General Order Number: 03-15	**Effective Date:** January 2010
Division: Communication and Information Management/Technology	
Chapter: Electronic Patient Care Report	
By Order of the Fire Chief: Marc S. Bashoor	**Revision Date:** N/A

POLICY

This General Order establishes the procedures for Fire/EMS Department personnel to complete electronic patient care reports (ePCR).

DEFINITIONS

Electronic Patient Care Report (ePCR) – A standardized patient care report form that has been adopted by the Prince George's County Fire/EMS Department for the intended use to document patient assessments and treatment modalities. The current ePCR for the Department is Triptix® from Intermedix Corporation.

EMS-Related Incident – incident types including, but not limited to:

- Ambulance and Medic Locals
- Rescue Locals
- Motor Vehicle Crashes
- Ambulance and Medic units assigned to the EMS Group during a working incident
- EMS units assigned to rehabilitation group during a working incident.

Unit Response – Any time a unit is assigned to an incident by Public Safety Communications and is listed as "responding" and/or "on the scene."

Tablet Computer – the Panasonic CF-19 tablet computer used for completing ePCR. Every EMS transport unit is assigned a tablet computer and an AC power adapter.

Tour of Duty – Career - the end of employee's scheduled shift

Tour of Duty – Volunteer – point in the current day when a volunteer member chooses to no longer participate in emergency operations.

PROCEDURES / RESPONSIBILITIES

1. General Guidelines

In accordance with State Law, COMAR 30.03.04.04, each emergency medical service (EMS) operational program is required to provide the Maryland Institute of Emergency Medical Services System (MIEMSS) a Maryland Ambulance Information System report for all EMS-related responses. To meet this State regulatory requirement, the Department utilizes an ePCR.

Confidentiality

The patient care data gathered while performing EMS duties is considered protected health information under the Health Insurance Portability and Accountability Act (HIPAA). Any hand written accounts of patient information must be destroyed once the ePCR is completed.

Public Disclosure

The Department's Information Management Division (IMD) is the only division authorized to provide reports to the public or other agencies. All requests for reports shall be referred to IMD.

Quality Assurance

All electronic patient care report data is subject to review as part of the Department's Quality Assurance Plan.

2. Indications

A patient care report must be completed by each unit that responds to an EMS-related incident. Reports can be completed either using the tablet computer or using the web-based version of Triptix.

Additionally, any patient contact requires the completion of individual patient care report.

All electronic patient care reports shall be completed prior to the end of the tour of duty.

Fire/RMS vs. ePCR Documentation

Electronic Patient Care Reports provide documentation of response information. Therefore, Records Management System (RMS) reports are not required when an ePCR is completed.

When the EMS unit responds on a non-EMS related call as part of a suppression unit, an ePCR is not required if the completed RMS report accounts for the personnel assigned to the EMS unit.

For fire incidents with an EMS component, (e.g. a civilian or firefighter injury) only the EMS units are responsible to complete an ePCR. All other suppression units are required to enter their reports into RMS.

3. Requirements

The ePCR system provides a number of data fields to accurately and completely document the incident, including, but not limited to, the following:

- Location of the incident
- Patient Identification Information
    - Full Name
    - Date of Birth

  - Social Security Number (if possible)
  - Home Address
  - Home Phone
- All available CAD data indicating dates and times
- Incident numbers in proper format: YR-DAY-INC# (e.g. 090230123)
- A complete narrative of events that occurred on the incident, including all patient assessments, treatments, and outcomes.
- Complete documentation of any patient refusal
- Receiving facility

Required fields must be completed to submit the official report. Refer to the Prince George's County Fire/EMS Department Triptix® Manual (Attachment # 5) for guidance in completing the ePCR.

The attached EMS Patient Information Form (Attachment #1) is intended to assist personnel with uniformly collecting and reporting all of this information.

Patient Transports

An ePCR shall be generated for each and every patient being transported by a Fire/EMS unit.

The ePCR is faxed to the receiving facility after completion and submission to Intermedix. The ePCR must be completed and provided to the receiving facility staff prior to returning to service. This is critical because the information is incorporated into the patient's medical record.

Prince George's County Fire/EMS Department bills an Emergency Transportation Fee for all patient transports. The HIPAA Billing Form tab on the Signatures page of the ePCR grants consent for Prince George's County, and its authorized agents, to bill a patient and their respective insurance providers. Providers must secure a signature, or suitable substitute, from all patients that are transported by the Prince Georges County Fire/EMS Department. Providers must also secure a signature from the Receiving Facility staff.

This signature form is a legal document that authorizes billing of government and third party insurance providers. Any false statements on this form can be interpreted as fraud and may carry criminal consequences.

Transfer of Care

Providers must document the transfer of patient care to the receiving facility in the narrative. This is accomplished by documenting the following:

- Patient Care Area (e.g. Bed #2)
- Name of the healthcare provider accepting patient care
- Time of transfer
- Securing a signature from the receiving facility staff

Patient Refusals

Any patient refusing transport shall have a patient assessment and vital signs performed and documented, unless the patient refuses the assessment as well.

Any patient refusing care must be informed of the following:

1. Limitation of a pre-hospital assessment.
2. Assessment findings.
3. Treatments rendered.
4. Anticipated complications or adverse effects.
5. Medical decision making capability.
6. Patient's right to seek medical attention at a later time by any means, including 911.

The ePCR shall document that all of the elements listed above were discussed. The patient must understand the risk of refusing medical care and acknowledge that understanding by signing the "Refusal of Care" Form on the Signatures page of the tablet computer. Units that do not possess a tablet computer will utilize the paper "Refusal of Care" form (Attachment #3). A bar code sticker will be placed on the original (top) copy of the "Refusal of Care" form and the bar code number documented on the Final page in the Other Documentation field in the ePCR. The original copy will be forwarded to IMD. The pink copy is the patient's copy and shall be provided to the patient or the patient's guardian, if minor.

Patients may elect to refuse treatment and/or transport to a hospital. Patients who refuse treatment or transport will be required to sign the "Refusal of Care" Form.

Advanced Airway Verification

An "Advanced Airway Verification" form (Attachment #2) must be completed when an ALS Provider performs any advanced airway maneuvers on a patient. The physician from the receiving hospital MUST sign the Advanced Airway Verification form and check off the manner in which the airway was verified. The Advanced Airway Verification form must be forwarded to the AEMS Office at the end of each tour of duty.

Controlled Substances

For ALS Providers, a "Controlled Substance" Form (Attachment #4) must be completed when documenting controlled substance waste disposal. This form will also be used to receive replacement narcotics at the hospital. A bar code sticker will be placed on the completed form and the bar code number documented on the Final page in the Narcotic/Hypnotic field in the ePCR. The completed form must be forwarded to the AEMS Office at the end of each tour of duty

5. Responsibilities

EMS Providers

Each EMS provider shall ensure that an ePCR is completed for each response, as outlined in this General Order. Failure to complete a report may be considered neglect or falsification of records by omission, and may result in disciplinary action.

