



# Section 5

# Forms



**PLEASE PRINT CLEARLY**

**MFR AGENCY INFORMATION SHEET**

*This form should be completed and returned to EHS MFR Services ASAP whenever there are changes to MFR contacts within an agency.*

MFR Agency Name: \_\_\_\_\_

Civic Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

*The following 3 names shall remain on file with EHS MFR Services for both consumable supply orders and information. Please note: All consumable supply orders and information will be sent to the mailing address of the MFR Agency as listed above.*

**THIS SECTION MUST BE COMPLETED – PLEASE PRINT CLEARLY**

<b>1<sup>st</sup> Contact Name</b>			
<b>Title/Position</b>	<b>FIRE CHIEF</b>		
<b>Telephone</b>	<b>Cellular</b>	<b>Fax</b>	<b>Email</b>
<b>2<sup>nd</sup> Contact Name</b>			
<b>Title/Position</b>			
<b>Telephone</b>	<b>Cellular</b>	<b>Fax</b>	<b>Email</b>
<b>3<sup>rd</sup> Contact Name</b>			
<b>Title/Position</b>			
<b>Telephone</b>	<b>Cellular</b>	<b>Fax</b>	<b>Email</b>

Does your agency have a defibrillator? Yes  No

If yes, what type? ZOLL  Philips  LP 500  Other \_\_\_\_\_ Serial # \_\_\_\_\_

\_\_\_\_\_  
 Authorized Signature  
 (Fire Department Chief or Non-traditional Agency MFR Coordinator)

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
 Date



## EHS Registered Medical First Responders

### APPROVED CONSUMABLES RE-ORDER FORM

FAX TO: (902) 832-8602

**NAME OF AGENCY:** \_\_\_\_\_

**CONTACT PERSON:** \_\_\_\_\_

**TELEPHONE/CELLULAR:** \_\_\_\_\_

*(PLEASE PRINT)*

DESCRIPTION	UOM	CURRENT INVENTORY	REQUESTED QUANTITY
Gauze Dressing, 4"x4" 8-Ply Sterile	50/Box		
Abdominal Pad, 5"x9" Sterile	20/Box		
Gloves, Small	100/Box		
Gloves, Medium	100/Box		
Gloves, Large	100/Box		
Gloves, X-large	100/Box		
Airways OPA, Pedi	Each		
Airways OPA, 0 (50mm)	Each		
Airways OPA, 1 (60mm)	Each		
Airways OPA, 2 (70mm)	Each		
Airways OPA, 3 (80mm)	Each		
Airways OPA, 4 (90mm)	Each		
Airways OPA, 5 (100mm)	Each		
Airways OPA, 6 (110mm)	Each		
V-Vac Cartridge	Each		
BVM, Adult	Each		
BVM, Pediatric	Each		
Saline, 0.9% NaCl Inj 1000ml	Each		
Collar, Adult	Each		
Collar, Pedi	Each		
Collar, Baby	Each		
Gauze, Conform, 4"x4.1" Sterile	12/Pkg		
Tape, Transpore 1"x10 yd	12/Box		
Airways NPA, 12Fr	Each		
Airways NPA, 18Fr	Each		
Airways NPA, 24Fr	Each		
Airways NPA, 32Fr	Each		
Triangular Bandage, 40"x60" w/2 pins	Each		
Non-Sterile Bulk 4"x4"	200/Pkg		
Lubricating Jelly, 3.5g	Each		
Alcohol Wipes	200/Box		
Band-aids	100/Box		
Oxygen Mask, Adult	Each		
Oxygen Mask, Pediatric	Each		
OBS Kit	Each		
Burn Kit	Each		
Corrugated Splint, XL (Red)	Each		
Corrugated Splint, L (Yellow)	Each		
Corrugated Splint, M (Blue)	Each		
Corrugated Splint, S (White)	Each		
Patient Care Report Forms	Pad		
Continuation Forms	Pad		

