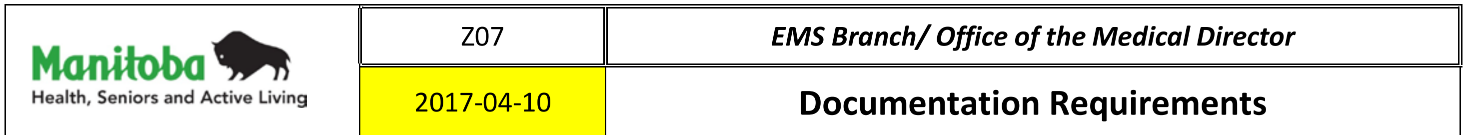

Every patient encounter requires a patient care record (PCR), even if there was no treatment given or transport rendered.

The following is the minimum information required on all PCR's:

1. Chief complaint & relevant secondary complaints.

2. Any and all information obtained from dispatch report, scene & bystander observations, and history taking, (including collateral history) relevant to the patient's presenting condition(s); supporting any diagnosis, diagnoses or differential diagnosis; and providing indication for any clinical procedure being performed or medication being administered.

3. Full head-to-toe or focused physical examination (as indicated) relevant to the patient's presenting condition(s); supporting any diagnosis, diagnoses or differential diagnosis; and providing indication for any clinical procedure being performed or medication being administered.

4. At least one complete set of vital signs, including GCS and oxygen saturation and glucometry measurements (with appropriate delegations).

5. Clinical reassessments at appropriate intervals as indicated by the patient's clinical condition, including before and after any clinical procedure or medication administration.

6. Repeat vital signs (full or partial set as indicated) at appropriate intervals as indicated by the patient's condition.

7. For any and all procedures performed:
   a. Indications & absence of contraindications
   b. How the procedure was performed including methods of verifying successful completion (eg. verification of correct ETI placement)
   c. Outcome of the procedure, including any recognized complications

8. For any and all medications administered;
   a. Indications & absence of contraindications
   b. Medication name, dose, route and time of administration
   c. Outcome of the administration, including any recognized adverse effects

9. Use of any operational procedures such as destination policies (eg. Acute Stroke Bypass).

10. Refusal of care rationale.

11. Discharge in the field rationale.

12. Any possible reportable event, including but not limited to:
    a. Clinical occurrence & critical incidents
    b. Workplace health & safety incidents
    c. Communicable disease or HAZMAT exposures
    d. Potential child or elder abuse / neglect
    e. Use of physical / mechanical restraint

13. Other relevant information as required by specific care maps (eg. evidence of open fractures)

14. Any consultation with on-call supervisor or on-line clinical support.

15. Documentation of any orders from non-EMS affiliated physicians including name.

16. Documentation of care provided by non-EMS personnel.

17. Signature and licence number of all EMS personnel involved in the patient's care.