PARAMEDIC PREHOSPITAL CARE REPORT FORM (Handwritten)

APPROVED: _____ _____
EMS Medical Director EMS Administrator

Note: This policy applies to handwritten Prehospital Care Reports (PCRs). These are being phased-out and replaced by electronic PCRs. In the future the only time that handwritten PCRs will be utilized will be upon the authorization of the EMS administrator on-call.

1. A Prehospital Care Report (PCR) must be completed for **every** patient contact, including non transports.

2. Complete all items on the report. If information is unknown, write unknown and explain the reason if possible.

3. Completed copies of the PCR (all copies except the white and pink) are to be left with the receiving facility. This is to be done as expeditiously as possible, but in no case shall it be longer than the end of the shift. For all critical patients the EMT-P shall make every effort to complete the PCR before leaving the receiving hospital. If unable to complete the PCR the EMT-P must leave a photocopy of the PCR. If a unit is on the scene of a coroner's case (10-55) the yellow copy will be left for the coroner's office. All coroner's cases shall be left with the yellow copy before leaving the patient even when at a hospital, and any request by the coroner's office for information will be complied with without delay.

4. The PCR has been divided into seven sections on legal length paper. To define each area, the following summary has been developed to be used with the attached copy of the PCR.

Issue Date: January 1, 2003
Effective Date: January 1, 2003
Review Date: January 2004

4.1 DISPATCH

4.1.1 **mo/day/yr**: Date of the incident
4.1.2 **LOC. ZONE**: Thomas Brothers Map Coordinates of the incident
4.1.3 **AMBULANCE#**: Unit number of the responding vehicle
4.1.4 **CODE**: Code of response and if reduced or increased
4.1.5 County Incident number
4.1.6 **Dispatch**: Time of dispatch
4.1.7 **10-97**: Time on scene
4.1.8 **10-49**: Time en route to the hospital
4.1.9 **10-7**: Time at the hospital
4.1.10 **Incident Location**: Address or location of the call
4.1.11 **City**: City the incident location is in
4.1.12 **Responding From**: Area unit responded from
4.1.13 **Pt # of**: Number of the patient to total patients (1 of 1)
4.1.14 **10-22**: If a dry run, the cancellation time
4.1.15 **Start/End**: Beginning and ending mileage of transport
4.1.16 **First In**: Indicate each agency on scene prior to your arrival, by indicating where from (i.e. FD: CDF; or SHERIFF: SMCO; or CHP: RC; or AMB: M21, etc.). **Please note whenever a BLS ambulance was first in.**

4.2 PATIENT ID

4.2.1 **Patient Name**: Last and first name, and middle initial
4.2.2 **DOB**: Patient's date of birth
4.2.3 **Patient's Home Telephone**: Area code and phone number
4.2.4 **Residence Address**: Patient's home address
4.2.5 **City**: City of patient's home address
4.2.6 **State**: State of patient's home address
4.2.7 **Zip**: Postal zip code of patient's home address
4.2.8 **Responsible Party**: Name of parent, guardian, conservator, or employer
4.2.9 **Responsible Party Telephone**: Area code and phone number
4.2.10 **Insurance**: Name of insurance company (**not optional**)
4.2.11 **I.D. or S.S. Number**: Insurance or Social Security number

4.3 HISTORY AND CONDITION

4.3.1 **Age**: Age of patient
4.3.2 **Sex**: Male or Female
4.3.3 **Wt**: Weight of patient in kilograms

4.3.4 **PMD/Hospital**: Patients physician and hospital
4.3.5 **ETA:** Estimated time to load and transport the patient, in minutes
4.3.6 If a patient is tagged with a county approved triage tag, place the triage tag number here.
4.3.7 **Before Arrival**: Check the appropriate box of who provided care prior to your arrival.
4.3.8 Check what care was given by first in responders prior to arrival.
4.3.9 If the patient requires CPR write the number of minutes the patient has been down (total).
4.3.10 **AED**: Check if an Automatic External Defibrillator was used by first in responders.
4.3.11 **General Assessment Code**: One of eighteen (18) codes to be defined on the back of the form which will categorize the call for data collection purposes
4.3.12 **Time of Onset**: Time the current chief complaint occurred
4.3.13 **Chief Complaint**: Patient's complaint
4.3.14 **History Present Illness**: Statement of present complaint/illness, PQRSTU, etc.
4.3.15 **Comments**: To describe incident further, if necessary, or any information that didn't fit in another category
4.3.16 **Past Med Hx**: Indicate the past medical history by checking the appropriate box and/or filling in the type of problem.
4.3.17 **Meds**: Medications the patient is currently taking
4.3.18 **Allergies**: Patient's allergies to medication
4.3.19 **MVA**: Section to describe a motor vehicle accident

- 4.3.19.1 What the patient was in (IN) a car, etc., and what the patient struck (VS)
- 4.3.19.2 Check if the patient was restrained and the type of restraint.
- 4.3.19.3 Write in the speed of the collision.
- 4.3.19.4 If time is spent extricating the patient, write the amount of time spent.
- 4.3.19.5 Check if the patient was ejected or ambulatory.
- 4.3.19.6 Check the vehicle damage (if a rollover, none, minor, moderate, or major, and a vehicle drawing to shade in and indicate the damage sustained).
- 4.3.19.7 If the steering wheel (ST WHL) was damaged
- 4.3.19.8 If the wind shield (WND SHLD) was damaged