Volunteer Chief/Career Station Supervisor

Each Volunteer Chief or Career Station Supervisor shall ensure 100% compliance on ePCR documentation for all subordinates.

The career supervisor or volunteer chief will be held accountable when a consistent pattern of non-compliance exists.

REFERENCES

The Code of Maryland Regulations (COMAR) 30:03:04:04

FORMS / ATTACHMENTS

Attachment #1 – EMS Patient Information Sheet

Attachment #2 – Advanced Airway Verification

Attachment #3 – Patient Refusal of Care Form

Attachment #4 – See General Order 05-18

Attachment #5 – Prince George's County Fire/EMS Department Triptix® Manual

Prince George's County Fire/EMS Department
EMS Patient Information Sheet

Inc Address: _____ Inc No.: ☐☐☐☐☐☐☐☐

PATIENT IDENTIFICATION & REQUIRED BILLING INFORMATION

Full Name: _____ Guardian: _____

DOB: DO NOT ESTIMATE ☐☐/☐☐/☐☐ (M M D D Y Y) Age: _____ ☐ Female ☐ Male **SSN:** ☐☐☐-☐☐-☐☐☐

Patient Address: **Street:** _____ **Apt#:** _____
City: _____ **State:** _____ **Zip:** _____
Phone: (_____)_____

PATIENT ASSESSMENT

Chief Complaint: _____

Initial Assessment					Immediate Interventions
Mental Status:	Alert	Verbal	Pain	Unresponsive	
Airway:	Patent		Obstructed/Non-patent		Suction OPA/NPA
Breathing:	Rate ## rpm	Depth	Quality	Sounds	O_2 ____ lpm by _____
Circulation:	Rate ### bpm	Rhythm	Color	Temp	CPR/AED Bleeding Control
Disability:	Right Arm P M S	Left Arm P M S	Right Leg P M S	Left Leg P M S	C-Spine

Vital Signs

Time	Resp Rate	Lung Snds	SpO_2	$ETCO_2$	Pulse	B/P	Glucose
:						/	
:						/	
:						/	

PATIENT HISTORY

Signs/Symptoms: _____
Onset: _____ **P**rov./Pall.: _____
Quality: _____ **R**adiation: _____
Severity: 1 2 3 4 5 6 7 8 9 10 **T**ime: _____

Allergies: _____

Medications: _____

Past Medical History: _____

Last Oral Intake: _____

Events leading to: _____

PROTOCOL EXECUTION & PATIENT TREATMENT

Time	Interventions
:	
:	
:	
:	

Time	Medications
:	
:	
:	
:	

1-800-222-1222 Poison Control • 1-877-840-4245 EMRC

SENSITIVE INFORMATION - THIS DOCUMENT SHALL BE DESTROYED ONCE THE INFORMATION IS TRANSFERRED TO THE ELECTRONIC PATIENT CARE REPORT

PRINCE GEORGE'S COUNTY, MARYLAND
FIRE/EMS DEPARTMENT

ADVANCED AIRWAY VERIFICATION

Incident #:	☐☐-☐☐☐-☐☐☐☐	**ePCR #:**	☐☐☐☐☐☐☐☐
Date:	☐☐/☐☐/☐☐☐☐	**Unit #:**	☐☐ ☐☐☐☐
Provider ID:	☐☐☐☐☐		

Airway Documentation (also to be documented on ePCR)			
ET Tube placement		**Capnography**	
Depth	☐☐ **cm at teeth**	**Starting $ETCO_2$**	☐☐ **mmHg**
		Ending $ETCO_2$	☐☐ **mmHg**

To Be Completed By Verifying Physician	
ET Tube Placement:	☐ **Tracheal (Adequate Depth)** ☐ **Tracheal (Right Mainstem)** ☐ **Esophagus** ☐ **Hypopharynx**
ET Tube placement verified by:	☐ **Visualization** ☐ **Auscultation** ☐ **Colorimetric Device** ☐ **Capnography**
Difficult Airway:	☐ **Yes** ☐ **No**
Intubated or Re-Intubated at Hospital:	☐ **Yes** ☐ **No**
Combitube® Properly Placed:	☐ **Yes** ☐ **No**
VERIFYING PHYSICIAN	
Printed Name	**Signature**

PRINCE GEORGE'S COUNTY, MARYLAND
FIRE/EMS DEPARTMENT

REFUSAL OF CARE FORM

Patient's Name: _____ **Date**: ☐☐/☐☐/☐☐☐☐

Incident Location: _____ **Inc #:** ☐☐-☐☐☐-☐☐☐☐

ACKNOWLEDGEMENT OF INFORMATION

I have been offered an evaluation, medical care and/or transportation to a medical facility; however I am refusing the services offered as checked below. I have been advised and understand the risks and consequences of refusing care/transport, including the fact that a delay in treatment and/or transport by means other than an ambulance could be hazardous to my health and, under certain circumstances include disability or death.

RELEASE FROM RESPONSIBLITY WHEN PATIENT REFUSES SERVICES

This is to certify that I, _____, am refusing the services offered by the
(Patient's Printed Name)
emergency medical services provider(s). I acknowledge that I have been informed of the risks involved and hereby release the emergency medical services provider(s), the physician consultant, and consulting hospital from any liability, claim, or cause of action that I may now or hereafter have in any way related to my decision to refuse medical care/transport.

I have read and understand the "Acknowledgement of Information" and "Release from Responsibility". I refuse the following services:

☐ Examination/Assessment ☐ Medications ☐ IV/IO ☐ Other_____
☐ Spinal Immobilization ☐ Care ☐ Transport ☐ **All Services**

Patient/Representative Signature: _____

Relationship (if not the patient) ☐ Parent ☐ Guardian

Disposition: ☐ Placed in care of self Placed in care/custody of: ☐ Parent ☐ Guardian
☐ Released to law enforcement ☐ Other_____
Agency: _____
Name/ID #:_____

Form Completed by: _____ **I.D. #** _____

If you change your mind or your condition changes, call 9-1-1 (in an emergency), go to an emergency department in your area, or call your private doctor (if appropriate).

