Rice EMS Guide to Patient Documentation

July 2007

The PCR

Our revised PCR now has 3 pages. The first page (white) is the original and official PCR. It is kept by the In-Charge at the end of the call and filed in a secure location. The second page (yellow) is a complete carbon copy of the first, and is provided to the transport unit (if applicable) for their records. If no transport occurs, the second page goes with the In-Charge. The third page (pink) is provided to the EMT writing the narrative. It is a carbon copy as well, but all patient information except for age and sex is blacked out. This pink page should always be returned with the narrative. Since neither contains the patient's name or other identifying information, it is now possible to send these documents by campus mail (which is **not** a secure service, and should **not** be used for anything with identifying patient information).

Because we are now making three copies, please remember to **press hard** with the pen when writing the chart!

Statistical Checkboxes

☐ EMERGENCY	☐ RESPONSE	☐ STUDENT	☐ TIMES	PAGE ___ OF ___
☐ NON-EMERGENCY	UPGRADED PER:	☐ FACULTY / STAFF	☐ PT DATA	
☐ STAND-BY	_____	☐ VISITOR / PUBLIC	☐ SURVEY EN / SP	

The top of the PCR contains checkboxes designed to aid the Captain during the compilation of the weekly call report. The first and second columns deal with response type. For nearly every call on campus, you should mark "Emergency." The exceptions are when dispatch specifies that the call is "Non-Emergency," or when the call is generated by an EMT on "Stand-by" at a Special Event, Occasionally, a call will be dispatched as "Non-Emergency" and the on-duty In-Charge or an RUPD officer will request that it be upgraded to an "Emergency" response. In this case, both the "Emergency" and "Response Upgraded" boxes should be checked, and the Unit Number of the person requesting the response upgrade should be filled in on the line. This happens extremely rarely; any questions about which box to check should be directed to the on-duty In-Charge.

The third column is designed to categorize the patient into one of three groups: Students, Faculty/Staff, or Visitor/Public. We occasionally get calls for relatives of Faculty/Staff or Students; these individuals should be classified as "Visitor / Public," with their relation to faculty or staff member noted in the "Other Information" box (see below).

The final column (in grey) is designed to be marked by the Captain during call report to ensure that all required data is present. It is not necessary to mark any of these boxes while on scene.

Finally, the "Page __ of __" is self-explanatory. You should, however, wait until all portions of the chart are completed before marking this section, so you'll know the total number of pages.

Call Information

DATE	RUN NO.
CALL LOCATION	
DISPATCH INFORMATION	

This section contains basic information about the call. All of this information should be filled out **before** leaving the scene. The "Date" should be the date of the start of the call as recorded by dispatch. This is usually not an issue except for calls that occur on or around midnight. To be certain, ask dispatch for the Run Number at the conclusion of the call. The Run No. comes in the form YY-MM-DD-XXXXXX, where XXXXXX is a six-digit number that resets every year – the entire run number must be written down. For the "Date" box, write all dates in the common format MM/DD/YY – inverting it or abbreviating the month can lead to filing difficulties during call report.

"Call Location" should also be self explanatory. Make sure that if there was a discrepancy between the information received in the page from dispatch and the actual location of the call that you write the actual location in this box **and** advise dispatch over the radio of the proper location once you've finished treating the patient.

