PREHOSPITAL CARE REPORT CONTINUATION FORM

Alameda County
Health Care Services Agency
Emergency Medical Services

❒ Prehospital
❒ Hospital

Date:	Time:	C-MED #:	Unit #:	Agency:	Hospital:
/ /	am pm		N/A	N/A	N/A

Patient Name: | **Age:** | **Sex:** M F

Time	Management	Response	B/P	P	R

Signature: