	1	See Instructions of	n Back of this s	sheet)				NSN 7540-01-075-3786
EMERGENCY CARE AN (Medical Reco		TREATMENT FAC	CILITY (Stamp)			LOC	g number	
ARRIVAL DATE TIME	TRANSPORTATION TO (Attach care enroute sheet		CURRENT ME	DS. (tetanu r data)	s immun-	HIS	TORY OBTAIN	NED FROM OTHER <i>(Specify)</i>
DAY MONTH YR.	PRIVATE VEHICLE OTHER (Specify)	AMBULANCE				ALL	ERGIES	
PATIENT?S HOME ADDRESS OR DUTY S		' Code)				но	ME TELE. NO.	(Inc. area code)
CHIEF COMPLAINT(S) (Include symptom(s),	luration)		SE	х	AGE	POS	 T	PARTY PAYER?
VITAL SIGNS	DESCRIBE (1) <b>S</b> ubjectiv include results of tests and	e data (Pertinent Hist	tory); (2) <b>Q</b> bjecti	ive data (Exa	mination -	TIN	∫ YES IE SEEN BY PI	NO ROVIDER
TIME	(Treatment/Procedures - in	clude medication give	en and follow-up)	(4) <u><b>r</b></u> um				
BP DU SE	-							
PULSE RESP.	-							
TEMP.	-							
WT. (Child)	-							
CATEGORY (See reverse)	-							
EMERGENT	-							
URGENT	-							
NON-URGENT	-							
ORDERS INITS. TIME	-1							
	-							
	-							
	-							
	-							
	1							
	-							
ASSESSMENT/DIAGNOSIS								
DISPOSITION (Check all that apply)								
HOME FULL DUTY								
QUARTERS								
24 Hrs. 48 Hrs. 72 Hrs								
MODIFIED DUTY UNTIL:								
DAY MONTH YEAR.								
REFERRED TO (Indicate clinic)	_							
	_							
EMERGENCY TODAY	-							
ADMIT. TO HOSP. UNIT/SERVICE	-							
CONDITION UPON RELEASE	-							
	-							
IMPROVED UNCHANGED	_							
TIME OF RELEASE:	-	10	ONTINUE O	N SE 50		FDI		
		SIGNATURE OF I				LD)		
PATIENT'S IDENTIFICATION (Mechanical i FOR WRITTEN ENTRIES GIVE: Name - las	, first, middle; SSN; DOB,							
service status, name and relation of sponsor or LIST FACILITY HOLDING TREATMENT REC	INSTRUCTIONS	TO PATIENT (In	nclude medic	ations ordered. a	anv lir	nitations and fol	low-up plans)	
						.,		······································

## INSTRUCTIONS FOR COMPLETION OF THE EMERGENCY CARE AND TREATMENT FORM

- NOTE: This form will be used to record all care rendered to patients in the Emergency Room and will be used in lieu of *all* locally prepared emergency rooms forms. This form is not a substitute for line of duty, accident/injury or third party liability forms, but it may be used as a basis for completing those forms.
- 1. Complete form for each patient entered on Emergency Room Log.
- 2. Complete all parts of form.
- 3. Enter patient's log number from Emergency Room Log.

4. Check appropriate condition in "category" block based on following definitions:

*Emergent* - A condition which requires immediate medical attention and for which delay is harmful to the patient; such a disorder is acute and potentially threatens life or function.

*Urgent* - A condition which requires medical attention within a few hours or danger can ensue; such a disorder is acute but not necessarily severe.

*Non-Urgent* - A condition which does not require the immediate resources of an emergency medical services system; such a disorder is minor or non-acute.

5. Use SF 522, Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, to obtain authorization for any necessary procedures.

6. Orders: Provider enters orders; i.e., CBC, UA, etc. The person completing the action enters the time and his/her initials at the time of completion.

7. Give "Patient's Copy", containing instructions, to patient, sponsor (NOK) or person accompanying patient, except when patient is admitted.

8. File original in patient's treatment record (i.e., Military Health Record, Outpatient Treatment Record or Inpatient Record) as applicable.

9. Establish a treatment record for any patient who does not have a record. File and maintain treatment record in accordance with appropriate directives.

