Section: EMS **Page: 1 of 24**

Section No: 4.14 **Date: August 29, 2022**

Title: EPCR Documentation **Authorized By:**

I. Policy

It is the policy of Prince George Fire/EMS that all medical providers prepare thorough documentation on all patient care reports (PCR). This policy aims to establish the standards of documentation on PCRs for Prince George Fire and EMS. Many parties will view your PCR during the multi-phase patient care process: hospital staff, quality assurance and quality improvement designees, supervisors, attorneys, the media, the patient and/or the patient's family, and potentially others. Your report will be written in a professional manner, avoiding any remarks that might be construed as derogatory. A seemingly innocent phrase or use of jargon may be difficult to explain later. Remember, your reports must be understood as if a non-clinical person is reading this to determine what you did, why you did it, or why applicable protocols/policies were not followed.

II. Acceptable Medicare Terminology

a. **Postural Instability**- Unable to stand unattended without losing their balance and falling over. (Hypotension, Seizure/Postictal, Syncope, Vertigo, Alcohol/Drug Toxicity).
b. **Non-Weight Bearing Condition**- Prevented from putting weight on one or both lower extremities. (Fractured hip or femur, sprained knee or ankle, Total replacement of hip or knee, severe hip or leg pain, Gout, Gangrene to foot).
c. **Restraints or Sedation Required**- Requires soft restraints, leather restraints, or some form of sedation to be transported safely.
d. **Unmanageable/Non-Compliant Behavior**- Does not follow commands/instructions intended to ensure their safety. (Will not stay on the stretcher, is prone to wander aimlessly, physically strikes out at attendants, Attempts to unbuckle stretcher straps).
e. **Unable to Transfer Independently**- Cannot move from stretcher to bed without the assistance of others. (CVA, Coma, Unresponsive, Lethargic, Contracted in the fetal position).
f. **Alteration in Cognition**- Confused as to person, place, time, and surroundings rendering them unable to make sound judgments. (Mental retardation, mental disease, Alzheimer's, severe dementia, Alcohol/Drug toxicity, Seizure/Postictal, TIA).

g. **Sitting Contraindicated**- The patient cannot sit. (Decubitus ulcers to buttocks, hip or flank area, recent hip or femur fractures/surgery/replacement, Inability to balance or position self in wheelchair without risk of falling out).

h. **Late Stages of Terminal Illness**- The patient is approaching or has reached the stage in their life where illness has debilitated them to the extent that they can no longer care for themselves. (AIDS, CHF, Alzheimer's, Multiple Sclerosis, ESRD, etc.).

i. **Inability to Position or Balance Self**- The patient cannot change positions in bed without the assistance of others. The patient would be unable to prevent themselves from falling off a stretcher/bed. (A patient with decubitus bedsores, Contractures, Paralysis, Unresponsive, or Comatose).

j. **Patient Completely Immobile**- This patient cannot move at all and exists in a vegetative state. This patient is entirely dependent on others for all mobility.

k. **Requires Total Care for All Activities of Daily Living (ADLs)** - The patient Cannot Eat, Drink, Brush teeth, Got to the bathroom, or Dress independently. This patient must have these tasks done for them; otherwise, the tasks go undone.

III. **Critical Areas of Documentation**

a. Demographic Information (name, date of birth, SSN, phone, address, weight, medical record number [MRN], and other state/local required data points validated on the PCR.
b. You must place the MRN in the name fields if a name cannot be obtained.
c. If you cannot obtain a SSN, "000-00-0000" will be used.
d. Date and times associated with the transport as captured in CAD
e. Reason for transport (patient complaints/conditions).
f. Indications of emergency vs. non-emergency responses
g. Comprehensive patient assessment by ambulance personnel and a chronological narrative of care/services rendered by ambulance personnel (DACHART method will be used as outlined later in this policy).
h. Patient's related medical history (if pertinent)
i. Name and address of origin and destination.
j. Number of loaded miles, documented as starting at 0 miles and ending with actual miles (i.e. 4.9 miles) traveled from starting destination to ending destination. The operator must reset their odometer to obtain the actual mileage.
k. Names, titles, and signatures of ambulance personnel.
l. Type of equipped vehicle used for transport (BLS/ALS).

m. Narrative
n. The PCR should be precise and comprehensive. Include all relevant information that might be pertinent now or at a later date. Exclude all superfluous information. You should complete both the check box and the narrative portion of the PCR. The narrative is the core of the PCR. ***INCLUDE pertinent POSITIVES and NEGATIVES… the following is a review of how to conduct an interview with your patient to help gather the information you are looking for:***

IV. SAMPLE Assessment

S- Signs and symptoms. What signs do you visualize, and what symptoms does the patient describe?

