



## **Documentation of the Patient Care Report**

### **Policy:**

An EMS patient care report form (PCR) will be completed accurately and legibly to reflect the patient assessment, patient care and interactions between EMS and the patient, for each patient contact which results in some assessment component.

### **Purpose:**

To document:

- The total patient care provided including:
  - (a) System data regarding the EMS systems response
  - (b) Dispatch information regarding the dispatch complaint, and EMD card number
  - (c) Care provided prior to EMS arrival
  - (d) Exam of the patient as required by each specific complaint based protocol
  - (e) Past medical history, medications, allergies, living will / DNR, and personal MD
  - (f) All times related to the event
  - (g) All procedures and their associated time
  - (h) All medications administered with their associated time
  - (i) Disposition and / or transport information
  - (j) All communication with medical control
  - (k) Signature of technicians providing care
  - (l) Signature of treatment authorization if any deviation from protocol
  - (m) Signature of receiving individual assuming patient care at the medical facility
  
- Reason for inability to complete or document any above item

### **Procedure:**

1. The patient care report should be completed as soon as possible after the time of the patient encounter.
2. All patient interactions are to be recorded on the patient care report form or the disposition form (if refusing care).
3. The patient care report form must be completed with the above information.
4. A copy of the patient care report form should be provided to the receiving medical facility.
5. A copy of the patient care report form is to be filed at the EMS office.
6. **Documentation will be completed prior to leaving the destination facility unless call demand dictates otherwise, in which case documentation must be completed prior to the end of the personnel's shift.**