

**GEORGIA EMS PATIENT CARE  
REPORT 2000**

**PCR SCAN SHEET  
INSTRUCTION BOOK**

**PCRs are to be completed for each response made by a licensed vehicle (ambulance, first responder unit, neonatal transport unit, etc.) even if the patient is not transported, it was a false call, no patient found or call was cancelled. On round-trip calls (from point A to point B and back to point A) the local service may decide whether one or two reports will be completed for the response. If only one report is completed, the time of completion of the entire round trip is to be entered in the “In Service” time area. On calls that have two destinations, one of which is a brief stop (such as from a nursing home to the doctor’s office and then to the hospital) point A to point B to point C, only one report is necessary.**

## **FREQUENTLY ASKED QUESTIONS**

**Do I use a pen or a pencil to fill out the report?**

Use ink (blue or black only) to enter your information on page 2. You can use ink (blue or black) on page 1, the scan part. A gel medium ink pen may be best.. Do not use erasable ink on either copy.

**Do I “X” in my choices in the boxes?**

**NO!** You must blacken in the appropriate boxes. Try to stay within the box and fill it ascompletely as possible. Do not put an “x” or “check mark” in the box.

**If a section is “Not Applicable” should I mark “N/A” in that section?**

**NO!** Do not make any marks other than those called for by your patient information. “N/A” or a line through a section will give false data.

## **FREQUENTLY ASKED QUESTIONS-CONTINUED**

### **What if I make a mistake on the form?**

The local service should establish a policy on how to handle mistakes on the scan form. You may correct the top copy of page one with a white pigment marker (not “white out”) and then correct the copies of the scan sheet. The proper method on the page 2 narrative section is to mark a line through the error and write the word “error” above the mistake along with the date and your initials.

### **What if there is not enough space on page 2 in the “narrative” and “vital signs” sections to finish my documentation? What should I do?**

Use a supplemental report.

### **Will I always have to fill in every section?**

Fill in **ALL** that apply to your call. If there is an **N/A** in a field that is not applicable to your call please mark that. If there is **no N/A** and the field is not applicable to your call you should leave it blank.

### **There’s no Refusal area on either page. How do I do a refusal?**

The Refusal area on the old PCR was inadequate without extensive backup documentation. It is suggested that your service adopts one or have an attorney draw up a separate Refusal Form. **REMEMBER...All Refusals require additional documentation to be valid.**

# **FREQUENTLY ASKED QUESTIONS- CONTINUED**

## **Should I use “leading zeros”?**

**YES!** Use “leading zeros” as indicated in the PCR Instruction Booklet. Basically you can use a “leading zero” in any field that has a “zero” in it if the numbers you need to enter don’t fill up the space provided. **The exception to this might be in the “Miscellaneous” or “Study 1” or “Study 2” areas.**

## **I don’t understand some of the abbreviations on the Scan form.**

All abbreviations except the common or obvious ones are explained later in this document. If you have further questions contact your Regional EMS office.

## **Where do the signatures go?**

All signatures go on the Narrative page. Receiving nurse and M.D. on the left and Medics on the right.

# Additional Information

## Who gets which copies?

The top copy of Page 1, the scan page, goes either to your Regional EMS Office or whoever scans your reports for data. This original scan copy does not need a narrative page attachment. The top copy of Page 2, the narrative page, goes to your service for a record of the call along with the third page of the scan form and any attachments such as supplemental reports or ECG strips. A copy of the scan form, the narrative page, and copies of any attachments go to the hospital. Do not staple forms submitted to the state.

The State of Georgia code lists are available online at <https://gemsis.dhr.state.ga.us>. The lists will be periodically updated.

***If there is no code or the code is invalid for 'Agency', 'Date' or 'Unit Response Time' the report will be rejected and not included in the database because it cannot be properly counted as a single unique EMS run.***

# Row 1

AGENCY			UNIT			EMS VID				
0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9

<b>AGENCY:</b>	Enter the agency's state ID number and mark the corresponding boxes. This number should also be entered at the top of page 2.
<b>UNIT:</b>	Enter the EMS agency unit number. If only 1 or 2 digits use zero" as the first digits then mark the corresponding boxes.
<b>EMS VID:</b>	Enter the state assigned 5-digit vehicle number.

## Row 1-Continued

SERV REQ		VEH TYPE		LOCATION TYPE			
Scene		Grnd		Home		Res/Insti	
Unsched		Rotor		Farm		Educa Insti	
Sched		Fixed		Mine/Quarry		Hospital	
Standby		Other		Industry		Phys/Clinic	
Rendezv		None		Recreation		Other	
Other				Street/Hwy			
911 USED <input type="checkbox"/> Y <input type="checkbox"/> N							
RESPONSE MODE							
		Out	In			Out	In
RLS				Updgrade		WALK/DRIVE	
No RLS				Dwn Grade			

<b>SERVICE REQUEST:</b>	Fill in the appropriate box to describe <b>why</b> you were called.
<b>911:</b>	Fill in the appropriate box whether 911 was used or not.
<b>VEHICLE TYPE:</b>	Fill in the appropriate box for the type of vehicle you are using.
<b>LOCATION TYPE:</b>	Mark the appropriate box for the location you respond to.
<b>RESP. MODE:</b> (Response Mode)	Mark the appropriate box for <b>OUT</b> To <b>Scene</b> and <b>IN</b> From <b>Scene</b> <b>RLS=Red lights and siren. Walk-Drive</b> means a patient comes to your unit or station. For instance, if you are approached by a patient while you are at a restaurant or if someone comes to your station and requests care these would be in the "Walk-Drive" category.

