

How To Write A PCR:

Mahopac VFD 10-001 3950 3914 18-7-1, 18-7-2

MMDDYY	RUN NO	5-2095095	AGENCY	VEH ID
AGENCY NAME			MILEAGE	
DISPATCH INFORMATION			LOCATION CODE	CALL REC'D
CALL LOCATION			ENROUTE	AT SCENE
FIRST NAME			FROM SCENE	AT DESTINATION
LAST NAME			IN SERVICE	IN QUARTERS
ADDRESS			<input type="radio"/> Residence <input type="radio"/> Health <input type="radio"/> Farm <input type="radio"/> Industrial <input type="radio"/> Other Work <input type="radio"/> Recreational <input type="radio"/> Road <input type="radio"/> Other	
APPT/UNIT NUMBER			Call Received as <input type="radio"/> EMERGENCY <input type="radio"/> NON EMERGENCY <input type="radio"/> STANDBY	
CITY			We respond emergency or standby	
AGE			For an RMA, remember that "at destination" should be "N/A" Remember to add your "in quarters" time	
D.O.B. MM/DD/YYYY				

Obtain as much patient information as possible. If you are unable to obtain information from the patient, try to get information from the patient's family or friends. Remember, the patient's full name, address, and DOB can be found on their driver's license. For any information that you cannot obtain, put 0's in the places (ex: SSN=000-00-0000)

Remember that PIAA's are always in the "road"

If the patient has no doctor, write "none"
 If the patient doesn't know their doctor's name, try to include the group that they are associated with, or write "unknown"

Use your times from Putnam 911 to estimate extrication time if you do not have the exact time extrication was started

The fall is measured by the distance from the top of the patient's head to the ground. If a 5' pt falls off a 3' chair, its an 8' fall

Physician	CARE IN PROGRESS ON ARRIVAL:
MECHANISM OF INJURY	<input type="radio"/> None <input type="radio"/> Citizen <input type="radio"/> PD/FD/Other First Responder <input type="radio"/> Other EMS <input type="radio"/> PAD used
<input type="radio"/> MVA (✓ seat belt used -->) <input type="radio"/> Struck by vehicle	<input type="radio"/> Extrication required _____ minutes <input type="radio"/> Seat belt used? Yes No Unknown <input type="radio"/> Seat Belt Used Reported By Crew Police Other
<input type="radio"/> Fall of _____ feet <input type="radio"/> Unarmed assault	
<input type="radio"/> GSW <input type="radio"/> Knife <input type="radio"/> Machinery	
CHIEF COMPLAINT	SUBJECTIVE ASSESSMENT

This is exactly what the pt says is wrong. EX: "My back hurts." If the patient is non verbal, write "none voiced" and explain what is going on in your subjective/objective

State how the patient was found (sitting, laying, walking) and who they were in care of (family, CPD, PCM4, Fire, etc). State what the patient is complaining of, and the events leading up to why 911 was called (s/p car accident, fall, fight, etc). End this section by documenting the patient's A&Ox. If the pt is altered document what the family says is their baseline. If the patient is young and acting normally, write that the patient is "A&O age appropriate."

Your presenting problem is the problem that you see the patient is experiencing. Do not document what the call was originally for, because often they are not the same thing. Remember that you must document what may be a potential problem for the patient as well (due to MOI)- for example, a pt in a car accident would have "head injury" and "spinal injury" even if they may not be complaining of pain at the time. Remember that there is no limit on how many problems your patient may have, so cover yourself and mark everything that applies!