Signature of requester \_\_\_\_\_

Date \_\_\_\_\_

<b>EHS MFR SERVICES USE ONLY</b>	
Date order received	_____
Account #	_____
Date order filled	_____
Filled by	_____



## REQUEST FOR RETURN OF MISSING/DAMAGED EQUIPMENT

**Complete this form and submit to**  
 EHS MFR Services  
 239 Brownlow Avenue, Suite 300  
 Dartmouth, NS B3B 2B2  
 Fax: (902) 832-8602    Tel: (902) 832-8356

Item	Quantity	Please include all details: date, time, location of call, and damage or failure
V-Vac Suction Handle		
Oxygen Regulator		
Backboard		
Backboard Straps		
Head Immobilizer Unit		
Head Immobilizer Straps Only		
Head Immobilizer Blocks Only		
Head Immobilizer Base Only		
KED		
Blood Pressure Cuff		
Stethoscope		
A1000 Airway Kit		
Safety Vest		
Oxygen Wrench		
Scissors		
*LIFEPAK 500 Defib Pads		
*HeartStart FRx Defib Pads		
Other (please specify)		

*\* To exchange defibrillator pads, refer to EHS MFR Program Document 12006.00: MFR Supplies*

**Type of call:**            MVC             Cardiac Arrest             Other

### Report of Damage or Failure

Did damage or failure compromise patient care in any way?    Yes             No   
 If yes, please explain below:

---



---

\_\_\_\_\_  
**Agency Name**

\_\_\_\_\_  
**Agency Chief/MFR Coordinator**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Telephone**

\_\_\_\_\_  
**EHS MFR Services use only**



# EMERGENCY HEALTH SERVICES MFR SERVICES

239 Brownlow Avenue, Suite 300, Dartmouth, NS B3B 2B2  
Tel: (902) 832-4685 Fax: (902) 832-8602  
Email: [mfr.registry@emci.ca](mailto:mfr.registry@emci.ca) Website: [www.ehsmfr.ca](http://www.ehsmfr.ca)



## Medical First Responder Registration/Re-registration Application

Check the appropriate box : First Time Registration  Re-registration Card  Replacement Card  Paramedic

Current Registration # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender M/F \_\_\_\_\_

NAME: \_\_\_\_\_  
(LAST) (FIRST) (INITIAL)

### HOME MAILING ADDRESS

CITY \_\_\_\_\_ PROV \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

HOME PH. \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

For Office Use Only	
Date Rec'd	_____
Expiry Date	_____
Assigned Tag #	_____
Date Tag Sent	_____

NAME OF EHS RESPONSE AGENCY\* YOU ARE AFFILIATED WITH *(MANDATORY)*

### Registration and Re-registration requirements (please see EHS MFR Program Document Nos. 12008.00 & 12015.00)

For *Initial EHS MFR Registration*:

- Please attach a copy of your original St. John Ambulance or Canadian Red Cross Medical First Responder certificate.

For *Re-registration*:

- Medical First Responders may complete MFR recertification training through one of the EHS recognized Medical First Responder training agencies - St. John Ambulance or Canadian Red Cross. A Medical First Responder successfully completing recertification training by an EHS recognized MFR training agency can make application for his/her new EHS MFR tag by completing this form and attaching a copy of the St. John Ambulance or Canadian Red Cross certificate.
- OR**
- Medical First Responders may attend refresher training sessions authorized by EHS MFR Services and facilitated by EHS registered Paramedics who are approved volunteer EHS MFR facilitators. Within the three (3) year EHS MFR registration period, the date which can be found on the front of the EHS MFR tag, a Medical First Responder must attend the six (6) mandatory refresher training sessions. The mandatory refresher training topics are identified in Program Document No. 12014.00: Essential Competencies MFR. Attendance at these sessions is tracked by EHS MFR Services through course attendance rosters. When all required training sessions have been completed, the member should complete this form.