						(	See Instructions of	n Back of ti	his sheet)				NSN 7540-01-075-3786
E	MERG	ENC		RE AND		EATMENT	TREATMENT FAC	CILITY (Stan	ıp)		LO	g number	
		ARRI			TRAN	NSPORTATION TO		CURRENT	MEDS. (tetan other data)	us immun-	HIS	TORY OBTAI	NED FROM
	DATE		TIME		(Atto	ach care enroute sheet	)	ization ana	other data)			PATIENT	OTHER (Specify)
DAY	MONTH					PRIVATE VEHICLE	AMBULANCE				ALI		
						OTHER (Specify)							
PATIE	I NT'S HON	IE ADD	DRESS O	R DUTY STA		(City, State, and ZIP	Code)				НО	ME TELE. NO	. (Inc. area code)
CHIEF	COMPLA	NT(S)	(Include	symptom(s), d	uration	)			SEX	AGE	PO		PARTY PAYER?
												YES	NO
	V	ITAL S	SIGNS		DESC	CRIBE (1) <u>S</u> ubjective	data (Pertinent Histo	ory); (2) <u>Ob</u>	jective data (Ex	imination -	TIN	1e seen by p	ROVIDER
TIME					(Treat	le results of tests and s tment/Procedures - inc	c-rays); (3) <b>A</b> ssessm clude medication giver	eni (Diagnosi n and follow-i	up) (4) <b>P<u>ia</u>n</b>				
BP													
PULSE													
RESP.													
TEMP.													
WT. (0	hild)												
	CATEC	ORY	(See reve	erse)									
EI	MERGENT												
U	RGENT												
N	ON-URGE	NT											
	ORDER	S	INIT	S. TIME	4								
					1								
					1								
					1								
					1								
					1								
					1								
ASSES	SMENT/C	IAGNO	osis		1								
DIS	SPOSITIC	)N (Ch	neck all ti	hat apply)	1								
	OME			. DUTY	1								
		QUA	RTERS		1								
	24 Hrs.	- T - T	48 Hrs.	72 Hrs.	1								
			DUTY L		1								
D	AY		NTH	YEAR.	1								
RE	FERRED	TO (In	dicate clir	ıic)	1								
	EMERGE	NCY		TODAY	1								
$\vdash$	72 HOU			ROUTINE	1								
	 МІТ. ТО		UNIT/SI		1								
	CONDITI			FASE	1								
	PROVED		-	HANGED	-								
	TERIORA				1								
	OF RELEA				-		10		E ON SF 50	17 IE NEE	וחדח		
			ATION (	Mechanical in	nrint)		SIGNATURE OF I				DLD,		
FOR	VRITTEN	ENTRIE	S GIVE:	Name - last,	first, n	niddle; SSN; DOB,							
service LIST F	PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).			INSTRUCTIONS	TO PATIEN	[ (Include medi	cations ordered	l. anv li	nitations and fo	llow-up plans)			
									(			,	<u>1</u>
							EMERGENCY C			-		TANDADD	ORM 558 (BE\/ 6-82)

(See Instructions on Back of this sheet) NSN 754						
EMERGENCY CARE AND TREATMENT	TREATMENT FACILITY (St	amp)	LOG NUMBER			
(Medical Record)						
ARRIVAL TRANSPORTATION TO H DATE TIME (Attach care enroute sheet) DAY MONTH YR. PRIVATE VEHICLE OTHER (Specify)		NT MEDS. (tetan nd other data)	us immun-	HISTORY OBTAINED FROM PATIENT OTHER (Specify) ALLERGIES		
PATIENT'S HOME ADDRESS OR DUTY STATION (City, State, and ZIP	HOME TELE. NO. (Inc. area code)					
CHIEF COMPLAINT(S) (Include symptom(s), duration)		SEX	AGE	POSSIBLE THIRD PARTY PAYER?   YES   NO		

## PATIENT'S

COPY

(NOTICE TO PATIENT - PLEASE FOLLOW PHYSICIAN'S INSTRUCTIONS AS STATED BELOW)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT:	SIGNATURE OF PROVIDER AND ID STAMP						
LICT FACILITY HOLDING THE ATMENT DECODD	INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)						