

**CARSON CITY PURCHASING AND CONTRACTS**  
**201 North Carson Street, Suite 3**  
**Carson City, NV 89701**  
**775-283-7137/FAX 887-2107**  
**<http://www.carson.org/index.aspx?page=998>**

**NOTICE TO BIDDERS**  
**BID #1112-142**  
**Ambulance Billing Services**

Feb. 13, 2012

Addendum No. 1

Please make the following additions/changes to the above referenced project.

As of 2/8/2012, the following questions have been received. Answers are provided in italics

1. Will the City provide a sample call report(s)?

*Yes. We use a hand written PCR which we scan into Health EMS (a Sansio system) which turns the date into an ePCR. A representative copy of both are provided in Adobe.*

2. What is the Medicaid reimbursement rate for a BLS, ALS, ALS2, mileage?

*BLS Emergent = \$187.58  
BLS Non-Emergency = \$175.71  
ALS Emergent = \$247.00  
ALS Non-Emergency = \$219.73  
ALS2 = \$481.79  
Mileage = \$4.74*

3. What is the average mileage per transport?

*5.41*

4. Does the City currently outsource the transport billing services? Yes

If so:

- a. Who provides the service? *Intermedix. Corporate headquarters in Ft. Lauderdale, Florida*
- b. How long have they provided the service? *5 ½ years*
- c. What is the current fee? *Would prefer not to disclose.*

- d. Why is the City outsourcing the service under the current RFP? *Because the contract for services will expire 6/30/12, and we are required to re-bid the contract under state statutes.*
5. Are there any specific areas where the City wants an improvement in the billing and collection services? *We are always looking for improvement whenever possible; we do not have any specific area that we would single out.*
6. Please confirm that the City bills Medicare Part B. *Confirmed*
7. At the time of transport, does the City obtain and document the patient's authorization to release healthcare information to third parties for billing purposes? If not, how does the City obtain this information? *Every effort is made to obtain this information at the time of transport.*
8. For which payors is the City currently receiving electronic remittances? *Unknown – this work is outsourced.*
9. Will the successful vendor assume responsibility for any backlog of unbilled and/or previously billed accounts? If so, is an aged trial balance report of this backlog available that identifies by payor the volume and dollar value. *No*

What is the anticipated growth in the number of transports for the next several years?  
*Approximately 2%.*

Attachment A

End of Addendum 1

Agency Name: **CCFD ePCR** Call # **6476504**

Agency ID: **1309** Branch # **51** Shift # **C** Today's Date **02/01/12** 1st Resp. Agency **01** Crew Member ID **120755**

Call Times (24hr)	Patient Contact Time	Mileage (odometer)	Crew Member ID	Vehicle Unit #	Requested By
1720	1727	Start	3858	R51	911 Private Requested By Code
1723	1732	On Scene	3313	Other Vehicle	
1723	1739	At Destination	187	E51	
1726	1805	At Destination	2474		
		At Destination	2778		

Run Disposition	Dispatch Reason	Run Type	Destination Determination	Transport From	Transport To Code
<input checked="" type="checkbox"/> Treated / Transported <input type="checkbox"/> Treated / Transferred Care <input type="checkbox"/> Treated / No Transport <input type="checkbox"/> Transported / Refused Care <input type="checkbox"/> Cancelled <input type="checkbox"/> Pronounced Dead <input type="checkbox"/> Treat/Transport Private Veh. <input type="checkbox"/> No Transport/Refused Care <input type="checkbox"/> Other <input type="checkbox"/> No Patient Found	EMD Code: <b>28C1</b> Type: <input type="checkbox"/> (01-99) (A-O) (1-9)	<input checked="" type="checkbox"/> Emergency (Immediate) <input type="checkbox"/> Non-Emergency <input type="checkbox"/> Mutual Aid <input type="checkbox"/> Interfacility = <input type="checkbox"/> Stand-By <input type="checkbox"/> Intercept <input type="checkbox"/> Scheduled	<input checked="" type="checkbox"/> Nearest Facility <input type="checkbox"/> Weather / Supervisor <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Hospital Division <input type="checkbox"/> Medical Protocol <input type="checkbox"/> Online Physician <input type="checkbox"/> Mass Casualty <input type="checkbox"/> Special Resources	<input checked="" type="checkbox"/> Home / Residence <input type="checkbox"/> Residential, Custodial Facility <input type="checkbox"/> Scene of Accident or Acute Event <input type="checkbox"/> Educational Inst. <input type="checkbox"/> Farm <input type="checkbox"/> Industrial Place <input type="checkbox"/> Mine / Quarry <input type="checkbox"/> Public Building <input type="checkbox"/> Recreation/Sport <input type="checkbox"/> Site of Transfer (Between Ambulances)	<input type="checkbox"/> Street/Hwy <input type="checkbox"/> Other <input type="checkbox"/> Unspecified

