Patient Care Record
Instruction Booklet

Mountain-Valley
Emergency Medical Services Agency

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GENERAL INSTRUCTIONS

- Patient Care Reports shall be completed for all patient contacts as defined in Policy No. 560.11, Documentation of Patient Contact.
- **Be sure to attach each patient's ECG strips to the receiving hospital's copy of the Patient Care Report.**
- A separate form must be completed for each patient of each response for care (e.g. a patient transported to a hospital who is then transferred to another facility requires two PCRs).
- If a patient refuses care, be sure to note that fact in the **Procedure/Medication** section, and complete and obtain the patient's signature on an Refusal of Service form.
- Taber's Cyclopedic Medical Dictionary has been adopted by the agency to govern the spelling, definition and abbreviation of all medical terms and words for patient care charting, except as otherwise specified in policy or in this instruction booklet. The use of medical abbreviations not listed in Taber's, policy or this instruction booklet should be avoided.
- **All times are to be recorded on the PCR in 24 hour format (e.g. 23:14).**
- The patient care report is to be completed by the individual primarily caring for the patient. However, the responsibility for ensuring that patient documentation is complete and accurate rests with the highest certified or licensed prehospital care giver or field training officer attending the call.

SPECIFIC INSTRUCTIONS

The following is a brief explanation of each item of information that should be completed on each form.
The bolded titles correlate to the section titles on the PCR. A sample PCR has been included in this booklet for reference.

NOTE: Sections on the PCR requiring coded entry are shaded for clarity.
These codes can be found on the Patient Care Report Codes Sheet.

Call Date	Indicate the month, day and year the call is received by the provider's dispatch center (e.g. 03/28/93).
Provider Number	Enter the ambulance provider company identification number.
Unit Number	Enter the ambulance unit identification number.
Incident Number	Enter the incident number assigned by the dispatch center.

Inter-facility Transfer Number	When performing an inter-facility transfer, enter the number of the Inter-facility Transfer Form in this space. "Inter-facility transfer" refers to pre-arranged transfers between acute care facilities. Transports from doctor's offices or nursing homes to emergency departments are to be considered emergency calls rather than transfers, and do not require transfer numbers.
Call Disposition	Enter the appropriate Call Disposition code to indicate the final result of the EMS call. (See the Patient Care Report Form Codes sheet)

Response and Transport Codes

Check level of code enroute to scene, and level of code enroute to final destination.

Code 1:	Pre-scheduled non-urgent response
Code 2:	Urgent response, no red lights or siren
Code 3:	Emergent response, red lights and siren

Time of Call	Enter the time the call is received by the provider's dispatch center.
Time Enroute	Enter the time the EMS unit responding to the call begins physical motion (wheels rolling for EMS ground unit, lift-off for EMS aircraft).
Time First ALS on Scene	Enter the time the the first ALS unit arrived on scene, when different than the transporting unit.
Time Arrived on Scene	Enter the time the EMS unit arrives within 200 feet of the location it was dispatched to.
Time Left Scene/Call Canceled	Enter the time the EMS unit leaves the location it was dispatched to, or the time the call is canceled, as appropriate.
Time Arrived at Destination	Enter the time the EMS unit stops at its final destination.
Contact Made with:	Check Base Hospital only when a Base Hospital was contacted for orders or direction. Check Receiving Hospital when Hospital Contact was made (regardless of Base or non-Base Hospital status) <u>without</u> request for orders or direction. Check Disaster Control Facility when the DCF was contacted. Check None when contact was not possible or not made from the field.
Time of Contact	If contact is made with a base hospital , receiving hospital or DCF, enter the time of first contact.

Enter the patient's last name, first name, middle initial (e.g. Smith, John

Patient Name	Q.)
Patient Address	Enter the patient's home address including number, street, city or town, and zip code.
Incident Location	Enter the actual location of the scene including either an address, landmark or intersection as well as specific location of the patient, including city or town. If performing an inter-facility transfer, note the name of the hospital and department the patient is taken from.
Patient Age	Enter the patient's age, or estimated age if the actual age is unknown, in month or years, as appropriate.
Patient DOB	Enter the patient's date of birth or estimated date of birth if actual age is unknown for electronic documentation (example: 01/01/YYYY).
Patient Gender	Choose the appropriate option.
Estimated Patient Weight	Enter patient's estimated weight, <u>in kilograms</u>.
County	Enter the county where the scene is located (or two-digit county code - refer to the County codes list at the back of this booklet).
Map Zone	Enter the map zone number assigned to the section of the county in which the scene is located. Each provider should provide either a zone map or the zone number through their dispatch center.
Number of Patients at Scene	Enter the number of persons requiring medical care at the scene.