## Row 1-Continued

COUNTY			RESPONSE NUMBER					
0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

**COUNTY:** Enter the county ID number where the call originated and mark the appropriate boxes.

**RESPONSE NUMBER:** Enter your agency assigned Response or Incident Number and mark the appropriate boxes. This number should also be entered at the top of page 2.

## Row 1-Continued

DRV/MEDIC						T	MEDIC 1					T	MEDIC 2				
0	0	0	0	0	0	F	0	0	0	0	0	F	0	0	0	0	0
1	1	1	1	1	1	E	1	1	1	1	1	E	1	1	1	1	1
2	2	2	2	2	2	I	2	2	2	2	2	I	2	2	2	2	2
3	3	3	3	3	3	C	3	3	3	3	3	C	3	3	3	3	3
4	4	4	4	4	4	P	4	4	4	4	4	P	4	4	4	4	4
5	5	5	5	5	5	O	5	5	5	5	5	O	5	5	5	5	5
6	6	6	6	6	6		6	6	6	6	6		6	6	6	6	6
7	7	7	7	7	7		7	7	7	7	7		7	7	7	7	7
8	8	8	8	8	8		8	8	8	8	8		8	8	8	8	8
9	9	9	9	9	9		9	9	9	9	9		9	9	9	9	9

<b>DRV/MEDIC:</b>	Enter the Driver/Medic's state ID number and mark the corresponding boxes.
<b>T: (TRAINING)</b>	Mark the level of certification for each crew member. "F"= First Responder, "E"= Basic EMT, "I"= EMT Intermediate( <b>ALL Ga. EMTs are this level.</b> ) "C"= Cardiac Tech "P"= Paramedic "O"= Other, RN, MD, Resp. Therapist, LPN, anything that does not fit. Document exact level in your narrative.
<b>MEDIC 1:</b>	Enter the primary care Medic's state ID number and mark the corresponding boxes. Mark "T" as appropriate.
<b>MEDIC 2:</b>	Enter the secondary care Medic's (if any) state number and mark the corresponding boxes. Mark "T" as appropriate.

## Row 2

JAN		CALL DATE			
FEB		D	D	Y	Y
MAR		0	0	0	0
APR		1	1	1	1
MAY		2	2	2	2
JUN		3	3	3	3
JUL			4	4	4
AUG			5	5	5
SEP			6	6	6
OCT			7	7	7
NOV			8	8	8
DEC			9	9	9

**MONTH:** Mark the appropriate box to designate the month to go with the CALL DATE area.

**CALL DATE:** Enter the numeric day of the call and the last two digits of the year and mark the corresponding boxes for each.

## Row 2-Continued

REPORT 911				DISP NOTIFIED				UNIT NOTIFIED			
0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2
	3	3	3		3	3	3		3	3	3
	4	4	4		4	4	4		4	4	4
	5	5	5		5	5	5		5	5	5
	6	6	6		6	6	6		6	6	6
	7	7	7		7	7	7		7	7	7
	8	8	8		8	8	8		8	8	8
	9	9	9		9	9	9		9	9	9

<b>REPORT 911:</b>	Enter the time 911 or your dispatch center received the call from the public and mark the corresponding boxes.
<b>DISP. NOTIFIED:</b>	Enter the time Dispatch was notified of the call and mark the corresponding boxes. Note this time may be the same as REPORT 911 time.
<b>UNIT NOTIFIED:</b>	Enter the time your unit was notified to respond to the call and mark the corresponding boxes.

**Use 24 hour clock for all times.**

## Row 2-Continued

UNIT RESPONSE				AT SCENE				AT PATIENT			
0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2
	3	3	3		3	3	3		3	3	3
	4	4	4		4	4	4		4	4	4
	5	5	5		5	5	5		5	5	5
	6	6	6		6	6	6		6	6	6
	7	7	7		7	7	7		7	7	7
	8	8	8		8	8	8		8	8	8
	9	9	9		9	9	9		9	9	9

**UNIT RESPONSE:** Enter the time your unit responded (actually begins movement) to the call and mark the corresponding boxes.