Incident Address:  (Check the Box if same as Transport From Code)

City: **CARSON CITY** State: **NV** Zip Code: **89703**

Street Address:  (Check the Box if same as Incident Address)

City: **CARSON CITY** State: **NV** Zip Code: **89703**

First Name: **GOY** Last Name: **W KING**

Home Phone: **702-795-0406**

Insurance Company Name: **WELLS FARGO**

Policy Number: **19510**

Policy Holder First Name: **GOY** Last Name: **W KING**

Guarantor First Name: **GOY** Last Name: **W KING**

Airway	Breathing	Circulation (Skin)	L (Pupils)	R	Time 1	Glasgow	Time 2
<input checked="" type="checkbox"/> Patent <input type="checkbox"/> Partially Obstructed <input type="checkbox"/> Stridor <input type="checkbox"/> Choking <input type="checkbox"/> Drooling <input type="checkbox"/> Grunting <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Nasal Flaring <input type="checkbox"/> Intercoastal Retraction <input type="checkbox"/> Other <input type="checkbox"/> Completely Obstructed	Rate: <input checked="" type="checkbox"/> Normal Quality: <input checked="" type="checkbox"/> Unlabored <input type="checkbox"/> Slow <input type="checkbox"/> Labored <input type="checkbox"/> Rapid <input type="checkbox"/> Shallow <input type="checkbox"/> Apneic <input type="checkbox"/> Irregular <input type="checkbox"/> Wheeze <input type="checkbox"/> Diminished <input type="checkbox"/> Absent	Color: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/> Flush Temp: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Hot <input type="checkbox"/> Cool <input type="checkbox"/> Cold Cond.: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Hives <input type="checkbox"/> Itchy <input type="checkbox"/> Rash <input type="checkbox"/> Swollen <input type="checkbox"/> Erythema Cap. Refill: <input checked="" type="checkbox"/> <2Sec <input type="checkbox"/> >2Sec <input type="checkbox"/> Absent Edema: <input type="checkbox"/> Normal <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> Pitting	<input checked="" type="checkbox"/> Reacts <input type="checkbox"/> Sluggish <input type="checkbox"/> Unreactive <input type="checkbox"/> Dilated <input type="checkbox"/> Constricted	<input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> P <input type="checkbox"/> U	<b>1728</b>	<b>1735</b>	<b>15</b>

Provider Impression: **Stroke like symptoms**

Mechanism of injury: **None**

Injury: **None**



Unit Measure Route  
 1 gm 4 mcg 7 mcg/min 10 LPM 13 mcg/kg/min IV IM ETT RECTal  
 2 mg 5 unit 8 gtt/min 11 ml/hr 14 units/hr IO SQ NEB INHal  
 3 mcg 6 ml 9 mg/min 12 joules 15 Inch SL PO AUTO TRAnsdermal

6476504

Time	Staff #	Systolic B/P	Diastolic	Pulse	Respiration	SPO2	CO2	Blood Sugar	Pain (0-10)	Temperature
1729	2	168	96	92	28	99		94		