Chief Complaint	Describe the patient's impression of the primary reason / major symptoms responsible for the ambulance call. (A patient with major extremity injuries may have a chief complaint of back pain, and if he has not noticed his extremity injuries, these injuries might not be a part of the chief complaint). Examples of chief complaints: shortness of breath, pain right leg, headache, chest pain, fainting. Pain assessment should include "Patient denies pain" or "patient c/o midsternal chest pain, 4/10". If the patient is unconscious or has no complaint, enter "NONE."
Medical History	Document a summary of the patient's current medical problem, and any other information that pertains to the problem that is not a part of the physical examination. Include here such information as what brought on symptoms, and what symptoms were experienced. Include descriptions

of events surrounding the incident, past medical history which relates to the present illness, major unrelated medical problems, recent use of medications, and observations by bystanders. If information is received by someone other than the patient, include who gave the information.

Information obtained by observing or examining the patient belongs under in the Initial Physical Examination section, not the Medical History section.

Allergies

Enter anything to which the patient has a known allergy. If the patient has no known allergies, record "NKA" (no known allergies).

Medications

Enter any prescription or non-prescription medication taken regularly by the patient. If none, record "none."

Initial Physical Examination

Document all of the pertinent positive and negative physical exam findings, including those discovered during secondary assessment.

Prehospital care personnel may use the "unremarkable" check boxes located in the Physical Exam section of the Patient Care Record when recording "unremarkable" physical exam findings as defined below:

Documentation of initial pain assessment for every patient should be included here, utilizing a standard severity scale (1 - 10, 10 being the worst pain ever, and 1 being minimal pain).

Head: No obvious trauma, deformity or depression. Absence of fluid or blood in ear and nasal passages. Pupils equal and reactive to light. No tenderness to face or head. Jaw moves freely. Normal oral hydration. No abnormal odor to breath.

Neck: No obvious trauma, deformity, discoloration, or scars. No tenderness upon palpation. Veins non-distended. Carotid pulses present. Trachea mid-line. Absence of stoma.

Chest: Equal bilateral expansion of anterior chest with each respiratory effort. Bilateral upper and lower lobes clear on auscultation. No obvious trauma or scars. No crepitus or tenderness upon palpation.

Abdomen: No obvious trauma or scars. No tenderness guarding, masses, or rigidity in all four quadrants following palpation. No pulsatile masses.

Back: No obvious trauma or scars. No deformity or tenderness upon palpation.

Pelvis: No obvious trauma or deformity. No pain upon compression of the iliac crests bilaterally or the symphysis pubis anteriorly. No genital or perineal trauma. No urethral blood.

Limbs: No obvious trauma, swelling, deformity or tenderness. Full range of motion. Distal pulses intact.

Neurologic: Glasgow Coma Score of 15. Appropriate sensation in all extremities. Normal muscle tone. Equal grip strength and dorsi/plantar flexion. Sensation intact and equal in all extremities.

Skin Signs: Normal temperature, moisture and color. Mucus membranes pink. Capillary refill of 2 seconds or less.

Changes in physical exam findings following treatment or during transport, such as return of pulses in an injured extremity following traction and splinting, should be documented in the Procedure/Medication and Response section.

GCS For each Glasgow Coma Scale (GCS) assessment, enter the time, GCS sub-scores and GCS total in this section. Pediatric GCS equivalences are listed in the Patient Report Form Codes key at the back of this booklet.

Mechanism of Injury Complete this section only for patients who have sustained injury, including falls, burns, electric shocks, etc., from the Mechanism of Injury codes list.

Types of Illness/Injury Enter the patient's most significant types of illness/injury codes. Refer to the Type of Illness/Injury code list at the back of this booklet. All illness/injury codes are three digits long. Illness codes begin with "5" and injury codes begin with "7."

Field Clinical Impression Describe your clinical impression or working diagnosis of the patient's illnesses or injuries on this line. An example of a field clinical impression would be "2° burns over 30% of body."

Care Giver For others who provided care to the patient prior to you taking over care, enter agency abbreviation (such as "FD" or "PD"), or "BS" for bystander, or "PH" for physician on scene.