A- Allergies. What allergies does the patient have?

M- Medications. What medications is the patient currently taking?

P- Past Medical and Surgical History (PH) *Example*: Patient has a history of angina and insulin dependent diabetes mellitus.

a. A Head-to-Toe approach can help with a systematic and thorough assessment.
    i. *Example:* General Impression: The patient presents in moderate distress, sitting upright on his living room couch.
    ii. Vital signs: BP 146/82 indicating hypertensive; Pulse 82, strong and regular at the radial site; Respirations 18, slightly labored with work of breathing.
    iii. Neuro: Awake, alert, oriented x4. Pupils PERRL @ 4mm.
    iv. Chest: Lung sounds clear, equal bilateral. PO2 90 % on room air 98% on 4 lpm via NC. Cardiac monitor shows sinus rhythm without ectopy.
    v. Abdomen: Soft, non-tender. Bowel sounds present x4 quadrants. c/o slight nausea, no emesis at present.
    vi. GI/GU/Pelvis: Stable pelvis, no changes in bowel or bladder habits.
    vii. Extremities: CMS present in all extremities. Pulses 2+ radial and pedal good pulses, no peripheral edema.

L- Last oral intake. What was the patient's last oral intake (food, fluids, medications, etc.)?

E- Events. What were the events leading up to the cause of the activation of EMS?

b. History of Present Illness (HPI): For most chief complaints, the "OPQRST - pneumonic may help the provider recall important questions to ask the patient. Remember to ask open-ended questions: "What does the pain feel like?" NOT "Is it sharp?"
c. The following will be done as part of the focused, or secondary assessment:

O – Onset

Did the problem develop suddenly or gradually? What was the patient doing when it started?

P – Provoke and Palliate

Provoke: Does anything make the pain worse? Often, movement, deep inspiration, etc. can intensify pain. Exertion can intensify respiratory difficulty.

Palliate: Does anything make the pain better? Did the patient take any medication prior to your arrival – bronchodilators, nitroglycerine, etc.? If so, did it help? Did the patient change position – e.g. sitting bolt upright? If so, did it help?

Q – Quality: What does it feel like? It is important to ask open-ended questions, not questions where the patient can answer "yes" or "no". Example: "What does it feel like?" NOT "Is it sharp?" Quote the patient's description in the PCR.

R – Region and Radiation: Where is the symptom located? You can ask the patient with pain to point to where it hurts. Does the symptom move/migrate/radiate anywhere else?

S – Severity: Number scale from 0-10. 0 = no pain, 10 = the worst pain the patient has ever experienced. If the patient cannot understand the 0-10 scale, try using "mild, moderate, or severe". Look at the patient's appearance – are they grimacing and diaphoretic? With children, you can use the "faces" scale – ask the child to point to the face diagram that looks like how they feel

T – Time: When did the symptoms begin? Is it constant or intermittent? How long has it lasted? Any previous episodes?

AS – Associated Symptoms

Example: In the patient with chest pain, inquire about associated shortness of breath, nausea, dizziness, weakness, etc.

V. **PN – Pertinent Negatives**

a. Are any likely associated symptoms absent? This information might help rule out a particular illness or injury. Example: the patient with chest pain who does not complain of any shortness of breath, nausea, or dizziness but who does complain of increased pain with palpation or movement.

Example: "Sudden onset chest pain while walking to mailbox. Pain worsened while walking inside and got slightly better with rest. Patient took three sublingual nitroglycerine tablets without any relief. Patient states it feels like a horse is sitting on his chest. Pain is sub-sternal, with radiation into the right side of the jaw. Patient rates pain a 5/10. Symptoms present for 20 minutes now, constant. Associated with slight nausea and shortness of breath."

VI. **ASSESSMENT: What you think the problem/diagnosis is.**

a. This is where you document what you believe the patient's problem to be. This is also known as your working diagnosis", "field diagnosis, "impression", or "differential diagnosis." *Example:* "chest pain, patient showing signs of unstable angina or acute MI"
b. Record what you did for the patient, from start to finish. This includes how you packaged and moved the patient to your stretcher and ambulance. List any interventions initiated prior to contacting medical control. Describe any orders from your medical control physician, and include his or her name. Describe how you transported the patient and the effect of any interventions (treatment modalities, medication administration, etc.) you performed. Include any ongoing assessments/reassessments and any changes in the patient's condition. Finally, document the patient's condition upon arrival to the hospital and who assumed care of the patient. If you have initiated any advanced treatments (intubation, IV, pacing, etc.), document proper placement or patency at hand-off.

