Section 5

Forms

239 Brownlow Avenue, Suite 300
Dartmouth, NS B3B 2B2
Fax: 902-832-8602   Tel: 902-832-8356

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: ____

Fire Chief/Non-traditional Agency MFR Coordinator: ______________________________

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.

Primary Contact			
Title/Position			
Telephone	**Cellular**	**Fax**	**Email**
1st Alternate Contact			
Title/Position			
Telephone	**Cellular**	**Fax**	**Email**
2nd Alternate Contact			
Title/Position			
Telephone	**Cellular**	**Fax**	**Email**

______________________________ ______________________
Authorized Signature Print Name
(Fire Department Chief or Non-traditional Agency MFR Coordinator)

____
Date

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**

Telephone **Date**

EHS MFR Services use only

Request sent to: ***Date request sent:*** ***Date equipment returned:*** ***Initials:***

Please see Program Document No. 12007.00

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		
Bandaids	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

EHS MFR SERVICES USE ONLY

Date order received ____________________

Account # ____________________

Date order filled ____________________

Filled by ____________________

Oct09Rev

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 Website: www.ehsmfr.ca

Medical First Responder Registration/Re-registration Application

PLEASE PRINT CLEARLY

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 NS POSTAL CODE __________

TEL: HOME _________________ CELL _______________ WORK _____________________

E-MAIL ADDRESS ____

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

For Office Use Only

Date Rec'd: ____________________

Expiry Date: ____________________

Assigned Tag #: ________________

Date Tag Sent: _________________

TO VERIFY AFFILIATION WITH ABOVE EHS RESPONSE AGENCY (REQUIRED):

____ ____
SIGNATURE OF CHIEF NAME OF CHIEF (PLEASE PRINT)

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

Please see EHS MFR Program Document Nos. 12008.00 & 12015.00 for Registration and Re-registration requirements.

For *Initial EHS MFR Registration:*

- Please attach a **copy** of your 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. Please attach a **copy** of your 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. 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.)*

Six mandatory refresher sessions: ☐ AED ☐ CPR ☐ Primary Survey ☐ Vital Signs ☐ Triage ☐ Airway Management

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.

Name (please print clearly)	***EHS MFR Reg #***	***Signature***

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

MFR AGENCY TRAINING REIMBURSEMENT REQUEST FORM

Per Program Document 12008.00, Section 2.3:

> *Within the first 12 months of EHS sponsorship, fully sponsored EHS MFR agencies are entitled to receive training costs reimbursed to the EHS MFR agency at a maximum rate of $150 per person, to a maximum of $1,500.*
>
> *Each consecutive year, a fully sponsored EHS MFR agency is entitled to receive reimbursement for MFR training of two (2) persons at a maximum rate of $150/person.*
>
> *Cheques can only be issued to those agencies who supply an invoice that is marked "paid" when they apply for either their initial reimbursement or their annual reimbursement.*

PLEASE PRINT

Fire Department/MFR Agency: ____________________

Mailing address: ____________________

____

Telephone: ____________________ Fax: ____________________

Training provider: St. John Ambulance ☐ Canadian Red Cross ☐

Date and location of training: ____________________

Total claim: $ ____________________ Paid invoice/receipt attached: ☐

Submitted by: ____________________ Position: ____________________

Signature: ____________________ Date submitted: ____________________

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

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

Approved by: ____________________ Date: ____________________

Date processed to Finance: ____________________

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?	

Are there any geographical concerns (e.g. participants near/on water, hills, high traffic area)?	

Will there be facilities for MFRs to work from (i.e. tent, building, etc.)?	

Explain in detail any hazards that may arise from this event.	

Will there be street closures that will affect ambulance response? Provide details.	

Are there any communication concerns (i.e. poor cell service, paging problems, TMR issues etc.)?	

Does the surrounding area have a location that could be accessed for a LifeFlight landing zone?	

Have any dignitaries confirmed their attendance at the event? Please provide name and title.	