Witness Information

Signature: _____ **Name:** _____
(Print)

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone #:** _____

Original: Prince George's County Fire/EMS Department Canary: Other Agency Pink: Patient

Rev (3/2009)

Prince Georges County Fire/Emergency Medical Services Department
Ambulance Signature Form

Patient Name:	Receiving Facility:
Transport Date: MM/DD/YYYY	Jurisdictional Incident Number: YY–DDD–INC#

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Prince George's County, Maryland for any services provided to me by the Prince George's County Fire/Emergency Medical Services (EMS) Department now or in the future. I understand that I am financially responsible for the services provided to me by Prince George's County, Maryland, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Prince George's County, Maryland any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Prince George's County, Maryland. I authorize Prince George's County, Maryland to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to Prince Georges County, Maryland and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by Prince Georges County, Maryland now or in the future. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: By signing below, I acknowledge that I have been made aware that I may obtain a copy of the Prince George's County Fire/Emergency Medical Services Department's Notice of Privacy Practices using the website (http://www.co.pg.md.us/Government/PublicSafety/Fire-EMS/index.asp) or by contacting Information Management at (301) 883-7183.

ONE of the following three Signature Sections must be completed for each transport

SECTION I – PATIENT SIGNATURE

This Section is for **emergencies or non-emergencies**. The patient must sign here unless the patient is physically or mentally incapable of signing.

X _____
Patient Signature or Mark Date

If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness. This can be an ambulance crew member.

X _____
Witness Signature Date

_____
Witness Printed Name

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

This section is for **emergencies or non-emergencies**. Complete this section **only** if patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing:

_____

Authorized representatives include **only** the following individuals (check one):

☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
☐ Relative or other person who receives government benefits on behalf of patient
☐ Relative or other person who arranges treatment or handles the patient's affairs
☐ Representative of an agency or institution that furnished care, services or assistance to the patient.

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

X _____ _____
Representative Signature Date Printed Name of Representative

SECTION III - EMERGENCIES ONLY - AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURES

Complete this section **only** if **all** of the following are true: (1) the call is an **emergency** ambulance transport, (2) the pt was physically or mentally incapable of signing, **and** (3) no authorized representative (Section II) was available or willing to sign on behalf of the pt at time of service.

A. Ambulance Crew Member Statement (*must* be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. My signature is not an acceptance of financial responsibility for the services rendered.

Reason pt incapable of signing: _____

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X _____ _____
Signature of Crewmember Date Printed Name of Crewmember

B. Receiving Facility Representative Signature

The patient named on this form was received by this facility at the date and time indicated above. ***This signature is not an acceptance of financial responsibility for the services rendered to this patient.***

X _____ _____
Signature of Receiving Facility Representative Date Printed Name and Title of Receiving Facility Representative

C. Secondary Documentation (required only if signature in Section B above cannot be obtained)

If no facility representative signature is obtained, the ambulance crew should attempt to obtain one or more of the following forms of signed documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information to the ambulance service is expressly permitted by §164.506(c) of HIPAA.

☐ Patient Care Report (signed by representative of facility) ☐ Facility Face Sheet/Admissions Record
☐ Patient Medical Record ☐ Hospital Log or Other Similar Facility Record

Hospital Fax/Phone Numbers

Hospital	EMAIS Code	Emergency Department Phone Number	Emergency Department Fax Number
Andrew's Air Force Base	354	240-857-2333	240-857-8890
Anne Arundel Medical Center	221	443-481-6810	443-481-5575
Bowie Health Center	353	301-809-2024	301-809-2045
Calvert Memorial Hospital	266	410-535-8344	410-535-8335
Children's National Medical/ Trauma Center	317/717	202-476-5203	202-476-3311
Civista Medical Center	291	301-609-4160	301-934-4139
Doctor's Community Hospital	329	301-552-8665	301-552-8668
Fort Washington Hospital	522	301-203-2250	301-203-2270
George Washington University Hospital	335	202-715-4911	202-715-4909
Georgetown University Hospital	737	202-444-2000	202-444-2952
Greater Southeast Hospital	316	202-574-6541	202-574-7061
Holy Cross Hospital	244	301-754-7000	301-754-7504
Howard County General Hospital	223	410-740-7777	410-740-7551
INOVA Fairfax Hospital	230	703-504-3065	703-504-3076
Laurel Regional Hospital	352	301-497-7954	301-497-8741
Medstar Trauma Center	728	202-877-7210	202-877-3996
Prince George's Hospital/Trauma Center	232/632	301-618-3752	301-618-3962
Providence Hospital	288	202-269-7001	202-269-7990
R.Adams Cowley Shock Trauma Center	634	410-328-8869	410-328-8858
Southern Maryland Hospital Center	343	301-877-4505	301-877-4668
Suburban Hospital Trauma Center	649	301-896-3880	301-896-1358
Union Memorial Hospital - Curtis Hand Center	714	410-554-2626	410-554-2960
Washington Adventist Hospital	328	301-891-5070	301-891-6346
Washington DC Veterans Affairs Medical Cen	376	202-745-8360	202-745-8356
Washington Hospital Center	327	202-877-5515	202-877-7516

EOC Directive #63
October 30, 2007
Attachment #3

PRINCE GEORGE'S COUNTY, MARYLAND
FIRE/EMS DEPARTMENT

PGFD

Request for Narcotic Replacement and Verification of Narcotic Waste

Date: _____ Unit: _____ Incident #_____

Patient's Name: _____ Hospital Destination: _____

Drug Wasted (If Any): ☐ **Morphine Sulfate** ☐ **Valium**

Amount Wasted: _____

Witnessed by: _____
(Signature)

_____
(Print Name)

Date: _____ Unit: _____ Incident #_____

Patient's Name: _____ Medical Record #_____

Drug Requested (If Any): ☐ **Morphine Sulfate (10mg/ml)** **Qty.**_____

☐ **Valium (10mg/2ml)** **Qty.**_____

_____ _____
(Paramedic) **(Pharmacy Representative)**

Rev (10/2007)

Prince George's County

Fire/EMS Department

TripTix Manual

To be used as a supplement to the Intermedix® TripTix Mobile User's Guide

September 2009

General Information

For assistance or information regarding Triptix and/or Intermedix, contact the EMS Office or an EMS Supervisor. Providers can also submit emails for comments or concerns to: **pgfdtriptix@co.pg.md.us**

Detailed information on the Triptix application can be found in the *Triptix Mobile User's Guide* on the Documents Menu bar selection.

EMS providers will be given a PIN number to access the TripTix Program on the Toughbook tablets. Access to the Intermedix web version of Triptix is accomplished by use of a Username and Password. Once the provider is able to login to the Intermedix website, he or she may change their PIN number. **This can only be performed on the website**. It is important to understand changes may not occur immediately, therefore the provider will continue using their old PIN. The website address is: **https://emr.intermedix.org**.

Prince George's County providers will only use the Panasonic CF-19 Toughbook Tablet and the Intermedix website for entering reports into the Triptix application. Any information in the training manual that may refer to the Motion Tablet PC will not pertain to Prince George's County providers.