Example: "Patient placed on O2 at 4lpm by NC with noted improvement in respiratory status. Patient placed on the cardiac monitor and found to have a narrow complex sinus with a few PAC's. Medical control contacted, and the

following orders received from Dr. Smith: Nitroglycerine sublingual x3, 5 minutes apart for continued chest pain and BP >90/60. If no relief from nitroglycerine, administer morphine 2 mg Slow IV push, titrated to a maximum of 10 mg for continued chest pain and BP >90/60."

An important component of documentation is **reevaluation, or patient response to plan/treatment. It is crucial to document this aspect of care! For example: "chest pain decreased from 4/10 to 1/10 with O2."

c) **L.O.C.:** A: Alert and oriented (person, place, time, and event) V: Responds to verbal stimuli (call patient's name); Patient can verbalize, but is not oriented to person, place, time and event P: Responds to painful stimuli only (pinch, nail bed pressure) U: Unresponsive. You should explain the reason you give any patient an ALOC.

d) **PULSE** Enter rate (beats per minute). Check the quality: Regular, Irregular, Strong, Weak, etc.

e) **BP** Enter systolic and diastolic numbers. Examples: 124/78. It is not just enough to give the number you will need to state patient is hypertensive if B/P is above 140/90 and Hypotensive if below 100mmHg

f) **RESPIRATIONS** Enter rate (breaths per minute): Normal Abnormal Labored Shallow, describe the work of breathing the patient may be having if any.
Two sets of vital signs are required for all patients, and all transports greater than 5 miles.
**Document orthostatic/postural vital signs as appropriate and indicate patient position.
**If the patient is on the cardiac monitor, describe the rhythm.

g) **LUNG SOUNDS:** Record presence or absence of lung sounds in both lungs. Check applicable descriptors for each lung: Clear Absent Stridor Rales Rhonchi Wheezes.

h) **PUPILS:** Check all that applies for each eye: Reactive Unreactive Constricted Dilated Check if applicable for both eyes: Unequal Disconjugate. Document size (in mm) of each pupil.

i) **SKIN:** Check all that apply: Normal Cyanotic Moist Flushed Pale. How is the skin temp color and condition? Is there any edema is there signs of dehydration or poor skin turgor etc.

j) **TEMPERATURE** is an essential vital sign to record: Normal Warm/Hot Cool/Cold. ***Document the patient's actual temperature (number).*** Ideally, document an initial temp and the pt's temp at handoff - in addition to whatever means you used to Re-warm the pt or keep the pt warm. Remember that it is not enough to just put the temp you must document is they have a FEVER and list any other related signs or symptoms that were found.

VII. **Signatures**

a. **Provider Signatures**

i. All Patient care reports regardless of transport or cancelation must have the signatures of both crewmembers on the unit.

ii. All personnel on the medic unit at the time of transport shall sign a 'Technician Signature' box.

b. **Patient Signature Authorizations**

i. Section 424.36 of the Code of Federal Regulations requires a beneficiary signature authorization to be kept on file for all claims submitted to Medicare on the patient's behalf. The purpose of the signature is to authorize the ambulance supplier to:

1. Submit a claim to Medicare on the patient's behalf.
2. Release information.
3. Assign benefits/payments to the ambulance supplies.
4. Appeal a claim for denied benefits.
5. Acknowledgement of the receipt of the Notice of Privacy Practices under HIPAA regulations.
6. Verification that the ambulance services were provided.
7. In order to submit a claim to Medicare, the Federal regulations require a signature authorization from one of the following representatives:

c. **Patient Transport Signature**

i. Patients who are alert, oriented, and competent shall be asked to sign the 'Patient Transport' signature box.

ii. Ambulance Crew Members must attempt to obtain a patient signature authorization at the time of transport. If the patient is unable to sign, the documentation shall provide the reason in which the patient was unable to sign.

iii. If the patient is unable to sign for any reason (i.e. AMS, vision, life-threatening illness/injury), the AIC shall write ***PUTS*** (patient unable to sign) in the 'Patient Transport' signature box, select the appropriate PUTS drop-down reason, and are required to document in the narrative why the patient is unable to sign.