4.4 PRIMARY AND SECONDARY SURVEY

4.4.1 **Airway**: Check appropriate box
4.4.2 **Breathing**: Check appropriate box
4.4.3 **Circulation**: Check appropriate box
4.4.4 **Skin Color**: Check appropriate box
4.4.5 **Skin Temperature**: Check appropriate box
4.4.6 **Skin Moisture**: Check appropriate box
4.4.7 **Pupils**: Check if PERL (equal and reactive to light). The size: dilated, midrange, or constrict. The reaction to light: reactive, sluggish, or non-reactive
4.4.8 **Glasgow Coma Scale**: Write the time and indicate the response to eye opening, verbal response and motor response by "x"ing the appropriate number which corresponds to the response.
4.4.9 Determine the Initial Glasgow Coma Scale by putting the numbers next to the category and adding them appropriately.
4.4.10 **Vital Signs**: Indicate the time taken, the blood pressure, the pulse, and the respirations of the patient, the position the patient was in, and the person who took them (license # if applicable or initials).
4.4.11 **Initial EKG**: Time and interpretation

4.4.12 **EKG AT 10-7**: Time and interpretation upon completion of patient care or check if no change
4.4.13 **Secondary**: Check each area as to Within Normal Limits (WNL) or Abnormal (ABN). A front and back anatomical figure with lines is provided to indicate findings.

4.5 TREATMENT AND RESPONSE

4.5.1 **Airway**: Check the treatment performed: OPA (oropharyngeal airway), NPA (nasopharyngeal airway), EOA (esophageal obturator airway), CRIC (cricothyrotomy), suction, and/or endotracheal intubation. If ETT (endotracheal tube), the intubating EMT-P's license number, number of attempts, size, time and if successful (yes or no)
4.5.2 **Oxygen**: Time initiated, type of device used and liters per minute delivered
4.5.3 **BLS**: Indicate time and basic life support treatment initiated
4.5.4 **Spinal Care**: Indicate time and type of care initiated
4.5.5 **ALS Care**: MAST no longer applicable
4.5.6 For intravenous therapy, the time, type of solution, site, number of attempts, rate of flow, gauge of needle, if established (yes/no), and license number of EMT-P/candidate or initials of intern.

4.5.7 **Treatment and Response**: Additional treatment to include type, dose of medication, route of medication, response (may be indicated if the patient got better by an up arrow, or if no change by an N, or if the patient got worse, use a down arrow), and change in vital signs.
4.5.8 **Cont Form**: Check if a continuation form was used.
4.5.9 **Base Contact**: Check if consultation utilized.
4.5.10 The consulting MD's Name is to be written here (if used).
4.5.11 **Signature of MD on Scene**: If a MD on scene gave ALS treatment orders, it requires a signature from the MD.

4.6 DISPOSITION

4.6.1 **Transport to**: Write in where the patient was transported.
4.6.2 **Code**: Check the code of transport and if changed.
4.6.3 **Contact on BLUE**: Check if receiving facility contacted on blue.
4.6.4 **1st Resp Assist**: Check if a first responder assisted during transport.
4.6.5 **Reason**: Check reason for destination. If "other" please indicate the reason.
4.6.6 **Not Transported**: If not transported, indicate reason. Check if the release form was signed.

4.7 CREW

4.7.1 **Attendant**: Signature and State License Number of attendant
4.7.2 Print the Attendant's name here and company ID #, if applicable
4.7.3 **Driver**: Signature, State License Number of driver (**not optional**)
4.7.4 Print the Driver's name here and company ID #, if applicable
4.7.5 **Candidate Signature**: Signature and State License Number of county candidate
4.7.6 **Last Name:** Printed name of a ride along observer, intern, or county candidate

5. REFUSAL OF CARE FORM - SPANISH TRANSLATION

5.1 The following translation has been approved as an alternative refusal of care document for Spanish literate patients. It may be added to the printed PCR or printed separately.

Liberacion por Rehuso de Servicios

Yo (el paciente) comprendo lo que se me ha explicado sobre mi problema (s) médico (s) actual (es) y/o herida (s).

Me doy cuenta que rehusando un tratamiento en este momento o rehusando transporte al hospital para tratamiento y evaluación adicional puende hacer que mi contición (el paciente) empeore y ocasione que se desarrollen problemas adicionales incluyendo incapacidad permanente o muerte.

Yo libero a todas las personas actualmente involucradas en mi cuidado (incluyendo el personal del departamento de bomberos y sus jefes, Hospitales, medicós y enfermeros ambulantes de cuidado intensivo, y el Condado de San Mateo y sus empleados) de cualquier responsabilidad (acción legal) con respecto al resultado final del problema médico o herida por la que yo (el paciente) estoy rehusando tratamiento o transporte al hospital.

Nombre del Paciente_____ Fecha:_____
(letra de molde)

Firma: _____ Relación_____
(Del Paciente o Persona Responsable)

Fecha:_____