**AT SCENE:** Enter the time you arrived at the scene of the call and mark the corresponding boxes.

**AT PATIENT:** Enter the time you arrived at the patient's side and mark the corresponding boxes.

**Use 24 hour clock for all times.**

## Row 2-Continued

1ST SHCK/EXTRIC				ENROUTE				DESTINATION				IN SERVICE			
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	3	3	3		3	3	3		3	3	3		3	3	3
	4	4	4		4	4	4		4	4	4		4	4	4
E	5	5	5		5	5	5		5	5	5		5	5	5
	6	6	6		6	6	6		6	6	6		6	6	6
D	7	7	7		7	7	7		7	7	7		7	7	7
	8	8	8		8	8	8		8	8	8		8	8	8
	9	9	9		9	9	9		9	9	9		9	9	9

**1<sup>ST</sup> SHCK/EXTRIC:** Enter the time of the first defibrillation, if any, or when extrication was completed, if any, and mark the corresponding boxes. Please note the 1<sup>st</sup> Defib time may be before your arrival. ALSO mark the “E” if it is an extrication time or the “D” if it is a defibrillation time. Leave this area blank if it is not applicable.

**ENROUTE:** Enter the time you go enroute to your destination and mark the corresponding boxes.

**DESTINATION:** Enter the time you arrive at your destination and mark the corresponding boxes.

**IN SERVICE:** Enter the time you are available for your next call and mark the corresponding boxes.

**Use 24 hour clock for all times.**

## Row 3

GENDER		Jan	<input type="checkbox"/>	DOB			
MALE	<b>M</b>	Feb	<input type="checkbox"/>	D	D	Y	Y
FEMALE	<b>F</b>	Mar	<input type="checkbox"/>	0	0	0	0
Unkwn	<b>U</b>	Apr	<input type="checkbox"/>	1	1	1	1
RACE		May	<input type="checkbox"/>	2	2	2	2
Afr Am	<input type="checkbox"/>	Jun	<input type="checkbox"/>	3	3	3	3
Asian	<input type="checkbox"/>	Jul	<input type="checkbox"/>		4	4	4
Cauc	<input type="checkbox"/>	Aug	<input type="checkbox"/>	cent	5	5	5
Hispan	<input type="checkbox"/>	Sep	<input type="checkbox"/>	18	6	6	6
NatAm	<input type="checkbox"/>	Oct	<input type="checkbox"/>	19	7	7	7
Other	<input type="checkbox"/>	Nov	<input type="checkbox"/>	20	8	8	8
Unkn	<input type="checkbox"/>	Dec	<input type="checkbox"/>		9	9	9

<b>GENDER:</b>	Mark the appropriate box for your patient's gender. The "U" is for the patient who is so disfigured that the gender is unidentifiable.
<b>RACE:</b>	Mark the appropriate box for the patient's race.
The next date fields are for the patient's age. Mark the appropriate Month.	
<b>DAY:</b>	Enter the day of the month the patient was born and mark the corresponding boxes.
<b>CENT.:</b> (CENTURY)	This area is for the Century of the patient's birth. "18" is for 1800's, "19" is for the 1900's and of course "20" is for 2000's. Mark the right box.
<b>YEAR:</b>	Enter the last 2 digits of the patient's year of birth and mark the corresponding boxes.

## Row 3-Continued

PATIENT ID NUMBER									CLIN AREA	
									CARDIAC	<input type="checkbox"/>
0	0	0	0	0	0	0	0	0	MEDICAL	<input type="checkbox"/>
1	1	1	1	1	1	1	1	1	NEONATE	<input type="checkbox"/>
2	2	2	2	2	2	2	2	2	OB/GYN	<input type="checkbox"/>
3	3	3	3	3	3	3	3	3	PSYCH	<input type="checkbox"/>
4	4	4	4	4	4	4	4	4	TRAUMA	<input type="checkbox"/>
5	5	5	5	5	5	5	5	5	TRAUMA TRIAGE	
6	6	6	6	6	6	6	6	6	TRAUMA TRIAGE	
7	7	7	7	7	7	7	7	7	PHYSIO	<input type="checkbox"/>
8	8	8	8	8	8	8	8	8	ANAT	<input type="checkbox"/>
9	9	9	9	9	9	9	9	9	MECH	<input type="checkbox"/>

**PATIENT ID NUMBER-**This field is no longer in use. Agency may use this for it's own pt identification and use.

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**CLIN. AREA:** Mark the appropriate box to indicate the Clinical Area of the patient's primary problem. Mark only one.

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**TRAUMA TRIAGE:** Mark the appropriate box. See the explanation of the Trauma Triage Criteria on the next pages.

# Prehospital Trauma Triage

Prehospital management of the injured patient consists of assessment, extrication, initiation of resuscitation, and rapid transportation to the closest appropriate facility. Early identification of the injured patients that would most likely benefit from a trauma center is important. Prehospital Trauma Triage criteria provides for objective and consistent field identification of major trauma according to the guidelines by the American College of Surgeons Committee on Trauma (Resources for Optimal Care of the Injured Patient: 1999).

The use of consistent criteria with injured patients detects physiologic parameters, identifies specific anatomic injuries and considers the mechanism of forces that could lead to severe injury. The use of these criteria may guide destination decisions, protocols, and care at the receiving facility. Additionally, the use of consistent criteria builds trust relationships between prehospital and hospital providers since the same language is being used and strong professional relationships lead to better patient outcomes.

