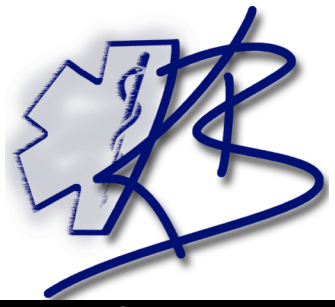

Chronological Method

Documentation is an extremely important skill that takes time and practice to develop. There have been debates throughout the EMS industry as to which is the best way to format the patient information. Each service may have their own requirements (SOAP, CHART) as to how patient care reports are written.

General Areas	Specific Areas (to include but not limited to these)
Upon Arrival Scene conditions How the patient was found Where the pt was found General pt impression	• Describe the scene / location • If an MVC, how are vehicles? • If a home, pt able to care for self • Where/how pt found (important in transfers) • Apparent LOC of pt (important in transfers) • General impression (important in transfers)
HPI *"The Story"* Subjective information What is told to you Description of event	• Chief Complaint • OPQRST and L&E of SAMPLE • Pt's description of events Interfacility Transport • Family / Bystander's description why was pt in the hospital and the diagnosis • Reason for transport by ambulance • Any complaint from the patient? • Was pt brought to ED? How? • When were they admitted?
PAST MEDICAL, SOCIAL, and FAMILY HISTORY	If you are not using a standardized PCR, or need more room, putting the pt's history here gives you and the reader an idea of what you may find in the physical exam. • Medical history • Smoking, Substance use/abuse • Family Hx of diseases
PHYSICAL EXAMINATION Objective information What you see & don't see Include pertinent negatives	• Neuro: CAOx?; GCS E/V/M; Calm v. Anxious • HEENT • Chest • ABD • Pelvis • EXTx4 • Neck/Back • Skin
TREATMENT Care rendered Chronological order Withholding Tx and why Patient response to Tx How pt moved to stretcher	• Use the flow chart if available • Pt response to treatment • May place in narrative • All treatment must be documented • Should include how pt transferred
COMMUNICATION Notifications Medical Command	• Contact Medical Command • What facility and with whom did you speak with • What did you ask for and did you receive it • MC orders • Communication problems
DISPOSITION Where pt transported to Reassessment Who assumed care Condition upon arrival Where pt placed How pt placed	• Did pt condition improve? • Who received pt? • What was their level of care? • What bed was pt placed? • Where was pt placed? • How did you transfer pt? • What did you do with the belongings of the patient? Transported by another unit / Upgrade by higher level of care • Name and level of care • Company and unit number • Intended destination • Condition of pt prior to them assuming care