d. **Authorized Representative Transport Signature**
   i. Patients who are unable or ineligible to sign (i.e. minors with parent present, incapacitated patients with Medical POA present) will require an 'Authorized Representative' to sign the 'Authorized Representative Transport' box.
   iii. Receiving agencies (air medical transport) and receiving facility staff are not permitted to sign this box in accordance with CFR 424.36.

e. **Patient Refusal**
   i. Only a patient who is mentally competent, alert and oriented may sign a patient refusal on their behalf.

f. **Public Assists**
   i. Persons who have requested public assistance shall have their names documented and sign the 'HIPAA Release for Transfer of Care to Another Agency (NO TRANSPORT)' signature box.

g. **Authorized Representative Refusal**
   i. Patients who are unable or ineligible to sign on their behalf (i.e. minors with parent present, incapacitated patients with Medical POA present) will require an 'Authorized Representative' to sign the 'Authorized Representative Refusal' box.

h. **Transportation of Incarcerated Person**
   i. If you are transporting a patient that is incarcerated in jail, prison, or any form of being detained by law enforcement, you are required to document the full name of the law enforcement officer accompanying the patient and have them sign the 'Law Enforcement Officer' signature box.

i. **Receiving Facility / Agency Signature**
   i. Anytime a patient is turned over to another agency or to a facility, the receiving provider signature must be obtained in this location.

VIII. ***Examples of Findings Necessary and Documented.***

NOTE: this list does not cover all possible documentation requirements. Other findings can and should be listed in the narrative of the patient care report. The list that follows are findings or non-findings that should be included as part of comprehensive and accurate documentation.

Abdominal pain	• Accompanied by other signs or symptoms • Associated symptoms include nausea, vomiting, fainting. • Associated signs include tender or pulsatile mass, distention, rigidity, rebound tenderness on exam, guarding. • List area that the patient is having the abdominal pain LLQ, LUQ, RUQ, RLQ. • Document how the patient presents (what position are they found)
Abnormal cardiac rhythm/cardiac dysrhythmia	• *Symptomatic or potentially life-threatening arrhythmia* • List symptoms to include: o Did patient have or are they experiencing syncope or near syncope o chest pain (scale of 1-10) o Dyspnea. • Signs required include severe bradycardia or tachycardia (rate < 60 or > 120) • Signs of congestive heart failure. Examples include o junctional and ventricular rhythms, o non-sinus tachycardia o PVCs > 6/min o bi- and trigemini o ventricular tachyarrhythmia o PEA o asystole. o Any other abnormal EKG • ACID or AED has fired • Patients are expected to have conditions that require monitoring during and after transportation.

Abnormal skin signs	• Includes diaphoresis, cyanosis, delayed capillary refill, diminished skin turgor, mottled skin. • Presence of other emergency conditions • Documentation needed as well: o Temperature of patient (if elevated write Elevated) o Cardiac Monitor reading o PO2 reading (must say hypoxic not low or use of numbers in narrative) Glucose reading (must state if normal, Hypoglycemic or Hyperglycemic. No use of numbers)
Advanced airway management.	Ventilator dependent, Apnea monitor intubation was needed. Was deep suctioning required
Alcohol or drug intoxication	• Severe intoxication, is there any slurred speech • Is the patient able or Unable to care for self. • Unable to ambulate or sit up, unsteady gate. • Altered level of consciousness. Is patient combative, did you have to keep stimulating the patient in order to maintain mentation. • Was airway at risk? (Signs of Vomiting, Snoring Respirations, Etc.) • D-Stick reading and if hypo or hyper. • Nausea / vomiting • Cardiac monitor reading • Can the patient sit on their own or did they need to be placed in lateral position? • Does patient need to be lying flat due to possible fall risk • Pharmacological intervention such as D-50 Mag. Etc. • Was cardiac monitoring needed? • Decreased level of consciousness resulting or potentially resulting in airway compromise.
Allergic reaction	• Potentially life-threatening manifestations, list them DIB, Swelling Etc, • Does patient have hives and if so where, if not you still must document if patient has or does not have • Itching • Redness • erythema • Includes rapidly progressive symptoms or slow progressing, prior history of anaphylaxis, wheezing, oral/facial/laryngeal edema. Note rashes, if any and their location on the patient