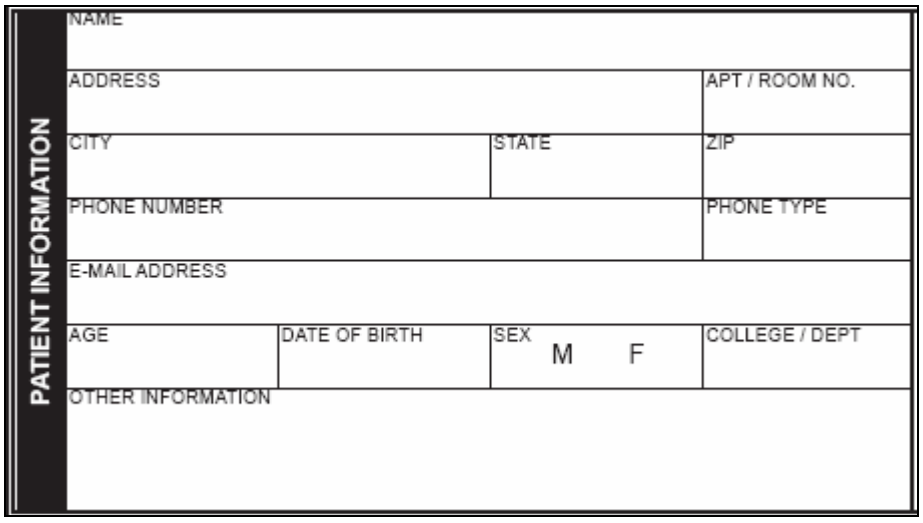
The "Dispatch Information" box should be copied (more or less) from what you see in the page. If you receive a walk-up at any time (on a Special Event or during regular duty), write "Walk-Up" in "Dispatch Information."

Times

CALL RECEIVED	REMS EN ROUTE	REMS ON SCENE	REMS PT CONTACT
HFD REQUESTED	HFD EN ROUTE	HFD ON CAMPUS	HFD PT CONTACT
RUPD REQUESTED	RUPD ON SCENE	PT FROM SCENE	REMS IN SERVICE

This information is always filled in **after the call** using information off of the Run Sheet generated by Dispatch. It is the In-Charge's responsibility to fill this out after you've submitted your narrative. The duty crew EMT's responsibility is to radio when an event occurs (HFD patient contact is a commonly missed example) so that Dispatch will have an accurate time noted on the Run Sheet.

Patient Information



This box contains personal identifying information about the patient. Certain boxes are mandatory while others are optional.

The "Name" and "Address" fields are required of every patient (assuming they are responsive). Place the patient's apartment or room number in the appropriate box. Remember that for students, "Sid Rich" is **not** an address. Feel free to note a student's college in the "College / Dept" box, and leave the address blank (the In-Charge can fill in the college's street address later). It doesn't matter whether the address a patient provides is their campus address or their permanent address, as long as we are able to reliably contact the patient at the address provided.

"Phone Number" is preferred for follow-up, but is not absolutely necessary. If the patient specifies an important detail about the number (i.e. a minor patient gives you their parent's work phone), note that in the "Phone Type" box. Otherwise, the box can be left blank; it is not necessary to ask the patient whether the phone number they provided is their cell, home, or work number.

"E-Mail Address" is a field that should be filled in on **every call**. We use e-mail to send our patients Quality Assurance surveys after a call. If a patient does not have an e-mail address or does not want to supply it, you must get a phone number instead.

"Age," "Date of Birth," and "Sex" are mandatory[*].

"Other Information" is designed for anything identifying about the patient that you feel should be included. If the patient hands you a Driver's License for identifying information, record the number and issuing state in this box. If the patient provides you with multiple contact numbers, list these here as well. This box isn't necessary on all calls, but can be useful in certain situations.

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[*] For transgender patients, sex refers to the patient's physical characteristics, not the identity they prefer. You may choose to note the patient's preferred gender in the "Other Information" box (see below).

Basic Call Information and History

CHIEF COMPLAINT
INITIAL ASSESSMENT
CARE PRIOR TO EMS ARRIVAL
MEDICAL HISTORY □ NONE □ Diabetes □ Stroke □ Hypertension □ Cardiac □ Seizures □ COPD □ Asthma □ Other:
MEDICATIONS
ALLERGIES

"Chief Complaint" should be the patient's chief complaint **in their own words**. It's a helpful practice to ask the patient "What can I help you with?" or a similar question at the beginning of the call and to document their response in quotes. If the patient says "I'm fine" in response, record that. If the patient has altered mental status, is unresponsive, or cannot answer your question appropriately for any other reason, note this in the chief complaint box. Try to avoid substituting your judgment about the presenting problem for the patient's complaint. Presenting problem comes later.