Treatment / Medication	Time	Staff #	Treat. Code	Med. Code	Dose	Unit	Route	Attempt	Cond.	Comments
ALS	1727	1	151					1	<input type="checkbox"/> +	
SpO2	1729	2	136					1	<input type="checkbox"/> +	
IV	1733	2	156					1	<input type="checkbox"/> +	195 L/c
ELB	1737	2	125					1	<input type="checkbox"/> +	
									<input type="checkbox"/> +	
									<input type="checkbox"/> +	
									<input type="checkbox"/> +	
									<input type="checkbox"/> +	
									<input type="checkbox"/> +	
									<input type="checkbox"/> +	
									<input type="checkbox"/> +	
									<input type="checkbox"/> +	
									<input type="checkbox"/> +	
									<input type="checkbox"/> +	

**Narrative History:** Key Words (Onset, Provokes, Quality, Radiates, Severity, Position, Changes En Route, Medications, Other Vital Signs) Illness / Injury Onset Date  
 Medical need (Must be successful in 200, mention)  Medically Necessary  Required Stretcher  Severe Pain  Visible Bleeding  
 Bed Confined  Unconscious  Needed Restraining  Non-Ambulatory  
 PMH:  Asthma  Chronic Renal Failure  Cancer  CVA/Stroke  Dialysis  HIV/AIDS  Psychiatric Problems  Substance Abuse  Tuberculosis  
 Amputee  Chronic Respiratory Failure  Cardiac  Diabetes  Emphysema  Hypertension  Seizure Disorder  Tracheostomy  Other

Allergies:  No

Medication: none  
 AOS to 4/0 M w/ CC of R-sided numbness beginning R Leg and traveling up R side to face. Pt also exhibited expressive dysphasia and slight loss of consciousness. All symptoms beginning @ approx 1645 hrs. Upon arrival, pt A+V, denied assoc w/ fall/NIB/dizziness/recent illness. Physical assess unremarkable. Neuro assess revealed dysphagia and R facial numbness. Negative findings - arm drift, pt had equal grips, EMS intact, pt ambulating. # During transport pt vitals remained stable, no incident occurred. Pt had no personal medical Hx, though had family Hx of CVA. Upon arrival @ CTH, pt care transferred to ED.

Moved to Ambulance By:				Transport Position:				Medication / Treatment Authorization:					
<input type="checkbox"/> Chair	<input type="checkbox"/> Scoop Stretcher	<input checked="" type="checkbox"/> Walked with Assist	<input type="checkbox"/> Met at Ambulance	<input type="checkbox"/> Supine	<input type="checkbox"/> Shock	<input checked="" type="checkbox"/> Semi / Full Fowlers	<input type="checkbox"/> Left Lateral Recumbent	<input checked="" type="checkbox"/> Protocol	<input type="checkbox"/> Written Orders	<input type="checkbox"/> On-Line Physician	<input type="checkbox"/> On-Line Med. Facility		
<input type="checkbox"/> Stretcher	<input type="checkbox"/> Carried	<input type="checkbox"/> Met at Ambulance	<input type="checkbox"/> Met at Ambulance	<input type="checkbox"/> Sitting	<input type="checkbox"/> Shock	<input type="checkbox"/> Semi / Full Fowlers	<input type="checkbox"/> Left Lateral Recumbent	<input type="checkbox"/> On-Line	<input type="checkbox"/> NA	<input type="checkbox"/> On-Scene	<input type="checkbox"/> On-Line Med. Facility		
Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code	Qty	Supply Code

**Authorization for Billing / Release of Patient Information / Assumption of Financial Responsibility:** I request that payment of authorized Medicare/Medicaid and/or other insurance benefits be made to the pre-hospital care provider ("Provider") for any services furnished to me. I authorize any holder of hospital or medical information about me to be released to the Provider, Centers for Medicare and Medicaid Services, and/or my insurance carriers and their agents, including any other information needed to determine these benefits or other benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand this authorization may be used by the Provider for all services furnished in the future until such time as I revoke this authorization in writing. I agree to assume full financial responsibility for payment of all charges not covered by my insurance carrier as well as any collection costs and/or attorney's fees as allowed by law. Patient:  Unable to Sign  Refused to Sign  PCS Collected  Other Insurance Collected