Altered level of consciousness	• Neurologic dysfunction in addition to any baseline abnormality • Acute condition with Glasgow Coma Scale <15 or transient symptoms of dizziness associated with neurologic or cardiovascular symptoms and/or signs or abnormal vital signs • If patient has a GCS of less than 15 you must document your findings and not just use "pt has GCS of 13" you must write pt is altered if that was your findings. • Document signs including any facial drooping, loss of vision without ophthalmologic explanation, aphasia, dysphasia, difficulty swallowing, numbness, tingling extremity, stupor, delirium, confusion, hallucinations, paralysis, paresis (focal weakness), abnormal movements, vertigo, unsteady gait/balance • Hyper or hypoglycemia • What is the cardiac monitor showing • Transient unconscious episode or found unconscious • Acute episode or exacerbation.
Animal bites/sting/ environmental	• Potentially life- or limb- threatening • Symptoms of specific envenomation, significant face, neck, trunk and extremity involvement. • Special handling and/or monitoring required such as EKG Airway etc. • Presence of other emergency conditions
Back pain (Non-traumatic)	• Suspect cardiac or vascular etiology. • Sudden onset must have Cardiac Monitor readings • Severe non-traumatic pain suggestive of cardiac or vascular origin or requiring special positioning only available by ambulance. • 7–10 on 10-point severity scale. • Neurologic symptoms and/or signs: o absent leg pulses or decreased pulses o pulsatile abdominal mass o Concurrent chest or abdominal pain. o Severe tearing feeling o Other emergency conditions o Also see Neurological distress list o Patient receiving pharmacological intervention

Blood glucose	Abnormal is any reading <80 or >250 **with symptoms.** Example. I feel weak, my head hurts, I feel dizzy. • Glucose reading (must state if normal, hypoglycemic or Hyperglycemic. No use of numbers) • Does patient have signs include altered mental status (altered beyond baseline function), • Is patient vomiting • significant volume contraction, • Is there significant cardiac dysfunction. • Documentation of cardiac output and cardiac monitor readings. • Includes diaphoresis, cyanosis, delayed capillary refill, diminished skin turgor, mottled skin. • Presence of other emergency conditions • Documentation needed as well: o Temperature of patient (if elevated write Elevated) o Cardiac Monitor reading o PO2 reading (must say hypoxic not low or use of numbers in narrative)
Burns	• Partial thickness burns > 10% total body surface area (TBSA); involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns electrical chemical inhalation burns with preexisting medical disorders burns and trauma

<u>Cardiac Symptoms other than chest pain</u>.	• Palpitations, skipped beats • Atypical pain or other symptoms, Persistent nausea and vomiting • Weakness (list how the patient feels weak, how long and tilt test) • Hiccups • Pleuritic pain, feeling of impending doom, and other emergency conditions • List any signs required include severe bradycardia or tachycardia (rate < 60 or > 100 or above 120) • Signs of congestive heart failure. Examples include junctional and ventricular rhythms, non-sinus tachycardia, PVCs > 6/min, bi- and trigemini, ventricular tachyarrhythmia, Any other abnormal EKG. List all abnormal EKG findings. Patients are expected to have conditions that require monitoring during and after transportation.
<u>Chest pain (non-traumatic)</u>	• Cardiac origin suspected. • Obvious non-emergent cause not identified • Pain Scale of 1-10 • Time of Onset • Pain characterized as o Severe o Tight o dull or crushing o substernal o epigastric o left-sided chest pain. • Document if pain is associated with o pain of the jaw o left arm o neck, back o GI symptoms (such as nausea, vomiting) o Arrhythmias o Palpitations o difficulty breathing o pallor o diaphoresis o alteration of consciousness. • Atypical pain accompanied by o nausea and vomiting o severe weakness o feeling of impending doom o abnormal vital signs.

	• Cardiac Monitor readings (12 lead on all chest pain patients) Medical treatment performed and what the patient response was to treatment.
Choking episode	• Respiratory or neurologic impairment • Noted Stridor
Cold exposure	• Potentially life- or limb- threatening • Findings include temperature < 95º F, signs of deep frost bite or presence of other emergency conditions.
Convulsions/seizures	• Active seizing or immediate post-seizure • Is patient at risk of repeated seizure and requires medical monitoring/observation. • Conditions include new onset or untreated seizures or history of significant change in baseline control of seizure activity. • Findings include ongoing seizure activity, post-ictal neurologic dysfunction. • Is this new seizure activity or different type of seizure? • Is patient compliant with medications
Dehydration (Severe)	• Does patient have or had any N/V • Does patient have or had Diarrhea • Does patient have or had any severe and or incapacitating problems resulting in severe side effects of dehydration. • What is the patient skin and temp? • Diaphoresis, cyanosis, delayed capillary refill, diminished skin turgor, mottled skin. • Presence of other emergency conditions • Documentation needed as well: o Temperature of patient (if elevated write Elevated) o Cardiac Monitor reading o PO2 reading
Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations.