As patient reports are called in to medical control and /or receiving facilities, use the criteria as part of report. For example, "...2 patients from a motor vehicle crash – 1 that meets physiologic criteria and 1 that meets mechanism, high speed" is much more descriptive than "2 patients from a motor vehicle crash". Concise, consistent information allows the facility to be better prepared to receive the injured patient. 16

## TRAUMA TRIAGE CRITERIA

The 1999 prehospital triage criteria in the Resources for Optimal Care of the Injured Patient are:

Physiologic: These are the simplest to perform and provide an accurate basis for field triage.

- Systolic BP <90 (or no radial pulses)
- GCS <14 (although Region 3 has been using GCS < or = 10)
- Respiratory rate <10 or >29

Anatomic: Patients with normal vital signs at the scene may still have a serious or lethal injury.

- All penetrating injuries to head, neck, torso, and extremities proximal to the elbow and knee
- Flail chest
- Combination trauma with burns
- Two or more long bone fractures
- Pelvic fractures
- Open and depressed skull fracture
- Paralysis
- Amputation proximal to wrist and ankle
- Major burns

## TRAUMA TRIAGE CRITERIA

**Mechanism:** Indications that significant forces were applied to the body.

- Ejection from automobile
- Falls >20 feet (>15 in reality or any ‘significant’ fall)
- Rollover
- Death in same passenger compartment
- Extrication time >20 minutes
- Auto/Pedestrian with significant (>5 mph) impact or pedestrian thrown on
- run over
- Auto/Bicycle with significant (>5 mph) impact
- Motorcycle crash >20 mph or with separation of rider from bike
- High speed motor vehicle crash with initial speed >40 mph or major
- deformity of >20 inches or passenger compartment intrusion of >12 inches

Documentation of the criteria on the Patient Care Report is important because it allows tracking of specific injuries or mechanisms and can be utilized by training departments to identify training needs or opportunities for improvement. At a regional or state level, documentation of prehospital criteria will provide “hard data” as to the number and severity of major trauma patients. This may be useful for services and communities applying for grants and funding and is invaluable for epidemiological purposes.

# TRAUMA TRIAGE CRITERIA GUIDELINES

## 1. PHYSIOLOGIC CRITERIA:

- A. Systolic BP < 90 (no radial pulses)
- B. GCS ≤ 10
- C. RR < 10 or > 29 or respiratory compromise or impending compromise.

YES

- ◆ Transport to Trauma Center if available.
- ◆ Notify hospital of Physiologic Criteria as soon as possible.
- ◆ Mark Physiologic Criteria on PCR

## 2. ANATOMIC CRITERIA:

- A. Penetrating wound to the head, torso or long bones.
- B. Flail chest.
- C. Pelvic fracture.
- D. Two or more proximal long bone fractures.
- E. Paralysis (related to current event)
- F. Amputations (excluding fingers and toes)
- G. Combination trauma with burns
- H. Open and depressed skull fractures.

YES

- ◆ Transport to Trauma Center if available.
- ◆ Notify Hospital of Anatomic Criteria as soon as possible.
- ◆ Mark Anatomic Criteria on PCR.

## 3. MECHANISM CRITERIA:

- A. Ejection from automobile
- B. Death in same passenger compartment
- C. Extrication time > 20 minutes.
- D. Falls > 15 feet
- E. Rollover
- F. High speed MVC: initial speed > 40 mph or major auto deformity > 20 inches or intrusion into passenger compartment > 12 inches.
- G. Auto pedestrian/ auto bicycle injury with impact > 5 mph.
- H. Pedestrian thrown or run over.
- I. Motorcycle crash > 20 mph or with separation of rider from bike.

YES

- ◆ Transport to Trauma Center if available.
- ◆ Notify Hospital of Mechanism Criteria as soon as possible.
- ◆ Mark Mechanism Criteria on PCR.

## Row 3-Continued

**CAUSE OF INJURY:** Mark the appropriate boxes. More than one box can be marked. Listed below are the explanations for the abbreviations in this area.

CAUSE OF INJURY				
Acc Hit		Fire		Pedest
Aircraft		GSW-Acc		Radiation
Assault		GSW-aslt		Rape
Bicycle		GSW-self		Rx OD
Bite		Heat Ex		Smoke
Chem-Exp		Lghtning		Stabbing
Cold Ex		Machine		Stings
Drwning		Mcycle		Suffocat
Electric		MVC		Unknown
Fall		Off Road		Watercft
Fall Obj		Other		

<b>Acc. Hit</b> =Accidentally hit by something or someone.	<b>Fire</b> =Injured by fire	<b>Pedest</b> =Pedestrian struck by a vehicle.
<b>Aircraft</b> =Any type aircraft	<b>GSW-acc</b> =Accidental GSW	<b>Radiation</b> =Radiation exposure.
<b>Assault</b> =Physically assaulted by another.	<b>GSW-aslt</b> =GSW by assault.	<b>Rape</b> =Physical rape.
<b>Bicycle</b> =Injured on bicycle	<b>GSW-self</b> =Self inflicted GSW.	<b>Rx OD</b> =Drug overdose.
<b>Bite</b> =Human or animal	<b>Heat Ex</b> =Heat exposure	<b>Smoke</b> =Smoke inhalation
<b>Chem Ex</b> =Chemical exposure	<b>Lghtning</b> =Struck by lightning.	<b>Stabbing</b> =Stabbed
<b>Cold Exp.</b> =Cold exposure	<b>Machine</b> =Injured by machinery.	<b>Stings</b> =Bee, Wasp, Jelly Fish, etc.
<b>Drwning</b> =Drowning or near drowning.	<b>Mcycle</b> =Injured on a motorcycle.	<b>Suffocat</b> =Suffocation
<b>Electric</b> =Injured by electric shock.	<b>MVC</b> =Injured in a motor vehicle crash.	<b>Unknown</b> =Unknown cause of injury.
<b>Fall</b> =Injured in a fall.	<b>Off Road</b> =Injured riding an Off Road Vehicle.	<b>Watercft</b> =Injured on a boat or jet ski.
<b>Fall Obj.</b> =Injured by a falling object.	<b>Other</b> =Fits no other injury cause category.	