Authorization Signature: [Signature] Date: 2/1/12 Guarantor Signature: [Signature]

Privacy Notice: I hereby acknowledge that I have been provided with a copy of the Provider's Notice of Privacy Practices explaining how my personal health information is used and understand my individual rights related to this information. Privacy Notice Signature: [Signature] Date: 2/1/12

Patient's Physician Name (please print): [Signature] Receiving RN / MD Signature: [Signature] Technician Signature: [Signature]

Refuse Treatment / Transportation and understand the consequences of my refusal: [Signature] Witness Signature for Refusal: [Signature] On-Line Medical Control Signature: [Signature]

User: sgiomi Customer No: 626-337 Carson City Fire Dept

Version: 4.50

Home myHealthEMS™ Setup eChart Reports Maps Finance Xchange Contact Mgmt

Log Out

Add Supplemental Unassign Other Doc Add Message Actions:

Registration Number: **Booklet ID: 6476504**

Agency ID Branch # Shift Incident Date 1st Resp. Agency Other Resp. Agency Call # Incident #

001309 51 C - C Shift 2 1 2012 01 - Carson City Fire 120755 120755

Call Times (24hr)	Mileage	Driver	Crew Member ID	Vehicle Unit #	Requested By
Time Call Received: 1720 :00	Start: 1727 :00	To Scene: [ ] To Hosp: [ ]	1 [Redacted] sort	Primary: R51	911 Private
Dispatched: 1723 :00	On Scene: 0 :0	[ ] [ ]	2 [Redacted] sort	Others: [ ]	Requested By Code: [ ]
En Route: 1723 :00	At Destination: 3 :4	[ ] [ ]	3 [Redacted] sort	Factors Affecting Delivery:	Requested By Code: [ ]
On Scene: 1726 :00	Calculated Mileage (via Map): 2532.14	[ ] [ ]	4 [Redacted] sort	Traffic [ ]	Requested By Code: [ ]
In Service: 1739 :00		[ ] [ ]	5 [Redacted] sort	Weather [ ]	Requested By Code: [ ]
At Destination: 1805 :00		[ ] [ ]	6 [Redacted] sort	Crowd [ ]	Requested By Code: [ ]
		[ ] [ ]	7 [Redacted] sort	Staff Delay [ ]	Requested By Code: [ ]
		[ ] [ ]	8 [Redacted] sort	Directions [ ]	Requested By Code: [ ]
		[ ] [ ]	9 [Redacted] sort	Distance [ ]	Requested By Code: [ ]
		[ ] [ ]	10 [Redacted] sort	Extraction [ ]	Requested By Code: [ ]

Run Disposition:  Treated / Transported

Run Type:  Emergency (Immediate)

Destination Determination:  Nearest Facility

Transport From:  Home / Residence

Incident Address: [Redacted] Apt. Number: [Redacted]

City: CARSON CITY County Code: 510 Carson City State/Prov: NV ZIP Code: 89703

First Name: [Redacted] Last Name: [Redacted] Generation: [Redacted]

Street Address: [Redacted] Apt. #: [Redacted] County Code: 510 Carson City

Age: [Redacted] Days: [ ] Months: [ ] Years: [ ]

Gender: Male Weight: [Redacted] lbs

Home Phone: [Redacted] Social Security Number: [Redacted] Date of Birth: 4/6/ [Redacted] Driver's License: [Redacted]

Ethnicity:  White

Insurance Company Name: [Redacted] Payer ID: [Redacted]

Policy Number: [Redacted] Group Number: [Redacted]

Policy Holder's First Name: [Redacted] Policy Holder's Last Name: [Redacted]

