Atlantic Partners EMS

General Documentation Worksheet

The following worksheet is a guide for the review of patient care reports utilizing a generalized approach. Although the worksheet does not outline every scenario and aspect of documentation, when combined with an understanding of contemporaneous practice, safety, and clarity of documentation it should offer the user a framework for the general review and documentation of EMS patient care reports.

Dispatch Information:	
Were Patient Care Report, Personnel, Response Information, and Incident Address sections completed?	☐
Was the Response Delay section completed? (If applicable, also should include details within narrative)	☐
Was EMD Information documented? (if applicable and your agency obtains EMD information)	☐

Disposition Information:	
Were Response Disposition, Destination Information, and Transport Mode sections completed?	☐
If "Additional Delays" occurred, was this completed and were further details included in the narrative?	☐
If applicable was the "Transfer of Patient Care" completed and were details included in the narrative?	☐

Demographic Information:	
Was the Demographic Information section completed?	☐
If applicable, does the report include patient guardian information?	☐

History & Assessment	
Were Patient Condition, Past Medical History, Medication, and Allergy sections completed?	☐
Was the Assessment Information section completed? (if not see narrative)	☐
Is a reassessment of the patient documented?	☐

Vital Signs:	
Was the Vital Signs section completed?	☐
Does the report have at least 2 sets of vital signs?	☐
Does the report have a set of vital signs after each intervention for which a change in the patient condition was anticipated?	☐
Are the vital sign times correct and in alignment with the patient contact time?	☐

Advanced Airway Verification (if applicable):	
If an advanced airway was placed (LMA, ETT, KING, Cricothyrotomy) was it verified and documented?	☐

Treatments/Interventions/Medications:	
Were all treatments, interventions, and medications administrations documented correctly?	☐
Are the intervention and treatment times documented correctly and within the time of patient contact?	☐
Were any difficulties or complications with the treatments or interventions appropriately documented?	☐
For intervention and treatment specific documentation checklists refer to the APEMS website	☐

Narrative:	
Does the narrative use a standardized format such as SOAP or CHART?	☐
Was the information within the narrative well organized and easy to read?	☐
Was a thorough patient assessment documented within the narrative?	☐
Does the narrative support the interventions or treatments that were administered or withheld?	☐
Does the narrative provide a thorough description of the scene and the initial patient presentation?	☐
Does the narrative include the appropriate pertinent negatives and positives for the patient's suspected condition?	☐
If there were delays or exceptions on the call, does the narrative provide supporting details?	☐

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Billing Information:	
Is the billing information complete?	☐

Signatures:	
Does the report include a patient, authorized representative, or witness signature(s)?	☐
If there is no signature, does the narrative explain why a signature was not or could not be obtained?	☐

Response Times:	
Are the response times completed and correctly documented?	☐

Cardiac Arrest Information (if applicable):	
If applicable is the Cardiac Arrest Information section completed with accurate information and times?	☐

Evaluator Review:	
Was the document easy to read, understand, and did it flow logically?	☐
Did the patient care report answer all questions regarding patient care?	☐
Were abbreviations avoided, or if used, used sparingly and correctly?	☐
Did the narrative support the care that was provided and the primary impression of the patient?	☐
Do the patient care report, patient assessment, treatments, and primary impression of the patient align and support one-another after reading the report?	☐
Does the patient care report or narrative outline exceptions, challenges, or delays that were experienced on the call?	☐
Does the report outline the transition of care to include names and levels?	☐
If applicable were vital signs, capnography, or EKGs uploaded and attached to the patient care report?	☐