Fever	• Significantly high fever (if the patient has a fever write FEVER) List if the patient has attempted to treat the fever and what was the response to the treatment. Was it Unresponsive to pharmacologic intervention or fever with associated symptoms • Temperature after pharmacologic intervention. This can be if the patient has attempted to self-treat. • Associated neurologic or cardiovascular symptoms/signs, other abnormal vital signs • You must list any other complaints that the patient may have such as o Headache o Stiff neck o Neurological changes
Gastrointestinal distress	• Accompanied by other signs or symptoms Severe nausea and vomiting or severe, incapacitating diarrhea with evidence of volume depletion, abnormal vital signs or neurologic dysfunction and what type
Hazardous substance exposure	• Was the nature of the exposure such that potential injury is likely • Toxic fume or liquid exposure via inhalation o Absorption o Oral o Radiation o Inhalation. • Noted rash • PO2 reading • Unresponsive or altered level of responsiveness
Headache Non-traumatic	Associated neurologic signs and/or symptoms or abnormal vital signs • Document if any past HX of HTN • List stroke scale and prescreen performed • Noted weakness • Any new onset of shaking, vision problem memory problems Document signs including any facial drooping, loss of vision without ophthalmologic explanation, aphasia, dysphasia, difficulty swallowing, numbness,

	tingling extremity, stupor, delirium, confusion, hallucinations, paralysis, paresis (focal weakness), abnormal movements, vertigo, unsteady gait/balance
Heat exposure	• Any signs of Potentially life-threatening condition • Cardiac monitor assessment findings • Pulses (is patient experiencing tachycardia) • Document any findings to include hot and dry skin o core temperature >105º, neurologic dysfunction, muscle cramps o profuse sweating, fatigue, diminished skin turgor, mottled skin.
Hip Fractures (Recent, Suspected)	A description of the patient's medical condition should indicate: The patient has a hip fracture that has not been surgically corrected, resulting in the presence of a hip pseudo arthrosis. Pseudo arthrosis is the formation of a false joint caused by the failure of the bones to fuse. This most commonly occurs when the bones do not heal properly after a fracture. If the patient has a possible hip fracture, the PCR should include: The paramedic's description of the patient's condition at the time of the transfer (e.g., "patient reportedly fell out of bed today and onto his right hip"). Patient complaining of severe hip pain and could not walk. Bruising and swelling were evident at the site. And/or, the right leg was shortened and turned in.

Hemorrhage	• Potentially life threatening. (can you estimate the amount) • Ongoing or recent surgical bleeding with potential for immediate re-bleeding. • Cardiac monitor readings • Indicate the cardiac output in the report such as Normotensive, hypotensive, hypertensive. Includes controlled or uncontrolled bleeding with signs of shock or other emergency condition o Severe, fear of impending dome, Thirst, Vomiting /Nausea o Weak pluses, Lethargy, confusion or combative o bleeding., Hypotension (b/p below 100) o Abdominal cramping, Bradycardia /Tachycardia o Pale skin, cool skin or clammy skin o Delayed CRT (if found indicate the patient is in Unresponsive o Active vaginal, rectal bleeding hematemesis, hemoptysis, epistaxis, active post-surgical.
Infectious diseases requiring isolation procedures/public health risk	• Was the nature of the infection or the behavior of the patient that in which that failure to isolate poses significant risk of spread of a contagious disease. (MRSA) • Infections in this category are limited to those infections for which isolation is provided both before **and** after transportation.
Moved By Stretcher, Draw sheet	Providers must describe the condition that resulted in the patient being moved by stretcher (e.g., patient unconscious, possible hip fracture, terminal-debilitating cancer, severe hemorrhage, description of patient's limitation to require the transport, etc.).
Medical device failure	• Life- or limb-threatening malfunction • failure or complication • Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery device, O_2 supply malfunction, orthopedic device failure.
Near Drowning	• Was patient unresponsive at any time • List possible infections water • Was the water salt water or fresh water. (many pools are now salt water) • Salt water can cause pulmonary edema

