

Standard Operating Procedure	PEORIA FIRE-MEDICAL DEPARTMENT
EMS DOCUMENTATION GUIDELINE	EMS
	400.21
	Rev. 09/28/2015
	Page 1 of 4

Procedure for EMS Documentation

The following is an explanation of the information in each section of the electronic patient care report. This guideline should be interpreted as the generally acceptable minimums for documentation. Every report will vary depending upon the patient presentation and treatment. Some of the areas of the report may not require completion, based upon your evaluation and treatment plan. Evaluation and treatment requirements are dictated by protocols or online Medical Direction.

1. Log On
 - a. First log onto the Image Trend program with your user name and password.
 - b. Enter the current engine or ladder and shift
 - c. Enter all crew members

2. New Incident – accept a new incident from list generated by CAD. This will populate the incident number, address of the incident and times.

Tabs Across the Top

1. Dispatch Info
 - a. CAD Data – information populated from CAD. Fill in any blanks encased in Red.
 - b. Personnel – this has been populated from crew members entered upon logging in, but members can be changed here if needed.
 - c. Response Disposition – mark appropriate response early into the call as your entry will dictate the amount of requirements.
 - d. Location Type – select appropriate location of the call.
 - e. Response Delay – this is ‘None’ in most cases but gives one the option to change if a delay in patient care is experienced.
 - f. Scene Delay – as above, ‘None’ is the default unless otherwise noted.

Standard Operating Procedure EMS DOCUMENTATION GUIDELINE	PEORIA FIRE-MEDICAL DEPARTMENT EMS 400.21 Rev. 09/28/2015 Page 2 of 4
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2. Patient Info/PMH

- a. Patient Info – patient name, date of birth, gender, weight. Enter patient address if different than CAD. The ‘Add New Patient’ tab at the bottom is used only if you are managing 2 patients on the program with the same incident number.
- b. Past Medical History – drop down box is provided, but if a condition is not listed, it can be freely typed in ‘Other medical History’.
- c. Patient Drug Allergies – add NKDA if applicable and save
- d. Patient Medications – add None if applicable and save
- e. Environmental/Food Allergies – only if applicable
- f. Designated Decision Maker – applicable if patient has a POA
- g. Advanced Directives – only if applicable

3. HPI / MOI

- a. Patient Condition – date & time of onset, chief complaint, trauma, etc. Fill in all that is applicable.
- b. Provider Impression – drop down box provided
- c. Cardiac Arrest – only when applicable
- d. Spinal Motion Restriction – applicable on trauma patients
- e. STEMI – complete if applicable
- f. Stroke – simple yes or no
- g. TBI – simple yes or no

4. AX / TX / Vitals

- a. Primary assessment, blood glucose, EKG, vital signs, secondary assessment (all areas will default to normal unless changed). These entries must be time stamped and saved.
- b. Personal Protective Equipment – only if applicable
- c. Prior Aid – only if applicable
- d. Intubation – drop down box to select reason for intubation

Standard Operating Procedure EMS DOCUMENTATION GUIDELINE	PEORIA FIRE-MEDICAL DEPARTMENT EMS 400.21 Rev. 09/28/2015 Page 3 of 4
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5. Narrative – free text area

6. Transport Info
 - a. Destination Information – fill in pertinent information
 - b. Transport Info – agency name and number
 - c. Destination Determination
 - d. Transport Mode from Scene – drop down box available
 - e. Barriers to Patient Care – will default to ‘None’ unless changed
 - f. Transfer to Patient Care – name of agency transferred to
 - g. Transport Delay – defaults to ‘None’ unless changed

7. Signatures
 - a. Author
 - b. Patient Refusal – additional information must be checked here before patient signs refusal
 - c. Receiving Agent Signature
 - d. Authorized Representative Signature
 - e. Peace Officer signature
 - f. Witness Signature
 - g. Controlled Substance Signature – used only when narcotic waste is applicable
 - h. Valuables – fill in only if applicable

8. CN – this information will pre-populate from other areas when entered or you may elect to enter patient information at the start from this field.

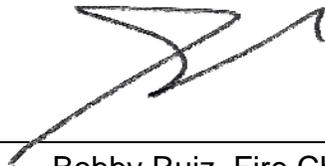
Power Buttons Along the Left - each power button must be time stamped and appropriate crew member selected for the procedure

1. GCS
2. Vitals
3. PQRST

Standard Operating Procedure	PEORIA FIRE-MEDICAL DEPARTMENT
EMS DOCUMENTATION GUIDELINE	EMS
	400.21
	Rev. 09/28/2015
	Page 4 of 4

4. IV
5. Cardiac – for use in cardiac arrest events
6. Meds
7. Procedure
8. EKG Import
9. Burn – will help calculate percentage of burn
10. Pediatric – Broselow tape and medications calculated

Approved:



Bobby Ruiz, Fire Chief

09/28/2015

Date