# Row 3-Continued

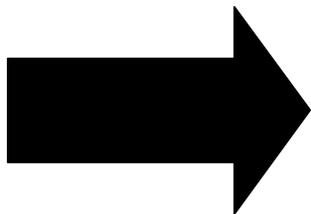
PROVIDER IMPRESSIONS/SIGNS AND SYMPTOMS							
Abd Pain		Chst Pain		Hyperten		Poisoning	
Air Obst		Crush Inj		Hypertherm		Psych	
Allergic		Diarrhea		Hypoglyc		Resp Arr	
Alt LOC		Dizziness		Hypotherm		Resp Dist	
App Death		Dysrhythm		Hypovolem		Seizures	
Back Pain		Ear Pain		Inhalation		Sex Aslt	
Bleeding		Eye Pain		Rash/Blister		Stroke	
Burn/Other		Fever		N/V		Syncope	
Burn/Therm		GI Bleed		OB Deliv		Unrespon	
Card Arr		Headache		Palpitation		Vag Bleed	
Choking		Hyperglyc		Paralysis		Weakness	

**PROVIDER IMPRESSIONS/  
SIGNS AND SYMPTOMS:**

Mark your impressions and/or the patient's Signs and Symptoms.

More than one box can be marked.

The explanations of the abbreviations in this area are to the right.



<b>ABD Pn=</b> Abdominal pain	<b>Chst Pain=Chest</b> Pain.	<b>Hyperten=HBP</b>	<b>Poisoning</b>
<b>Air Obst.=Airway</b> Obstruction	<b>Crush Inj.</b>	<b>Hypertherm=</b> Hyperthermia	<b>Psych</b>
<b>Allergic=Allergic</b> or Anaphylactic	<b>Diarrhea</b>	<b>Hypoglyc=Low</b> Blood Sugar.	<b>Resp Arr.=Resp</b> Arrest.
<b>Alt LOC=Altered</b> Level of Consciousness	<b>Dizziness</b>	<b>Hypotherm=</b> Hypothermia	<b>Resp Dist=</b> Respiratory distress.
<b>App Death</b>	<b>Dysrhythm=</b> Abnormal heart rhythm	<b>Hypovolem=</b> Hypovolemia	<b>Seizures</b>
<b>Back Pain</b>	<b>Ear Pain</b>	<b>Inhalation</b>	<b>Sex Aslt=Sexual</b> Assault
<b>Bleeding</b>	<b>Eye Pain</b>	<b>Rash/Blister</b>	<b>Stroke</b>
<b>Burn-Other</b>	<b>Fever</b>	<b>N/V=Nausea and</b> vomiting	<b>Syncope</b>
<b>Burn/Therm=</b> Thermal Burn	<b>GI Bleed</b>	<b>OB Deliv</b>	<b>Unrespon.</b>
<b>Card Arr</b>	<b>Headache</b>	<b>Palpitations</b>	<b>Vag. Bleed</b>
<b>Choking</b>	<b>Hyperglyc=High</b> Blood Sugar.	<b>Paralysis</b>	<b>Weakness</b>

## Row 4

SAFETY EQUIP		FACTORS		INJURY SITE & TYPE								
Not Used		Weather			A M P T	B U R N	D F X	G S W	L A C	P A I N	T U N C	S O F T
Shoulder		Road Cond										
Lap Only		Veh Prob		Head								
Lap/Shldr		Unsafe Scn		Face								
Child Seat		Language		Neck								
Airbag Dep		Ext> 20		Thorax								
Helmet		Haz Mat		Abdomen								
Eye Prot		Crowd		Back								
Float Dev		Other		Pelvis								
Prot Cloth		N/A		U Extrem								
Unkwn				L Extrem								

<b>SAFETY EQUIP:</b>	This is for safety equipment used by the patient. Mark the appropriate box. Use N/A if not applicable.
<b>FACTORS:</b>	This is for “Factors affecting the call.” Mark the appropriate boxes. Use N/A if not applicable.
<b>INJURY SITE &amp; TYPE</b>	Mark all appropriate boxes. NOTE: <b>DFX</b> Means: “Dislocation/Fracture.”

