REGIONAL PARAMEDIC PROGRAM
FOR EASTERN ONTARIO

Date: ________________ Time : ___________ Paramedic #:__________ ☐ ACP ☐ PCP

Pt Age: _______________ Sex: ☐ M ☐ F Weight: ______________

History:

Past Med History:

Medications:

Allergies:

Physical Examination:

BP: ____/_____

HR: _________

RR: _________

Sat.: _________

GCS: _________

Temp: _________

BS: _________

Skin: _________

Treatment(s) provided by Paramedic and Response:

Physician Orders:

Receiving Hospital:	**ETA**

MD Name (Print)	**MD #**	**MD Signature**

Revised: June 15 2009