(See Instructions on Back of this sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY *(Stamp)*

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	

TRANSPORTATION TO HOSPITAL *(Attach care enroute sheet)*

- PRIVATE VEHICLE
- AMBULANCE
- OTHER *(Specify)*

CURRENT MEDS. *(tetanus immunization and other data)*

HISTORY OBTAINED FROM

- PATIENT
- OTHER *(Specify)*

ALLERGIES

PATIENT?S HOME ADDRESS OR DUTY STATION *(City, State, and ZIP Code)*

HOME TELE. NO. *(Inc. area code)*

CHIEF COMPLAINT(S) *(Include symptom(s), duration)*

SEX

AGE

POSSIBLE THIRD PARTY PAYER?

- YES
- NO

VITAL SIGNS			
TIME			
BP			
PULSE			
RESP.			
TEMP.			
WT. *(Child)*			

CATEGORY *(See reverse)*

- EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS

DISPOSITION *(Check all that apply)*

- HOME
- FULL DUTY

QUARTERS

- 24 Hrs.
- 48 Hrs.
- 72 Hrs.

MODIFIED DUTY UNTIL:

DAY	MONTH	YEAR.

REFERRED TO *(Indicate clinic)*

- EMERGENCY
- TODAY
- 72 HOURS
- ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

DESCRIBE (1) **S***ubjective data (Pertinent History);* (2) **O***bjective data (Examination - include results of tests and x-rays);* (3) **A***ssessment (Diagnosis);* (4) **P***lan (Treatment/Procedures - include medication given and follow-up)*

TIME SEEN BY PROVIDER

(CONTINUE ON SF 507, IF NEEDED)

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)*

STANDARD FORM 558 (REV 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
USAPPC V1.00

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 rooms 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 medical attention and for which delay is harmful to the 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.

(See Instructions on Back of this sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT

(Medical Record)

TREATMENT FACILITY *(Stamp)*

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	

TRANSPORTATION TO HOSPITAL *(Attach care enroute sheet)*

- ☐ PRIVATE VEHICLE
- ☐ AMBULANCE
- ☐ OTHER *(Specify)*

CURRENT MEDS. *(tetanus immunization and other data)*

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER *(Specify)*

ALLERGIES

PATIENT'S HOME ADDRESS OR DUTY STATION *(City, State, and ZIP Code)*

HOME TELE. NO. *(Inc. area code)*

CHIEF COMPLAINT(S) *(Include symptom(s), duration)*

SEX

AGE

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS			
TIME			
BP			
PULSE			
RESP.			
TEMP.			
WT. *(Child)*			

DESCRIBE (1) **S***ubjective data (Pertinent History);* (2) **O***bjective data (Examination - include results of tests and x-rays);* (3) **A***ssessment (Diagnosis);* (4) **P***lan (Treatment/Procedures - include medication given and follow-up)*

TIME SEEN BY PROVIDER

CATEGORY *(See reverse)*

- ☐ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS

DISPOSITION *(Check all that apply)*

- ☐ HOME ☐ FULL DUTY
- ☐ QUARTERS ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
- ☐ MODIFIED DUTY UNTIL: DAY MONTH YEAR.
- ☐ REFERRED TO *(Indicate clinic)*
  - ☐ EMERGENCY ☐ TODAY
  - ☐ 72 HOURS ☐ ROUTINE
- ☐ ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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

Emergency Room Copy

STANDARD FORM 558 (REV 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
USAPPC V1.00

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY *(Stamp)*	LOG NUMBER

ARRIVAL				TRANSPORTATION TO HOSPITAL *(Attach care enroute sheet)*	CURRENT MEDS. *(tetanus immunization and other data)*	HISTORY OBTAINED FROM
DATE			TIME	☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER *(Specify)*		☐ PATIENT ☐ OTHER *(Specify)*
DAY	MONTH	YR.				ALLERGIES

PATIENT'S HOME ADDRESS OR DUTY STATION *(City, State, and ZIP Code)*	HOME TELE. NO. *(Inc. area code)*

CHIEF COMPLAINT(S) *(Include symptom(s), duration)*	SEX	AGE	POSSIBLE THIRD PARTY PAYER?
			☐ YES ☐ 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)*