"Initial Assessment" should include your initial size-up of the scene and/or patient. Some commonly included phrases include "ABC's intact, (-) major bleeding, (-) obvious deformity, (-) LOC," etc. Put these immediate findings along with any other elements of the call you feel should be included.

"Care Prior to EMS Arrival" should be used to **briefly** document any care performed by the patient or bystanders before EMS arrived – putting ice on an injury or stopping bleeding with a non-sterile cloth, for instance. Feel free to elaborate on the care provided in the narrative; keep the information in the box on the PCR clear and brief.

"Medical History" is designed to record any past medical problems. Several boxes are listed to cover more common histories, but also feel free to use the "Other" checkbox when needed. Make an effort to include everything you can elicit from the patient. If there is too much information to fit here, include all history pertinent to the present problem on the PCR itself and document the rest within the narrative.

"Medications" should be used to record what medications the patient takes. If the patient can give you dosages and frequencies, make an effort to record them. If the patient cannot remember the name of a medication, record the problem the medication is designed to treat (i.e. "unknown asthma med").

"Allergies" should be used for medication allergies or any food or environmental allergies relevant to the call (especially for a patient experiencing an allergic reaction). If

the patient doesn't have any allergies, use the acronym "NKDA" (No Known Drug Allergies) or "NKA" (No Known Allergies) rather than writing "None."

Presenting Problem

PRESENTING PROBLEM				
	□ Abdominal Pain	□ Cardiac Related	□ Head Injury	□ Psychological / Behavioral / Suicidal
	□ Airway Obstruction	□ Chest Pain	□ Headache	□ Respiratory Arrest
	□ Alcohol Intoxication	□ CVA / Stroke	□ Hemorrhage / Laceration	□ Seizure
	□ Allergic Reaction	□ Dead on Arrival	□ Hyperthermia	□ Sick / General Illness
	□ Amputation	□ Difficulty Breathing	□ Hypothermia	□ Syncope
	□ Animal Attack	□ Drug Overdose	□ Industrial / Machinery Accident	□ Trauma, Blunt
	□ Back / Spinal Injury	□ Electrocution	□ Motor Vehicle Collision	□ Trauma, Penetrating
	□ Blood Sugar Related	□ Fall	□ Near-Drowning	□ Unconscious
	□ Burns	□ Fracture / Dislocation / Sprain	□ OB / GYN	□ Unknown
	□ Cardiac Arrest	□ Hazardous Materials Exposure	□ Poisoning	□ Other _____

This is your judgment about the overall cause of the patient's problem. Please select **one** box only, and keep it simple. Avoid marking "Other" unless the patient fits none of the boxes. Please be as specific as possible; a patient with a cut on his knee from hitting it on a railing should be marked as "Hemorrhage / Laceration," **not** "Trauma, Blunt." A patient with a cut following a fall, however, has a specific mechanism of injury that caused the cut – mark the "Fall" box. Returning EMTs should be aware that certain Presenting Problem types have changed "Cold" and "Heat" are now "Hypo-" and "Hyperthermia." "Overdose" is now "Alcohol Intoxication" **or** "Drug Overdose." "Diabetic Related" became "Blood Sugar Related" to cover sugar emergencies in non-diabetics.

Vital Signs

VITAL SIGNS				
	TIME	TIME	TIME	TIME
	PULSE	PULSE	PULSE	PULSE
	RESP	RESP	RESP	RESP
	B/P	B/P	B/P	B/P
	SPO2	SPO2	SPO2	SPO2
	TEMP	TEMP	TEMP	TEMP
	BGL	BGL	BGL	BGL
	PUPILS	PUPILS	PUPILS	PUPILS
	GCS	GCS	GCS	GCS
	PMS	PMS	PMS	PMS
	SKIN CONDITION	SKIN CONDITION	SKIN CONDITION	SKIN CONDITION

This section is intended to allow trending of the patient. You must have **at least two sets** of vitals (preferably more). Ask the In-Charge on scene for the official time immediately after you record a set of vital signs. Vitals are **mandatory** for medical or potentially medical patients. Vitals are also mandatory for **all HFD transports**, unless HFD arrives on scene before vitals can be taken and there is a need for immediate transport. Returning EMTs should note that the vital signs section has been expanded.