Guarantor First Name: [Redacted] Guarantor Last Name: [Redacted]

Representative Address: [Redacted] Representative Phone: [Redacted]

Add Second Payer

Airway	Breathing	Circulation (skin)	L (Pupils)	R (Pupils)	Time 1 Glasgow Coma	Time 2
<input checked="" type="radio"/> Patent	<input checked="" type="radio"/> Normal	Color: <input checked="" type="radio"/> Normal	<input checked="" type="radio"/> Reacts	<input checked="" type="radio"/> Reacts	1728	1735
<input type="radio"/> Partially Obstructed	<input type="radio"/> Unlabored	Temp: <input checked="" type="radio"/> Normal	<input type="radio"/> Sluggish	<input type="radio"/> Sluggish	4 Spontaneous	4 Spontaneous
<input type="radio"/> Stridor	<input type="radio"/> Labored	Cond.: <input checked="" type="radio"/> Normal	<input type="radio"/> Unreactive	<input type="radio"/> Unreactive	3 To Speech	3 To Speech
<input type="radio"/> Drooling	<input type="radio"/> Shallow	Hives: <input type="radio"/> Normal	<input type="radio"/> Dilated	<input type="radio"/> Dilated	2 To Pain	2 To Pain
<input type="radio"/> Difficulty Swallowing	<input type="radio"/> Irregular	Cap. Refill: <input checked="" type="radio"/> < 2 Sec	<input type="radio"/> Constricted	<input type="radio"/> Constricted	1 Not at all	1 Not at all
<input type="radio"/> Nasal Flaring	<input checked="" type="radio"/> Clear	Cap. Refill: <input type="radio"/> > 2 Sec	<input type="radio"/> Mental Status	<input checked="" type="radio"/> Oriented	5 Oriented	5 Oriented
<input type="radio"/> Intercostal Retraction	<input type="radio"/> Wet	Cap. Refill: <input type="radio"/> Absent	<input type="radio"/> Sinus Tach.	<input type="radio"/> Confused	4 Confused	4 Confused
<input type="radio"/> Other	<input type="radio"/> Wheeze	Cap. Refill: <input type="radio"/> Absent	<input type="radio"/> PVC's > 6	<input type="radio"/> Inappr. Words	3 Inappr. Words	3 Inappr. Words
		Cap. Refill: <input type="radio"/> Absent	<input type="radio"/> Bi/Trigem	<input type="radio"/> Inappr. Sounds	2 Inappr. Sounds	2 Inappr. Sounds
		Cap. Refill: <input type="radio"/> Absent		<input type="radio"/> None	1 None	1 None

ATTACHMENT A

S I G N I F I C A N T	<input type="checkbox"/> Completely Obstructed	<input type="checkbox"/> Diminished	<input type="checkbox"/> Absent	Edema	<input checked="" type="radio"/> None	<input type="radio"/> 1+	<input type="radio"/> 2+	<input type="radio"/> 3+	<input type="radio"/> Pitting	<input type="checkbox"/> Sinus Brady.	<input type="checkbox"/> AV Block	<input checked="" type="radio"/> 6	<input type="checkbox"/> Obeys Command	<input checked="" type="radio"/> 6		
	<input type="checkbox"/> PAC's	<input type="checkbox"/> Junctional	<input type="checkbox"/> SVT		<input type="checkbox"/> V. Tach	<input type="checkbox"/> Atrial Flutter	<input type="checkbox"/> V. Fib	<input type="checkbox"/> Atrial Fib.	<input type="checkbox"/> P. E. A	<input type="checkbox"/> PVC's	<input type="checkbox"/> Asystole	<input type="checkbox"/> STEMI	<input type="checkbox"/> Paced	<input type="checkbox"/> 5	<input type="checkbox"/> Localized Pain	<input type="checkbox"/> 5
	<input type="checkbox"/> 4	<input type="checkbox"/> Withdraws to Pain	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> Flexes to Pain	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> Extends to Pain	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> None	<input type="checkbox"/> 1	<input type="checkbox"/> 15	Totals (3 to 15)	<input type="checkbox"/> 15	<input type="checkbox"/> 2