Six mandatory refresher sessions:  AED  CPR  Primary Survey  Vital Signs  Triage  Airway Management  
Current Heart & Stroke Foundation, St. John Ambulance & Red Cross AED & CPR cards will also be accepted. Submit copy with registration.

*MFRs may be required to provide proof of attendance of any refresher training session upon request.*

\* EHS MFR response agency is listed in the Computer Aided Dispatch (CAD) system at the EHS Communications Centre.

I hereby confirm that the information provided on this application is true. I acknowledge that I am responsible to maintain my registration. I am aware of the EHS MFR Services Program Documents, including No. 12010.00 as it pertains to patient confidentiality, and agree to work within the guidelines described therein. I understand that my EHS MFR tag is the property of EHS Emergency Health Services.	
Signature of Applicant _____	Date _____

**COMPLETED FORM MAY BE RETURNED BY FAX (902-832-8602) OR MAIL TO THE ABOVE ADDRESS.  
YOUR NEW TAG WILL BE PROCESSED AND SENT TO YOU WITHIN 2-3 WEEKS.**



**AGENCY NAME:** \_\_\_\_\_

Confidentiality is not something to take lightly. Releasing information, whether Patient Care Reports, your own personal notes, or even just discussing personal information about a patient, is a violation of the patient’s right to privacy. EHS is obligated to ensure those rights are protected at all levels of patient care and contact.

Please review **Program Document No. 12010.00: MFR Documentation Standards/CPR Completion** and sign below as having read and understood this policy as it relates to patient confidentiality.

<i>Name (please print clearly)</i>	<i>EHS MFR Reg #</i>	<i>Signature</i>

*Submit completed form to*  
EHS MFR Services  
239 Brownlow Avenue, Suite 300  
Dartmouth, NS B3B 2B2  
Fax: (902) 832-8602



## FIRST RESPONDERS TRAVEL CLAIM FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Fire Department/MFR Agency: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Fax: \_\_\_\_\_

Date, time and location of call: \_\_\_\_\_

Accompanied patient to: \_\_\_\_\_  
(*indicate health care facility*)

Mileage: \_\_\_\_\_ km @ \$0.39/km = \$ \_\_\_\_\_ **or** Transportation cost: \$ \_\_\_\_\_  
(*e.g. taxi; attach receipt*)

Signature: \_\_\_\_\_ Total claim: \$ \_\_\_\_\_

*Note: Payment of this claim will be issued to the Fire Department or MFR Agency.*

Submit completed form to: Senior Manager  
EHS MFR Services  
239 Brownlow Avenue, Suite 300  
Dartmouth, NS B3B 2B2  
Fax: (902) 832-8602

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_  
*Regional Manager,  
EHS Ground Ambulance Operations*



## EHS MFR Special Event Information Collection Form

Please complete one form for each event.

### General Event Details

Contact name	
MFR Agency	
Telephone	
Cell	
Fax	
Email	

Hosting organization	
Name of event	
Location of event	
Type of event	
Date(s) and times of event	

### Specific Event Details

Will the MFR agency receive remuneration for covering this event?	
---	--

Anticipated number of participants	
------------------------------------	--

Average age of participants	
-----------------------------	--

Will alcohol be served? At what times?	
---	--

Is this an outdoor or indoor event?	
-------------------------------------	--



<b>Are there any geographical concerns (e.g. participants near/on water, hills, high traffic area)?</b>	
<b>Will there be facilities for MFRs to work from (i.e. tent, building, etc.)?</b>	
<b>Explain in detail any hazards that may arise from this event.</b>	
<b>Will there be street closures that will affect ambulance response? Provide details.</b>	
<b>Are there any communication concerns (i.e. poor cell service, paging problems, TMR issues etc.)?</b>	
<b>Does the surrounding area have a location that could be accessed for a LifeFlight landing zone?</b>	
<b>Have any dignitaries confirmed their attendance at the event? Please provide name and title.</b>	

Submitted by:

Name	MFR Tag #	Telephone	Date (DD / MM / YY)

\*\*Please submit this form and any attachments (i.e. maps or other relevant information) to EHS MFR Services by fax (902-832-8602) or email (mfrservices@emci.ca).