Treatment

TREATMENT	ADMIN TIME	INTERVENTION	RESULT OF INTERVENTION	RESULT TIME

This section is used for recording any interventions performed along with their results. Returning EMTs should note that it is **no longer REMS policy to include Vital Signs, Physical Exam, taking a BGL, etc. as interventions.** An intervention should be something done to the patient that **is expected to have a result**. This result should then be documented, along with the time when the result was obtained. Both of these times are especially critical to record immediately; as with Vital Signs, ask the In-Charge on scene for the official time. These are several common examples of interventions:

- For Oxygen Administration, list the time you started administering oxygen and record the device used and flow rate under "Intervention." Record the patient's response (it alleviated their dizziness, O2 sat increased, "None," etc.) under "Result." For "Result Time," list the time you checked the O2 sat or asked the patient whether his dizziness had improved, etc.
- Medication administrations should be self-explanatory; list the time the medication is given and list the medication name, route, and dosage under "Intervention." After waiting the appropriate amount of time (this varies depending on the medication), check the patient's response, note it under "Result," and mark the exact time the response was checked. Do not forget to recheck vitals during the check of the patient's response to the medication. Vital signs should be recorded in the vital signs section and must include the same time as entered in the "Results" section
- For splinting, spinal immobilization, etc, list the time and the exact intervention performed. For "Result," include things such as "Alleviated pain," "Worsened pain," "(+) PMS following intervention," "No change in symptoms," etc., along with the time you checked for the result you included.
- For interventions such as starting an IV or bandaging a wound, you may list "IV/bandaging successful," etc. as the Result. (For IVs, list the location and size).

Cardiac Arrest Data

CARDIAC ARREST DATA			
RUPD AED ON SCENE:	□ YES	□ NO	□ BEFORE EMS
RUPD AED INDICATED:	□ YES	□ NO	
WITNESSED ARREST:	□ YES	□ NO	BY: _____
BYSTANDER CPR:	□ YES	□ NO	BY: _____
AED USAGE:	□ POLICE	□ PUBLIC	□ EMS
AED SHOCK DELIVERED:	NUMBER: _____		BY: _____
PULSE RETURNED ANY TIME:	□ YES	□ NO	
PULSE ON TRANSPORT:	□ ABSENT	□ PRESENT	
RESQPOD (ITD) USED:	□ YES	□ NO	
EPINEPHRINE USED:	□ YES	□ NO	

This information is used for statistical purposes. Even though things like "AED Shock Delivered" and "ResQPod (ITD) Used" are listed here, they should **still** be documented in "Interventions." For most calls, you may draw a single line through this section.

Disposition

DISPOSITION:	□ Refusal	□ POV	□ RUPD Escort
	□ Refusal AMA	□ No Pt Contact	□ HFD / Ambulance

This is what happened to the patient at the conclusion of the call. Check one box only. If the patient changes his mind, draw one line through the incorrect box and initial the error.

The bottom-right corner

TRANSPORT UNIT	RECEIVING FACILITY
HFD UNITS	RUPD UNITS
□ College Masters Notified □ Workman's Comp / Supv Notified	EMT SIGNATURE
HFD SURVEYS: ___	

This section covers responding HFD and RUPD units, transport unit (if applicable), destination, and whether any HFD surveys were given out (Mark Ø if HFD was not involved in the call). The "EMT Signature" field is for the EMT **writing the narrative**. This must be signed before leaving the scene, as the In-Charge keeps the white copy.

Responding REMS Units

IN-CHARGE B I P LP	EMT B I P LP
EMT B I P LP	EMT B I P LP
PATIENT ___ OF ___	

Names, unit numbers (if applicable), and certification level should be recorded here. If more than four units respond, additional personnel can be added to the bottom margin. Below the responding units, mark which patient the chart contains information about. Most of our calls involve single patients – in this case, mark "1 of 1" here.