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).

NOVA SCOTIA
Department of Health

MFR PATIENT CARE REPORT

EHS
Emergency Health Services

TRAINING

Please Complete → Dept./Agency Name (Do NOT Abbreviate or Use Station Number)

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

PATIENT INFORMATION

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? Yes ☐ No ☐
(If Yes, patient info is NOT required)
Did you assist the Medics? Yes ☐ No ☐

When Did it Happen/Start?

Ambulance on Scene: Time:________ Unit #________

MEDICAL CONDITIONS

None ☐ Lung Disease ☐ Seizures ☐ Stroke ☐
Heart Problems ☐ Diabetes ☐ High BP ☐ Infectious Disease ☐ Other ________

ALLERGIES

None Known ☐ Unknown ☐ ASA ☐ Sulfa ☐ Penicillin ☐ Bee Sting ☐ Peanuts ☐ Other ________

Have Family Gather Meds and Hospital Card

ASSESSMENT

Level of Consciousness	Skin: Color	Skin: Temp	Skin: Condition	Vitals: Time	Vitals: Resp Rate	Vitals: Pulse	Vitals: BP	Level of Pain
Alert ☐	Pink ☐	Hot ☐	Dry ☐	______	______	______	______	1 2 3 4 5 6 7 8 9 10
Responds to Voice ☐	Pale ☐	Cold ☐	Moist (Clammy) ☐	______	______	______	______	Mild➝➝➝➝Severe
Responds to Pain ☐	Blue ☐	Warm ☐	Sweaty (diaphoretic) ☐	______	______	______	______	
Unresponsive ☐	Flushed ☐							

CARDIAC ARREST

Time of collapse or last seen? ________ Time CPR started? ________

Was the arrest witnessed? Yes ☐ No ☐ If yes, by whom? ☐ Family ☐ Bystander ☐ MFR Dept. ☐ Other ________

CPR on Arrival of MFR? Yes ☐ No ☐ If yes, by whom? ☐ Family ☐ Bystander ☐ Police ☐ Other ________

Initial Analyze: No Shock Advised ☐ Shock Advised ☐ Time of First Shock? ________ Total # of Shocks by MFR? ________

TREATMENT

Airway	Breathing	Circulation	Trauma / Burn	Protective Equipment
OPA ☐ NPA ☐ Recovery Position ☐ Jaw Thrust ☐ Head Tilt ☐ Suction ☐ Heimlich ☐	BVM Yes ☐ No ☐ 02 Admin Yes ☐ No ☐ LPM ________	CPR Yes ☐ No ☐	Bandage Applied? Yes ☐ No ☐ Wet ☐ Dry ☐ Controlled Bleeding? Yes ☐ No ☐ C-collar ☐ KED ☐ Backboard ☐ Splint ☐ Circulation OK post splinting: Yes ☐ No ☐	Seat Belt Use Y ☐ N ☐ ? ☐ Helmet Worn Y ☐ N ☐ ? ☐ Airbag Deployed Y ☐ N ☐ ? ☐ Car Seat Y ☐ N ☐ ? ☐

NOTES

REFUSAL

Is the patient aware of their name? Yes ☐ No ☐ Is the patient aware of the place? Yes ☐ No ☐ Is the patient aware of the date? Yes ☐ No ☐

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.

____
Patient or Representative Name Please Print

(See Back for additional information) ________
Date

____
Patient or Representative Signature

PROVIDER INFORMATION

Documented by	Name - Please Print	Signature	MFR Tag #
Provider #1	Name - Please Print	Signature	MFR Tag #
Provider #2	Name - Please Print	Signature	MFR Tag #

WHITE COPY- SEND WITH PARAMEDICS YELLOW COPY - FORWARD TO EHS MFR SERVICES
NOTE: (If unable to send White Copy with Paramedics submit all copies to EHS MFR Services)

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	**Breathing**		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)	**Circulation**		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