DOCUMENTATION CRITERIA ADMINISTRATIVE 1.13

The patient care report, or first care form, provided by prehospital personnel establishes the documentation that forms a cornerstone of patient care. Documentation should accurately and precisely reflect observations, orders, treatments, and outcomes arising from the patient encounter. Proper documentation will reflect adherence to the standards of care established by the EMS community.

I. CRITERIA FOR DOCUMENTATION

A. Chief complaint should include
1. Patient description of problem
2. Mechanism of injury if trauma related

B. History should include
1. Onset - when did symptoms begin
2. Provocation - what makes it worse
3. Quality - what does the pain feel like
4. Radiation - can it be felt in any other body location
5. Severity - rating the pain using a 0-10 scale
6. Time - constant or intermittent, is there a history
7. Pertinent past medical history, related to complaint

C. Patient assessment should include
1. Scene survey and mechanism of injury if trauma related
2. Initial survey, to include signs, symptoms and immediate interventions related to the following
    a) Airway
    b) Breathing
    c) Circulation
    d) Level of Consciousness
    e) Spinal precautions, if appropriate

D. Focused history and physical should include signs and symptoms of presenting problem and review of body systems as needed
1. Vital signs, including postural vital signs if indicated
2. Color, temperature, appearance of skin
3. Blood pressure, both arms if indicated
4. Capillary refill, if appropriate
5. Pupillary response, if appropriate
6. Motor, sensory, circulatory status of extremities, if appropriate

E. Orders received, treatment initiated and patient response to treatment

F. Drug therapy given and patient response to treatment

G. On-going assessment of patient

H. Transfer summary should include
1. Condition of patient on transfer
2. Name and signature of receiving agency/person assuming care of the patient
3. Disposition/Status of patient upon transfer of care