> patient's house <input type="checkbox"/> public place <input type="checkbox"/> trafficated area <input type="checkbox"/> work place <input type="checkbox"/> school <input type="checkbox"/> agricultural area <input type="checkbox"/>
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## II. EXAMINATION

<b>GLASGOW COMA SCALE</b> <b>EYE OPENING</b> spontaneous 4 to sound 3 to pressure 2 none 1 <b>VERBAL RESPONSE</b> orientated 5 confused 4 words 3 sounds 2 none 1 <b>MOTOR RESPONSE</b> obey commands 6 localising 5 normal flexion 4 abnormal flexion 3 extension 2 none 1 SUM <input type="text"/>	<b>RTS</b> <b>RESPIRATORY RATE</b> 10–29 4 > 29 3 6–9 2 1–5 1 none 0 <b>SBP</b> > 89 4 76–89 3 50–75 2 1–49 1 0 0 <b>GCS</b> 13–15 4 9–12 3 6–8 2 4–5 1 3 0 SUM <input type="text"/>	<b>RESPIRATION</b> <b>respiratory rate</b> .../min dyspnoea <input type="checkbox"/> <input type="checkbox"/> cyanosis <input type="checkbox"/> <input type="checkbox"/> apnoea <input type="checkbox"/> <input type="checkbox"/> normal <input type="checkbox"/> <input type="checkbox"/> respiratory sound rhonhi <input type="checkbox"/> <input type="checkbox"/> wheezing <input type="checkbox"/> <input type="checkbox"/> rhales <input type="checkbox"/> <input type="checkbox"/> crackles <input type="checkbox"/> <input type="checkbox"/> no sound <input type="checkbox"/> <input type="checkbox"/> other <input type="checkbox"/> <input type="checkbox"/> <b>Saturation</b> <input type="text"/> %	<b>PUPILS</b> <b>Reaction to light:</b> L R normal <input type="checkbox"/> <input type="checkbox"/> slow <input type="checkbox"/> <input type="checkbox"/> none <input type="checkbox"/> <input type="checkbox"/> Diameter: L R normal <input type="checkbox"/> <input type="checkbox"/> narrow <input type="checkbox"/> <input type="checkbox"/> dilated <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> No injuries <input type="checkbox"/> O open fracture <input type="checkbox"/> F closed fracture <input type="checkbox"/> L luxation <input type="checkbox"/> C contusion <input type="checkbox"/> W wound <input type="checkbox"/> H wound haemorrhage <input type="checkbox"/> CR crushing <input type="checkbox"/> A amputation <input type="checkbox"/> N non-traumatic pain <input type="checkbox"/> B burn <input type="checkbox"/> degree <input type="text"/> % <input type="checkbox"/> degree <input type="text"/> % <input type="checkbox"/> damage inhalants
<b>SIGNS</b> shock <input type="checkbox"/> <input type="checkbox"/> sudden cardiac arrest <input type="checkbox"/> <input type="checkbox"/> meningeal irritation <input type="checkbox"/> <input type="checkbox"/> seizures <input type="checkbox"/> <input type="checkbox"/> aphasia <input type="checkbox"/> <input type="checkbox"/> vomiting <input type="checkbox"/> <input type="checkbox"/> diarrhoea <input type="checkbox"/> <input type="checkbox"/> bleeding <input type="checkbox"/> <input type="checkbox"/> oedema <input type="checkbox"/> <input type="checkbox"/> fainting <input type="checkbox"/> <input type="checkbox"/> <b>OTHER</b> pregnant <input type="checkbox"/> <input type="checkbox"/> labour <input type="checkbox"/> <input type="checkbox"/> Infectious disease <input type="checkbox"/> <input type="checkbox"/>	<b>SKIN</b> <b>Appearance:</b> normal <input type="checkbox"/> pale <input type="checkbox"/> reddened <input type="checkbox"/> yellowish <input type="checkbox"/> peripheral cyanosis <input type="checkbox"/> central cyanosis <input type="checkbox"/> <b>Moisture:</b> normal <input type="checkbox"/> wet <input type="checkbox"/> dry <input type="checkbox"/> <b>Temperature:</b> normal <input type="checkbox"/> cold <input type="checkbox"/> warm <input type="checkbox"/>	<b>ABDOMEN</b> normal <input type="checkbox"/> pain on palpation <input type="checkbox"/> no peristaltics <input type="checkbox"/> peritoneal irritation <input type="checkbox"/> <b>PSYCHOMOTOR</b> <b>EVALUATION</b> normal <input type="checkbox"/> slowed down <input type="checkbox"/> agitated <input type="checkbox"/> aggressive <input type="checkbox"/>	<b>HEART SOUNDS</b> clear/loud <input type="checkbox"/> silent <input type="checkbox"/> other <input type="checkbox"/> <b>PARESIS/PARALYSIS</b> upper limb L & R <input type="checkbox"/> <input type="checkbox"/> lower limb <input type="checkbox"/> <input type="checkbox"/> <b>BREATH SMELL</b> organic solvent <input type="checkbox"/> alcohol <input type="checkbox"/> other <input type="checkbox"/> <b>GLYCAEMIA</b> <input type="text"/> mg% <input type="text"/> g/L	<b>ECG</b> sinus rhythm <input type="checkbox"/> supraventricular tachycardia <input type="checkbox"/> ventricular tachycardia <input type="checkbox"/> atrial fibrillation/flutter <input type="checkbox"/> AV block <input type="checkbox"/> sVES <input type="checkbox"/> VES <input type="checkbox"/> VF/VT <input type="checkbox"/> asystole <input type="checkbox"/> PEA <input type="checkbox"/> cardioverter <input type="checkbox"/> ACS <input type="checkbox"/> infarct <input type="checkbox"/> other .....	<b>DESCRIPTION</b>