## Row 4-Continued

PULSE			RESP		SYS B/P			DIAS B/P		
0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2
	3	3	3	3	3	3	3		3	3
	4	4	4	4	<b>P A L P</b>	4	4		4	4
	5	5	5	5		5	5		5	5
	6	6	6	6		6	6		6	6
	7	7	7	7		7	7		7	7
	8	8	8	8		<input type="checkbox"/>	8	8		8
	9	9	9	9		9	9		9	9

<b>PULSE:</b>	Mark the appropriate boxes. <b>USE LEADING ZEROS.</b> For example for a pulse of 80 mark “0-8-0”. <b>PLEASE NOTE—THIS IS FOR THE ACTUAL <u>PALPATED</u> PULSE RATE, <u>NOT</u> THE READING ON THE PULSE OX.</b>
<b>RESP:</b>	Mark the appropriate boxes. <b>USE LEADING ZEROS IF NEEDED.</b>
<b>SYS B/P:</b>	Mark the appropriate boxes. <b>USE LEADING ZEROS IF NEEDED.</b> Mark <b>PALP</b> if appropriate.
<b>DIAS B/P:</b>	Mark the appropriate boxes. <b>USE LEADING ZEROS IF NEEDED.</b> If B/P is palpated leave blank.

## Row 4-Continued

PULSE OX			Resp Effort	GLASCOW COMA SCORE				TREATMENT AUTH. BY		
				EYE		MOTOR		Stand Ord		
0	0	0	N	Spontan	4	Obedient	6	On-line		
1	1	1	L	To Voice	3	Localize	5	On-scene		
	2	2	S	To Pain	2	Withdrwl	4	Written		
	3	3	A	None	1	Flexion	3			
	RA	4	Skin	VERBAL		Extension	2			
	5	5	Perf	Oriented	5	None	1	CLINICAL COURSE		
	6	6	N	Confused	4			Improv		
	O2	7	D	Inapprop	3	GCS Total		Maintain		
	8	8		Incompre	2			Deterior		
	9	9		None	1			Expired		

<b>PULSE OX:</b>	Mark the appropriate boxes. <b>USE LEADING ZEROS IF NEEDED.</b> Mark <b>R/A</b> if initial O2 saturation is on <b>Room Air</b> Mark <b>O2</b> if initial saturation is <b>with the patient on oxygen.</b>
<b>RESP EFFORT:</b>	“ <b>N</b> ”= Normal, “ <b>L</b> ”= Labored, “ <b>S</b> ”= Shallow, “ <b>A</b> ”= Absent. Mark the appropriate box.
<b>GCS EYE:</b>	Mark the appropriate box
<b>GCS VERBAL:</b>	Mark the appropriate box.
<b>GCS MOTOR:</b>	Mark the appropriate box. Add EYE, VERBAL and MOTOR For <b>GCS TOTAL.</b>
<b>SKIN PERF:</b>	Mark the appropriate box.
<b>TREAT AUTH BY:</b>	Mark the appropriate box. (If by Protocol mark Standing Order.)
<b>CLINICAL COURSE:</b>	What happened to the patient while in your care?

## Row 5

ENV. CAUSE				Neglect				INJURY INTENT			
Abuse	<input type="checkbox"/>							Unintent	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>							Intent-self	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Housing	<input type="checkbox"/>							Intent-other	<input type="checkbox"/>		<input type="checkbox"/>

**ENV. CAUSE:** This is for identifying an environmental cause that contributed to the patients present condition. You should make an objective observation and back it up in your narrative. Mark the appropriate box. Use N/A if not applicable.

**INJURY INTENT:** Choices are: **Intent-self**=Intentional by self, **Intent-oth**=Intentional by another person, **Unintent**=Unintentional by any means, **Unknown and N/A**. Mark the appropriate box.

RHYTHM															
Sinus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Narrow Complex Tach	<input type="checkbox"/>	<input type="checkbox"/>	Vtach	<input type="checkbox"/>	<input type="checkbox"/>	PEA	<input type="checkbox"/>	<input type="checkbox"/>	2nd Deg Type 2	<input type="checkbox"/>	<input type="checkbox"/>
S. Brady	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wide Complex Tach	<input type="checkbox"/>	<input type="checkbox"/>	Vfib	<input type="checkbox"/>	<input type="checkbox"/>	Atrial Fib	<input type="checkbox"/>	<input type="checkbox"/>	3rd Deg Block	<input type="checkbox"/>	<input type="checkbox"/>
S.Tach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PVC,PAC,PJC	<input type="checkbox"/>	<input type="checkbox"/>	Asystole	<input type="checkbox"/>	<input type="checkbox"/>	2nd Deg Type 1	<input type="checkbox"/>	<input type="checkbox"/>	Paced	<input type="checkbox"/>	<input type="checkbox"/>

**RHYTHM:** Mark **ONE** box to indicate the patient's **initial** rhythm. Mark **initial** rhythm in the "I" box.  
Mark **ONE** box to indicate the patient's rhythm when arriving at your destination. Mark **destination** rhythm in the "D" box.