The Refusals Sheet

We are now recording refusals on a separate sheet of paper. This is a regular piece of copy paper (not a multi-page form). The patient should sign **one** copy of this form. A blank copy of the form should then be given to the patient for his records. **Every patient who refuses must be given a copy of this form!** If you (or the patient) prefer, you may X or circle the refusals the patient signed on his blank sheet.

Basic Call Information

RICE UNIVERSITY Emergency Medical Services		PAGE ___ OF ___
DATE	RUN NO.	PATIENT NAME

These should be the same as on the PCR, with the exception of Page Number. The refusals sheet should go immediately after the PCR, and should be numbered as such. Typically, it will be page 2.

Refusal of Specific Interventions

RELEASE OF LIABILITY – REFUSAL OF SPECIFIC INTERVENTIONS			
By initialling next to the interventions listed below, I indicate that I fully relinquish **all liability** by refusal of those interventions. I understand that this does not preclude alternative interventions, further treatment / evaluation, or transport to an emergency room or other appropriate medical facility.			
PT INITIAL	INTERVENTION	PT INITIAL	INTERVENTION
PT INITIAL	INTERVENTION	PT INITIAL	INTERVENTION

This section was added to take into account situations where a patient consents to transport but refuses a particular intervention. List the intervention in the space and have the patient initial to the left. Be sure to explain to the patient the dangers of their refusing the intervention in question, and feel free to contact a superior to try and convince the patient if necessary. **Even if a patient is going by HFD, if they initial a refusal of a specific intervention, they must provide their full signature at the bottom**. Initials alone are not sufficient to release liability. A signature **must** be present. Returning EMTs should note that this is a change from previous procedures in which a patient going by HFD was not required to provide any signature to REMS (though this is sometimes still the case). A non-EMS/RUPD witness is preferred as well.

Refusal Checklist

REFUSAL CHECKLIST				
Pt oriented to: ☐ Person ☐ Time ☐ Place ☐ Event	☐ No evidence of altered mental status	☐ No evidence of head injury	☐ No evidence / suspicion of alcohol / drug ingestion	
☐ Medical control / superior contacted via:		☐ Authorized refusal AMA of treatment or transport	☐ Authorized use of restraints or force	
☐ Pt advised treatment / evaluation needed	☐ Pt advised transport needed	☐ Pt advised of dangers of refusing treatment / transport	☐ Pt advised of dangers of not using ambulance transport	

This checklist should be completed by you, the EMT, before any refusal. Any time an unusual circumstance occurs (an alert and oriented patient who has evidence of minor head injury wants to refuse, or an AMA refusal is obtained without contacting a superior, or authorized restraints or force is used, etc.) this must be thoroughly documented in the narrative. Consult an In-Charge if you have any doubt or question about the specifics of this checklist.

Information for the Patient

RELEASE OF LIABILITY – INFORMATION FOR THE PATIENT	
This form has been given to you because you have refused treatment and/or transport by Rice University Emergency Medical Services (REMS). Your health and safety are our primary concern. Even though you are electing to refuse treatment and/or transport, please remember the following:	
PT INITIAL	The evaluation and/or treatment provided to you by REMS is not a substitute for evaluation and treatment by a doctor. We advise you to get medical evaluation and treatment.
PT INITIAL	Your condition may not seem as bad to you as it actually is. Without treatment, your condition or problem could become worse. If you are planning to get medical treatment, a decision to refuse treatment by REMS or transport by ambulance may result in a delay which could make your problem or condition worse.
PT INITIAL	Medical evaluation and/or treatment may be obtained by calling your doctor, if you have one, or by going to any hospital emergency room in this area, all of which are staffed 24 hours a day by Emergency Physicians. You may be seen at these emergency rooms without an appointment.
PT INITIAL	If you change your mind or your condition becomes worse and you decide to accept treatment by REMS and/or transport by ambulance, please do not hesitate to call us back, by dialing 713-348-6000. We will do our best to help you.
PT INITIAL	Don't wait! When medical treatment is needed, it's usually better to get it right away.
After reading and initialing the above information, read initial, and sign the specific releases indicated by the Emergency Medical Technician. A copy of this form will be provided to you for you records.	

