Louisiana Department of Health
Disaster EMS-Patient Care Report (PCR)

Call Type

Placard Number

Call Information

PCR #		911/Imbed #		Event Name	
Service Provider Name				☐ Emergency ☐ Non-Emergency	
Call Location Street Address					
City		State		Zip	

Patient Information

Patient's Name					Date	Departed	
Age		DOB	Sex --	Phone #	Enroute	Arrived	
Street Address					On-Scene	Complete	
City		State		Zip	Mileage to Scene	Total Miles	

Assessment/Medical Care/Narrative

Chief Complaint		Onset	
Pertinent Past Medical History			
Medication			
Alleregies			
Pertinent Findings from Physical Exam			

Vital Signs/Procedures

Time	HR	RR	BP	CBG	SPO2	Temp	GCS	Time	Procedure	Medication	Dose

Attach ECG Strips with Interpretation on back of form

Disposition/Medical Control/Receiving /Crew Information and Signature

Patient Destination/Location		Care Transferred to: (print name)		
Medical Control Name (if Applicable)		Receiving Signature		
Medic #1 Name		NREMT #		Attending Medic Signature
Medic #2 Name		NREMT #		

Louisiana Department of Health

Disaster EMS Patient Care Report (Optional) Continuation Form for additional information

Pt. Info

PCR #		Date	
Patient Name			

Assessment/Medical Care/Narrative

Attending Medic Signature

Vital Signs/Procedures

Time	HR	RR	BP	CBG	SPO2	Temp	GCS	Time	Procedure	Medication	Dose

ECG

Attach ECG Strips Below with Interpretations

This form must have a PCR report (without fail)

PCR #_____

DATE: _____

A. RELEASE OF MEDICAL RESPONSIBILITY (REFUSAL)

I, _____, hereby release the Louisiana Department of Health and the State of Louisiana, Personnel, Surge Plan System and Physicians and any and all of the state employee's and personnel of any responsibility. I acknowledge that I have been advised of the risks of not having emergency treatment and/or transportation to the nearest appropriate facility, which I am refusing.

_____ _____

Patient Name or Authorized Consent for Patient | Patient or Authorized Agent's Signature

_____ _____

Witness Name | Witness Signature

_____ _____

EMT's Name | EMT's Signature

B. REFUSAL OF SPECIFIC MEDICAL CARE/TREATMENT

I, _____, refuse the following medical care/treatment; _____. I have been advised of the possible risks/consequences of not obtaining the above listed care/treatment. I release the State of Louisiana and the Louisiana Department of Health and it's employees of responsibility.

_____ _____

Patient Name or Authorized Consent for Patient | Patient or Authorized Agent's Signature

_____ _____

Witness Name | Witness Signature

_____ _____

EMT's Name | EMT's Signature