## Row 6

CARE RENDERED		MEDIC			PROCEDURE	MEDIC			ATTEMPT			SUCCESS	
12 Lead EKG		D	1	2	AED	D	1	2	1	2	3	Y	N
Assist Delivery		D	1	2	Sync Cardvrt	D	1	2	1	2	3	Y	N
Auto Ventilation		D	1	2	Manual Defib	D	1	2	1	2	3	Y	N
Bag-Valve-Mask		D	1	2	Chest Decomp	D	1	2	1	2	3	Y	N
Bleed Control		D	1	2	Oral/Nas Airway	D	1	2	1	2	3	Y	N
Cardiac Monitor		D	1	2	Combitube	D	1	2	1	2	3	Y	N
CPR		D	1	2	ET/NT Intub	D	1	2	1	2	3	Y	N
C-Spine Mgmt		D	1	2	Intraosseous	D	1	2	1	2	3	Y	N
Glucose Monitor		D	1	2	IV #1	D	1	2	1	2	3	Y	N
MAST		D	1	2	IV #2	D	1	2	1	2	3	Y	N
Oxygen		D	1	2	IV #3	D	1	2	1	2	3	Y	N
Splints		D	1	2	Needle Cric	D	1	2	1	2	3	Y	N
Suction		D	1	2	Pacing	D	1	2	1	2	3	Y	N
Traction Splint		D	1	2	Vagal Manvr	D	1	2	1	2	3	Y	N

<b>CARE RENDERED:</b>	Mark all appropriate boxes under <b>“medic”</b> by <u>who</u> rendered the care. <b>“D”</b> = Drv/Medic, <b>“1”</b> = Medic 1, <b>“2”</b> = Medic 2.
<b>PROCEDURE:</b>	Mark all appropriate boxes under <b>“Medic”</b> .
<b>ATTEMPT:</b>	Mark the single appropriate number per procedure. Mark all that are applicable.
<b>SUCC:</b> <b>(SUCCESSFUL)</b>	Mark <b>“Y”</b> or <b>“N”</b> for successful or unsuccessful procedure.

## Row 6-Continued

MED 1		MED 2		MED 3		MED 4		MED 5		MED 6		MED 7	
0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9	9

<b>ROSC</b>			
Y	N	N/A	

**MED 1-MED 7:** Fill in the proper code for each med given and mark the corresponding boxes to match. Medication codes are listed in the education book. If you use a medication not included in the list use code “99” and explain in your narrative. **Use the proper area on the Narrative Page to list your medications by name, dose, route, time, and who gave the medication. PLEASE NOTE THERE ARE EXTRA BLANK CODES ON THE MEDICATION LIST FOR MEDS THAT MIGHT BE SPECIFIC TO YOUR EMS SERVICE. YOUR SERVICE SHOULD DEFINE THE CODE FOR THESE MEDS.**

**ROSC:** Return Of Spontaneous Circulation. Mark the “Y” box to indicate the return of a pulse, or the “N” box to indicate no return of a pulse in the cardiac arrest patient. **Mark N/A if not applicable.**

## Row 6-Continued

DEST CODE			MILES OUT			MILES IN			PRE-EXISTING
									Asthma
0	0	0	0	0	0	0	0	0	Diabetes
1	1	1	1	1	1	1	1	1	Tuberculosis
2	2	2	2	2	2	2	2	2	Emphysema
3	3	3	3	3	3	3	3	3	Chronic Renal
4	4	4	4	4	4	4	4	4	Cardiac
5	5	5	5	5	5	5	5	5	Hypertension
6	6	6	6	6	6	6	6	6	MR/Dev Delay
7	7	7	7	7	7	7	7	7	Premature Baby
8	8	8	8	8	8	8	8	8	Psychiatric
9	9	9	9	9	9	9	9	9	Seizure Disorder
									Tracheostomy
									Traumatic Brain Inj.

<b>DEST.:</b>	Enter the Destination/Hospital number here and mark the corresponding boxes.
<b>MILES OUT:</b>	Write in the appropriate number of miles <b>to the scene</b> and mark the corresponding boxes. <b>Use leading zeros.</b>
<b>MILES IN:</b>	Write in the appropriate number of miles <b>to your destination</b> and mark the corresponding boxes. <b>Use leading zeros.</b>
<b>PRE-EXISTING:</b>	Mark the appropriate box to indicate a pre-existing condition or pertinent medical history. More than one box can be marked. <b>NOTE: M/R Dev. Delay means Mental Retardation with developmental delay. You also need to list these and other history on the Narrative Page in the Past Medical Hx area.</b>

## Row 7

INCIDENT/PATIENT DISPOSITION										
Cancelled	<input type="checkbox"/>	Treated, Transported	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
No Patient Found	<input type="checkbox"/>	Treated, Xfer Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
False Call	<input type="checkbox"/>	Treated, POV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Refused All	<input type="checkbox"/>	Treated, Released	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Assist at Home	<input type="checkbox"/>	Treated, Refused Transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Dead at Scene	<input type="checkbox"/>	Transport Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
No Treat Required	<input type="checkbox"/>	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

**INCIDENT/PATIENT DISPOSITION:** Mark the appropriate box to indicate what happened on the incident and /or to the patient.

