SCENARIO FORM
Medical #1
Acute Myocardial Infarction

Student Name______________________________ Date_________________________________

Examiner Name_______________________________ Examiner Signature____________________

Dispatch/Background Information: At 1738 hours you are dispatched Code 3 to a private residence for a 57 year old male complaining of chest pain. You are an EMT on a dual BLS unit working in a system that does not dispatch fire to medical complaints. You are 10 minutes away from a basic ED and 20 minutes away from a STEMI center. As you arrive, you find your patient sitting on his front porch, clutching his chest, and looking at your anxiously. He reports that he was gardening when he developed sudden CP and dizziness.

Yes "x"	***SCENE SIZE UP***	
	Personal Protective Equipment	Safety glasses, gloves
	Environmental Safety/Considerations	Well kept, upper-middle class residence.
	Number of Patients	1
	Mechanism of injury/Nature of Illness	Chest pain/dizziness
	Additional Resources	No fire.
	Need For C-Spine	Not at present
	PRIMARY SURVEY	
	General Impression (CBC)	Poor.
	AVPU	Spontaneously alert and tracking you as you approach
	Alert and oriented x ___	4
	a. Person	Yes, oriented
	b. Place	Yes, oriented
	c. Time	Yes, oriented
	d. Event	Yes, oriented
	Chief Complaint/Life-threats	Chest pain
	Airway (Assess & Manage)	Open, no obstruction
	Breathing (Assess & Manage)	Slightly elevated respiratory rate
	a. Lung sounds	Clear and equal bilaterally
	b. Work of breathing	Non-labored. Negative for accessory muscle use, intercostal retractions, tripoding, and pursed lipped breathing
	Circulation (Assess & Manage)	--
	a. radial pulse -rate & quality	Present, fast, thready, and irregular bilaterally
	b. skin signs	Cool, pale, clammy
	c. capillary refill	<2 seconds
	Neurological exam	CSM Intact x4
	Identifies priority patients and makes transport decision	Priority patient, Code-3 transport
	HISTORY TAKING	
	Signs & Symptoms	Poor skin signs, anxiety, CP, and dizziness
	Allergies	NKDA
	Medications	ASA, nitroglycerine, lisinopril, simvastatin
	Pertinent Past history	HTN, Angina, hyperlipidemia
	Last Meal	Lunch. Tuna sandwich and iced tea.
	Events	Gardening and developed acute onset of CP
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	Onset	Gardening
	Provokes/Palliates	Walking, nothing
	Quality	Heavy
	Radiation	Down both arms
	Severity	7/10
	Time	25 minutes PTA

	Provocation	N/A
	Associated CP	N/A
	Sputum	N/A
	Talk	N/A
	Exercise tolerance	N/A
	Targeted History (Pulmonary, Cardiac, Neurological, OB/GYN, GI/GU, Musculoskeletal, Integumentary, Psychological/Social, etc…	AMI hx? Similar event/dx? Associated signs and symptoms: Dizziness, N/V, syncope, SOB, weakness? Did he take his medications?

	SECONDARY ASSESSMENT	
	Assess affected body part/system or if indicated performs rapid assessment.	Cardiovascular system
	Skin	Cool, pale, clammy
	Head	Atraumatic. No deformities, depressions, crepitus.
	ENT	Mucous membranes moist. Pale.
	Neck	Negative for: cervical spine tenderness, step off, and restriction to movement, JVD, tracheal deviation, accessory muscle use.
	Chest	Equal bilateral chest rise. Negative for: intercostal retractions, accessory muscle use, urticarial, scars, pacemaker, and bruising.
	Respiratory	Slightly elevated rate, no increased work of breathing
	Cardiovascular	Poor impression: pale skin signs, elevated HR
	Abdomen/GI/GU	Non-distended, no masses, soft in all quadrants, no scars, no G-tube
	Pelvis	No Foley catheter, stable pelvis, negative urinary/fecal incontinence
	Posterior	No bedsores, no sacral edema
	Extremities	No deformities, crepitus, bruises, scars, shunts, or medic alerts
	Psychological	Anxious
	VITAL SIGNS/DIAGNOSTICS	
	Pulse	108, irregular, thready
	Respirations	26, non-labored
	Blood Pressure	156/100
	Temperature	98.8
	Pupils	PERRL
	SPO2	94% Room air
	FIELD IMPRESSION & ***DIFFERENTIAL DIAGNOSIS***	
	Field Impression	AMI
	Differentials	Angina, PE, Aortic dissection, GERD, vertigo
	TREATMENT PLAN	
	Intervention	2-4 LPM O2 via NC. Makes base contact to assist with NTG. DOES NOT WALK PATIENT!
	Reassessment	Pain: 6/10 LOC: Alert, A+Ox4. Skin signs: Pale, cool, moist. BP: 148/90 RR: 28 HR: 110, irregular SPO2: 98% on 2-4 LPM O2
	Intervention	Load patient, transport Code 3 to STEMI center
	Reassessment	Patient vomits.
	Intervention	Provides emesis basin and ensures airway patency
	Reassessment	Pain: 5/10 LOC: Alert, A+Ox4. Skin signs: Pale, cool, moist. BP:

		140/90 RR: 28 HR: 106, irregular SPO2: 99% on 2-4 LPM O2
	Transport Decision	Code-3, nearest facility
	REASSESSMENT	
	Repeats Primary Survey	Same as above
	Repeats Vital Signs	Same as last set
	Evaluates Response To Treatment	Airway protection/management provided, oxygenation improving
	Repeats secondary as appropriate	Same as previous findings

POST SCENARIO DEBRIEF:

Provide me with a hospital turn over report.

What is your field impression? Give me your rationale.

Give me three differential diagnoses you considered?

List your interventions. Why do they work in this particular setting?