Please Complete →

Dept./Agency Name (Do NOT Abbreviate or Use Station Number) \_\_\_\_\_

**TRAINING**

Incident Location	Date	M	D	Y	Time Call Received	Time of Arrival	Time Cleared
-------------------	------	---	---	---	--------------------	-----------------	--------------

<b>PATIENT INFORMATION</b>	Chief Complaint (see back for complaint code)	Chief Complaint Code
----------------------------	---	----------------------

Patient Name	DOB	M	D	Y	Age
--------------	-----	---	---	---	-----

What Happened? (Mechanism of Injury)	EHS on scene prior to MFR Arrival? (If Yes, patient info is NOT required) Yes <input type="checkbox"/> No <input type="checkbox"/>
When Did it Happen/Start?	Did you assist the Medics? Yes <input type="checkbox"/> No <input type="checkbox"/>
Ambulance on Scene: Time: _____ Unit # _____	

<b>MEDICAL CONDITIONS</b>	None <input type="checkbox"/>	Lung Disease <input type="checkbox"/>	Seizures <input type="checkbox"/>	Stroke <input type="checkbox"/>
	Heart Problems <input type="checkbox"/>	Diabetes <input type="checkbox"/>	High BP <input type="checkbox"/>	Infectious Disease <input type="checkbox"/>
	Other _____			

<b>ALLERGIES</b>	None Known <input type="checkbox"/>	Unknown <input type="checkbox"/>	ASA <input type="checkbox"/>	Sulfa <input type="checkbox"/>	Penicillin <input type="checkbox"/>	Bee Sting <input type="checkbox"/>	Peanuts <input type="checkbox"/>	Other _____
Have Family Gather Meds and Hospital Card								

<b>ASSESSMENT</b>				Skin				Vitals				Level of Pain		
Level of Consciousness	Color	Temp	Condition	Time	Resp Rate	Pulse	BP							
Alert <input type="checkbox"/>	Pink <input type="checkbox"/>	Hot <input type="checkbox"/>	Dry <input type="checkbox"/>	_____	_____	_____	_____				1 2 3 4 5 6 7 8 9 10 Mild → → → → Severe			
Responds to Voice <input type="checkbox"/>	Pale <input type="checkbox"/>	Cold <input type="checkbox"/>	Moist (Clammy) <input type="checkbox"/>	_____	_____	_____	_____							
Responds to Pain <input type="checkbox"/>	Blue <input type="checkbox"/>	Warm <input type="checkbox"/>	Sweaty (diaphoretic) <input type="checkbox"/>	_____	_____	_____	_____							
Unresponsive <input type="checkbox"/>	Flushed <input type="checkbox"/>			_____	_____	_____	_____							

<b>CARDIAC ARREST</b>	Time of collapse or last seen? _____		Time CPR started? _____	
Was the arrest witnessed? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, by whom? <input type="checkbox"/> Family <input type="checkbox"/> Bystander <input type="checkbox"/> MFR Dept. <input type="checkbox"/> Other _____			
CPR on Arrival of MFR? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, by whom? <input type="checkbox"/> Family <input type="checkbox"/> Bystander <input type="checkbox"/> Police <input type="checkbox"/> Other _____			
Initial Analyze: No Shock Advised <input type="checkbox"/>	Shock Advised <input type="checkbox"/>	Time of First Shock? _____	Total # of Shocks by MFR? _____	