For ambulance personnel, enter certification number, or A, B, or C from signature lines at the bottom of the form.

Time

Enter the time each procedure, medication, or assessment is administered, in 24 hour time.

Procedure/Medication Code and Description

Enter the description of each procedure or medication administered, as well as the code for that procedure or medication from the code lists.

For medications also include dosage and route.

Response/Comments/ ECG/MD Signature: Base Order

Enter any response or comments related to the procedure, medication, or assessment, including ECG interpretation if applicable. MD Signature is required for ALL Base Hospital Orders. (Be sure to also attach the patient's ECG strips to the receiving hospital's copy of the PCR when applicable.)

Respiration Rate

Enter respiration rate. Note respiration sounds in the Response/Comments section.

Blood Pressure

Enter blood pressure.

Pulse Rate

Enter pulse rate. Note quality of pulse in the Response/Comments section.

Pain Level

Document level of pain on every patient, utilizing a standard severity scale (0 - 10). Additionally, document level of pain following any interventions for pain, and as part of periodic condition updates in every patient who presented with pain as part of the chief complaint.

NOTE: Usually, not all fields in this section will be filled in for a given row. For instance, when taking vitals, the **Procedure/Medication** field can be left blank. Similarly, if a procedure or medication is administered and no vitals are taken immediately, the vitals fields should be blank for that row.

Vital signs should be assessed and documented as part of the initial assessment on every patient, and re-evaluated following any procedure or treatment that could have an effect on the VS. In addition, periodic VS updates should be documented according to patient condition (every 5 minutes for unstable patients, and every 15-20 minutes on stable patients).

As much as possible, information in this section should be recorded in chronological order.

An example completed PCR for a burn patient is included at the back of this booklet.

Medication Wasted	Document medication name, amount, and time of wasted medication. Signatures must be obtained from the wasting party and witness.
Special Scene Conditions	Document conditions relating to the circumstances at the scene.

ALS without base hospital contact	ALS procedures or medications listed in the Treatment Guidelines below "Contact Base Hospital" were performed prior to, or without, base hospital contact. If this box is checked, the completion of an ALS Without Base Hospital Contact form (560.20) is also required.
Complicated extrication	Patient care has been affected by a difficult extrication of the patient.
DNR	Patient has a valid Do Not Rescusci-tate medallion or form.
Drug use suspected	Illicit drug use is suspected. Drug use suspicion includes medic suspicion, patient self-reported use, and police reported suspicion.
ETOH use suspected	ETOH use is suspected. ETOH use suspicion includes medic suspicion, patient self-reported use, and police reported suspicion.
Hazardous material	hazardous material precautions or procedures were utilized, or when a hazardous material was present or involved at the scene of a call.
MCI	A scene has been declared as an Multi-Casualty Incident according to regional policy.
Multiple EMS providers	More than one ALS ambulance is present at the scene of a call.
Possible provider exposure	EMS personnel may have been exposed to

		pathogens at the scene of a call.
	Unsafe scene	Any call where patient care may have been affected because the scene of that call was in some way unsafe.
	Other	Briefly describe any additional special scene condition that may have affected patient care on a call.

Safety Equipment Used Document safety equipment used by the patient.

MVA Conditions Document conditions of the vehicle and/or passengers.

Destination Decision Reason Document reason which most closely describes the reason for taking this patient to his/her particular destination.

Tier I Trauma Document all factors which exists for Tier I Trauma patients.

Tier II Trauma **Document all factors which exists for Tier II Trauma patients.**

Pediatric Trauma **Document all factors which exists for Pediatric Trauma patients.**

Receiving Hospital Enter the facility receiving the patient (or facility code from the Hospital codes list).

Base Hospital Enter the facility providing medical control (or code from the Hospital codes list).

NOTE: The current hospital codes are two digits long. However, four spaces have been allowed on the PCR in case state-assigned four-digit hospital identifiers are used in the future.

Base MD, MICN Enter the names of the base physician and MICN.

Care Transferred To Enter the name of the agency and of the individual that accepts care of the patient. Also record the time care is transferred here.

Certification Number, Name, Signature On the first line, enter the certification number, name and signature of the person who primarily attended the patient. On subsequent lines, enter the certification numbers, names and signatures of other team members.

Continuation form used Check this box if a Patient Care Report Continuation form is used.

If a continuation form is used, be sure to record the corresponding PCR Number on the continuation form. Also, be sure to sign the continuation form at the end of the text entered there.