This section is to be given to the patient for him to read and initial prior to signing a refusal.

Briefly, the first box tells the patients that we're not doctors. The second says that things could be worse than they seem and that they could be doing harm to themselves by refusing treatment/transport. The third informs the patient of the option for POV transport or seeing a doctor later. The fourth line advises the patient that it's OK to call back later if they want. The fifth line reminds the patient that it's usually better to treat problems now rather than later.

These should already be things you remind your patient of when they wish to refuse; the box gives it to them in writing and their initialing each box ensures that they have been fully informed.

The Big Refusals Section

RELEASE OF LIABILITY – REFUSAL OF EMERGENCY MEDICAL ASSISTANCE OR AMBULANCE TRANSPORT		
PT INITIAL	I fully understand my medical condition as it has been explained to me by the Emergency Medical Technician, and I fully relinquish **all liability** by refusal of ambulance transportation to a medical facility for further evaluation by a physician.	
PT INITIAL	I fully understand and assume **total responsibility** for my medical condition by not allowing the Emergency Medical Technician to examine me / treat me / transport me to a medical facility for further evaluation by a physician.	*RMA*
PT INITIAL	Additionally, I understand that my refusal of examination, treatment, and/or transport is **against the medical advice** of the Emergency Medical Technician.	*AMA*
PT INITIAL	Additionally, I will seek the advice of a medical doctor at a later time.	*MD*
PT INITIAL	Additionally, I will go to the emergency room or other appropriate medical facility in a private vehicle.	*POV*
PT INITIAL	Additionally, I consent to a non-medical escort to the emergency room or other appropriate medical facility by the Rice University Police Department.	*RUPD*
PT INITIAL	I consent to the release, as deemed necessary by the REMS In-Charge, of my name and information related to my illness or injury to the necessary parties, as listed below, for the purposes of follow-up care, advice, and completion of illness or injury reporting paperwork. Information released to: _____	*RELEASE*
PT INITIAL	Additionally, by signing this release in lieu of the patient, I assume custody and full responsibility for this patient. Relation of custodian to patient:	*CUSTODY*

This section has specific types of refusals for different situations.

The first line is a general refusal of ambulance transport. This box is initialed for **all** refusals.

The second line (RMA) is a general refusal of treatment/transport. This is also initialed for **all** refusals. Any time the patient does not go in an ambulance, we are not transporting them to a medical facility – going by RUPD or POV doesn't count as a transport in this sense.

The third line (AMA) is used for refusals **Against Medical Advice**. In this case, you must document the pertinent information in the second line of the Refusal Checklist. In addition, you **must** contact the Director (or the Captain, if the Director is unreachable) before getting a Refusal AMA. When this box is initialed, a witness signature is **mandatory**. In this case, a non-EMS/RUPD witness must be obtained if at all possible.

The fourth line (MD) is for patients who are refusing transport but state that they will see a doctor later. This box may also be used if the patient says they will contact a doctor if the problem does not improve. Get these initials whenever possible – it removes liability from our end by demonstrating that we have convinced the patient they need to see a doctor, but they are choosing not to do it immediately.

The fifth line (POV) is for patients who go to the hospital in a private vehicle (either in their own vehicle or with a friend/bystander). Again, try to convince the patient to go POV if he/she does not want an ambulance or RUPD escort.

The sixth line (RUPD) is for patients receiving an RUPD escort to the hospital. It is critical that you advise the patient that this is a non-medical escort and that the RUPD officer will not be able to provide treatment in route if the patient's condition worsens.

The seventh line (RELEASE) is for patients who give us permission to release otherwise confidential information to a person of their choosing (this is usually for college masters or work supervisors). Please remember to check the appropriate box on the bottom-right of the PCR if this release is used.

The eighth line (CUSTODY) is to be used if the person signing the release is not the patient, but a custodian. Make sure to note the custodian's relation to the patient. It may also be helpful to record the custodian's contact information (if different from the patient's) in the "Other Information" box on the front on the PCR. Note that if this release is used, a special signature line will also be used (see below).

