DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **MASS GATHERINGS AND SPECIAL EVENTS**
PATIENT CARE LOG

(EMT, PARAMEDIC, HOSPITAL)
REFERENCE NO. 842.4

Name of Event/Incident: _____				**Event/Incident Date:** _____			
Time	**Patient Name/Patient Identifier**	**Age**	**M/F**	**Chief Complaint**	**Treatment**	**Disposition**	**Diagnosis**

Must be submitted within 72 hours after the event.