It is each provider's responsibility to maintain the Toughbook Tablet by ensuring each tablet is turned on and off daily for system and departmental upgrades, to keep the battery charged above 75%, and to disinfect and clean the unit.

User Settings Page

Crew # 1 will be the primary caregiver
Crew #2 will be the driver
Crew #3, #4, and #5 will be additional crew members

Unfinished Runs

Refer to the Department's General Order 03-15 Electronic Patient Care Report (ePCR) regarding completion of ePCRs.

Menu bar Options

Power
Stand By and Shutdown options will either exit the Triptix application and shutdown the Toughbook tablet or place the computer in a hibernation mode.

Documents
The Emergency Response Guide, Maryland Protocols, WMD Supplement, and Trauma Decision Tree are included. These should be used as references when needed.

Tools

Screen calibration allows the provider to re-calibrate the digitizer pen to the screen if the pen does not perform as expected.

Websites
The MIEMSS CHATS webpage is included for hospital diversion status.

Toolbar Options

Error Check
Selecting the button will run an error report on any page. This should be performed throughout the document.

Notepad
It is important for each provider to understand that any notes written on the notepad become a part of the permanent record unless they are erased by the provider prior to submitting the ePCR.

SSN Lookup/Driver's License Lookup
You must confirm with each patient their current address. This feature may not reflect recent changes of address.

Monitors
The current setup of the LIFEPAK 12 does not support Bluetooth wireless transmissions.

Fax Draft
Selecting the button will allow the provider to fax a Draft copy of the ePCR to a receiving facility or other fax number. Providers should refrain from using this option.

Transfer/Receive Run
Selecting the button allows the provider to transfer or receive an ePCR from another Toughbook tablet.

CAD
Selecting the button will show all the incidents for the last 24 hours for the unit that was selected in the login screen. Selecting an incident will import the incident number, address, and date of incident into the ePCR. Providers need to enter the city, zip code, and all the times into the ePCR.

Logout
Selecting the button logs out the current provider and returns the screen to the login page.

Entering a Run Report

Deleting Reports
Reports which require deletion can only be performed by a system administrator. To delete a report, send an email including the date, incident number, patient name (if applicable) and the reason why the report must be deleted to: pgfdtriptix@co.pg.md.us

Text Box Color Coding

Every field with a red border is mandatory and must be completed. Providers must make every attempt to obtain this information. **This manual will also indicate which sections are required by the Department.** N/A shall only be used when the information is not available.

Boxes with a green border indicate the active text box on the screen.

Boxes with dark yellow border are recommended information. Leaving these boxes blank will trigger a warning message during the system review before submission, but will not prevent the report from being submitted.

Incident Page

Response Type

911 Call	Any call dispatched via PSC **within Prince George's County.**
Emergency Transfer	Inter-facility transfers (hospital to hospital)
Mutual Aid	Any call dispatched via PSC to a location **outside of Prince George's County.**
Non-Emergency Transfer	Non-emergency service transfers that are not dispatched. (i.e. hospital to residence, residence to nursing home, etc.)
Standby	Sporting events, special events, standby for Law enforcement, etc.
Unknown	**Ignore this selection. Do not use.**

Patient Disposition

Call Cancelled	Anytime after initial dispatch. Use when placed in service prior to arrival or placed in service on the scene with no patient contact.
DNR, no transport	**Ignore this selection. Do not use.**
DNR, transport	**Ignore this selection. Do not use.**
Dead on scene	Patients that have received no EMS medical interventions
False Al/Unfounded/No pt	Incident or patient was not found
No treatment, no transport	Unit arrived on the scene, made patient contact and provided no treatment and no transport.
Transport, no treatment	The patient requested transport to a hospital but refused **all** treatments. Non-emergency transfers that only require transport of a patient.
Treatment, no transport	Unit arrived on scene and provided treatment/assessment but did not transport. Use in cases where other unit on scene transported. Medic Units that assess a patient and send BLS will

	use this disposition. Also patients that are flown by Medevac will use this disposition.
Treatment, transport refused	EMS provided treatment (bandages, glucose, oxygen, etc) but the patient did not wish transport. A patient refusal of transport must be obtained.
Unknown	**Ignore this selection. Do not use.**

Dispatched As/Found To Be
These may be the same or different. The provider must select the appropriate or as close as possible to each choice in both boxes.

Dispatch ID Number
The only acceptable format for entering the incident number will be XXXXXXXXX (i.e. 090120017) .

Map Page
Not required

Responding Unit
The unit which the author of the ePCR responded in.

Response Mode to Scene

N/A	**Ignore this selection. Do not use.**
Init L&S, Downgrade	Initially lights and sirens were used while responding to the incident but the unit was downgraded to continue to the scene non-emergency (without lights and siren)..
Init No L&S, Upgrade	Initially no lights and sirens were used while responding to the incident but the unit was upgraded to continue to the scene in an emergency mode (with lights and sirens).
Lights & Sirens	Emergency response to the scene
No Lights & Sirens	Routine responses to standby, special events, etc.

Mutual Aid Reason

Additional Staffing	Reporting unit responded to assist with lifting, CPR, patient care
Disaster Response	Self-explanatory
Other	
Rendezvous for equipment failure	Reporting unit responded to provide oxygen, ECG monitor, cot, etc.
Rendezvous for level of care	Reporting unit responded to upgrade to ALS
Rendezvous for patient pick up	Reporting unit responded to pick up the patient and transport for the out-of-county unit due to multiple patients, patient choice, hospital

	destination, etc.
Unknown	**Ignore this selection. Do not use.**

Response Delay
Choose the correct selection for anything that delays response time to the scene.

Crowd	Unit response to the scene was delayed because of crowds or mass gathering in which pedestrians and pedestrian traffic delayed arrival.
Directions	Unit response to the scene was delayed because directions provided to the unit were not correct.
Distance	Unit response to the scene was delayed because the responding unit was not in the first-due area or the call was not in the responding unit's first-due area.
Diversion	Road closures or anything that caused the responding unit to reroute
HazMat	Hazardous materials caused the responding unit to be delayed.
None	
Other	i.e. – waiting for trains to clear RR crossings
Traffic	Unit response to the scene was delayed because of heavy vehicle traffic.
Vehicle Crash	Unit was involved in a vehicular crash which required the responding unit to stop while responding, therefore delaying arrival at the scene.
Vehicle Failure	Unit experienced an electrical or mechanical failure which required the responding unit to stop while responding, therefore delaying arrival at the scene.
Weather	Weather conditions were severe enough to cause a delay in arrival (i.e. snow, ice, heavy rain).