The Signatures

PATIENT NAME (PRINT)	PATIENT SIGNATURE	DATE
CUSTODIAN NAME (PRINT)	CUSTODIAN SIGNATURE	DATE
WITNESS NAME (PRINT)	WITNESS SIGNATURE	DATE

The bold box is for the patient. The second box is for the custodian (if applicable). The third is for a witness. Note that if the Custodian release is initialed, the custodian **must** sign in the appropriate box. Returning EMTs should also note that the "Relation to Patient" section has been moved up into the Custodian release above.

Witness signatures should be obtained whenever possible, but a witness may not always be available. A witness signature is **mandatory** for any AMA refusal.

For Very Disagreeable Patients

The possibility of medical complications has been explained to this patient, and said patient attests he / she understands what has been explained. Said patient refuses to accept further evaluation, treatment, and/or transport to a medical facility for evaluation by a physician, and refuses to sign the Release of Liability.			
EMT NAME (PRINT)	EMT SIGNATURE	EMT DOB	DATE
WITNESS NAME (PRINT)	WITNESS SIGNATURE	WITNESS DOB	DATE

When a patient not only refuses assistance but also refuses to read and/or sign paperwork, the EMT and a witness must print their names, sign, and write their dates of birth in the appropriate boxes. No other initials or signatures are necessary, but you **must** contact the Director (or Captain, if the Director is unavailable) prior to accepting a refusal in this manner, and the patient **must** meet all the criteria on the refusal checklist, or an exception must be made by the Director (or Captain).

When this situation occurs, you must still complete and turn in the chart with as much information as possible. Insert times, dispatch information, location and all other information you can obtain without talking to the patient.

Patient Number

PATIENT ___ OF ___

This allows us to more easily keep track of our paperwork. It should be numbered the same as on page 1 (the chart itself).

The Narrative

Remember: The first draft of all narratives **must** be e-mailed to the on-duty In-Charge **within 24 hours of the call**. Also, **please type your narratives**. We have a computer and printer available in the Jones crew quarters. There are also multiple computer labs on campus that have printers available. Hand-written narratives should be avoided if at all possible, as typed narratives look more professional and eliminate ambiguity or errors caused by illegible handwriting.

Narratives for REMS should have the following information at the top:

- Date
- Run No. (this should be collected at the conclusion of **every** call)
- Pt name: _____ (**leave a blank space** – the pink copy you have will not contain the patient's name and the narrative should not either, since it may be transmitted via a non-secure manner such as campus mail)
- Pt __ of __ (this must match the numbering on the PCR)
- Page __ of __ (**don't** list page numbers; the In-Charge will do this when compiling the paperwork)

The narrative should then be written in a standard format. The REMS format is a modified version of SOAP.

The first sentence of the first paragraph should contain the patient age, sex, chief complaint, and position found in, along with a **brief** initial assessment. The rest of the first paragraph is the Subjective information. Anything told to you by the patient goes here, including SAMPLE and OPQRST information, care prior to EMS arrival, and any explanation of how the problem may have come about.

The second paragraph is the Objective and Assessment section. Describe the results of your exam, any injuries or abnormalities from your perspective as an EMT, and any pertinent negatives. You may also document vitals here or state that they are listed on page 1. Be sure to specifically note any abnormal or unstable vital signs in your narrative.

The third paragraph is the Plan section. Write about any interventions performed and the response to those interventions. The disposition and transport information, along with any other notable information, can either be listed here or in a fourth paragraph.

After writing these paragraphs, **hand-write** EOR at the conclusion of the narrative, print your name and certification level, sign the narrative, and write the date.

Before printing and submitting the narrative, a draft should be e-mailed to the In-Charge who was at the call. The In-Charge will provide you with suggested changes or areas to improve, and will then ask you to submit another draft to him/her. This goes on until the In-Charge approves the narrative, at which point you should finalize and submit the narrative. **Never** submit a narrative that has not been approved by the In-Charge who responded to the call. Contact the In-Charge by phone if an email goes unanswered.