+ Abdominal Assessment  
+ Pediatric Trauma Score  
+ APGAR Score

P R E S E N T	Provider Impression Circle all descriptions that apply and X the box below			Mechanism of Injury (X all that apply)		Injury												
	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Cardiac Arrest *	<input type="checkbox"/> Hyperthermia	<input type="checkbox"/> Alcohol Intox	<input type="checkbox"/> Fall 2X height	<input type="checkbox"/> Major Int Injuries	<input type="checkbox"/> Amputation	<input type="checkbox"/> Penetrating	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Bruising	<input type="checkbox"/> Burn	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Pain	<input type="checkbox"/> Laceration	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Swelling	<input type="checkbox"/> Soft Tissue
<input type="checkbox"/> Dehydration Symp.	<input type="checkbox"/> Cardiac Symptoms	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Alcohol Intox Severe	<input type="checkbox"/> Fall > 20 ft	<input type="checkbox"/> Assault Firearms	<input type="checkbox"/> Fight/Brawl												
<input type="checkbox"/> GI-Bleed	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Obvious Death	<input type="checkbox"/> Animal Bite	<input type="checkbox"/> Fall	<input type="checkbox"/> Assault Sexual	<input type="checkbox"/> Fire												
<input type="checkbox"/> GI-Constipation	<input type="checkbox"/> Cough W/Blood	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Assault Stabbing	<input type="checkbox"/> Hazardous Materials	<input type="checkbox"/> Bicycle Accident	<input type="checkbox"/> Machinery												
<input type="checkbox"/> GI-Diarrhea	<input type="checkbox"/> Dyspnea-SOB	<input type="checkbox"/> Post-Op Comp.	<input type="checkbox"/> Blunt Trauma	<input type="checkbox"/> Med. Device Failure	<input type="checkbox"/> Burn/Scald-Non Fire	<input type="checkbox"/> MVA to Bicycle *												
<input type="checkbox"/> Nausea	<input type="checkbox"/> Hyperventilation	<input type="checkbox"/> Shock	<input type="checkbox"/> Diving Injury	<input type="checkbox"/> MVA to Fixed Obj *	<input type="checkbox"/> Near Drowning	<input type="checkbox"/> MVA to MV *												
<input type="checkbox"/> Urinary Bleeding	<input type="checkbox"/> Pneumonia Symp.	<input type="checkbox"/> Trauma Injury	<input type="checkbox"/> Drug Overdose	<input type="checkbox"/> MVA Non-Traffic *	<input type="checkbox"/> Elderly Abuse	<input type="checkbox"/> MVA to Pedestrian *												
<input type="checkbox"/> Urination Problem	<input type="checkbox"/> Pulmonary Edema	<input type="checkbox"/> Monitoring Req.	<input type="checkbox"/> Electroconvulsion	<input type="checkbox"/> Smoke Inhalation	<input type="checkbox"/> Excessive Cold	<input type="checkbox"/> Suicide												
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Respiratory Arrest	<input type="checkbox"/> Restraints Required	<input type="checkbox"/> Excessive Heat	<input type="checkbox"/> NA	<input type="checkbox"/> Excessive Heat	<input type="checkbox"/> NA												
<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Respiratory Failure	<input type="checkbox"/> Seclusion Required	Injury Intent:		Other MOI													
<input type="checkbox"/> Alt Level Conscious	<input type="checkbox"/> Syncope/Fainting	<input type="checkbox"/> Special Handling	<input type="radio"/> Intentional <input type="radio"/> Unknown															
<input type="checkbox"/> Anxiety	<input type="checkbox"/> OB/Gyn	<input type="checkbox"/> Isolation Required	<input type="radio"/> Unintentional <input type="radio"/> N/A															
<input type="checkbox"/> Behavioral Disorder	<input type="checkbox"/> OB/Gyn (comp.)	<input type="checkbox"/> Orth. Device Req.	<input type="radio"/> Intentional Self															
<input checked="" type="checkbox"/> CVA/Stroke *	<input type="checkbox"/> Newborn	<input type="checkbox"/> Positioning Req.																
<input type="checkbox"/> Depression (acute)	<input type="checkbox"/> Allergic Reaction	<input type="checkbox"/> No Medical Prob.																
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Elev Temp/Fever	<input type="checkbox"/> Unknown Medical																
<input type="checkbox"/> Headache	<input type="checkbox"/> Flu Symptoms	<input type="checkbox"/> Other PI 1																
<input type="checkbox"/> Migraine	<input type="checkbox"/> Med. Reaction	<input type="checkbox"/> Other PI 2																
<input type="checkbox"/> Psychiatric Emerg.	<input type="checkbox"/> Nose Bleed	<input type="checkbox"/> 1 Protocol																
<input type="checkbox"/> Seizure	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> 2 Protocol																
<input type="checkbox"/> Unconscious	<input type="checkbox"/> Back Pain	<input type="checkbox"/> 1 Protocol																
<input type="checkbox"/> Weakness	<input type="checkbox"/> Carbon Mon. Poison	<input type="checkbox"/> 2 Protocol																
<input type="checkbox"/> Airway Obstruction	<input type="checkbox"/> Diabetic Symptoms	<input type="checkbox"/> 1 Protocol																
<input type="checkbox"/> Apnea	<input type="checkbox"/> Eye Symp.	<input type="checkbox"/> 2 Protocol																
<input type="checkbox"/> Asthma Symptoms	<input type="checkbox"/> Hemorrhage	<input type="checkbox"/> 1 Protocol																