	Did patient need airway monitoring.
Neurologic dysfunction Possible stroke or other issues ***Transient Ischemic Attack (TIA)***	Acute or unexplained neurologic dysfunction in addition to any baseline abnormality Document signs including: o facial drooping o loss of vision without ophthalmologic explanation o aphasia/dysphasia (slurred speech or unable to speak) o difficulty swallowing o numbness/tingling extremity o stupor/delirium/confusion/hallucinations o paralysis/paresis (focal weakness) o Abnormal movements/vertigo/unsteady gait/balance. • There should be a note in the documentation indicating whether the Transient Ischemic Attack (TIA) is recent (date of TIA). If the patient is post-TIA and it is written as part of the history, documentation should support rationale for the ambulance transport (coma, non-responsive, contractures and any descriptive information that will help determine medical necessity of the transport). Example: Patient was found supine on living room couch, and responded to verbal commands. Could only move left arm and leg upon command. Right arm and leg were flaccid. Patient also has facial drooping to the right side and appeared anxious and upset because her speech slurred.
Obesity	Morbid obesity (as a sole qualifying condition) must meet the regulatory definition of bed-confined to be covered. Medicare does not expect this to occur with persons whose Body Mass Index (BMI) is <80. Documentation should give the patient's height and weight if obesity is listed as the reason the patient needed transport by ambulance. Any special handling and/or equipment used or the use of extra personnel resources should also be documented.
Objective evidence of abnormal respiratory function	• Includes tachypnea, labored respiration, hypoxemia requiring oxygen administration. • Includes patients who require advanced airway management such as ventilator management with Vent or BVM, • apnea monitoring for possible intubation and deep airway suctioning. • Includes patients who require positioning for care not possible in other

	non-ambulance vehicles. (tri-podding) • Stridor, any abnormal lung sounds • Patient must require oxygen therapy and be so frail as to require assistance of medically trained personnel. • Documentation of medications and response to the medications
Oxygen Administered	• Vital signs should be included on the run sheets. The run sheet should also include the patient's respiratory rate and oxygen saturation. There should be information to describe why the patient requires oxygen (e.g., respiratory distress, respiratory arrest, shock, terminal debilitating lung cancer, etc.). • Example**:** Patient was placed on oxygen at 6 LPM via nasal cannula due to ashen appearance and shallow breathing. Normally patient is on 2 LPM by NC
Pain not otherwise specified in this table	• Pain is the reason for the transport, where is the pain and possible reasons. • Acute onset or bed confining. • Pain is severity of 7–10 on 10-point severity scale despite pharmacologic intervention. • Patient needs specialized handling to be moved, what is it and explain in detail. • Other emergency conditions are present or reasonably suspected, list all that you find and or looked for • Signs of other life- or limb-threatening conditions are present. • Associated cardiopulmonary, neurologic, or peripheral vascular signs and symptoms are present. Cardiac Monitor readings when appropriate.
Poisons ingested, injected, inhaled or absorbed, alcohol or drug intoxication	• Potentially life-threatening, note is airway is at risk • Requires cardiopulmonary and/or neurologic monitoring and support and/or urgent pharmacologic intervention. You must explain in the documentation. • Includes circumstances in which quantity and identity of agent known to be life threatening; Documentation must reflex what the possible substance is. • Instances in which quantity and identity of agent are not known but there are signs and symptoms of neurologic dysfunction o abnormal vital signs o Abnormal cardiopulmonary function. • Also, includes circumstances in which quantity and identity of agent are not known but life-threatening poisoning reasonably suspected. • Unable to care for self.

	• Unable to ambulate. • Altered level of consciousness. • Airway may or may not be at risk. • Blood glucose reading and if hypo or hyper. • Nausea / vomiting • Cardiac monitor reading • Can the patient sit on their own? • Does patient need to be lying flat due to possible fall risk Is there any slurred speech
Post—operative **Procedure complications**	• Major wound dehiscence, evisceration, or requires special handling for transport.
Pregnancy/childbirth	• Did the mother have prenatal care? • Any known complications with pregnancy? • Number of previous pregnancies. • Previous number of live births. • Number of contractions and time between them. • APGAR and score for childbirth. .

Psychiatric/behavioral	Disorientation, suicidal ideations, attempts and gestures, homicidal behavior, hallucinations, violent or disruptive behavior, drug withdrawal signs/symptoms, severe anxiety, acute episode or exacerbation of paranoia.
	
