


**REMO MIST FORM**

Hospital: \_\_\_\_\_

Agency: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Date of Service: \_\_\_ / \_\_\_ / \_\_\_

Patient Contact Time: \_\_\_:\_\_\_ Hospital Arrival Time: \_\_\_:\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

 ALERTS:  Trauma  STEMI  STROKE/CVA Last Seen Normal Time: \_\_\_:\_\_\_

<b>M</b>	<b>Mechanism of Injury</b> or <b>Medical Complaint/History</b>				
<b>I</b>	<b>Injuries</b> <i>(time of injury, list head to toe)</i> or <b>Illness Identified</b> <i>(time of onset, brief medical exam/ findings)</i>				
<b>S</b>	<b>Vital Signs</b> <i>(first set and significant changes)</i>	<b>Time</b>		<b>Time</b>	
		<b>HR</b>	<b>RR</b>	<b>HR</b>	<b>RR</b>
		<b>BP</b>		<b>BP</b>	
		<b>BG</b>		<b>BG</b>	
		<b>SpO2</b>		<b>SpO2</b>	
		<b>EtCO2</b>		<b>EtCO2</b>	
		<b>GCS</b>		<b>GCS</b>	
<b>T</b>	<b>Treatment Provided</b>  <b>Concerns for Transition of Care</b>				

Please label and attach any 12 lead EKG.

Agency contact number must be provided please.