



Community College of Aurora Student Patient Care Report Form

- 1.** Abd Adult AMS Cardiac Adult Dys Ped Dys Ger ETT IV
 Med OB Ped Psych Syncope TL Trauma Vent

Student's name 2.	Circle one I P	Date of call 3.	Precepting agency 4.	Preceptor's name 5.
Nature of call 6.	Pt. age 7.	Patient transport by 8.	Patient destination 9.	Refusal 10.
Base Contact Physician: 11.				
Narrative: SUBJECTIVE or C/C				
12.				
Objective or History				
13.				
Assessment				
14.				
Plan or Treatment and Transport				
15.				
Past medical history				
16.				
Patient Medications 17.			Allergies 18.	

Patient Care Form annotation guide

1. This section is used to mark the type of patient contacts and skills that were performed on the run being documented. Do mark a box if the skill or assessment was not performed by YOU. In your PCR you must document all patient care, whether performed by you or not, but this section is only to document what you did.

- Abd = abdominal assessment
- Adult = assessment of a patient between the ages of 18 and 64
- AMS = altered mental status. This does NOT include cardiac arrest. This would be used for anyone with a low GCS, slow to respond verbally (or not at all) such as ETOH, hypoglycemia, hypoxia, etc.
- Cardiac = cardiac assessment of a patient, regardless of their chief complaint. If you feel that their complaint of abdominal pain, for instance, may have a cardiac element, and you do a cardiac assessment, then that is appropriate. However, you MUST attach a copy of the EKG to the PCR in order to get credit for a cardiac assessment.
- Adult Dys = adult dyspnea. Anyone over the age of 17 with a complaint or component of dyspnea fits this category.
- Ped Dys = pediatric dyspnea. Anyone up to the age of 17 with a complaint or component of dyspnea fits this category.
- Ger = geriatric. Anyone above the age of 64 fits this category.
- ETT = Endotracheal tube. If YOU intubate the patient SUCCESSFULLY than mark this category.
- IV = well, IV. Again, just like ETT, YOU must perform the skill SUCCESSFULLY in order to get credit.
- Med = medication administration, regardless of the route. If you give more than one medication to the same patient, mark the box then put how many meds you gave. Oxygen does not count.
- OB = obstetric. An OB assessment does not equal an abdominal assessment. However, if suspect that your abdominal complaint patient may also be pregnant, you can mark both boxes.
- Ped = pediatric. Any patient 17 or under.
- Psyche = psychiatric. Any obvious history of a psychiatric illness or any bizarre or erratic behavior fits this category.
- Syncope = just that. Syncope does not mean unconscious. If your patient was out for more than a few seconds it wasn't syncope. Hypoglycemia, stroke, hypoxia, ETOH, etc. do not count as syncope.
- TL = team lead. This means that you were in charge of the call, at least at some point in the call. You made decisions as to patient treatment and transport, as well as logistical decisions such as additional resources and calling a trauma alert.
- Trauma = any patient with trauma from any source.
- Vent = ventilation. Every time you ventilate a patient you can check this box, as long as it is a different ventilation technique. If you bag a patient before they are intubated, then bag them via the ETT, you can get credit for two ventilations. However, if you bag the same patient through the ETT at different times during the call, you still only get credit for one vent.

2. Print your name and circle whether you are an intermediate or a paramedic student.
3. The date you were dispatched to the call. If you were dispatched before midnight but arrived on scene after midnight, the date of the call is the date you were dispatched.
4. The name of the agency you are riding with.
5. The name of your preceptor. Include their last name!
6. Give the nature of the call. This is based on what you were dispatched to, like an MVA or chest pain.
7. List the patient's age. If you don't have an exact age, estimate.
8. Who transported the patient? If the patient went by private vehicle put POV. If they weren't transported put N/A.
9. Where was the patient transported to? If they weren't transported put N/A.
10. If the patient refused transport put a check mark or 'yes' in this box.

11. If you or anyone else on the crew contacted the base station for orders list the physician who gave you the orders.
12. This is where you describe the scene and how you find the patient. For instance: “this 44-year-old female was found lying left-lateral recumbent on the living room floor, conscious and alert, but slow to respond, complaining of a severe right parietal headache.”
13. This is where you document what you are told about the patient and/or the scene by bystanders and the patient. For instance: “the patient’s husband states that he heard a loud noise from the living room while he was in the kitchen, and when he checked he found the patient lying on the floor. He also says that the patient has been c/o of a headache all day (about 6 hours).”
14. Document your focused, detailed and ongoing assessments here.
15. Document your treatment plan and transport mode here. For instance: “patient was placed in position of comfort, IV, O2 and cardiac monitor applied and analgesic administered.”
16. List the patient’s significant past medical history here. We don’t need to know that they had an appendectomy twenty years ago, but we do need to know about MIs, CVAs, relevant surgeries, etc. If the patient has none put N/A.
17. List all significant medications the patient is on. DO NOT put ‘see attached list’ unless you actually attach a list. If the patient has none put N/A.
18. List all significant food and medication allergies. If the patient has none put NKDA.
19. Put the time that the vitals were taken. It is appropriate to list vitals taken before your arrival on scene. In that case put PTA.
20. Respiratory count is the single most important vital sign there is. Make sure there is a respiratory count on all patients!
21. List the heart rate as counted on the patient, not the cardiac monitor.
22. Auscultated blood pressure is okay, as long as you list at least one diastolic blood pressure, if can get one. If you’re unable to get a BP then indicate where you found your pulse on the patient.
23. Indicate the size of the pupils in millimeters.
24. Everyone gets a GCS, including patients in cardiac arrest.
25. If the pulseox was applied, list the reading here.
26. If a blood sugar was taken, list it here.
27. Indicate your interpretation of the cardiac rhythm and attach a copy of the strip to the back of the chart. You will NOT get credit for a cardiac assessment if there is not a strip attached to the PCR.
28. For IVs you need to document the time the line was started, what size catheter was used, the location of the IV insertion (back of the hand, etc.), whether the attempt was successful or not, and the initials of the person starting the IV. If you didn’t start the IV you can put the initials of the agency that the person who did start the IV is from, like AFD or AMR.
29. List all medications that were administered to the patient, whether by you or someone else on the call. This list includes oxygen, but you do not receive medication administration credit for giving oxygen. List the dose, route of administration and time of the medication was given. If you need more space, list further meds on the back of the PCR.
30. List treatment that was administered to the patient, whether by you or someone else. For instance: pillow splint applied to left ankle.
31. Indicate how the patient responded to the treatment. For instance: patient got moderate pain relief with application of splint. Also list the time the treatment was administered and the initials of the person performing the treatment.
32. Indicate what you think was wrong with the patient. For instance: subdural hematoma, fractured tibia, or inferior MI. Things like MVA, chest pain and abdominal pain are not acceptable.
33. The Advanced Airway box should be self-explanatory. Fill in all areas that are applicable to any advanced airway maneuvers performed on the patient.
34. Use this diagram to indicate where trauma patients were injured.
35. Sign your PCR here.
36. Submit all your PCRs to your preceptor for their review and comment.