<b>Cancelled</b> =Cancelled prior to arrival or cancelled on the scene.	<b>Treated, Transported</b> =Treated and Transported by your unit.
<b>No Patient Found</b> =No patient on the scene.	<b>Treated, Xfer Care</b> =Treated and transfer care to another unit. For example you turn over your patient to a helicopter crew or an ALS unit.
<b>False Call</b> =Bogus call or false alarm	<b>Treated, POV</b> =Treated by you but transported by POV.
<b>Refused All</b> =Patient refuses all EMS treatment and transport.	<b>Treated, Released</b> =Treated and released, transport by EMS is not needed.
<b>Assist at home</b> =Assist a patient to bed or do home care, etc.	<b>Treated, Refused Transport</b> =Patient treated but refuses transport.
<b>Dead at scene</b>	<b>Transport Only</b> =No treatment given. Such as a return call to a skilled care facility.
<b>No Treatment Required</b> =Patient needs no treatment by EMS.	<b>N/A</b> =Use this category for a standby at a sports event or doing Rehab at a fire scene where you don't actually do patient care.

## Row 7-Continued

DEST CHOICE		MISCELLANEOUS						STUDY 1			STUDY 2		
Closest													
Pt/Fam Choice		0	0	0	0	0	0	0	0	0	0	0	0
Pt Phys Choice		1	1	1	1	1	1	1	1	1	1	1	1
Manag Care		2	2	2	2	2	2	2	2	2	2	2	2
Law Enforce		3	3	3	3	3	3	3	3	3	3	3	3
Protocol		4	4	4	4	4	4	4	4	4	4	4	4
Specialty		5	5	5	5	5	5	5	5	5	5	5	5
On-Line Med		6	6	6	6	6	6	6	6	6	6	6	6
Diversion		7	7	7	7	7	7	7	7	7	7	7	7
Trauma		8	8	8	8	8	8	8	8	8	8	8	8
		9	9	9	9	9	9	9	9	9	9	9	9

<p><b>DEST. CHOICE:</b> Mark the appropriate box to indicate <b>WHY</b> you transported the patient to a particular destination.</p>
<p><b>MISCELLANEOUS:</b> This box is to be used and defined by the individual service. Write in and mark as directed by your service.</p>
<p><b>STUDY 1:</b> This box is for special study data to be designated by the state, region or individual service.</p>
<p><b>STUDY 2:</b> This box is for special study data to be designated by the state, region or individual service.</p>

# Row 7-Continued

TECH ASSISTED		
Home Ventilators		<input type="checkbox"/>
CPAP		<input type="checkbox"/>
Cent IV Catheter		<input type="checkbox"/>
Pacemaker		<input type="checkbox"/>
Feeding Catheter		<input type="checkbox"/>
CSF Shunt		<input type="checkbox"/>
Colostomies		<input type="checkbox"/>

**THIS IS A SECTION SPECIFICALLY DESIGNED AND REQUESTED BY EMSC. IT'S PURPOSE IS TO COLLECT DATA ON CHILDREN WHO HAVE SPECIAL PROBLEMS AND ARE TAKEN CARE OF AT HOME.**

MARK ALL AREAS THAT APPLY

**Home Ventilators:** Mark this area for children on home ventilators.

**CPAP:** Mark this area if your pediatric patient is on Continuous Positive Air Pressure.

**Cent. IV Catheter:** Mark this area if your pediatric patient has a central line.

**Pacemaker:** Mark this area if your pediatric patient has a pacemaker.

**Feeding Catheter:** Mark this area if your pediatric patient has a feeding catheter.

**CSF Shunt:** Mark this area if your pediatric patient has a Cerebral Spinal Fluid Shunt.

**Colostomies:** Mark this area if your pediatric patient has a colostomy

## PCR Page 2 Overview

Page 2 of the PCR is for written information only. The top part of the form is designed to supply minimal patient information to the hospital and the individual EMS service. It is not designed to take the place of a billing form.

Just below the Patient Information area is a line for Chief Complaint. The Chief Complaint should be the primary problem voiced by the patient or by bystanders if the patient can't communicate. Your diagnosis of the patient's condition does **not** go on this line. For instance if the patient is in cardiac arrest the chief complaint from the bystanders or family might be "unconscious per bystanders" or if a qualified first responder is there prior to your arrival it might be "cardiac arrest per Engine 12 crew". Chief complaint for a motor vehicle crash will **not** be MVC but whatever complaint the patient expresses to you such as "My neck hurts." Or "Neck pain."

The next three lines are for Current Medications, Allergies and Past Medical History. If there are "None Known" mark that spot. Past Medical History also has a spot on the scan sheet.

In response to many requests for more narrative space the next 12 lines are for your narrative. This should, in conjunction with the next area, be more than enough narrative/vital sign information area on a large percentage of your patients.

The next 13 lines are for vital signs, orders, treatment, response to treatment and medications given. The first set of vital signs should match those on your scan sheet.

Receiving person, MD signature and crew signatures are at the bottom of the form. Crew signatures should include level of certification and state number.

The original copy of page two goes to the EMS service, the second copy goes to the hospital along with the second copy of the scan sheet. Your pharmacy copy should come from the third copy of the narrative page.