PRESENTING PROBLEM		ALLERGIC REACTION		UNCONSCIOUS/UNRESP.		SHOCK		MAJOR TRAUMA		OB/GYN							
<input type="checkbox"/> Airway Obstruction <input type="checkbox"/> Respiratory Arrest <input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Cardiac Related (Potential) <input type="checkbox"/> Cardiac Arrest		<input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Syncope <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> General Illness/Malaise <input type="checkbox"/> Gastro-Intestinal Distress <input type="checkbox"/> Diabetic Related (Potential) <input type="checkbox"/> Pain		<input type="checkbox"/> Unconscious/Unresp. <input type="checkbox"/> Seizure <input type="checkbox"/> Behavioral Disorder <input type="checkbox"/> Substance Abuse (Potential) <input type="checkbox"/> Poisoning (Accidental)		<input type="checkbox"/> Shock <input type="checkbox"/> Head Injury <input type="checkbox"/> Spinal Injury <input type="checkbox"/> Fracture/Dislocation <input type="checkbox"/> Amputation		<input type="checkbox"/> Major Trauma <input type="checkbox"/> Trauma-Penetrating <input type="checkbox"/> Soft Tissue Injury <input type="checkbox"/> Bleeding/Hemorrhage		<input type="checkbox"/> OB/GYN Burns <input type="checkbox"/> Environmental <input type="checkbox"/> Heat <input type="checkbox"/> Cold <input type="checkbox"/> Hazardous Materials <input type="checkbox"/> Obvious Death							
<input type="checkbox"/> None <input type="checkbox"/> Allergy to <input type="checkbox"/> Hypertension <input type="checkbox"/> Seizures <input type="checkbox"/> COPD <input type="checkbox"/> Other (List)		<input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Cardiac <input type="checkbox"/> Asthma		<input type="checkbox"/> Other (List)		<input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresp.		<input type="checkbox"/> Normal <input type="checkbox"/> Dilated <input type="checkbox"/> Constricted <input type="checkbox"/> Sluggish <input type="checkbox"/> No-Reaction		<input type="checkbox"/> Unremarkable <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced							
PAST MEDICAL HISTORY <input type="checkbox"/> None <input type="checkbox"/> Allergy to <input type="checkbox"/> Hypertension <input type="checkbox"/> Seizures <input type="checkbox"/> COPD <input type="checkbox"/> Other (List)		VITALS TIME: [] [] [] [] [] [] RESP: Rate: [] [] [] [] <input type="checkbox"/> Regular <input type="checkbox"/> Shallow <input type="checkbox"/> Labored		PULSE: Rate: [] [] [] [] <input type="checkbox"/> Regular <input type="checkbox"/> Irregular		B.P.: [] [] [] [] [] []		LEVEL OF CONSCIOUSNESS: [] [] [] [] [] [] <input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresp.		GCS: R [] [] [] [] [] [] <input type="checkbox"/> Normal <input type="checkbox"/> Dilated <input type="checkbox"/> Constricted <input type="checkbox"/> Sluggish <input type="checkbox"/> No-Reaction		PUPILS: L [] [] [] [] [] [] <input type="checkbox"/> Unremarkable <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced		SKIN: [] [] [] [] [] [] <input type="checkbox"/> Unremarkable <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced		STATUS: [] [] [] [] [] [] <input type="checkbox"/> C <input type="checkbox"/> U <input type="checkbox"/> P <input type="checkbox"/> S	
Current Medications (List)																	

If the patient has no allergies, document "NKDA" (no known or diagnosed allergies). For patients with a large medical history, it may be easier to use a blank sheet of paper to write down their meds and history and attach it to the PCR

Ensure that you document AT LEAST 2 SETS OF VITALS! Be sure to include the times that the vitals were taken. Remember that trauma patients need VS every 5 minutes, and stable patients need vitals every 10 minutes. For your GCS be sure to write each number, then circle the final score. For the patient's status, remember that a pt that is a DOA or cardiac arrest, the pt is considered stable because their status is not changing. For cardiac arrest, if the pt comes back, they are then considered critical.

OBJECTIVE PHYSICAL ASSESSMENT

COMMENTS

Document all that applies to your patient:

- A&O x 1,2, or 3
- +/- ABC
- +/- JVD
- +/- TD
- +/- SOB (if + what provoked it)
- +/- LOC (if + how long)
- +/- PEARL (if not, describe pupils)
- HEENT = normal, abnormal, etc
- +/- PMSx4 (describe abnormalities)
- +/- Pain (if + use scale and state location)
- Abdo (soft, rigid, tender, non tender, pain)
- L/S (uni/bilateral, clear, ronchi, rales, etc)
- Extremities (deformities, abnormalities)
- DCAPBTLS (location and extent of injury)

Medications that the patient took

Steps that the patient took to relieve problem

Treatments:

- Oxygen (rate, device)
- ASA, Glucose, Epi, Atro. (med control)
- Immobilization (PMS pre/post)
- Dressings, splints, MAST, heat/cold
- Suction, oral/nasal airways
- CPR (document start/down time)
- AED (document how many shocks)
- Baby delivered (time, county, how)

How was the patient moved to the rig?