Multiple Patients at Scene
Select this box when there is more than one patient at the scene

Mass Casualty
Select this box when a Mass Casualty Incident has been declared

Suspected Disaster
Select the most appropriate reason when a MCI or disaster is declared:

Biological Agent	Biological agents were released causing the disaster/MCI
Building Failure	Building collapse with numerous patients
Chemical Agent	Chemical agents were released causing the

	disaster/MCI
Explosive Device	An explosive device detonated causing the disaster/MCI
Fire	Large scale fire erupted causing the disaster/MCI
Hostage Event	Any event that involves tactical resources from a law enforcement
Nuclear Agent	Nuclear agent was released causing the disaster/MCI
Secondary Destructive Device	Planes, trains, vehicles, crane collapse
Shooting/Sniper	Mass shooting with numerous victims
Vehicular	Mass transit vehicles or numerous autos
Weather	Flooding, tornado, etc

Cardiac Arrest
This box must be completed for every incident.

Pickup Location Page

Pickup Facility
This box lists the top incident locations responded to by the Department. Selecting an entry will complete the address fields and location type for the pickup facility.

Pickup Location

C-Clinic	Urgent care centers and employee/student health centers
D- Diagnostic/Therapeutic Center	Radiology center, surgical center
E-Nursing Home	Nursing facilities where the patients are residents and dependent on staff for daily care. Ex. Magnolia Gardens, Saint Thomas Moore
G-Hospital Base Dialysis	**DO NOT USE**
H-Hospital	
I-Site of Transfer	**DO NOT USE**
J-Non-hospital based dialysis	
N- Skilled Nursing Facility	**DO NOT USE**
O-Other	
P-Physician's Office	
R-Residence	Apartment, house or assisted living facilities, group homes, non-skilled facilities, etc.
S-Scene of Accident	
X-Intermediate Stop	**DO NOT USE**

Location Type
Select the type of location where the unit was dispatched.

Street Number, Street Name, Zip Code
This is the location the unit was dispatched (or corrected location if applicable). A street number is required. In the event the call occurred at an intersection, highway or interstate please insert the

number zero (0) in this box. Type the names of the intersecting roads or the highway/interstate name and indicate the mile marker. (i.e. Annapolis Rd/ 68th Ave or Interstate 95 at 42 mm).

Scene Delay
Only one option can be selected. Select the most appropriate.

N/A	
Crowd	Crowds caused delay arriving at the patient 's side and/or transferring patient to ambulance
Directions	Directions to patient's location were inaccurate
Distance	Patients along trails, in fields, in woods, etc. where there is considerable distance to reach the patient
Diversion	Crews were diverted to another patient (festivals, mass gatherings, and nursing facilities) at the scene causing a delayed on-scene time.
Extrication >20 minutes	Extrications from vehicles, machines, or patient removal from locations other than ground level floors that cause a delay on the scene.
HAZMAT	Hazardous materials and/or decontamination caused the scene delay.
Language Barrier	Non-English speaking or hearing impaired patient(s)
None	
Other	**MUST BE EXPLAINED** in the narrative section
Safety	An unsafe environment, scene or location
Staff delay	Staff members at a school, skilled care facility, nursing facility, medical facility, etc caused a delay (i.e. paperwork not available)
Traffic	Transporting unit was unable to depart the scene in a timely manner because of vehicular traffic
Vehicle Crash	Transporting unit was involved in a property damage accident or accident with injury while at the scene.
Vehicle Failure	Transporting unit had electrical or mechanical failure that delayed departure from the scene
Weather	Heavy rains, winds, ice contributed to scene delay.

Patient Page

Last Name - Required
If the patient's last name is unknown and it cannot be obtained by any other means (SSN, driver's license, hospital database, etc), enter "Unknown" in the appropriate section.

First Name - Required
If the patient's first name is unknown and it cannot be obtained by any other means (SSN, driver's license, hospital database, etc), enter "Unknown" in the appropriate section.

DOB – Required

If the patient's DOB is unknown and it cannot be obtained by any other means (SSN, driver's license, hospital database, etc), enter 01/01/(the approximate year of birth) in the appropriate section. Check the box *Approximate DOB.*

Address – Required
If the patient's address is unknown, and it cannot be obtained by any other means (SSN, driver's license, hospital database, etc) use the pick up address.

Gender – Required
Selecting the gender will also prompt the correct gender in the Systemic →Human Body section of the ePCR.

Weight – Required
This box must be completed for all patients. The default setting is for the weight to be entered in pounds. If the provider chooses to enter the weight in kilograms, "kg" must be highlighted.

Chief Complaint Page

Chief Complaint – Required
This area is where the patient's chief complaint is listed in quotes. If the patient is unconscious please enter "none" in the space provided.

Anatomic Location – Required
The anatomic location of the patient's complaint.

Organ System – Required
In the provider's opinion, which organ system is responsible for the patient's condition?

Primary Symptom – Required
What the patient relates as their primary symptom.

Other Associated Symptoms
Primary Impression
In the provider's opinion, what is the patient's primary reason for seeking medical treatment?

Secondary Impression
In the provider's opinion, any related reason for the patient seeking medical treatment.

Onset of Event Occurred
Enter the appropriate number followed by selecting the appropriate unit (1 day, 3 hours etc)

History

List all of the patient's history utilizing the lettered tabs. If the history is unknown, please use the "unknown" button. If the patient has no history please use the "none" button. Your selections will appear in "History" box on right side of the screen.

Write In
Space used to write or type in any patient history that is not listed in the system. Click the "add" button to add entry into the report.

Patient's Physician
Space used to write or type in the patient's physicians. Multiple entries are possible by using the enter key following each entry.

History Provided By
Document how the provider obtained the history for the patient.

Medications

List all of the patient's medications utilizing the lettered tabs. If the medications are not known or you are unable to obtain them, please use the "unknown" button. If the patient takes no medications please use the "none" button. Your selections will appear in "History" box on right side of the screen.

Medication dosage and route information can be added to each medication by using the "Add/Edit Dosage" button.

Medications can be deleted using the "delete" button on the screen.

Write In
Space used to write or type in any patient medication that is not listed in the system. Click the "add" button to add entry into the report.

Allergies

List all of the patient's allergies utilizing the lettered tabs. If the allergies are not known or you are unable to obtain them, please use the "unknown" button. If the patient has no allergies please use the "NKDA" button.

Write In
Space used to write or type in any patient allergies that are not listed in the system. Click the "add" button to add entry into the report.

Initial Assessment Page

Within Normal Limits
Selecting this button will automatically fill Glasgow Scale, Pupils, Capillary Refill, Skin Color, Skin Moisture, Skin Temperature, Breath Sounds, Mental Status and Neurological Status to those of a completely awake and alert patient with normal, dry and warm skin.

LOC

AAOxO	Patient is not awake and alert.