Chief Complaint: STROKE LIKE SYMPTOMS

V I T A L S	Time	PTA Staff #	Systolic B/P	Diastolic	Pulse	Respiration	SPO2	CO2	Blood Sugar	Pain(0-10)	Temperature
	1729   00	2	168	96	PAL	92	28	99	94		

[Add New Vital Record](#)

F L O W C H A R T	Time	PTA Staff #	Treat. Code	Med. Code	Dose	Unit	Route	Attempts	Unable Condition
	1727   00	1	151 ALS Assessment					1	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <a href="#">Comments More FlexFields</a>
	1729   00	2	136 Pulse Oximetry					1	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <a href="#">Comments More FlexFields</a>
	1733   00	2	156 IV Start (Saline Lo					1	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <a href="#">Comments More FlexFields</a>
	1737   00	2	125 EKG monitor					1	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <a href="#">Comments More FlexFields</a>

[Add New Flow Record](#)

W A S T E	Time	Staff #	Med. Code	Amount Wasted	Unit	Box#	Seal#

[Add New Medication Wasted Record](#)

Medication Wasted Signature

Medication Wasted Witnessed Signature

N A R R A T I V E	Narrative History: Key Words - (Onset, Provokes, Quality, Radiates, Severity, Position, Changes En Route, Medications, Other Vital Signs)										Illness/Injury Onset Date/Time	
	<input checked="" type="checkbox"/> Medical need (Must be supported in documentation)	<input checked="" type="checkbox"/> Medically Necessary	<input type="checkbox"/> Required Stretcher	<input type="checkbox"/> Severe Pain	<input type="checkbox"/> Visible Bleeding	<input type="checkbox"/> Other	<input type="checkbox"/> Bed Confined	<input type="checkbox"/> Unconscious	<input type="checkbox"/> Needed Restraining	<input type="checkbox"/> Non-Ambulatory	<input type="checkbox"/> Comment	
PMH	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chronic Renal Failure	<input type="checkbox"/> Cancer	<input type="checkbox"/> CVA/Stroke	<input type="checkbox"/> Dialysis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> None		
ALLERGIES	<input type="checkbox"/> Amputee	<input type="checkbox"/> Chronic Respiratory Failure	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Other	<input type="checkbox"/> Comment		
	Environmental Allergies	Medication Allergies		Current Medications								
	<input type="checkbox"/> Add	<input type="checkbox"/> Lookup <input type="checkbox"/> Add		<input type="checkbox"/> Lookup <input type="checkbox"/> Add								