	• Is expressing active signs and/or symptoms of uncontrolled psychiatric condition or acute substance withdrawal.
	• Is a threat to self or others requiring restraint (chemical or physical) or monitoring and/or intervention of trained medical personnel during transport for patient and crew safety?
	• Is the patient a flight risk?
	• List if patient is a threat to self or others.
	• It is not enough to say the patient wants to die. You should add that the patient wants to commit suicide if they have made such statements
	• Includes disorientation
	  o suicidal ideations
	  o attempts and or gestures
	  o homicidal behavior
	  o hallucinations

	o violent or disruptive behavior o sign/symptoms or DTs o drug withdrawal signs/symptoms o severe anxiety o acute episode or exacerbation of paranoia • Was the transport required by state law/court order. List whom told you to transport. • It may not be enough just to put that the patient stated "I want to die" you will need to also write that the patient wants to commit suicide • Requires monitoring and/or intervention of trained medical personnel during transport for patient and crew safety • Example "Patient had to be restrained in a supine position with a Reeves stretcher and four additional straps due to violent uncontrollable thrashing of his arms and legs"
Respiratory distress/ arrest	Includes apnea or hypoventilation Did patient require ventilator assistance and airway management, Level of Respiratory distress, shortness of breath need for supplemental of oxygen. Use of accessory muscles, Level of distress? Skin color, nail bed color? Oxygen saturation level? Breath sounds, Lung sounds, PO2 and ETCO2 reading need to state if the patient is hypoxic • **Example**: Patient experienced severe Difficulty in Breathing and was very anxious and agitated. Skin was cool and dry with nail beds cyanotic. Oxygen sat. was 89%"
Sexual assault	Document if patient has or complains of significant external and/or internal injuries. Documentation must be very complete

Shock	• Level of consciousness described. • Use of Glasgow coma scale • What type of shock? • Signs and symptoms of the shock • Syncopal episode, post-ictal from a seizure, postural hypotension? • Witness? Example: Patient was alert and conversational and oriented to time, place, person and situation. "Patient was unresponsive to voice, and would only respond to a sternal rub by opening his eyes"
Special handling Enroute - isolation.	Special infectious disease precautions.
Special handling	• Backboard, splinting, or positioning for comfort or pain relief.
Trauma ***Major or Other trauma***	As defined by Field Triage Decision Scheme. Trauma with one of the following: • Glasgow <14 you must document the explanation that you are given the patient a GSC of 14 not just list the number • systolic BP<90 (write hypotension ; RR< 10or >29 • is there any all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; 2 or more long bone fractures; open or depressed skull fracture; paralysis; • Severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls >20'', 20'' deformity in vehicle or 12'' deformity of patient compartment, auto pedestrian/ bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle. • All major trauma patients must have documented a complete primary, secondary and rapid trauma assessment. Please list all injuries found in the narrative. • If not major trauma did patient need airway monitoring or maintenance Decreased LOC, bleeding into airway, trauma to head, face or neck

Trauma ***Major Bleeding***	Uncontrolled or significant bleeding. List all injuries found. Is patient in or showing shock signs and symptoms? **Example**: "Patient was bleeding from a gaping three inch laceration to upper left arm in biceps region. Blood was dark and oozing upon arrival with approx. blood loss of 100 cc on the floor. Controlled bleeding with multiple trauma dressing and direct pressure maintained during transport
Trauma ***Suspected fracture/dislocation requiring splinting or*** ***immobilization for transport***	Spinal, long bones, and joints including: • shoulder elbow, wrist, hip, knee, and ankle, • deformity of bone or joint • Upper or lower extremity • Angulation? • Loss of use • Distal pulses and sensation? • Skin color • Splinting that was used **Example: "**Patient had severe leg pain and was screaming loudly. Left leg was angulated at appx. 45 degrees at mid thigh. Large hematoma the size of a soccer ball mid thigh. Was unable to move leg below the injury site. Traction splint applied with significant pain relief**"**
Trauma *(Penetrating extremity injuries)*	Isolated with bleeding stopped and good PMS.

Trauma *(Suspected internal, head, chest, or abdominal Injuries).*	Signs of closed head injury or open head injury • Pneumothorax • Hemothorax • Abdominal bruising • Positive abdominal signs on exam, • Internal bleeding criteria Evisceration.
Weakness (General)	Generalized weakness is not a covered condition for ambulance transfers. Documentation should describe specific signs and symptoms that require an ambulance transfer.