AAOx1	Awake & Alert to **only:** Person
AAOx2	Awake & Alert to **both** of the following: Person & Place
AAOx3	Awake & Alert to **all three** of the following: Person , Place, Time
AAOx4	Awake & Alert to **ALL** of the following: Person , Place, Time, Event

AVPU
These are listed in alphabetical order by default. Be careful when selecting a choice.

Blood Pressure
Palpated BP's must be indicated by writing a "P" in the diastolic box

Pulse Rate
The quality of the pulse rate must be documented in the box next to the numerical value. This will require the provider to physically assess the pulse and **cannot be determined** by using the pulse oximeter or cardiac monitor.

Respiratory Rate
The quality of the respirations must be documented in the box next to the numerical value. This will require the provider to physically observe the patient's respirations.

SpO2
Pulse oximetry value either on RA (room air) or O2 (with oxygen).

ETCO2
This field is for ALS only.

Glucose
Enter exactly what is displayed on the Glucometer screen.

Glasgow Eye, Glasgow Verbal, Glasgow Motor
Self-explanatory

Pulses
Select the location where the pulse was obtained.

Pupils
Choose the correct assessment of the left pupil in the left box and the right pupil in the right box

Artificial	The patient has an artificial eye
Blind	The patient has pre-existing blindness in the eye
Constricted	Pupils are found in this state but react
Dilated	Pupils are found in this state but react
Fixed, Dilated	Pupils are found in this state but do not react
Missing	This can be pre-existing or as a result of injury

PERRL	Pupils Equal, Round, Reactive to Light
See Notes	For findings other than above or if the patient's eyes have dressings applied. Document the findings in the narrative section.

Capillary Refill
Select the appropriate response

Skin Color

Cyanotic	Self-explanatory
Flush	Self-explanatory
Jaundiced	Yellowish discoloration of skin and whites of the eye
Lividity	Discoloration, as of dependent parts, by gravitation of blood in the **pulseless** patient.
Mottled	Areas of irregular skin coloring specifically due to blood vessel changes in the skin which cause a patchy appearance in patients **with a pulse**.
Normal	Pink
Pale	Self-explanatory
Red	Self-explanatory
See Note	Document in the narrative section

Skin Moisture
Self-explanatory

Skin Temperature
Self-explanatory

Breath Sounds
Assessment of the right upper lobe, right lower lobe, left upper lobe, and left lower lobe can be documented.

Mental Status
This section coincides with the LOC section of this page. Please select one of the following:

Combative	Not obeying commands and hostile in nature
Confused	Disoriented to person, place, time or events
Hallucinations	Perceptions in an awake state in the absence of external stimuli
Normal	Alert and Oriented X 4
Not done	
Oriented – Person	This response applies to AAOx1 in LOC section
Oriented – Place	This response applies to AAOx1 in LOC section
Oriented - Time	This response applies to AAOx1 in LOC section
Unresponsive	This response applies to AAOx0 in LOC section

Neurological Status

Abnormal Gait	Abnormal walking pattern
Facial Droop	Self-explanatory
Normal	Self-explanatory
Not Done	Self-explanatory
Seizures	Self-explanatory
Speech Normal	If a first responder unit claimed a patient had slurred speech upon their assessment and the reporting unit finds normal speech, this is the appropriate selection.
Speech Slurring	Self-explanatory
Tremors	Self-explanatory
Weakness- Right Sided	Self-explanatory
Weakness – Left Sided	Self-explanatory

Possible Injury
Mark the box if the medical patient may have a possible injury in addition to the medical event.

An ALS assessment was performed and warranted
An **ALS** assessment was performed **and** warranted by an ALS provider. If the ALS provider arrived on scene prior to other units and performed BLS skills and assessment, this box should not be marked. When in doubt, ask the ALS provider.

Protective Equipment Used
Select which equipment was used by the primary provider during delivery of care to the patient. More than one may be selected.

Systemic Page

Within Normal Limits
Selecting this button will automatically fill each of the specific body systems boxes with normal. If this is selected, please be certain to change the specific system that was abnormal. If a system was not assessed, be certain to mark “Not Done” in the appropriate box.

Head/Face Assessment
Self-explanatory

Neck Assessment

JVD	Jugular venous distension
Normal	
Not Done	
Stridor	A harsh, high pitched, crowing inspiratory sound
SubQ Air	Subcutaneous air – Air beneath the skin
Tracheal Dev	Tracheal deviation (Note side of deviation in

	narrative)

Heart Assessment
ALS provider optional assessment

Abdominal Assessment
Self-explanatory

GU Assessment
Self-explanatory

Back Cervical Assessment/Back Thoracic Assessment/Back Lumbar-Sacral Assessment
Assessment of the regions of the spine

Normal	Self-explanatory
Not Done	Self-explanatory
Pain to ROM	Pain in the area with movement of neck
Tender para-spinous	Tenderness to areas next to the spine
Tender spinous process	Tenderness to the vertebra

Extremities Assessments
Only one option can be selected. Chose the most appropriate selection and document the others in the narrative.

Write in Assessment Tab (Systemic Page)

The write in assessment tab allows the provider to enter additional information related to that body area.

Human Body Tab (Systemic Page)

The male or female body will appear based on the selection of the gender on the "Patient" page. Providers are encouraged to use the diagram to indicate areas of injury, burns, etc that are found on the actual patient during examination**. Any drawings rendered that are not erased prior to the submission of the ePCR will become part of the permanent record.**

Events Page

Times: Received, Dispatched, En route, On Location, Patient Contact, Departed Location, Arrived Destination, Clear Hospital, In service (All times must contain 4 digits ie. 0934)
Self-explanatory

The below options can be entered as many times as needed to reflect the dynamic changes of patient care.

Medication
Select this page any time medications (BLS and/or ALS) were administered.

- **Date-** Self-explanatory
- **Time -** Self-explanatory
- **Performed By -** Self-explanatory
- **Description** – Used to document reason for the medication, reason(s) the entire dose was not administered, a description of any complications or reactions to the meds. Etc
- **Dosage** – Numerical value only
- **Units** – Self explanatory
- **Route** - Self explanatory
- **Order** – Self Explanatory
- **Authorizing Physician** – Only needed if medication was ordered or approved by a physician
- **Response** - This is the patient's response to the medication administered
- **Complication –** Any complication the patient may have experienced as a result of the medication administered. Select "none" if there were no complications.

O2

Select this page any time oxygen was administered. BLS providers will document only the delivery device and amount administered. If a provider changed the delivery device, then a new event must be documented with the appropriate changes.. ALS providers do not need to replicate documentation of the oxygen administration but should provide a note in the narrative that oxygen therapy was continued. If the ALS provider upgraded or downgraded the oxygen delivery device or flow, they must complete a new event.

