SUBJECT: 500.02 DOCUMENTATION/COMMUNICATION: MISSOURI AMBULANCE REPORTING FORM (ARF)

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Overview

Complete, thorough, accurate and legible information must be documented on all patients on the Ambulance Reporting Form (ARF). Some specific points of importance follow:

1. A Revised Trauma Score, RTS, must be completed on **ALL** patients.

2. **ALL** times must be completed.

3. All applicable fields should be completed. A set of vital signs should be documented unless refused.

4. The Run Number assigned by the hospital should be recorded on the ARF.

5. The "narrative" section should be completed on all patients, including refusals of care. Criteria in the documentation includes: age, sex of patient, chief complaint/mechanism of injury, history of the present injury or illness, significant past medical history, medications, allergies, physical examination findings with vital signs, pertinent negatives, EKG interpretation if patient monitored, SaO_2 reading if pulse oximeter applied, treatment performed in the field, response to treatment and condition en-route to the hospital.

   Mnemonics such as those listed below may be helpful in many situations:

P	provokes	S	symptoms (associated)
P	palliates	A	allergies
Q	quality	M	medication
R	region	P	past history
R	radiation	L	last oral intake/last menstrual period
S	severity	E	events leading up to
T	timing		

   Either "SOAP" (Subjective, Objective, Assessment, Plan) or "CHART" (Chief Complaint, History, Assessment, Rx - Treatment, Times) formats may be used for documentation in the narrative section. While no specific format is required, it is highly recommended that the EMT or paramedic choose one format and consistently follow it for thorough documentation.

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6. When cardiac monitoring is performed, a ten second EKG should be attached to the ARF and an appropriate sample provided to the ED Staff.

7. Any 12 lead EKG done by the crew should be provided the ED staff for review.

8. The completed ARF should be presented to the Emergency Department nurse or physician caring for the patient.

9. EMS personnel should remember that the ARF is a legal document and a permanent component of the patient's chart.

10. A report will be done on all patients including refusals, invalid assists and patients transported by other agencies. If the patient is transported by another agency, the name and license number of the medic assuming care of the patient should be documented.

11. Remember, the most common error in documentation is **OMISSION** of patient or treatment information.

IF IT IS NOT DOCUMENTED, IT WAS NOT DONE.