Remove Selected      Remove Selected      Remove Selected

Allergies  No

Medication Narrative Text

H  
I  
S  
T  
O  
R  
Y

<b>Moved to Ambulance By:</b> <input type="checkbox"/> Chair <input type="checkbox"/> Scoop Stretcher <input type="checkbox"/> Walked with Assist <input checked="" type="checkbox"/> Stretcher <input type="checkbox"/> Carried <input type="checkbox"/> Met at Ambulance			<b>Transport Position:</b> <input type="checkbox"/> Supine <input type="checkbox"/> Shock <input checked="" type="checkbox"/> Semi/Full Fowlers <input type="checkbox"/> Sitting <input type="checkbox"/> Prone <input type="checkbox"/> Left Lateral Recumbent <input type="checkbox"/> Trendelenburg <input type="checkbox"/> Reverse Trendelenburg			<b>Medication/Treatment Authorization:</b> <input checked="" type="checkbox"/> Protocol <input type="checkbox"/> Written Orders <input type="checkbox"/> On-Line <input type="checkbox"/> NA <input type="checkbox"/> On-Scene			<b>On-Line Physician:</b> [Dropdown] <b>On-Line Med. Facility:</b> [Dropdown] <a href="#">sort</a> <b>On-Line Med. Facility Location:</b> [Dropdown]		
--	--	--	--	--	--	--	--	--	--	--	--

S	Qty	Supply Code													
U															
P															
P															
L															
Y															

Agency Definable 1 [ ] 2 [ ]

**Authorization for Billing / Release of Patient Information / Assumption of Financial Responsibility:** I request that payment of authorized Medicare/Medicaid and/or other insurance benefits be made to the pre-hospital care provider ("Provider") for any services furnished to me. I authorize any holder of hospital or medical information about me to be released to the Provider, Centers for Medicare and Medicaid Services, and/or my insurance carriers and their agents, including any other information needed to determine these benefits or other benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand this authorization may be used by the Provider for all services furnished in the future until such time as I revoke this authorization in writing. I agree to assume full financial responsibility for payment of all charges not covered by my insurance carrier as well as any collection costs and/or attorney's fees as allowed by law.    Patient:  Unable to Sign     Refused to Sign

Yes     No     PCS Collected     Other Insurance Collected

Patient Signature       Guarantor Signature

**Privacy Notice:** I hereby acknowledge that I have been provided with a copy of the Provider's Notice of Privacy Practices explaining how my personal health information is used and understand my individual rights related to this information:      Privacy Notice Signature

Patient's Physician Name Obtained  Name: [ ]      Receiving RN / MD Signature       Technician Signature

I Refuse Treatment / Transportation       Witness Signature for Refusal       On-Line Medical Control Signature

**Unable to Sign: The following information must be provided in order to meet CMS signature requirements.**

1) Patient Unable To Sign Reason [ ]

2) Authorized Representative type signing on behalf of the Patient [ ]      Authorized Representative Signature

3) Secondary Documentation [ ]      Secondary Documentation Signature       [Unable to Sign Comments](#)

Additional Fields:

[ ] Please choose a field. [Add](#)

EKG Device: [ ] EKG Device Incident Number: [ ]

Mark as Private

Recommended Service Level: ALS1  
Medically Necessary: Yes (Score: 5)  
Trauma Score: 12

Data Entry Comments

[ ]

General Comments

[ ]

[Save](#)

This run has been billed. You must document what changes you have made in the area below

Billing Comments

[ ]

Unauthorized access is prohibited. Usage will be monitored.  
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