The Charlotte Hungerford Hospital

EMERGENCY MEDICAL SERVICES

Aspirin Quality Assurance form

Patient Name:_____ Date:_____
Patients Age: _____
Patients Sex: _____

Patients Chief Complaint_____
Patients Medical History_____
Patients Medications_____
Contraindications to ASA_____

Time of Call_____ Time Arrived_____ Total On-Scene Time_____ Hosp_____

Medical Control contacted Yes____ No____
Paramedic intercept was initiated Yes____ No____

Drugs/dosages administered:

Oxygen _____ Dose_____
Aspirin _____ Dose_____

Other interventions_____

Describe any difficulties or significant vital signs change during and/or following the administration of ASA, the actions taken, and the result.

_____
_____
_____
_____
_____

EMT (print name)_____Signature_____

EMS SERVICE_____

PLEASE REMEMBER TO SEND A COPY TO THE EMS COORDINATOR