Transport (hospital, what position, ALS/BLS)

Patient status (did it improve/get worse?)

Cross out empty space, sign last name/EMT #

TREATMENT GIVEN FILL IN CIRCLE

- Moved to ambulance on stretcher/backboard
- Moved to ambulance on stair chair
- Walked to ambulance
- Airway Cleared
- Oral / Nasal Airway
- Esophageal Obturator Airway / Esophageal Gastric Tube Airway (EOA/EGTA)
- EndoTracheal Tube (E/T) [] []
- Oxygen Administered @ [] [] L.P.M., Method _____
- Suction Used
- Artificial Ventilation Method _____
- C.P.R. in progress on arrival by: Citizen PD/FD/Other First Responder Other
- C.P.R. Started @ Time [] [] [] [] Time from Arrest Until C.P.R. [] [] [] Minutes
- EKG Monitored (Attach Tracing) [Rhythm(s)] _____
- Defibrillation/Cardioversion No. Times [] manual Semi-automatic

This is how many times you actually shock, NOT how many times you attempt to shock. Our department uses ONLY semi-automatic defibrillators

- Medication Administered (Use Continuation Form) [] []
- IV Established Fluid _____ Cath. Gauge [] []
- Mast Inflated @ Time _____
- Bleeding / Hemorrhage Controlled (Method Used: _____)
- Spinal Immobilization Neck and Back
- Limb Immobilized by Fixation Traction
- (Heat) or (Cold) Applied
- Vomiting Induced @ Time _____ Method _____
- Restraints Applied, Type _____
- Baby Delivered @ Time _____ In County _____
- Alive Stillborn Male Female
- Transported in Trendelenburg position
- Transported in left lateral recumbent position
- Transported with head elevated
- Other: _____

Other: use this section if the pt was transported on the backboard, with police escort, in car seat, or held by parent.

Residence	003
Treated By This Unit, Txp By Another Unit	004
Refused Medical Aid or Transport	005
Call Cancelled	006
Standby Only (no patient)	007
No Patient Found	008
Other	010
Putnam Hospital Center	392
Northern Westchester Hospital	810
Westchester Medical Center	803
Danbury Trauma Center	890

DISPOSITION (See List)		DISP. CODE	CONTINUATION FORM USED
IN CHARGE	DRIVER'S NAME	NAME	NAME
<input type="checkbox"/> EMT <input type="checkbox"/> AEMT #	<input type="checkbox"/> CFR <input type="checkbox"/> EMT <input type="checkbox"/> AEMT #	<input type="checkbox"/> CFR <input type="checkbox"/> EMT <input type="checkbox"/> AEMT #	<input type="checkbox"/> CFR <input type="checkbox"/> EMT <input type="checkbox"/> AEMT #

EMT=EMT Basic

AEMT=Paramedic (be sure to bubble this for members who are also medics-Ex: Rev, Jose, Price)
Remember that the In Charge EMT is the one who does all of the care and signs off on the PCR; you are ultimately responsible for all care provided for that patient. If there are other EMT's on the crew, they are acting as attendants and will not assume care for that patient. Be sure to fill out all EMT numbers. Remember that if this goes to court, it is assumed that the people on the PCR are the people that were in the ambulance, do not fill in names of people who just go to the scene!

General Tips:

Please write legibly. These get reviewed by our department and the state. If you do not document something (or if we are unable to read it) it never occurred. It's better to write too much than not enough. If you need more room for your narrative, please fill out a continuation form (write "see continuation form" in narrative). You must bubble in all treatments under that section as well as document it in your narrative. Lastly, remember that there are many great members in this department that are always willing to help you. If you have questions, do not be afraid to ask!!!

