# Patient Care Report Guidelines

**A** rrival on scene / Scene assessment

A. Position of patient
B. Impression of patient
C. Does the patient acknowledge your presence
D. Any significant characteristics of the scene

**C** omplaint

A. What is the patient's chief complaint (CC)
B. What are the associated complaints
C. The complaint(s) should be in the patients words if possible

**H** istory

A. Patient level of consciousness
    a. If using AAOx3 and patient is not x3 state what they are alert to, (i.e. pt AAOx1, alert to person only) and if this is normal for them
    b. Describe the patient. Avoid ambiguous terms like "lethargic"
B. Does patient respond to questions appropriately?
C. Address all factors of OPQRST and SAMPLE
D. Symptoms as the patient describes them
E. Identify Pertinent negatives
F. What does the patient think the cause is
E. Was this a sudden or gradual event?
F. When did the event start
G. What was the patient doing when it occurred
H. How the patient qualifies and quantifies the complaint
I. What factors aggravate or alleviate the condition
J. What has the patient done to treat or mitigate the condition
K. Last oral intake
L. Intake as compared to output
M. Past medical history (PMH)
    i. Include any significant past medical history
    ii. Medications and compliance or lack thereof (all meds should be indicated somewhere on the call report)
    iii. Allergies
    iv. Family and social history as applicable


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# Patient Care Report Guidelines

**A** ssessment

A. Airway
   a. Patent
   b. Foreign matter
   c. Obstructions

B. Breathing
   a. Relative rate rhythm and quality
   b. Qualify and quantify respiratory effort
   c. Breath sounds in all fields
   d. Use of accessory muscles and/or retractions
   e. Condition of the chest wall
      i. Symmetry
      ii. Abnormal movement
      iii. Crepitus / Bony instability
      iv. Discoloration
   f. Ability to complete sentences
   g. JVD / Tracheal deviation

C. Circulation
   a. Pulse
      i. Relative rate rhythm and quality
      ii. Locations (compare carotid and radial)
      iii. Does it match the monitor
      iv. Quantify the pulse
   b. Skin color, temperature and moisture
   c. Major external hemorrhage

D. Vital signs
   a. First set should be within 5 minutes of arriving on scene
   b. Documented every 15 minutes for stable patients, every 5 minutes for unstable patients
   c. Minimum of two sets of vital signs
   d. Palpated BP should rarely be used and only in extreme circumstances
   e. Rate, rhythm and quality of the pulse
   f. Rate rhythm and quality of the respirations
   g. Orthostatic vital signs

E. Abdomen
   a. Discoloration
   b. Palpation
   c. Specific signs and findings


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# Patient Care Report Guidelines

F. Pelvis
   a. Stability
   b. Crepitus
   c. Deformity
   d. Soft tissue injury

G. HEENT
   a. Head and Face
      i. Signs of trauma
      ii. Symmetry
      iii. Bony instability
   b. Eyes
      i. Discoloration
      ii. PERRLA
      iii. Extraoccular movements
      iv. Consensual reflexes
      v. Nystagmus
      vi. Presence and description of visual disturbances
   c. Ears
      i. Discharge
      ii. Presence and description of hearing disturbances
   d. Nose
      i. Drainage
      ii. Signs of trauma
   e. Throat
      i. Any abnormal findings if exam is indicated

H. Neurologic exam
   a. Glasgow Coma Scale
   b. Presence, strength, and equality of gross motor function to all extremities
   c. Presence of sensory function to all extremities
   d. Evaluation of cranial nerves
   e. Evaluation of speech and memory
   f. Evaluation of spinal nerves
   g. Evaluation of reflexes if indicated
   h. Any findings related to specific neurological tests


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# Patient Care Report Guidelines

I. Extremities
   a. Obvious signs of trauma
   b. Discoloration
   c. Any swelling or deformity
   d. Dependent edema and it's description
      i. Pt history of edema and relation to current presentation
      ii. Recent changes in edema
   e. Presence of needle marks
   f. Range of motion

J. Anterior Neck and Back
   a. Obvious signs of trauma
   b. Discoloration
   c. Nuchal rigidity
   d. Point tenderness
   e. Range of motion
   f. In-line, deformity, step-offs

**R** x

A. Include your field diagnoses
   a. What you think the patients problem is based on your exam
   b. This justifies your treatment
B. Treatment
   a. What was done
   b. Be accurate, clear, and concise with all treatment descriptions
   c. Identify when each treatment modality was given
   d. Identify who performed each treatment modality
   e. Include any diagnostic tests and their results
   f. Include flow rate and delivery method for all oxygen therapy
   g. Include the size, location, type of fluid, and flow rate for all IV's
   h. Include the concentration, dose, and route of all medications
   i. Include any other procedures or treatments performed
   j. Include methods used to verify treatment was correct
   k. Include any specific patient response to treatment (expected or otherwise) and how you assessed that change
   l. Identify any improvement or deterioration of the patient after treatment
   m. Include what your actions were based on the patient response


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# Patient Care Report Guidelines

**T** ransport / Transfer

A. Include transport mode and destination
B. Include the patients condition enroute – did any changes take place
C. Identify what you did enroute
D. Include any treatment and response to treatment while enroute
E. Identify who you transferred the patient to (name and level)
F. Identify if a verbal report was given
G. Identify who took possession of the patients belongings

Refusals

A. Identify if the patient is refusing treatment, transport, or both
B. Document what you did to convince the patient for the need for treatment and/or transport
C. Document that you informed the patient of the risks of refusal AND what those risks were, including death if applicable
D. Document what follow-up instructions you left with the patient including visiting with their personal physician, going to the ER on their own, or calling EMS again
E. Document what education you offered the patient regarding change in condition etc.
F. Document which physician you spoke with and what facility they were at (if applicable)


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