- **Date-** Self-explanatory
- **Time -** Self-explanatory
- **Performed By -** Self-explanatory
- **Description** – Used to document the reason oxygen was not administered or reason the protocol was not followed (i.e. A priority 1 patient with constant vomiting could not tolerate a NRB but a NC was used).
- **LPM** – Numerical value only
- **Route** - Self-explanatory
- **Order** – Self Explanatory
- **Authorizing Physician** – Only needed if a physician ordered oxygen administration
- **Response** - This is the patient's response to the oxygen administered
- **Complication –** Any complication the patient may have experienced as a result of the oxygen. Select "none" if there were no complications.

IV/IO

- **Date-** Self-explanatory
- **Time -** Self-explanatory
- **Performed By -** Self-explanatory
- **Description** – Used to document the reason an IV was not administered, a description of any complications or infiltrations, any IV's established prior to arrival, etc.
- **Success** – Mark only if IV was successful
- **Site** – Self-explanatory
- **Size** – Self-explanatory
- **Set** – Self-explanatory

- **Fluid**- Self-explanatory
- **Rate** – Self-explanatory
- **Total Volume Infused-** Numerical value only
- **Response-** Self-explanatory
- **Complication-** Self-explanatory
- **Authorization-** Self-explanatory
- **Authorizing Physician-** Self-explanatory

Vitals
This page is for the vital signs other than those documented on the Initial Assessment page

- **Date-** Self-explanatory
- **Time -** Self-explanatory
- **Performed By -** Self-explanatory
- **Description** – Used to document the reason vital signs were not performed, orthostatic findings, or any description not found elsewhere on this page
- **Blood Pressure** – Numerical value only for Systolic Blood Pressure. A "P" can be used for palpated BP's and inserted in the Diasystolic Blood Pressure box.
- **Pulse rate –** Numerical value only. Select the quality of the pulse
- **Respiratory Rate -** Numerical value only. Select the quality of the respirations
- **SpO2 -** Pulse oximetry value either on RA (room air) or O2 (with oxygen).
- **ETCO2 -** This field is for ALS only.
- Temperature – Optional field. Numerical Value only (Fahrenheit)

Adding a new event

The provider can add a new event not listed on the "hot" button tabs at the top by either using the "New" button located at the bottom of the events screen or hitting any one of the "hot" buttons at the top of the events screen.

Each of the above tabs on the Events page has a drop down list that appears on the left side of the screen. Any of the listed events in the drop down list can be accessed by selecting Medication, O2, IV, EKG, or Vitals Tabs. Once the event is selected, a new page will appear with the following information:

(Name of the Event)
- **Date-** Self-explanatory
- **Time -** Self-explanatory
- **Performed By -** Self-explanatory
- **Description** – Used to document the reason for the event selected, reasons, pertinent negatives, and any supporting documentation needed if applicable.

End – This button takes the provider to the bottom of the chronological log.

Resort – This button places the events in chronological order. The provider can use this to sort the chronological log after all events are entered.

Cardiac Arrest Page

This page will only appear if cardiac arrest was indicated on the Incident Page.

Arrest Witnessed By
Self explanatory.

Resuscitation Attempted
This pertains to EMS only.
Select all that apply.

Arrest Rhythm (this is the initial rhythm)

N/A	Select if no AED or ALS Monitoring device was applied to the patient
Asystole	ALS selection only
Other	ALS selection only. Provide information in the narrative.
PEA	ALS selection only
Unknown AED Non-Shockable Rhythm	Select if the AED did not deliver a shock on the initial rhythm analysis
Unknown AED Shockable Rhythm	Select if the AED did deliver a shock on the initial rhythm analysis
Ventricular Fibrillation	ALS selection only
Ventricular Tachycardia	ALS selection only

Etiology

N/A	
Drowning	Self explanatory
Electrocution	Self explanatory
Other	Known drug overdose, anaphylaxis, and GI bleed. Provide information in narrative.
Presumed Cardiac	Known chest pain/discomfort or cardiac event prior to cardiac arrest
Respiratory	Known respiratory issues (CHF, choking, etc) or respiratory arrest prior to cardiac arrest
Trauma	Trauma, GSW, hangings, stabbings, etc

Spontaneous Circulation

No	Patient never regained pulses
Yes, prior to ED arrival only	Patient regained pulses but was pulseless upon arrival at ED
Yes, prior to ED arrival and at the ED	Patient regained pulses before arrival at ED **and** pulses present upon arrival at ED

Time CPR Discontinued
Record the time that **EMS** discontinued CPR in the field (providers arrived to find lay person providing CPR to a patient with obvious signs of death, an order was received to discontinue in the field, a valid DNR was presented, or the patient had a return of spontaneous circulation).

Reason CPR Discontinued
Select the most appropriate choice.

Down Time before EMS Arrival
Select the most appropriate choice.

Crash Page

This page will only appear if "Traffic Accident/MVA" was selected as "Dispatched As" or "Found To Be" on the Incident Page.

All applicable boxes regarding the crash type must be answered.

Car Picture Tab (Crash Page)

A bird's eye drawing of a passenger vehicle will be displayed. Providers are encouraged to use the diagram to indicate areas of damage and location of patients. Any drawings rendered that are not erased prior to the submission of the ePCR will become part of the permanent record.

Fire Page

Mark the box if a smoke detector was working and present at the location
This should be performed when adequate personnel are present to perform a courtesy check of the residential smoke detectors. Common sense should be used when choosing to test the smoke detector. If a smoke detector is found to be inoperable, the homeowner shall be assisted or educated on changing batteries. Coordination with the first due fire station should be made to assist with installation of a new detector for the resident.

Trauma Page

When the **Possible Injury** check box is selected on the Initial Assessment page, the Trauma page is added to the page selection list

All applicable boxes regarding the trauma type must be answered**.**

Cause of Injury- Self-explanatory
Injury Intent- Self-explanatory
Injury Mechanism- Self-explanatory

Fall Height – Numerical value only
Trauma Injury 1 Type/Body System – Choose the most appropriate type of injury and then select the area. The primary injury should be recorded in this box.
Trauma Injury 2 Type/Body System – If applicable, choose the most appropriate type of injury and then select the area. The secondary or next most serious injury should be recorded in this box.
Trauma Injury 3 Type/Body System – If applicable, choose the most appropriate type of injury and then select the area. The third most serious injury should be recorded in this box.
Trauma Injury 4 Type/Body System - If applicable, choose the most appropriate type of injury and then select the area. The fourth most serious injury should be recorded in this box.

