DOCUMENTATION TEMPLATES

All patient care reports should include the following information in the narrative:

Patient Data:

-Chief Complaint
-Mechanism of injury/Nature of illness
-Associated signs and symptoms/pertinent negatives
-Location of patient when first encountered
-Rescue and treatment by bystanders/first responders
-Patient history including meds, allergies, pertinent info to chief complaint
-Physical findings not listed in check-off area

Treatment Data:

-BLS/ALS treatment provided
-Time of treatment
-Response to treatment
-Reason for variation from the SMOs

Any situation or response out of the ordinary should be thoroughly documented in the narrative.

In addition to the above information, refusals should include the following information:

-Evidence of competence/decision making capabilities
-The patient's reason for refusal
-Explanation to the patient why they should go to the hospital, including the possible ramifications of refusal
-Suggestions for alternative care
-A physical assessment and vitals (if the patient refuses these, document it)
-Signatures

REFUSALS

In addition to the normal information for a run, the narrative must include:

- Evidence of decision making capability:
  -Patient alert and oriented x 3
  -Patient understands and answers questions appropriately
- The exact ramifications that were explained to the pt. (the worst thing that could happen)
- Alternatives to care (suggest contacting your physician immediately, etc.)
- Signature by pt. or legal guardian
  -A wife is not a legal guardian unless the courts have appointed her.
  -Durable Power of Attorney for Health Care
- All refusals should be called in to the Resource Hospital for medical-legal reasons. Document who you spoke with.
- A physical assessment
- Events leading up to 911 call, mechanism of injury or nature of illness

REFUSAL RADIO REPORT

The radio report should include:

- Evidence of decision making capability:
  -Patient alert and oriented x 3
  -Patient understands and answers questions appropriately
- The exact ramifications that were explained to the pt. (the worst thing that could happen)
- Alternatives to care
- Signature obtained from pt. or legal guardian
- A physical assessment

CHEST PAIN

The narrative should include:

- What pt. was doing at onset of pain
- If anything makes the pain worse or better
  -Should include whether pain increases with palpation and/or breathing
- If the pain radiates, where it radiates
- A description of the pain
  -Sharp, dull, cramping, etc.
- The severity of the pain on a scale of 1-10 when you first see pt. and after any & all treatment
- What time the pain started
- Pertinent physical exam findings & pertinent negatives
- Any medical history related to this episode
- Any treatment prior to your arrival
- Any abnormal findings
- Response to each treatment

In addition to the normal information, the radio report should include:

- The OPQRST history
  -This should include whether pain increases with palpation or breathing
- Any treatment prior to your arrival
- Treatment given and response to treatment
- Medications that the pt. is taking that are pertinent to current complaint/condition
- Any deformities
- Any medical history related to this episode
- Anything unusual related to the run
- Pertinent physical exam findings

ABDOMINAL PAIN

The narrative should include:

- What the pt. was doing at the time the symptoms started
- If anything makes the pain worse or better (movement, palpation, vomiting)
- A description of the pain (sharp, dull, cramping, intermittent, etc.)
- Any radiation of the pain and where it radiates
- Severity of pain on 1-10 scale before and after any and all treatment
- What time the pain started
- Any associated signs and symptoms (nausea, # of times vomited and color, # of time diarrhea and color, color and amount of bleeding, etc.)
- Any pertinent negatives
- Menstrual history (if applicable)
- Any pertinent medical history and treatment prior to arrival
- Any abnormal findings
- Response to each treatment

ABDOMINAL PAIN RADIO REPORT

In addition to the normal information, the radio report should include:

- The OPQRST history

  -This should include whether pain increases with palpation or breathing
- Any associated signs and symptoms (nausea, # of times vomited and color, # of time diarrhea and color, color and amount of bleeding, etc.)
- Menstrual history (if applicable)
- Any pertinent medical history and treatment prior to arrival
- Any pertinent medications the pt. is taking
- Any treatment prior to arrival

BURNS

The narrative should include:

- Location and severity of burned areas
- Total body surface area involved
- Mechanism of injury
- Any respiratory system involvement
- Pertinent negatives
- What time the pt. was burned
- The source of the burn (fire, chemical, etc.)
- Pertinent pt. medical history and medications
- Rating of pain on scale of 1-10 before and after treatment
- Treatment given and response to treatment
- Any changes in pt. condition
- Anything unusual
- Any treatment prior to arrival

In addition to the normal information, the radio report should include:

- Location and severity of burned areas
- Total body surface area involved
- Any respiratory system involvement
- What time the pt. was burned
- The source of the burn (fire, chemical, etc.)
- Pertinent pt. medical history and medications
- Rating of pain on scale of 1-10
- Treatment given and response to treatment
- Any changes in pt. condition
- Anything unusual
- Any treatment prior to arrival

MVC

The narrative should include:

- Description of the accident
  -Location of patient in vehicle and restraints used
  -Whether the air bag deployed
  -Damage to vehicle, if head-on, etc.
  -Approximate speed
  -Treatment prior to arrival
- Pt. complaint
  -Location and description of pain/deformities
  -Severity rating on scale of 1-10 for each injury
- Location of bleeding and whether bleeding was controlled
- Any and all treatment and response to treatment
- Distal motor, sensory and circulatory status of injured areas before and after treatment
- Whether the pt. lost consciousness and a neuro-check
- Any pertinent history and medication
- Pertinent negatives
- Where you found pt. upon your arrival

MVC RADIO REPORT

In addition to the normal information, the radio report should include:

- Description of the accident
  -Location of pt. in vehicle and restraints used
  -Whether the air bag deployed
  -Damage to vehicle, if head-on, etc.
  -Approximate speed
- Pt. complaint
  -Location and description of pain/deformities
- Location of bleeding and whether bleeding was controlled
- Any and all treatment and response to treatment
- Distal motor, sensory and circulatory status of injured areas
- Whether the pt. lost consciousness and a neuro-check
- Any pertinent history and medication
- Any treatment prior to arrival

FULL ARREST

The narrative should include:

- Location and position of pt. on arrival
- Events leading to arrest
- Approximate down-time and whether CPR was initiated prior to your arrival and when
- Anything unusual on scene
- Treatment given that is not included elsewhere on the run report
- Dexi reading
- Confirmation of ET tube placement (a c-collar and head roll should be applied to help keep the ET tube in place)
- # of attempts for ET and IV
- # of cm at lips for ET tube
- Response to each treatment
- Pertinent negatives
- Pertinent medical history and medications
- Any deformities
- Changes in skin condition with treatments
- Confirmation of ET tube placement on arrival to the emergency room
- Any complications during treatment

In addition to the normal information, the radio report should include:

- Approximate down-time and whether CPR was initiated and when
- Anything unusual on scene
- Rhythm pt. found in and changes in rhythm
- Whether you were able to initiate an IV, ET, drugs given, defibrillation, pacing
- Dexi reading
- Response to treatment
- Pertinent medical history and medications
- Any deformities

CVA

The narrative should include:

- Exact time of onset of symptoms
- What the pt. was doing at onset of symptoms
- Location and onset of pain, any radiation of pain
- Rating of pain on scale of 1-10 before and after treatment
- Signs and symptoms pt. complaining of
- Neuro-check, Dexi
- Pertinent negatives
- Any treatment prior to arrival
- Any pertinent medical history and medications
- Any treatment given and response to treatment
- Any changes in pt. condition
- Anything unusual
- If pt. has previous history of CVA, list known deficits from that CVA

In addition to the normal information, the radio report should include:

- Exact time of onset of symptoms
- What the pt. was doing at onset of symptoms
- Location and onset of pain, any radiation of pain
- Rating of pain on scale of 1-10
- Signs and symptoms pt. complaining of
- Neuro-check, Dexi
- Any treatment prior to arrival
- Any pertinent medical history and medications
- Any treatment given and response to treatment
- Any changes in pt. condition
- Anything unusual

ALTERED LOC

The narrative should include:

- Pt. complaint, description of altered LOC
- What the pt. was doing at onset of symptoms
- Anything that makes symptoms worse or better
- Exact time of onset of symptoms
- Anything unusual
- Any possible contributing factors (drugs, alcohol, poisoning, etc.)
- Neuro-check, Dexi
- Any treatment prior to arrival
- Any deformities
- Any pertinent medical history and medications
- Any unusual odors, etc.
- Treatment given and response to each treatment

In addition to the normal information, the radio report should include:

- Pt. complaint, description of altered LOC
- Exact time & what the pt. was doing at onset
- Anything that makes symptoms worse or better
- Anything unusual
- Any possible contributing factors (drugs, alcohol, poisoning, etc.)
- Neuro check, Dexi
- Any treatment prior to arrival
- Any deformities
- Any pertinent medical history and medications
- Any unusual odors, etc.
- Treatment given and response to treatment

SEIZURES

The narrative should include the following:

- Length, duration and body areas involved
- Any injuries sustained
- Events leading up to seizure
- Level of consciousness upon your arrival, any postictal state
- Any changes in LOC
- Any medical history and medications
- Compliance with medications
- Neuro check
- Dexi
- Any treatment given and response to each treatment
- Anything unusual
- Rating of pain if present
- Any contributing factors

In addition to the normal information, the radio report should include:

- Length, duration and body areas involved
- Any injuries sustained
- Level of consciousness upon your arrival, any postictal state
- Any changes in LOC
- Any medical history and medications
- Compliance with medications
- Neuro check
- Dexi
- Any treatment given and response to treatment
- Anything unusual
- Rating of pain if present
- Any contributing factors

RESPIRATORY COMPLAINTS

The narrative should include the following:

- What patient was doing at onset of complaint
- Anything that makes complaint worse or better
- Description of pain if present, any radiation of pain
- Severity on scale of 1-10 for DIB and for pain (if present)
- Time complaint started
- Any associated symptoms (chest pain, fever, cough, etc.)
- Any treatment prior to your arrival
- Any treatment given and response to each treatment
- Any pertinent medical history and medications
- Any pertinent negatives
- If patient has been intubated in the past for this condition
- Location where you initiate treatment (SMO states initiate Albuterol enroute, if you deviate from this explain why in narrative)

In addition to the normal information, the radio report should include:

- What pt. was doing at onset of complaint
- Anything that makes complaint worse or better
- Description of pain if present, any radiation of pain
- Severity on scale of 1-10
- Time complaint started
- Any associated symptoms (chest pain, fever, cough, etc.)
- Any treatment prior to your arrival
- Any treatment given and response to treatment
- Any pertinent medical history and medications
- If pt. has been intubated in the past for this condition

FALLS

In addition to the normal information documented, the narrative should include:

- Mechanism of injury:

  -How fall occurred, what the pt. was doing before the fall
  -How far pt. fell
  -If pt. hit anything on the way down
  -What type of surface the pt. fell onto

- Pt. positioning upon your arrival
- Any loss of consciousness and the duration of unconsciousness
- Pt. complaint and any deformities
- Nature of any bleeding and if bleeding was controlled
- Location and description of each deformity
- Distal motor, sensory and circulatory status of each injured area before and after treatment
- Severity rating on scale of 1-10 for each injured area before and after treatment
- Any and all treatment given and response to each treatment
- Neuro check, Dexi
- Any pertinent history and medications
- Pertinent negatives
- Anything unusual on scene
- Any treatment prior to your arrival
- Any changes in pt. condition

POISONING/OVERDOSE

In addition to the normal information documented, the narrative should include:

- Events

  -Name of poison/drug

  -Amount exposed to or taken

  -Time of exposure or ingestion

  -How exposed or reason for taking med

  -Route of exposure

  -Length of time of exposure or ingestion

  -Treatment before your arrival

- Airway and breathing status
- Signs and symptoms pt. exhibiting
- Pertinent negatives
- Neuro check
- Dexi
- Pupil size and response
- Any abnormal findings
- Treatment given and response to each treatment
- Any changes in pt. condition
- If pt. vomiting, color, amount, evidence of pills/poison in vomit
- Pt's psychological state

  -Eye contact

  -Behavior (combative, agitated, cooperative, etc.