

EMERGENCY CARE AND TREATMENT <i>(Medical Record)</i>				TREATMENT FACILITY				LOG NUMBER							
ARRIVAL				TRANSPORTATION TO HOSPITAL <i>(Attach care enroute sheet)</i> <input type="checkbox"/> PRIVATE VEHICLE <input type="checkbox"/> AMBULANCE <input type="checkbox"/> OTHER <i>(Specify)</i>				CURRENT MEDS. <i>(tetanus immunization and other data)</i>				HISTORY OBTAINED FROM <input type="checkbox"/> PATIENT <input type="checkbox"/> OTHER <i>(Specify)</i>			
DATE			TIME									PATIENT'S HOME ADDRESS OR DUTY STATION <i>(City, State and ZIP Code)</i>			
DAY	MONTH	YEAR		CHIEF COMPLAINT(S) <i>(Include symptom(s), duration)</i>				SEX		AGE					
VITAL SIGNS								DESCRIBE <i>(1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)</i>							
TIME															
BP															
PULSE															
RESP.															
TEMP.															
WT. <i>(Child)</i>															
CATEGORY <i>(See Page 2)</i>															
<input type="checkbox"/> EMERGENT															
<input type="checkbox"/> URGENT															
<input type="checkbox"/> NON-URGENT															
ORDERS		INITS.		TIME											
ASSESSMENT/DIAGNOSIS															
DISPOSITION <i>(Check all that apply)</i>															
<input type="checkbox"/> HOME		<input type="checkbox"/> FULL DUTY													
QUARTERS															
<input type="checkbox"/> 24 Hrs.		<input type="checkbox"/> 48 Hrs.		<input type="checkbox"/> 72 Hrs.											
MODIFIED DUTY UNTIL:															
DAY		MONTH		YEAR											
REFERRED TO <i>(Indicate clinic)</i>															
<input type="checkbox"/> EMERGENCY		<input type="checkbox"/> TODAY													
<input type="checkbox"/> 72 HOURS		<input type="checkbox"/> ROUTINE													
ADMIT. TO HOSP. UNIT/SERVICE															
CONDITION UPON RELEASE															
<input type="checkbox"/> IMPROVED		<input type="checkbox"/> UNCHANGED													
<input type="checkbox"/> DETERIORATED															
TIME OF RELEASE:				<i>(CONTINUE ON SF 507, IF NEEDED)</i>											
PATIENT'S IDENTIFICATION <i>(Mechanical imprint)</i> FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. <i>(IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).</i>				SIGNATURE OF PROVIDER AND ID STAMP											
				INSTRUCTIONS TO PATIENT <i>(Include medications ordered, any limitations and follow-up plans)</i>											
EMERGENCY CARE AND TREATMENT				Medical Record Copy				STANDARD FORM 558 (REV. 6-82) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45 505							

EMERGENCY CARE AND TREATMENT <i>(Medical Record)</i>				TREATMENT FACILITY				LOG NUMBER							
ARRIVAL				TRANSPORTATION TO HOSPITAL <i>(Attach care enroute sheet)</i> <input type="checkbox"/> PRIVATE VEHICLE <input type="checkbox"/> AMBULANCE <input type="checkbox"/> OTHER <i>(Specify)</i>				CURRENT MEDS. <i>(tetanus immunization and other data)</i>				HISTORY OBTAINED FROM <input type="checkbox"/> PATIENT <input type="checkbox"/> OTHER <i>(Specify)</i>			
DATE			TIME									ALLERGIES			
DAY	MONTH	YEAR		PATIENT'S HOME ADDRESS OR DUTY STATION <i>(City, State and ZIP Code)</i>				HOME TELE. NO. <i>(Include area code)</i>							
CHIEF COMPLAINT(S) <i>(Include symptom(s), duration)</i>								SEX	AGE	POSSIBLE THIRD PARTY PAYER? <input type="checkbox"/> <input type="checkbox"/>					
VITAL SIGNS				DESCRIBE (1) Subjective data <i>(Pertinent History)</i> ; (2) Objective data <i>(Examination - include results of tests and x-rays)</i> ; (3) Assessment <i>(Diagnosis)</i> ; (4) Plan <i>(Treatment/Procedures - include medication given and follow-up)</i>								TIME SEEN BY PROVIDER			
TIME															
BP															
PULSE															
RESP.															
TEMP.															
WT. <i>(Child)</i>															
CATEGORY <i>(See Page 2)</i>															
EMERGENT															
URGENT															
NON-URGENT															
ORDERS		INITS.	TIME												
ASSESSMENT/DIAGNOSIS															
DISPOSITION <i>(Check all that apply)</i>															
HOME		FULL DUTY													
QUARTERS															
	24 Hrs.	48 Hrs.	72 Hrs.												
MODIFIED DUTY UNTIL:															
DAY	MONTH	YEAR													
REFERRED TO <i>(Indicate clinic)</i>															
EMERGENCY		TODAY													
72 HOURS		ROUTINE													
ADMIT. TO HOSP. UNIT/SERVICE															
CONDITION UPON RELEASE															
IMPROVED		UNCHANGED													
DETERIORATED															
TIME OF RELEASE:															
PATIENT'S IDENTIFICATION <i>(Mechanical imprint)</i> 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).															
(CONTINUE ON SF 507, IF NEEDED)															
SIGNATURE OF PROVIDER AND ID STAMP															
INSTRUCTIONS TO PATIENT <i>(Include medications ordered, any limitations and follow-up plans)</i>															
EMERGENCY CARE AND TREATMENT Emergency Room Copy															
STANDARD FORM 558 (REV. 6-82) Prescribed by GSA and ICMR FIRM (41 CFR) 201-45 505															

EMERGENCY CARE AND TREATMENT (Medical Record)			TREATMENT FACILITY			LOG NUMBER					
ARRIVAL			TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)			CURRENT MEDS. (tetanus immunization and other data)			HISTORY OBTAINED FROM		
DATE			TIME			<input type="checkbox"/> PRIVATE VEHICLE <input type="checkbox"/> OTHER (Specify)			<input type="checkbox"/> PATIENT <input type="checkbox"/> OTHER (Specify)		
DAY	MONTH	YEAR							ALLERGIES		
PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)						HOME TELE. NO. (Include area code)					
CHIEF COMPLAINT(S) (Include symptom(s), duration)						SEX	AGE	POSSIBLE THIRD PARTY PAYER?			
								<input type="checkbox"/> Yes <input type="checkbox"/> 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: LIST FACILITY HOLDING TREATMENT RECORD).

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (REV. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45 505

**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 room 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 attention and for which delay is harmful to 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.