## III: DIAGNOSIS

Description	ICD10 code	ICD10 code	CD10 code
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## IV. INTERVENTIONS CARRIED OUT

<b>PROCEDURES</b> aspiration <input type="checkbox"/> defibrillation <input type="checkbox"/> collar <input type="checkbox"/> peripheral venous access <input type="checkbox"/> compression bag ventilation <input type="checkbox"/> external stimulation <input type="checkbox"/> spinal board <input type="checkbox"/> central venous access <input type="checkbox"/> oropharyngeal tube <input type="checkbox"/> cardioversion <input type="checkbox"/> vacuum mattress <input type="checkbox"/> catheter, gastric <input type="checkbox"/> intubation <input type="checkbox"/> heart massage <input type="checkbox"/> immobilisation <input type="checkbox"/> tube <input type="checkbox"/> respirator <input type="checkbox"/> ECG <input type="checkbox"/> bandage <input type="checkbox"/> monitoring <input type="checkbox"/> passive oxygen therapy <input type="checkbox"/> teletransmission <input type="checkbox"/> other .....	<b>ADMINISTERED DRUGS AND MEDICAL PRODUCTS</b> <b>(name, dose, mode of administration)</b>
<b>EMS TEAM HEAD ORDERS/COMMENTS</b>	

## V. PATIENT DATA AND REFERRAL

<b>PATIENT DATA</b> Name: ..... Surname: ..... Address of residence: ..... Street: .....no: ..... Identity card: no., date of issue: .....	NHS identifier: ..... Date of birth/age: ..... NATIONAL IDENTITY CODE of patient ..... Signature and stamp of the EMS team head: ..... Date of intervention .....	Decision at the referral centre: <input type="checkbox"/> Patient admission <input type="checkbox"/> Refusal of admission Stamp of emergency unit ..... Signature and stamp of the physician ..... Referral to emergency unit/other unit: date ..... hh ..... min ..... Death confirmed/intervention abandoned date ..... hh ..... min .....
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\*Explanatory translation