

**EMERGENCY CARE AND TREATMENT**

(Medical Record)

TREATMENT FACILITY (date)

LOG NUMBER

|                                                                    |               |             |                                                         |                                    |                                                         |                                                                                                    |
|--------------------------------------------------------------------|---------------|-------------|---------------------------------------------------------|------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| ARRIVAL                                                            |               |             | TRANSPORTATION TO HOSPITAL<br>(check one or more above) |                                    | CURRENT MEDS. (list all known<br>action and other date) | HISTORY OBTAINED FROM<br><input type="checkbox"/> PATIENT <input type="checkbox"/> OTHER (specify) |
| DAY                                                                | DATE<br>MONTH | TIME<br>YR. | <input type="checkbox"/> PRIVATE<br>VEHICLE             | <input type="checkbox"/> AMBULANCE |                                                         | ALLERGIES                                                                                          |
| PATIENT'S HOME ADDRESS OR DUTY STATION (City, State, and ZIP Code) |               |             |                                                         |                                    |                                                         | HOME TELE. NO. (list area code)                                                                    |

CHIEF COMPLAINT(S) (include symptoms, duration)

SEX

AGE

POSSIBLE THIRD PARTY PAYER

☐ YES ☐ NO

TIME SEEN BY PROVIDER

**VITAL SIGNS**

|           |  |  |  |
|-----------|--|--|--|
| TIME      |  |  |  |
| BP        |  |  |  |
| PULSE     |  |  |  |
| RESP.     |  |  |  |
| TEMP.     |  |  |  |
| WGT. (lb) |  |  |  |

DESCRIBE: (1) Subjective data (Pain, Nausea); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan

(Treatment/Procedures - include medications given and follow-up)

**CATEGORY (See reverse)**
☐ EMERGENT  
☐ URGENT  
☐ NON-URGENT

ORDERS      INTS.      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 (list name clearly)

☐ EMERGENCY  
☐ 72 HOURS  
☐ TODAY  
☐ ROUTINE  
 ADMIT. TO HOSP. USE SERVICE
**CONDITION UPON RELEASE**
☐ IMPROVED ☐ UNCHANGED  
☐ DETERIORATED

TIME OF RELEASE

PATIENT'S IDENTIFICATION (Mechanical imprint)  
FOR WRITER ENTIRE USE: (Name - last, first, middle; SEX; DOB;  
service codes; name and address of provider or next of kin. (IMPORTANT)  
USE FACILITY HOLDING TREATMENT RECORD.)*(CONTINUE ON SF 507, IF NEEDED)*

SIGNATURE OF PROVIDER AND ID STAMP

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

EMERGENCY CARE AND TREATMENT

Medical Record Copy

STANDARD FORM 558 (REV 6-83)  
Prescribed by GSA and ICMR  
FORM 141 GPO: 201-45,605

GSAHPC 171.00

# Fake Emergency Room Papers

**DP Hallahan**



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## **Table of Contents Fake Emergency Room Papers**

1. Understanding the eBook Fake Emergency Room Papers
  - The Rise of Digital Reading Fake Emergency Room Papers
  - Advantages of eBooks Over Traditional Books
2. Identifying Fake Emergency Room Papers
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Fake Emergency Room Papers
  - User-Friendly Interface
4. Exploring eBook Recommendations from Fake Emergency Room Papers
  - Personalized Recommendations
  - Fake Emergency Room Papers User Reviews and Ratings
  - Fake Emergency Room Papers and Bestseller Lists
5. Accessing Fake Emergency Room Papers Free and Paid eBooks
  - Fake Emergency Room Papers Public Domain eBooks
  - Fake Emergency Room Papers eBook Subscription Services

- Fake Emergency Room Papers Budget-Friendly Options
- 6. Navigating Fake Emergency Room Papers eBook Formats
  - ePub, PDF, MOBI, and More
  - Fake Emergency Room Papers Compatibility with Devices
  - Fake Emergency Room Papers Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Fake Emergency Room Papers
  - Highlighting and Note-Taking Fake Emergency Room Papers
  - Interactive Elements Fake Emergency Room Papers
- 8. Staying Engaged with Fake Emergency Room Papers
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Fake Emergency Room Papers
- 9. Balancing eBooks and Physical Books Fake Emergency Room Papers
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Fake Emergency Room Papers
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Fake Emergency Room Papers
  - Setting Reading Goals Fake Emergency Room Papers
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Fake Emergency Room Papers
  - Fact-Checking eBook Content of Fake Emergency Room Papers
  - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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