Destination Location

Destination Facility - Self-explanatory

Destination Location

C-Clinic	Urgent care center and employee/student health center
D- Diagnostic/Therapeutic Center	Radiology center, surgical center
E-Nursing Home	DO NOT USE
G-Hospital Base Dialysis	Patient was taken to an hospital based dialysis unit
H-Hospital	
I-Site of Transfer	Landing Zone
J-Non-hospital based dialysis	DO NOT USE
N- Skilled Nursing Facility	DO NOT USE
O-Other	MUST BE EXPLAINED in the narrative section
P-Physician's Office	
R-Residence	
S-Scene of Accident	DO NOT USE
X-Intermediate Stop	DO NOT USE

Location Type – Self-explanatory

Street Number, Street Name, Zip Code, City, State, Zip- Self-explanatory. Once destination facility is selected, the above listed sections should be auto populated.

Zip Code is a mandatory field, if the Zip Code is unknown use "00000" to indicate an unknown zip code.

Transport Type

N/A	**Do not use**
Init L&S, Downgrade	Initially lights and sirens were used while responding to the facility but the unit was downgraded to continue to the facility non-emergency (without lights and siren).
Init No L&S, Upgrade	Initially no lights and sirens were used while responding to the facility but the unit was upgraded to continue to the facility in an emergency mode (with lights and sirens).
Lights & Sirens	Emergency response to the facility
No Lights & Sirens	Self-explanatory

Loaded Transport Mileage
BLS units and ALS ambulances must enter the odometer readings from the scene to the destination facility by tapping on the odometer readings button. This will open a screen where they can enter the

starting and ending odometer readings, to calculate the loaded transport miles. **Drivers are responsible for recording the mileage.**

Destination Reason– Self-explanatory

Transport Delay
This is the cause of transport delay to the receiving facility once transport begins.

Turn-Around Delay
Anytime a unit is out of service at the receiving facility for ≥30 minutes

N/A	
Clean-up	Prolonged clean up of unit or personnel
Decontamination	Providers or equipment required decontamination
Documentation	Self-explanatory
ED Overcrowding	Crew had to remain in ED with a patient on the stretcher due to no available beds. Any time ≥ 30 minutes.
Equipment Failure	Self-explanatory
Equipment Replenishment	ALS providers needed to go to pharmacy
None	Self-explanatory
Other	Document in narrative section.
Staff Delay	Nurse or physician at hospital requests crew to remain for use of equipment, discussion, etc.
Vehicle Failure	Self-explanatory

Number of Patients- The total number of patients transported by the reporting unit. Enter a numerical value only.

Destination Assessment

This page must be completed when patient care is transferred to the destination facility. This also includes transfer of care to aviation.

Within Normal Limits
See Initial Assessment section of this manual for explanation.

ALL FIELDS MUST BE COMPLETED WITH THE EXCEPTION OF THE BELOW LIST:

ETCO2
ALS only - Must be completed for all intubated patients.

Glucose
Must be completed if the patient was treated for hypoglycemia or hyperglycemia or if the patient's mental status changed during transport.

Arrival Condition
Self explanatory

Compliance

Select the most appropriate reason the ambulance was needed. Choose only one.

Sketch Pad

The sketch pad tool is an aide to documentation. It can be used to draw diagrams of the incident if needed. These may include location of a patient that was struck and thrown from a car, homicide/suicide patient's location in a room in relation to furniture or where a gun was found in relation to the patient, multiple vehicle MVC's, etc.

Any drawings rendered that are not erased prior to the submission of the ePCR will become part of the permanent record.

Narrative

Spell Check
This tab should be used once the narrative has been completed to assist the provider with correct spelling.

Narrative Assistance
The narrative assistance feature is an optional tool to assist the provider with documenting assessments and findings. This tool will not provide detailed descriptions nor will it provide treatments rendered. Therefore, each provider will more than likely have to provide their own input into the narrative.

Insurance

This is typically not for field providers. If the provider has access to this information from documentation received at the pick up facility, then the provider should complete as much of this screen as possible.

Signatures

The Toughbook tablets Signatures page will be used in lieu of paper forms for patient refusals, cardiac arrest forms, and HIPAA/Billing.

HIPPA/Billing - EMS providers must obtain a patient signature for this form by selecting the tab ***Hippa Billing Form***. The patient or patient representative must sign in the Signature box, the EMS provider signs if the patient is unable or refuses. Below the signature box the appropriate selection of who signed must be chosen. If an EMS provider or a patient representative signs for the patient, then additional

responses for why the patient did not sign must be completed. If the patient is transported to a hospital, then a receiving facility staff signature must be obtained.

Refusal of Care – If the patient refuses treatment and/or transport, the EMS provider will obtain a signature on the ***Refusal of Care*** tab. The EMS provider will complete all the pertinent blanks and checkboxes and have the patient sign the form. The EMS provider writes refusal in the Signature box and selects patient in the Signed By area.

Maryland Cardiac Arrest Form – If the EMS Providers respond on an incident where a cardiac arrest occurs then the Maryland Cardiac Arrest Form is completed. The EMS providers will complete this form by selecting the tab ***Cardiac Arrest Form Page 1*** and fill in all the appropriate blanks. Then the tab ***Cardiac Arrest Form Page 2*** is selected and the remainder of the form is completed. This is done in addition to any other form that is required.

Patients transported by another unit will require that the Signature box contain the entry ***Patient transported by xxxx*** (xxxx is the unit which transported the patient, i.e. MD812, A826, or Trooper 2) on the non-transporting unit's report. The EMS Provider will select EMS Personnel in the Signed by area and select Patient Care Transferred in the Reasons Unable to Sign area.

GPS Readings

Do not use.

Final

This page will prompt the provider to correct errors and heed warnings. Each item listed is a hyperlink and will automatically redirect to the page which the error or warning is located.

The boxes below represent the many different forms or information that needs to be included with the ePCR but are in paper form. These items will be scanned into the system by the vendor. Therefore, a barcode label must be applied to the information. In the box below each choice, the numbers on the bar code label that was applied to the sheet must be entered so it can be linked to the correct patient ePCR. If more than one form is submitted, all forms shall be attached together using a **paperclip** and **only one** barcode label will need to be applied to the **top sheet.** Each additional sheet must include the date and incident number. This should preferably be written in the top right corner to ensure any loose papers will be attached to the appropriate ePCR. Refer to General Order 03-15 Electronic Patient Care Report (ePCR) regarding where to send the forms.

Signature card #	n/a
EKG	ECG's, Code Summaries (AED & ALS), Facility ECG's (if ALS provider feels this is needed to support documentation).
Other Documentation	DNR orders or when two or more different forms are submitted (Face sheet and DNR).
Physician Certification	n/a
Face Sheet	From facilities such as skilled care, nursing homes, med clinics, urgent care , etc that contain patient demographics and billing information

Narcotic/Hypnotic	PGFD Controlled Substance Form – top copy

Emergency Department Disposition
This information is not applicable to Prince George's County.

Hospital Disposition
This information is not applicable to Prince George's County.

Draft

This is a draft of the final ePCR and shall be reviewed for accuracy before submission.