<b>TREATMENT</b>				
Airway	Breathing	Circulation	Trauma / Burn	Protective Equipment
OPA <input type="checkbox"/> NPA <input type="checkbox"/>	BVM Yes <input type="checkbox"/> No <input type="checkbox"/>	CPR	Bandage Applied? Yes <input type="checkbox"/> No <input type="checkbox"/>	Seat Belt Use Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>
Recovery Position <input type="checkbox"/>	O2 Admin Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/>	Wet <input type="checkbox"/> Dry <input type="checkbox"/>	Helmet Worn Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>
Jaw Thrust <input type="checkbox"/>	LPM _____	No <input type="checkbox"/>	Controlled Bleeding? Yes <input type="checkbox"/> No <input type="checkbox"/>	Airbag Deployed Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>
Head Tilt <input type="checkbox"/>			C-collar <input type="checkbox"/> KED <input type="checkbox"/> Backboard <input type="checkbox"/>	Car Seat Y <input type="checkbox"/> N <input type="checkbox"/> ? <input type="checkbox"/>
Suction <input type="checkbox"/>			Splint <input type="checkbox"/> Circulation OK post splinting: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Heimlich <input type="checkbox"/>				

<b>NOTES</b>				

<b>REFUSAL</b>	Is the patient aware of their name? Yes <input type="checkbox"/> No <input type="checkbox"/> Is the patient aware of the place? Yes <input type="checkbox"/> No <input type="checkbox"/> Is the patient aware of the date? Yes <input type="checkbox"/> No <input type="checkbox"/>			
As the patient or patient's representative, I hereby refuse care from the Medical First Responders, knowing that by doing so, I am not refusing the care of, or treatment by, responding Paramedics.				
				_____ <b>Patient or Representative Name</b> Please Print
(See Back for additional information) _____				_____ <b>Patient or Representative Signature</b>
				_____ <b>Date</b>

<b>PROVIDER INFORMATION</b>			
<b>Documented by</b>	Name - Please Print _____	Signature _____	MFR Tag # _____
<b>Provider #1</b>	Name - Please Print _____	Signature _____	MFR Tag # _____
<b>Provider #2</b>	Name - Please Print _____	Signature _____	MFR Tag # _____

# MFR PATIENT CARE REPORT REFERENCE SHEET

## CHIEF COMPLAINTS

Altered Mental Status		Airway		Trauma		Non Trauma	
101	Fainting/Near Fainting	201	Complete A/W Obstruction	501	Burns	601	Abdominal Pain
102	Generalized Weakness	202	Partial A/W Obstruction	502	Extremity Injury	602	Generalized Pain
103	One-sided Weakness	<b>Breathing</b>		503	Eye Trauma	603	Headache
104	Seizure	301	Shortness of Breath	504	Head/Facial Trauma	604	Nausea/Vomiting
105	Unresponsive	302	Respiratory Arrest	505	Major Trauma (multi system)	605	Non-Traumatic Bleeding
106	Psychiatric (non trauma)	<b>Circulation</b>		506	Minor Trauma	606	No Patient Contact
		401	Chest Pain	507	Neck/Back Pain/Injury	607	No Injury/Complaint
		402	Cardiac Arrest	508	Major Traumatic Bleeding	608	No Applicable Code
		403	Other Cardiac	509	Minor Traumatic Bleeding		

### REFUSAL PROCESS

- ▶ If a patient refuses care or you are denied access to a patient, attempt to retrieve the following information:
  1. Chief Complaint (What is wrong?)
  2. Is patient aware of their name, the place, and the time?
  3. Name and signature of patient or representative
  
- ▶ Contact EHSNS Communications Centre via TMR and advise them of refusal of care and attempt to get an ETA (estimated time of arrival) for responding ambulance.

### OXYGEN CALCULATIONS

To calculate how long your oxygen tank will last - "D" Cylinder

[PSI in tank] minus [safe residual (200psi)] x [0.16] divided by [LPM]

**Example: 2000 psi running at 10 LPM**

[2,000 psi] - [200 psi] = 1,800 x [0.16] = 288 ÷ [10 LPM] = 28.8 minutes of oxygen remaining

